Submission No. 144

City of
KINGSTON

Submission to the House of Representatives Standing Committee on Ageing Inquiry into Long Term Strategies to Address the Ageing Australia Population

March 2003

Contents

Supporting Document

City of Kingston Aged Care Strategy
(copy made available to Committee members)

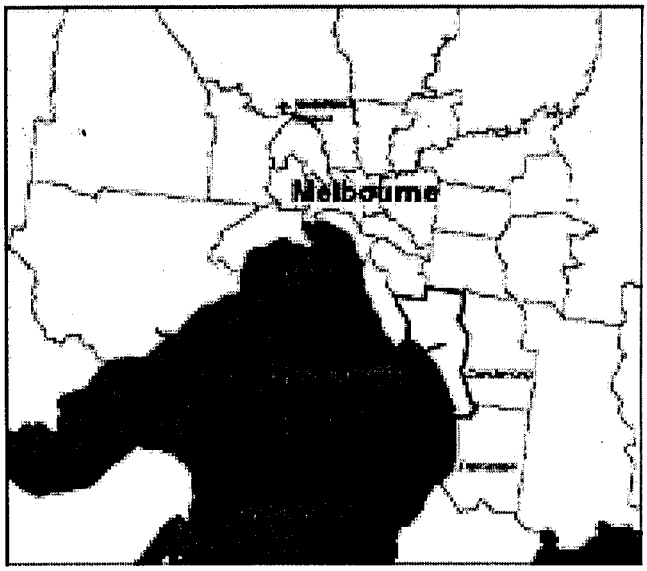
1. Introduction

Kingston Council has a strong commitment to its ageing residents as reflected in its roles as social planner, systemic advocate and service provider. Council welcomes the opportunity to make this presentation to the Inquiry.

Our submission draws from work done in developing the recently released Kingston Aged Care Strategy. The submission does not seek to duplicate the submissions made by the Municipal Association of Victoria or other local government agencies but rather to provide further illustration of some of the themes picked up in other submissions by highlighting a number of key points and via a number of case studies and examples.

2. Background

Kingston is one of the largest municipalities in Victoria with a population of 128,171 (ABS 2001 Census) and is located approximately 15 kilometres southeast of the Melbourne CBD.



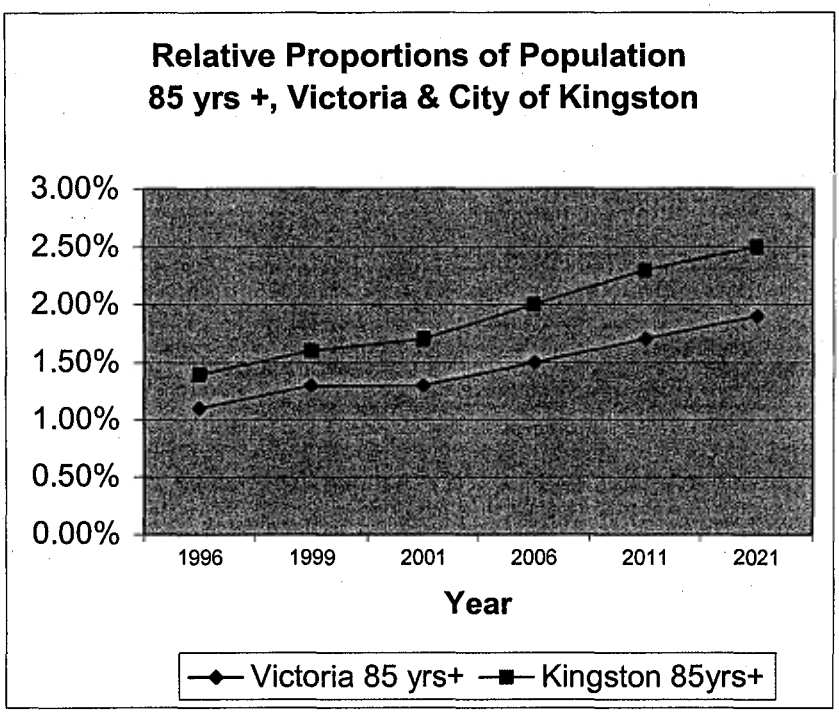
The Kingston community is diverse and multi-cultural with 28.7% of our residents born overseas. The proportion of people born overseas varies considerably from locality to locality. In the suburbs of Clarinda and Clayton South over 50% of the population were born overseas.

The table below details current and expected population changes for the older age groups between 2001 and 2016 for the Kingston LGA.

Age	2001	2006	2011	2016
70 - 79	9924	9623	9603	10705
80 - 84	2941	3545	3657	3443
85+	2222	2662	3198	3515
Totals	**15087**	**15830**	**16458**	**17663**

Source: Department of Infrastructure, Victoria in Future 1996 – 2021

The over 70 population in Kingston is expected to increase by 17% in the 15 year period between 2001 and 2016 with the over 85 cohort expected to increase by 58% in the same period. This increase is well above the Victorian state average, particularly in the over 85 age category.



3. Kingston's Aged Care Strategy

Kingston Council adopted its Aged Care Strategy in December 2002 following over 12 months of research, consultation and planning.

The development of the strategy involved:

- Consultations with a broad range of aged service providers
- Consultations with older residents, service users, local area committees
- Facilitation of planning and review forums for aged service providers
- Extensive programmatic and literature review
- Consultations with ACAS and review of ACAS program data
- Analysis of demand and supply data, present and projected
- Development and adoption of the Aged Care Strategy

To assist the Committee's analysis, comments in this submission have been kept brief and focus on the findings of the City of Kingston Aged Care Strategy developed in 2002.

A copy of the detailed Aged Care Strategy is attached in support of this submission and for further consideration of Committee Members. It covers both Community Care and Residential Aged Care. It also provides analysis of a broad range of systemic issues impacting on service delivery in Kingston.

The Aged Care Strategy highlighted a number of key themes, which inform and shape many of the specific matters to be addressed by Council over the next few years. These may be summarised as:

- Older residents of Kingston have demonstrated a strong preference for ageing in the home, and are increasingly assertive in relation to the right and need for community/home based care programs
- Older residents and their families have demonstrated a strong preference for ageing in place opportunities, but these are limited by the small scale of many of the residential aged care facilities in Kingston
- The relative frailty of the consumer profiles of both CACPs and high and low residential aged care have increased markedly in recent years
- The excess of demand relative to supply at all levels (high care, low care and CACPs is resulting in service users staying in their existing program for durations which involve levels of risk and the displacement of other valid service users waiting lists. This pressure works its ways right down through Linkages and to general HACC programs. This pattern tends to hide and compensate for the real levels of service needs in the City.
- The pressure for places at all levels tends to be reflected in the marginalisation of clients whose needs are more challenging, eg people with dementia or psycho-geriatric issues, people with cultural and linguistically diverse backgrounds, concessional residents and people who for a range of reasons are socially marginalised.
- Service viability remains a major issue for many residential providers whose longer-term future is dependent on the allocation of additional places.
- The aged and their carers report being confused by the array of programs and providers in the community care sector and find choosing, engaging and coordinating services frustrating and overwhelming
- The Council contribution to its own HACC program is currently being subsidised by the scale of the Veterans Home Care Program. The demographics suggest that demand (and hence funding) from this group will diminish in four to five years leaving Council with significant potential funding/contribution pressure
- The aged care workforce is going to be faced with key shortages in the absence of some planned strategic initiatives that reduce the dependence of an ageing female workforce.
- There is a strong need to engage volunteers in the support of older residents and for the development of a strategy to recruit and support volunteers.
- The emerging programs and funding around community capacity building present a potential opportunity for Council to take a leadership role in promoting these types of strategies, which have a strong dependence on voluntary effort.

4. Overview of Priority Action areas

The priorities for Kingston as a planner and provider of aged care services are similar to those for Victorian local government generally, which are well documented in the submission to the Inquiry provided by the Municipal Association of Victoria (MAV). The submission made by Moreland City Council also documents issues relevant to Kingston.

In summary Kingston would like to nominate the following issues as the most critical to resolve to adequately provide for the long-term future of our ageing population:

4.1 Resolving funding issues for Home and Community Care

There are many drivers contributing towards funding difficulties in Home and Community Care:

The increasing gap between the subsidies provided and costs of providing service are well documented in the MAV submission. Grant indexation simply does not recognise cost increases being experienced by Councils in:

- Enterprise bargaining agreement labour costs (increasing at average 4% per annum)
- Increased labour costs through return to Award conditions
- Additional costs of implementing accreditation and quality systems

Demand for in home care is increasing at a rapid rate. This is not just a direct function of population change as other factors such as the increasing preference to remain in the home need to be taken into account. This impacts adversely not only on the number of potential clients but also on the complexity of care needs. Failure of the community care sector to cater for this increased demand will result in long waiting lists and increased pressure on the residential care and acute sectors to take clients earlier.

Client expectations with respect to range and quality of service are ever increasing. Attempts have been made in Kingston to engage with the different ethnic communities in an equitable way. This has led to the need for a greater range of service solutions, for example in meals on wheels menus and social support initiatives.

Over the past seven or eight years local government has explored every avenue for internal efficiency savings in aged care service provision through competitive tendering, detailed system analysis and reform. This, along with new funding sources such as Department of Veterans Affairs (DVA) funding, has enabled some of the service growth in recent years to be absorbed. The limits of this absorption have now been reached in most Councils and opportunities for further efficiencies will be very limited. Service reduction and waiting lists are inevitable in most Councils. (Refer Case Study on the Impact of Increasing Demand for HACC Services in Kingston.)

Local government can no longer be relied on to fill the growing funding gap and it is expected that Councils will increasingly cap their contribution to a maximum dollar amount or a maximum percentage contribution. Councils' only avenue to increased aged care funding lies in increasing property rates. This will be locally unpopular and often unpalatable to ratepayers who will see aged care as a federal or state responsibility. Property rates have the limitation that they are not a growth-based tax and do not have any connection to population change or consumption. Future solutions to the longer-term funding of aged care will need to provide some more direct connection to a growth-based form of taxation.

4.2 Service fragmentation and complexity

The current service system is difficult to navigate, cumbersome for providers and wasteful in terms of operational efficiency. Two parallel HACC programs (HACC and DVA) operating with different assessment rules and levels of service provision is one example of this. The numerous providers of CACP service is another example of wasted administration resources. Not only do these examples provide difficulties for assessment teams and case managers but also create real continuity of care issues for clients as case managers find it necessary to play the system to stretch limited funding.

There is an urgent need for a fundamental structural review of the service system to merge programs such as HACC, DVA, CACP and other programs into a nationally consistent community care program that integrates planning, assessment, care management and service provision into one equitable system. This will not be an easy task but could commence with integrated planning between levels of government and a commitment to draw together the different blocks of funding into one stream.

4.3 Workforce Retention Issues

The recruitment of sufficient well-qualified staff is becoming an increasing challenge for providers. Carers in the HACC program and in residential care have been predominantly older women working part-time and receiving relatively low pay rates. This historically made the HACC program relatively inexpensive to provide. In recent years the higher demand for carers has led to many staff working longer hours, creating burn out and occupational health and safety risks. Councils have responded by recruiting higher numbers of carers (where they can), increasing skill training and in some cases limiting the number of hours provided to carers to avoid injury risk.

In parallel to this the higher quality standards and accreditation requirements have made the work requirements of individuals more difficult, leading to some staff choosing to leave the service.

As service demand increases further in the future the competition for quality staff will increase between employers and new approaches will need to be taken to attract staff. This will continue to put pressure on competitive pay rates and require other innovative methods of attraction. The attached Case Study on Residential Aged Care outlines one such approach taken by Kingston to retain Hostel staff.

4.4 Residential Aged Care Issues

The level of frailty of clients in both high and low residential aged care has increased markedly in recent years as places in the next higher level of care become more scarce. Clients are staying in their existing program for durations which involve levels of risk and the displacement of other potential service users on waiting lists. This in turn puts pressure on CACP, Linkages and on general HACC programs. This also leads to funding problems for the provision of quality services in hostels as illustrated in the attached Residential Aged Care Case Study.

Service viability remains a major issue for many residential providers (including Kingston Council as the operator of three aged care hostels) whose longer-term future is dependent on the allocation of additional places. The Kingston Aged Care Strategy provides some detail on the challenges faces by small providers. The major concern for Kingston in future years in that local providers will become non-viable and will either close altogether or relocate to outer-suburban areas where land is cheaper. This will result in a potential under-supply of residential beds in Kingston and a dislocation of residents out of their traditional home area. Kingston will be working with the Commonwealth and residential aged care providers to address these issues on both a policy and local level.

4.5 Commitment to Active Ageing

Kingston is committed to supporting older people to remain both physically and socially active for as long as possible. This will involve providing infrastructure and program support for independence, personal development and good health and require approaches to dealing with social isolation.

Such an approach will require:

- Increase in resources dedicated to proactive social support and community capacity building.
- Changes to urban design guidelines to cater for the aged.
- The inclusion of design features supporting aged people in buildings and other infrastructure.
- Expansion of leisure programs to include specific programs for older adults

Kingston has made a start on all of these areas and is committed to continuing to develop the range of active ageing initiatives as funds permit. Examples of existing projects include:

- *The Community Connection Program*
  This program endeavours to address the needs of the most socially isolated members of the community and connect them to mainstream programs wherever possible. The attached case study describes the program and typical client profiles.
- *Leisure Choices for Older Adults Strategy*
  - The Strategy identified barriers that prevented older adults from adopting active lifestyles which included issues of:
    - Affordability
    - Availability of appropriate activities
    - Accessibility due to personal ability and transport options
    - Deteriorating health
    - Access to information on activities and services available
    - Lack of motivation
    - Deteriorating social networks
    - Unsustainable clubs
  - To address these barriers a community development approach has been adopted. Partnerships are being established with older adult support networks, leisure providers and community health networks and agencies, to develop and deliver active participation programs that seek to ensure that older adults are:
    - Staying active and happy
    - Getting out and about
    - Being informed
    - Staying connected
- *Other Leisure Programs*
  - Fabulous 50s Program at Waves Leisure Centre, which offers fitness classes & outings for older adults
  - Council of the Ageing (COTA) endorsed exercise program is being delivered at Don Tatnell Leisure Centre
  - Activities for residents of Council's Aged Care Hostels that offer opportunities for socialisation and physical activity. This includes the development of a COTA exercise program at Don Tatnell; developing partnerships between local community groups and businesses to deliver programs in the hostels
  - Exercising a Wiser Choice – Council has received funding to run a program focusing on women over 50 who are socially isolated and may be at risk of developing gambling problems. It seeks to introduce these women to a variety of recreational opportunities to facilitate pathways for social connectedness

- *Urban Design*
  - The Chelsea/Bonbeach Urban Renewal project includes the development of urban design guidelines aimed at making neighbourhoods more "liveable" for older adults.
  - Council building redevelopments include a commitment to disabled access.

5. Case Studies

The following Case studies have been included to help illustrate how the current service system deficiencies are affecting clients and how Kingston Council is responding.

Case Study 1: Impact of increasing demand for HACC services in Kingston

This Case Study has been included to illustrate the impact of the inadequate funding for HACC services. A number of specific client impact examples have been included.

Case Study 2: Residential Aged Care

This example includes an outline of the career development strategies implemented by Kingston to address the staff retention issues at its three aged care hostels along with a series of case scenarios illustrating funding issues for hostels being required to keep high care clients longer due to the unavailability of high care beds.

Case Study 3: The Community Connection Program

This Case Study describes the Community Connection program aimed at addressing the needs of socially isolated clients and provides a case example.

A CASE STUDY 1: IMPACT OF THE INCREASING DEMAND FOR HACC SERVICES IN KINGSTON

Purpose

This case study has been developed to illustrate the dilemmas facing Kingston Council in relation to the increasing numbers of aged residents requiring in-home services. The case study will provide information about:

1. The increasing demand for HACC services being experienced
2. Concerns regarding longer term demographic trends impacting on the HACC service delivered by Kingston Council.
3. Strategy options to manage the growing demands for Home Care services in 2003/2004 and future years.

(Note: This case study does not include all services and expenditure incurred by Kingston Council in the delivery of aged services. Specifically, it excludes Meals on Wheels, Social Support, Senior Citizen Centre support and corporate overhead costs)

Background

Kingston's population is ageing at a rate that is well above the State average. This will continue over the coming decades and will therefore require a strategy that manages the demand for HACC Services. Research has demonstrated the desire for people to remain in their home for as long as they wish and are able. In accordance with people's wishes to remain at home State and Commonwealth Governments fund a range of community care services. The current levels of funding do not match the increasing demand for services or the complex care needs of those choosing to remain at home.

Information retrieved from the Home Care Service's database indicates that those remaining at home have increasingly complex care needs and require more intense levels of care than previous recipients of services. The service has maintained the allocation of additional hours to a minimum through the use of priority of access tools and tight criteria. The average increase is only 1 – 2 hours per client per year although when this is combined with the increase in client numbers it is beginning to cause a financial strain that is not sustainable.

It is worth noting that there has been no growth in the average number of hours provided per client through the domestic service. All increases relate to personal care and respite care. This demonstrates the increased complexity and level of frailty of those remaining at home combined with the lack of appropriate residential care.

There is a range of other funded programs in addition to those services provided through Council's HACC program. They include the Veterans' Home Care Program, Community Aged Care Packages and Linkages Packages. Community Aged Care Packages are funded directly via the Commonwealth and Linkages are a joint Commonwealth-State funded program. They are both aimed at people with complex care needs and requiring services at levels that are higher than would ordinarily be expected to be provided through mainstream HACC programs. Council's HACC

program pursues every opportunity to link residents who would more appropriately be serviced by other programs into these, however all programs assisting older people are experiencing a level of demand that can no longer be met. This is having an impact on Council's HACC program as, in reality, when a client requires more intense service levels and no programs are in a position to take these clients, they continue to sit in the Home Care program until a place becomes available. This can now be for a period of up to six to twelve months.

Whilst Council's HACC program has been able to absorb growth over recent years and the additional costs associated with delivering these services, such as Enterprise Agreement wage rises and a return to the full award in relation to penalty payments and increased travel reimbursements, the Home Care program is now approaching saturation point.

Population Changes

General Population

The table below details current and expected population changes until 2016 for Kingston LGA.

Age	2001	2006	2011	2016
70 - 79	9924	9623	9603	10705
80 - 84	2941	3545	3657	3443
85+	2222	2662	3198	3515
Totals	**15087**	**15830**	**16458**	**17663**

Source: Department of Infrastructure, Victoria in Future 1996 – 2021

In 2001, 15087 residents were aged over 70. Of this number 3,443 utilised the Home Care Service or 23% of the over 70 population. In 2006, it is estimated that 15,830 residents will be in the 70+ age group. If the existing ratio did not alter 3641 people or 23% could be expected to be utilising Home Care Services. It is more than probable the ratio will alter as the growth between 2001 and 2006 occurs with those aged over 80 and this group is more likely to require assistance to remain at home than those aged 70 – 79. Should the ratio increase to 30% of those over 70 utilising HACC services, then 4749 residents or 1100 additional clients to those currently receiving a service could be expected.

The following table details population changes for Kingston and neighbouring Councils.

LGA	70 -84 2001	70 - 84 2006 est	85+ 2001	85+ 2006 est	Total 70+ 2001	Total 70+ 2006 est
Kingston	**12865**	**13168**	**2222**	**2662**	**15087**	**15830**
Bayside	9902	8870	2413	2565	12315	11435
Glen Eira	13272	12162	2795	2512	16067	14674
Stonnington	7618	6984	1899	1519	9517	8503
Port Phillip	5585	5553	1283	1328	6868	6881

Source: 2001 ABS Census, 2006 DOI Projections

Other than Port Phillip, which has a slight increase in the 70+ population between 2001 and 2006, Kingston is the only LGA who will encounter a marked increase in this group.

Veteran Population

At the same time that our community is ageing the veteran population will be declining. The table below indicates the number of veterans eligible to access the Veterans' Home Care Program. It can be gauged by the data that Kingston is likely peaking, or close to peaking with residents eligible to access the Veterans' Home Care Program. Whilst many are likely to be in need of services for some years the income being generated through the Veterans' Home Care Program is not sustainable for more than another 3 - 4 years. This will place a considerable added strain on Council's HACC Services after this period.

Current Veteran Age	Number of Veterans
55 - 59	80
60 - 64	91
65 - 69	114
70 - 74	452
75 - 79	1321
80 - 84	986
85 - 89	370
90+	94

Source: Department of Veterans Affairs

The Veterans' Home Care Program is currently also enduring budgetary restrictions. This resulted in the Department of Veterans' Affairs writing to agencies in January 2003 stating as clients are reviewed, which occurs every six months, they are likely to have their service levels reduced. The Department has acknowledged that they underestimated the demand for their service and were perhaps overly generous in their allocation of hours in the first 18 months.

This client review process has commenced and the Home Care service is finding residents are contacting the office requesting they return to Council's HACC program. This concern has been raised with the Department of Veterans' Affairs and they have been made aware that there is in fact no places available for the veterans to return to as all available HACC places that were freed up by veterans transferring are being utilised. In addition the Department was made aware that based on the Departments advice, the City of Kingston transferred veterans in good faith and advised veterans they would not be disadvantaged as a result. The Department have since given an undertaking that veterans will retain the hours they **transferred** on, however no guarantees will be given for increased services as a veterans' health deteriorates.

Program Income and Expenditure

Funding

The primary source of funding is through the State Department of Human Services (DHS) HACC Program. Kingston Council has vigorously pursued funding opportunities through our own individual funding submissions and the development of partnerships with other agencies who service Kingston residents. The percentages of income sources that contribute to the HACC program at Kingston Council are detailed in Appendix A and B.

DHS altered their formula twelve months ago with the aim of distributing funds more equitably across the State. Senior Council staff along with other agencies in the Southern region advocated strongly against the proposed DHS formula, as it excluded the veteran population. DHS reasoning for this was that veterans have the ability to access another Home Care program. At the same time that this occurred the Department of Veterans' Affairs advised veterans that as Australian citizens veterans could not be excluded from making a personal choice between the Veterans' Home Care Program and HACC funded services.

DHS have very recently advised (24 March 2003), that as a result of the outcome of their Funds Allocation Review, they will now include 50% of the veteran population back into their HACC funding formula. Additionally, funding will focus for the next three years on prioritising to HACC basic Services, that is, domestic and personal care and property maintenance. Depending on the total size of the growth funds for HACC this financial year, these changes could represent some good news for Kingston Council in relation to servicing the increasing needs of the frail aged population. DHS in the Southern region receive an allocation of the available state-wide funds. They then have responsibility to share the available funds as equitably as possible across the Southern Region. However, it should be noted that Mornington Peninsula and Greater Dandenong are significantly under resourced compared to other LGA's and are likely to receive a greater proportion of the funding.

The 2002/2003 DHS growth funds provided dollars for innovative services, but did not support HACC basic services to the extent that was required to meet demand this year. Hopefully, the outcomes of the DHS funds allocation review will reverse this trend.

Council's contribution to the Home Care program has remained almost constant for three years. This has mainly resulted from efficiencies made and the income that has been generated through the Veterans' Home Care program. The Home Care service encouraged and transferred almost 95% of eligible veterans to the Veterans' Home Care program. Over the last two years the Home Care program has increased service levels to residents, employed additional office staff to meet those increased service levels, absorbed all EBA increases, met the increased public sector rates for work related travel and returned to award penalty rates for Home Care staff with no additional funding from Council.

The service is now at saturation point and cannot absorb any increases in either staff remuneration or service levels.

Rationale for Strategies

A strategy needs to be implemented due to service demand as a result of the following:

- The ageing population
- The decreasing veteran population and budgetary restrictions associated with this program
- The desire for people to remain at home for as long as possible and an increasing expectation services will be delivered in the home
- The increased staff remuneration costs for a workforce that is very labour intensive
- The associated increased travel costs which increase as service levels increase
- The increasing frailty of clients necessitating more intense and complex levels of care
- The waiting lists for clients requiring Community Aged Care or Linkages Packages
- The limited opportunities for Council to increase fees and charges.

Currently, Council is budgeted to contribute approximately 15% of funding for the Home Care program, including Home Maintenance services. However, due to the increased client demand, it is likely that Council will contribute close to 17% of funding this financial year. The projection for next financial year is that Council may need to contribute between 24 and 28% of funding due to increases in Salary costs linked to Enterprise Bargaining Agreement pay rises, continuation of servicing current clients of this service and catering for some new clients to enter the service.

The implications of remaining at a the current 15% contribution for Council would be that:

- Some existing clients would need to be taken off the service indefinitely. Only those clients who have a high level of need would remain on the service, and they would receive only basic levels of domestic and personal care. Clients with low-level care needs would not be able to access services, unless their level of need increased.
- Waiting lists for all Home Care services, including personal care would need to be implemented immediately.
- Prospective clients would be likely to have a very long wait for service, as only very high priority clients would get access to services. Prospective clients with low level needs would be unlikely to gain access to services at all.
- The 'prevention' benefits of Home Care would be minimised, as potential clients with lower needs will be unlikely to access the service. Research clearly shows that even minimal assistance enables frail aged people to stay home longer and avoid 'crises' which can trigger either hospital or residential admission.

Options that will need to be considered by Council

The following short-term and longer-term options will be amongst those to be considered by Council over the coming months as we seek to balance the current year's budget and set a sustainable budget for future years:

Short-Term Options

- Cancelling domestic assistance between Easter Monday and Anzac Day.

  Whilst this will not save payment to carers as they will take annual leave it will save travel costs for this week and backfill staffing costs.

- Introducing a fee for client related travel.

  The service has a large allocation for the payment of kilometres, which is approaching a quarter of a million dollars. A considerable amount of this expenditure cannot be avoided, as it is payment for home care staff travelling between jobs. The remainder is payment to home carers when they accompany clients shopping or shop on behalf of clients; take clients on outings or to medical appointments. Clients are currently not charged for these kilometres. The Social Support Program has a volunteer transport service and clients are charged $0.60 per kilometre. The Community Bus takes clients on scheduled shopping trips or outings and a payment is made. The Home Care service is the only Council Aged and Disability service not charging clients for related travel costs. If clients were not accessing the service and either catching public transport or driving to the shops they bear a cost

related to this. It is an option to introduce a fee of an average $0.65 per km for all client related travel.

- Introduce a trigger point to refer clients to higher need programs.

  All new clients to receive a maximum of 6 hours service a week only, in line with MAV recommendations. MAV recommend that Council HACC providers clearly articulate that in the aged care industry, they only provide for low-level client needs. Once client's needs rise to receiving 4 hours of total service a week, this will form a trigger to refer these clients to services that cater for higher needs, such as Commonwealth Care packages and aged care residential facilities.

- Reduce hours for higher needs clients.

  Consistent with an approach of providing a low-level program only through HACC, Council may need to look at decreasing all existing Home Care clients, including high needs clients (who currently receive up to 15 hours per week) to 6 hours of service a week, except where there would be extreme hardship experienced, as assessed on an individual basis. These high needs clients would be referred to aged care services that provide for high needs clients.

Longer-Term Options

Council has conducted detailed analysis of the financial implications of increasing demand and increasing costs as part of its budget preparation process. The following strategies are to be considered by Council as part of the annual budget process.

- Increase fees to clients

  Council has the option of increasing fees beyond the set limits imposed by the Department of Human Services. Many local governments have taken this path, since the MAV highlighted the need to increase fees to the Department of Human Services. DHS have previously stated the fee structure is a recommended guideline only.

- Further Increase Council rate budget contribution

  If Council does not adopt any demand reduction strategies for the next financial year the total net cost to Council will increase from $628,029 in 2002/03 to $1,672,561 in 2003/04, an increase of 166%. With the adoption of all the demand reduction options listed in this case study the increase would be to $1,380,006, a 120% increase. This increase is due to the need to maintain services for clients already receiving service and the increasing cost of labour through enterprise agreement wage increases and progression to award conditions for all staff. Even with a significant increase in the Council contribution the number of new clients that can be accommodated on the program will be severely limited. Even at the higher of these two funding levels only 688 additional hours of care will be able to be provided. Waiting lists will be inevitable.

- Waiting lists

  Waiting lists would be implemented only as a last resort for domestic and respite services. The trigger point to activate a waiting list would be when the target hours, as budgeted in any one quarter are exceeded. It is considered inappropriate to have a waiting list for personal care, as this would greatly compromise the clients' health.

  Waiting lists will need to continue for Home Maintenance when target hours are exceeded in any one quarter except for urgent jobs that are required to keep clients safe in their home.

- Limits on Funding Contribution

  Council sets a trigger that its contribution to the Home Care program will be a maximum of 25% in any one financial year. This includes the program of Domestic Care, Home Maintenance and Respite Care. Council contribution could potentially be higher for Personal Care to ensure that client have immediate access to this program. MAV benchmarking activities indicate that Council contributions to the HACC program range from 15 to 33%, with the majority between 25 and 30%. Many of these councils are now considering capping the level of overall rate funding contribution.

Conclusions

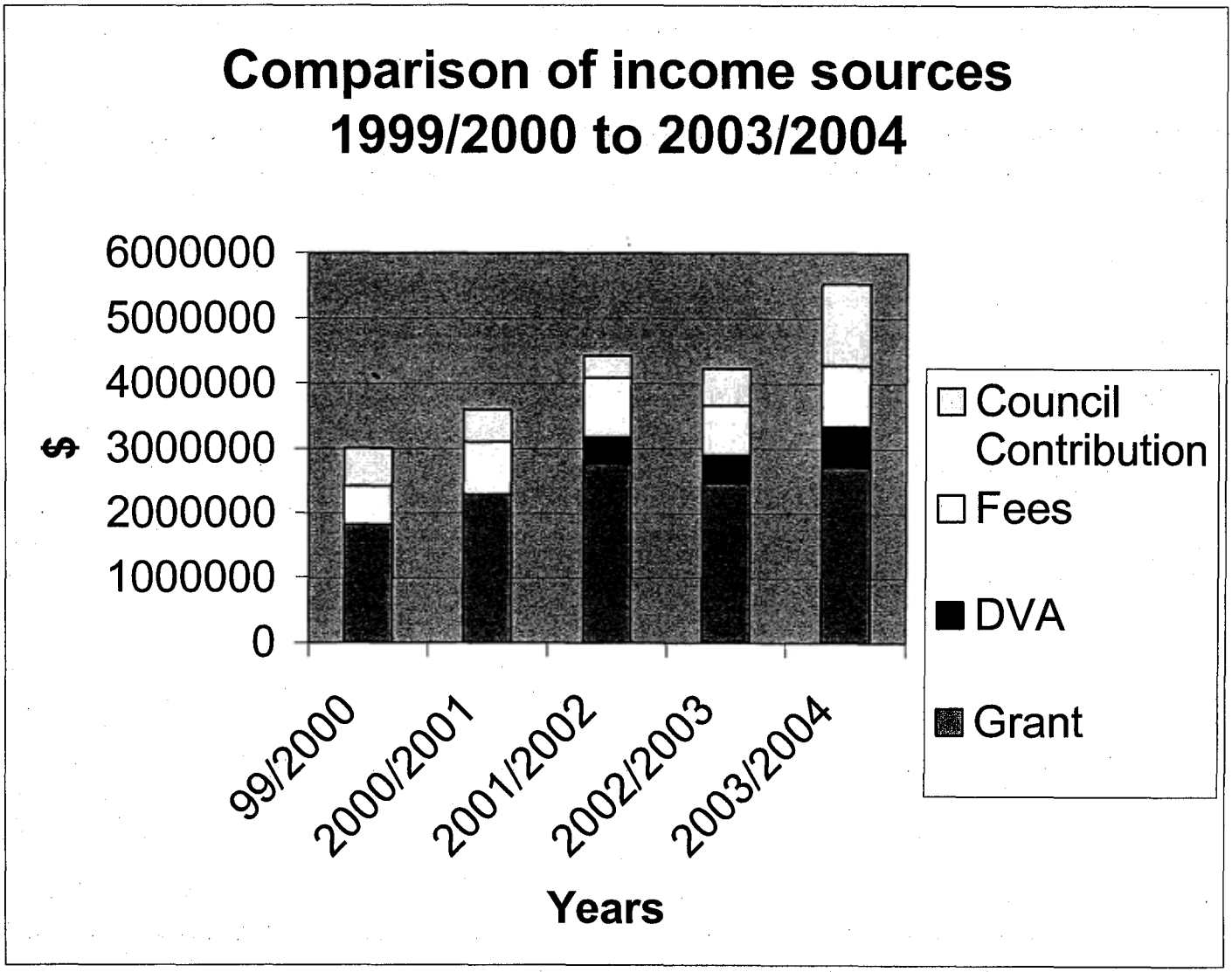
This case study illustrates graphically that even with the introduction of the Veteran's Home Care program in 2001/2002, there is now no spare capacity left to support any high needs clients on the HACC service at the level that they require to safely stay in their homes in 2002/2003. This is because even through the Veteran's Home Care program initially created some spare capacity in subsidised HACC places due to the translation of veterans from the HACC program, the growth in new clients has utilised all this capacity over the last two years.

Kingston Council's desire is to ensure that prospective HACC clients do not wait for services. To achieve this aim, there must be a significant increase from the rates contribution and growth in grant income. The service demand strategies should assist meet this aim, in part, as well as the higher levels of income for 2003/2004 financial year. Waiting lists, however, seem inevitable from 2003/04.

The disadvantage of the implementation of the service demand strategies are that all clients will receive minimal levels of service. The clients with the most complex needs will receive inadequate amounts of service; at the most, 1.5 hours per fortnight domestic assistance, 3 showers per week and 2-3 hours of respite care per week. The HACC service will be unable to provide services for clients with complex care needs, for instance, assistance to rise and retire from bed. If aged care services such as CACP's or Linkages are unable to be accessed for these high needs clients, Council will be placed in a most invidious position in that these clients will be unable to be supported in their own home.

Please see Appendix C for case scenarios based on clients who are currently receiving high levels of service, and the impact on these individuals when services are reduced.

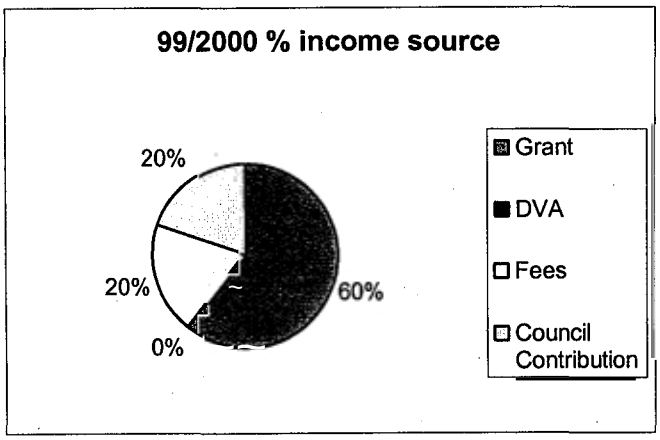
Appendix A

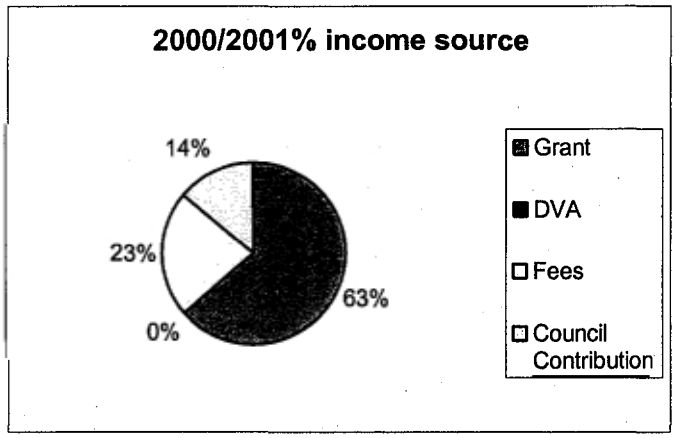


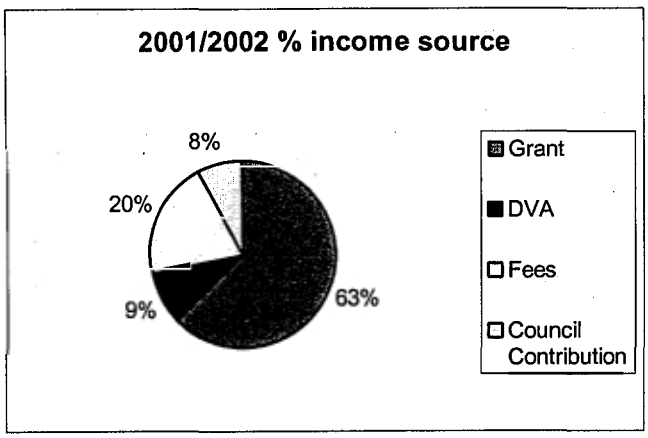
*99/2000, 2002/2001, 2001/2002 fee income includes full cost respite hours purchased by Carers Respite Centre

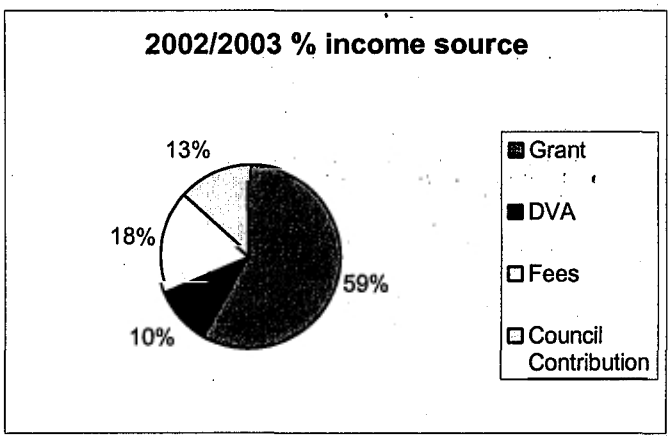
*2001/2002 includes Service development grants in overall grant income

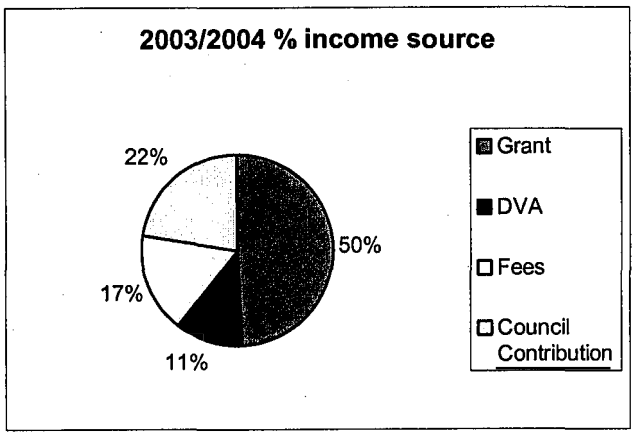
Appendix B: Income comparison per financial year











* Does not include home maintenance

Appendix C: Client profiles and projected impact of demand management strategies.

Client Scenario One
"Frank" is a gentleman in his 80's, who has Parkinson's disease. He requires a wheelchair for mobility, is frail and his obesity makes care very difficult. He has a live in companion who has injured her shoulder due to years looking after Frank. The carer requires an operation, but is putting off treatment, as she is concerned about his welfare at home during her hospital stay. There is very little residential respite available in Kingston, so this is not an option for Frank's care while the companion is in hospital.

Council currently provides:

- 1.5 hours of domestic assistance per fortnight
- 4.5 hours per week one on one respite to take Frank fishing to a local pier. This trip incorporates visits to his G P, hairdresser or other necessary appointments.
- 3 x 45 minutes per week personal care visits to provide a shower to Frank.
- 3 hours of respite per week to accompany Frank to a day centre. A carer is required to accompany Frank to the centre due to his very limited mobility.

Impact of Service reduction: Frank will be unable to attend the day centre on a weekly basis and the weekly one on one respite will need to be reduced. The impact will be to reduce Frank's socialisation opportunities greatly and his carer will have much less chance of having a break for herself. If the carer's shoulder worsens, Frank's only option will be placement in residential care, as even Linkages would be unable to support his care needs, if the carer loses her capacity to care for Frank.

Client Scenario Two
"Lucie" is an Italian lady in her 80's, who was referred to HACC by a hospital after treatment for Lymphoma. Lucie lives with her family and has mental health issues, predominantly anxiety and depression. Her son works from home and recently had a heart attack. Lucie is very emotionally dependant on her family which impacts to a degree on the family dynamics.

Council currently provides:

- 7 hours of respite per week with an Italian speaking carer.
- 3 x 30 minutes of personal care per week to provide a shower for Lucie.
- "Top up" respite for evenings when the son and daughter in law wish to go out.

Impact of service reduction: There will need to be a reduction in weekly respite offered which will diminish Lucie's ability to have a companion outside of the family that speaks Italian. The son will not have as much of a break and he and his wife will be unable to socialise in the evening.

Client Scenario Three
"Tom" is a veteran in his 80's who is totally bed ridden and dependant on a respirator, due to a broken neck. His care needs are constant and he must be turned every couple of hours, which is undertaken by his elderly wife. His wife's sleep is consequently routinely interrupted and she is now suffering poor health. Council currently provide services to Tom under the

Veterans Home Care program and provide respite care under the HACC program to his wife to give her a break. The HACC program is putting in over 12 hours per week of respite care, often overnight. Neither CACP's nor Linkages are willing to provide service to this client because they have such high care needs. It is probably against 'guidelines' to put in both the Veterans Home Care program and the HACC program in one household.

Impact of service reduction: The couple will need to review their decision re not placing Tom in a nursing home. The high levels of respite provided under the HACC program is enabling the wife to have enough of a sufficient break to continue to care for Tom to keep them together in their home.

Client Scenario Four

Jean is a lady in her late 80's with dementia and has schizophrenia, which is controlled through medication. Her carer is her live in son, who has a disability that involves a psychiatric condition which is managed. Jean is a chronic smoker, who will often leave the gas burner on after she has lit her cigarette due to memory loss. Her son is often absent from the house and is not always happy for her to receive HACC services due to fees incurred, even though there are adequate finances to cover costs.

Council currently provides:

- Clinical nursing 5 days a week to administer medication.
- 3 x 45 minutes personal care per week for showers.
- 1.5 hours of domestic care a fortnight.
- 7 hours of respite a week-1 hour a day to ensure that jean has eaten and that she is safe.

Impact of service reduction:

Respite care will need to be reduced which may impact on Jean's safety as the daily 'checks' for nutrition and safety will not be performed. Given the issues surrounding the quality of care provided by the son, Jean may need to be admitted into residential care.

CASE STUDY 2: RESIDENTIAL AGED CARE

Kingston City Council owns and operates three aged care facilities in the south-eastern corridor of Melbourne. This case study explores two issues:

1. A positive case history relating to career development strategies utilised in Council's three low care aged facilities to increase its workforce capacity.
2. Individual case histories of residents in relation to the current funding arrangements challenging the ability to provide quality care arrangements within a residential care aged context.

1. Career Development Strategies

Council has made significant investment in the upskilling and career development of the hostel staff to develop and sustain high levels of quality care to the residents.

In 1999, Council made a conscious decision to embark on a range of strategies to improve career development within its hostel staffing structure. Workforce issues of untrained staff were addressed through provision of traineeships that gave staff skills, knowledge, experience, and a qualification. These traineeships covered the full range of occupations in an aged care facility, with nursing traineeships being introduced for the first time. Council also developed an in house training program that focused on the provision of care and introduced a performance management system that was linked to the hostel's quality system.. Benefits, apart from increased retention levels, job satisfaction, and the attainment of formal qualifications was the empowerment of staff and an enormous increase in self esteem resulting in a hunger to continue personal development.

There were financial benefits to the organisation of approximately $100,000 in training subsidies and this income was used to create opportunities for this further development to take place. Additional financial benefits were gained through staff knowledge that enabled them to maximise care relating funding. Workcover claims went from extremely high to nil; premiums reduced significantly. This team was recognised by Workcover Victoria, winning the risk minimisation award in 2002.

To consolidate staff satisfaction and retention, and to ensure the future viability of Kingston's staffing structure and delivery of quality care, succession planning and career pathways were developed. Key staff were identified and a tailored internal education program developed and implemented. Staff have progressed from no qualification to Certificate III, Certificate IV Nursing, Diplomas and Advanced Diplomas in Business.

Three managers have been recognised at national level, winning awards for leadership excellence. Other areas of success include awards for innovative programming in recreation and leisure at national level.

Through the succession planning program leadership skills have been developed in staff at all levels to the point where staff now present at national conferences. Participants at the conferences have approached Kingston looking for assistance in their own development. A mentor program was established to assist a rural sector worker who was isolated. This program continues today; the facility and the worker

recognised for the partnership in national awards - for the worker, improved confidence and significant contribution to quality of life programs in a remote nursing home in north-eastern Victoria.

Succession planning has achieved excellent results clearly demonstrated through resident and employee satisfaction surveys. Sound systems have been developed that will ensure the business continues regardless of the changes that may occur in staffing, or through legislation. Good results in employee and resident satisfaction surveys demonstrate that investment in staff in terms of their professional development and career succession planning assist in making a quality aged care residential facility.

2. Funding arrangements and quality of care

Whilst Kingston Council has been able to greatly improve the quality of care in all three aged care residential facilities, there has been some difficulty experienced in the provision of quality care in relation to funding arrangements.

Case scenarios:

Case Scenario 1
A gentleman living in a one-room bed sitter was discharged from acute sector to his home. He was not able to cook meals due to gangrene in both feet and associated pain; complicated further by being an insulin dependent diabetic. Staff assessed this gentleman in his home, and found him in a depressed state, in pain and requiring intensive wound management.

Admission was arranged immediately and within three weeks, the man was returned to the acute sector for pain management, and further investigation for wound management. It was established that after several attempts to save leg, amputation was necessary.

The facility kept the client's place open, but the ramifications of this decision resulted in loss of care funding after 30 days hospitalisation. From the acute sector, the man was transferred to rehabilitation for a further 60 days resulting in a loss of $5142.60 for the 90 day period.

The facility was informed by the acute sector that the gentleman required a non-tip wheelchair at a cost of $2000, and a cushion to prevent pressure area on his buttocks at a cost of $325. Acute sector case manager informed the facility that because he lived in an aged care facility, it was expected that we would fund the purchase of the wheelchair and cushion. An explanation was given to the case manager by the facility, that care funding did not cover the cost of these items. The case manager explained that if living in his own home the State Government would have funded this support. This has resulted in an additional $2325 costs for the facility added to the existing care funding loss, totalling $7467.60.

Funding provided for this man is $38.11 per day – to cover provision of personal care such as washing and dressing, meals, wound treatments, diabetic and pain

management, lifestyle programming, assisting with personal finances, and physiotherapy.

Case scenario 2 is that of a lady who is blind and an insulin dependent diabetic, requiring the services of the Royal District Nursing Service to administer twice daily insulin. Again, funding for this person was $38.11 per day; the cost of this service is $47.00 per day for 20 minutes of service. We still need to provide all of the services as mentioned in the first case scenario – how is this possible?

As people live longer because of improved medical practice, their health issues become complex requiring hospitalisation for periods of time.

Case scenario 3 is that of a lady with fractured her hip, who was to be returned from hospital three days after surgery. The facility would have been required to purchase additional nursing care services at a cost of $1,680 per day until an appropriate high care facility could be found. The care subsidy received for this person is $91.96 per day – a loss of $11,116.28 per week.

CASE STUDY 3: The Community Connection Program

Addressing the needs of Socially isolated and most disadvantaged who are HACC eligible.

Background and Purpose

The program, which began in July 2000, is funded by the Department of Human Services and is operated in conjunction with Southern Health and the City of Kingston. The program aims to improve the health and quality of life of the target population by increasing access to mainstream and specialist services through referral and advocacy.

The underlying philosophy of the Community Connection Program is that support is provided in a non-judgmental and culturally/age/gender sensitive manner with an on-going respect for the client's decisions. The client is consulted and engaged in all decisions related to their health and well being. An integral component of the Program is the development of trust. To achieve client trust, the privacy and dignity of the client must be maintained and supported as much as possible.

An "assertive outreach" approach is used to identify the client population through analysis of service gaps as well as referrals from a variety of sources. Case management is provided to clients with complex needs that may be related to age, frailty, disabilities, addiction or mental health issues. This also includes an effective withdrawal of services when on-going support is no longer required. The program allows for the purchasing of goods and services to assist with short-term immediate needs and brokerage funds are available to assist with immediate and short term housing needs which arise due to inappropriate or unstable housing or closure of accommodation.

A key element of the program is the facilitation of the development of partnerships between mainstream and specialist service providers in order to enhance their accessibility and responsiveness to the needs of the above target group. This process will assist in the identification of the barriers that prevent equitable access to health and well being services. This will contribute to the development of strategies to reduce the risk factors that may lead to homelessness, incarceration, preventable hospitalisation and premature admission to residential care through enhanced social contact and support networks as well as increased access to mainstream and specialist health services.

Client Profile

The target population for the Community Connection Program is people who live in low cost housing, homeless people or at risk of becoming homeless and people with unmet complex and/or multiple needs and those who are eligible for the home and Community Care program. This includes frail, aged people; people with an intellectual, physical or sensory disability; people with a mental or psychiatric *illness* (disability); people with acquired brain injury and people with drug or alcohol substance abuse problems.

One of the most common characteristics of the Community Connection Program is that the clients often feel they have nowhere left to turn. This is a fairly common perception which may be due to a number of different reasons:

- It may be that the client has had previous experiences with a service system that has "failed" them (ie. their needs were not appropriately met – often this occurs when the service provider identifies a client's need which is not in line with the client's perception of his/her need);
- The client may have been identified by a number of services as belonging to the "too hard basket" (ie. they may be perceived as difficult and/or uncooperative clients or abusers of the service system);
- Another possibility is that complex needs have generated a social isolation such that they are unaware of the supports that may be available to them.

Case Example (As reported by the Community Connections Coordinator)
"Bill" is a sixty-year-old gent who has alcohol related brain injury and is being evicted from the rental property, which has been his home for the past eight years. Living with "Bill" are his beloved dog and a male co-tenant who has shared the house for over six years.

Notification to Vacate was issued in December 2000 which gave the household sixty days to find alternative accommodation. I was contacted in early March by "Bill's" worried sister who believed that physical eviction was imminent and that "Bill" had nowhere else to go.

I immediately arranged to visit "Bill" at his rental property and offered support and assistance with regard to his immediate housing needs. One of the most significant aspects of this case is "Bill's" fear and grief at the loss of his home and his life as he knew it. This fear and grief coupled with "Bill's" limited cognitive capacity meant that he was incapable of acknowledging, let alone responding to, his impending homelessness. Indeed, his Landlord, Real Estate Agent and possibly even his siblings perceived his inactivity as defiance or laziness where in fact he was immobilised by his fear and grief.

Since my first meeting with "Bill" a number of crises have ensued which have caused further distress. A summons to attend the Residential Tenancies Tribunal, a subsequent Order to Vacate, re-location in Emergency accommodation and finally a fire and attempted suicide by "Bill's" co-tenant.

Action and services provided through the CCP have been as follows:

- *Crisis intervention – counselling and practical support;*
- *Liaison and advocacy with the Real Estate Agents;*
- *Liaison with family;*
- *Liaison with and referral to Tenant Support Service;*
- *Transport to and support at Frankston Magistrates' Court (Residential Tenancies Tribunal);*
- *Location of suitable Emergency Accommodation where "Bill" could also take his dog;*
- *Visits to possible temporary accommodation facilities;*

- *Assistance with collecting mail and personal items from the house;*
- *Liaison and advocacy with Dandenong Housing Office;*
- *Advocacy with Centrelink;*
- *Advocacy with Cheltenham Housing Office;*

To date, "Bill" is still in temporary accommodation awaiting a decision from the Housing Office re his Application for Early Housing. Whilst he is currently in temporary accommodation outside the Kingston boundaries I will maintain my involvement with "Bill" until he is established in more secure accommodation where he will be referred to other appropriate support services.
Note: All names have been changed to ensure confidentiality.

Further Client Case Examples::

- *An eighty-five year old woman with a physical disability living in sub-standard housing;*
- *A dying man and his seventy year old wife whose housing was in jeopardy due to his illness;*
- *A forty year old woman and her son with mental health problems who desire a priority housing transfer;*
- *A forty year old man with alcohol problems;*
- *A fifty year old man, addicted to pain killers;*
- *A sixty year old woman being evicted from a caravan park;*
- *An eighteen year old homeless young man with mental health problems;*
- *A sixty-two year old man in insecure housing;*
- *A family experiencing severe financial hardship due to ill health and addiction problems;*
- *A single mother and her family in insecure housing;*
- *A number of people facing eviction due to rent arrears;*
- *A number of people requiring financial assistance to obtain dental urgent treatment;*
- *An elderly gent suffering dementia and requiring an SOS Identity bracelet;*
- *The purchase of a Nebuliser Pump;*

Program Utilisation

The most common type of assistance is related to housing, case conference, health, financial support and social support. Other needs have included mental health, family support, drug and alcohol issues and HACC. All types of needs have shown increases throughout the progress of the Program. The most common type of client are older people and people with some form of disability.