The Auditor-General
Audit Report No.58 2004–05
Performance Audit

Helping Carers: the National Respite for Carers Program

Department of Health and Ageing

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
29 June 2005

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled *Helping Carers: the National Respite for Carers Program.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

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Abbreviations

ACAR	Aged Care Assessment Round
ACAT	Aged Care Assessment Team
CACP	Community Aged Care Packages
CISP	Carer Information and Support Program
CRC	Commonwealth Respite for Carers Program
CSTDA	Commonwealth State/Territory Disability Agreement
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
FaCS	Department of Family and Community Services
HACC	Home and Community Care
Health	Department of Health and Ageing
MDS	Minimum Data Set
NCAP	National Carer Action Plan
NCCP	National Carer Counselling Program
NFPO	Not-For-Profit-Organisation
NPCP	National Palliative Care Program
NRCP	National Respite for Carers Program
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PBS	Portfolio Budget Statement
Resource Centre	Commonwealth Carer Resource Centre
Respite Centre	Commonwealth Carer Respite Centre
STO	State/Territory Office
VHC	Veterans' Home Care

Glossary

Carer A carer is a person such as a family member, friend or neighbour who provides regular, sustained care and assistance to another person without payment other than for possible receipt of a pension or a benefit.

Primary Carer A primary carer is a carer of any age who provides the most assistance to the care recipient.

Respite Respite care is defined as an alternative or supplementary care arrangement with the primary purpose of giving the carer:

- a short-term break from the usual caring role; and/or
- assistance with performance of the caring role.

Respite care is divided into direct respite services and indirect respite services, which are defined as follows:

- direct respite services provide the carer with quality alternative care for the person for whom he/she is the primary carer. Alternative care may be provided in the home, suitable temporary accommodation or an appropriate community setting; and
- indirect respite services provide the carer with assistance which relieves the carer of tasks other than the caring role, for example, provision of a shopping, gardening or cleaning service.

Summary and Recommendations

Summary

Background

1. In 2003, an estimated 2.6 million people (carers) provided assistance to those who needed help because of a disability.[1] This included assistance with self-care, mobility, communication, transport and housework.

2. The Australian Government and State and Territory governments deliver support services for carers and care recipients. Support services include basic care, coordinated services for those with complex needs, financial support, and respite and information services. Carer-focused respite, information and counselling services are provided under the National Respite for Carers Program (NRCP).

3. NRCP is a collection of activities arising from successive Australian Government policy and funding initiatives to support a variety of carers in the community. Health has defined NRCP's objective as:

> the support and maintenance of caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances, and those of the people for whom they care.[2]

4. Respite care, and associated information and counselling services, are primarily delivered through NRCP's three major components, which are:

- Resource Centres—these Centres act as points of contact for carers seeking **information and advice** about services and other support and assistance. For example, carers can telephone their nearest Resource Centre, located in each State and Territory capital city, for information on various topics, referrals to a range of community and government services, emotional support and counselling, and for a wide range of resources including a free carers' kit. Resource Centres assisted 42 627 carers in 2003–04;

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1 Australian Bureau of Statistics, *2004 Disability, Ageing and Carers: Summary of Findings*, 2004, Canberra, p.3. The Australian Bureau of Statistics defines disability as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision.

2 Respite care is defined as an alternative or supplementary care arrangement with the primary purpose of giving the carer:

- a short-term break from the usual caring role; and/or
- assistance with the performance of the caring role.

- Respite Centres—these Centres **arrange short-term or emergency respite for carers through existing services.** They are also funded to purchase or subsidise flexible respite care, provide emergency respite services, and link carers to residential respite services. For example, Respite Centres are able to provide immediate in-home respite to assist carers in an emergency or unplanned situation, assist carers to access other emergency/after hours services, and arrange ongoing respite if the carer requires emergency assistance for more than a few days. Respite Centres assisted 47 800 carers in 2003–04; and
- Respite Services—these Services **deliver respite** to carers and the people they support in a variety of settings, including in-home, day centre, host family and other short-term respite accommodation. Respite Services assisted 28 000 carers in 2003–04.

5. Health does not deliver services directly to carers, with funding provided to a range of organisations to operate NRCP Centres/Services, including community organisations, charitable organisations, State/Territory governments, local government, religious organisations, and private sector organisations.

6. In 1996–97, the Australian Government commenced funding for NRCP, with Program funding increasing from $19 million in that year to $134.8 million in 2005–06. The most significant increases have occurred over the last three years, including additional funding to expand NRCP target groups. Funds are currently allocated across the three major Program components as follows[3]:

- Resource Centres—$4.7 million (9 Centres);
- Respite Centres—$46.2 million (61 Centres); and
- Respite Services—$59.5 million (432 service providers).

7. This funding is part of an estimated $2.5 billion in carer support, provided each year by the Australian Government and by State and Territory governments through joint programs with the Commonwealth.

8. The delivery of Australian Government funded community care services, including NRCP, is currently the subject of reform following the completion of a major review. In 2002, the then Minister for Ageing initiated a review of Health's 17 community care programs. The Minister released the resulting report, *A New Strategy for Community Care—The Way Forward*, on

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[3] The amount of funds allocated across the three major Program components is less than the annual budget because some funding announced in the 2005–06 Budget, which is included in the annual NRCP budget, is yet to be allocated to components.

3 August 2004. This report proposed significant changes to the way in which community care services, including NRCP, are delivered. These changes are intended to provide consumers with easier access to care and support, a fairer system, comprehensive services, and greater consistency in the quality of care. It is in this context that Health has advised that it is working to streamline and improve administrative arrangements for NRCP in association with administrative reform in other community care programs. Implementation of reforms may involve consultation with industry and/or State and Territory governments where appropriate, pilot testing and evaluation prior to full implementation. Health is already well advanced on some initiatives stemming from the review.

9. The audit objective was to assess the effectiveness of Health's administration of NRCP. The audit comments on a range of issues, including program design, planning on the basis of need, funding, coordination, performance monitoring, and compliance management. It also takes into account Community Care Review initiatives.

Key findings

Designing the Program (Chapter 2)

NRCP has a number of parts, with different administrative practices for each part.

10. The design of NRCP reflects the influences of a series of policy initiatives that have shaped the Program since its inception in 1996. These initiatives have created separate components and targeted services within them. As a consequence, NRCP has a number of components, each with its own administration team, guidelines, model of service delivery and reporting processes. This structure, while aligned to the Government's policies, poses challenges for administration and increases costs.

The target groups established by Health for each component of NRCP are consistent with government policy, with the department advising that work is underway to improve guidance to Respite Centres on the targeting of resources.

11. The target groups for NRCP are based on the policy initiatives that have shaped the Program and the adaptation by Health of the target groups from the Home and Community Care Program (HACC).[4] While Health has established target groups for each major component of NRCP and communicated these to funded organisations, it is yet to develop sufficient

[4] Australian Government and State and Territory governments jointly fund community care services through HACC, with State and Territory governments setting priorities for funding across their jurisdictions. Services include delivered meals, home help, respite, personal care, gardening, home modification and transport.

guidance for Respite Centres, and to a lesser extent Resource Centres, to inform the allocation of services to the different types of recipients within target groups. This guidance is particularly important for programs like NRCP that were designed to complement a range of other programs. It is also an important approach to limit potential cost shifting between programs, departments and different levels of government. Health has advised that refinements to performance targets, once complete, will provide greater assistance to Respite Centres in the allocation of resources.

While Health does not currently have a common assessment tool for NRCP, the department has commenced work to develop one.

12. A consistently applied assessment tool is an important element in the equitable delivery of services under national programs. Health is yet to establish a common assessment tool to determine eligibility for NRCP services. Differences in assessment practices for NRCP have led to access and equity issues for carers. Health has, however, identified common assessment as a key initiative stemming from the Community Care Review and has commenced work on development of an NRCP assessment tool.

Health has adopted multiple service delivery approaches for NRCP, with some approaches posing administrative challenges.

13. Health's adoption of flexible service delivery approaches under NRCP facilitates the achievement of policy objectives, supports a carer focus, and is strongly supported by service providers. However, it is more administratively challenging than other approaches. Health has acknowledged these challenges and is working to limit their impact.

Planning Program Delivery (Chapter 3)

Health's planning requires further strengthening to support the current size and complexity of the Program.

14. Health has not developed a strategic plan for NRCP to guide the deployment of resources. The development of a plan of this type would assist Health to integrate the various components within the Program and guide development and expansion. It would also facilitate the establishment of a set of NRCP performance measures against which the performance of the Program could be assessed.

Health has not implemented a methodology to inform its targeting of NRCP services to areas of greatest need.

15. The absence of an effective needs-based planning approach for NRCP, incorporating service delivery data from other community care programs, has limited Health's ability to target funding to areas of greatest carer need. The assessment of need is an important element of sound program planning. It

allows funding providers to target the provision of respite services. It also provides baseline information against which the impact of programs can later be assessed.

While Health has not established a comprehensive set of performance measures for NRCP, it is working to improve performance information.

16. Health's use of performance information to inform Program delivery and future expansion is limited. This is partly due to the complexity involved in developing performance information of sufficient detail and appropriate coverage. The performance information that Health has established for the Program is not sufficiently integrated, nor does it support the effective monitoring of Program performance. Health is, however, working to improve the quality, quantity and appropriateness of performance information for NRCP.

Administering the Program (Chapter 4)

There is an absence of documented policies and procedures on Health's funding approaches.

17. Health has not documented administrative procedures or guidelines governing the allocation of funding under NRCP. In addition, the department has not documented a funding formula or funding methodology. The absence of procedures, methodologies and formulae makes it difficult for Health to explain its funding decisions.

Health's approach to the planning of its funding rounds has resulted in timing issues for the release of funds and the conduct of funding rounds.

18. There are timing issues for funding rounds with NRCP moneys often allocated and required to be committed late in the financial year. Increased service delivery at the end of the financial year can build carer expectations that cannot be met once funding levels return to normal. Further, Health does not have a documented approach to the monitoring of its funding rounds. In particular, Health does not analyse information that would allow it to determine the appropriateness of the time allowed for each phase of its funding rounds. Therefore, it is not in a position to inform future funding activities or to advise the Government of the optimal time required to implement policy initiatives.

Short-term agreements have created uncertainty for service providers and an increased workload for Health administrators.

19. Health has issued a series of short-term funding agreements to streamline its existing agreements and allow for the introduction of revised contractual terms stemming from the Community Care Review. These short-term agreements have created uncertainty for providers and increased the

workload for Health's administrators. Health is working, however, to address this issue, with the implementation of new three-year agreements for funded organisations from 1 July 2005.

Health's administrative practices for NRCP are not nationally consistent.

20. The absence of an up-to-date NRCP policy and procedures manual has resulted in inconsistent administrative practices between Health's State/Territory Offices (STOs) as well as less efficient, reactive management. While Health has recognised the need for a Program procedures manual, and commenced preliminary work, an up-to-date manual was not in place at the time of audit. Health does, however, hold regular program manager meetings, at which NRCP administrative practices are discussed.

Coordination between NRCP and other community care administrators is limited.

21. There is insufficient communication and coordination between NRCP and other community care programs. As a consequence, the exchange of planning and service delivery information between programs is limited and is not a routine part of administration. While NRCP program officers are aware of other community care programs, they generally have a limited understanding of the services being provided and their impact on NRCP. This hinders the identification of gaps and inequities in, and duplication of, service delivery. This issue is discussed in *The Way Forward*, with proposed initiatives aimed at creating a simple, streamlined, responsive and better coordinated community care system.

Administrative resources for Health's smaller programs, including NRCP, are allocated across several programs.

22. Health allocates its limited administrative resources across its programs on the basis of size and risk. As such, NRCP as one of Health's smaller programs, shares administrative resources with a number of other programs. In meeting the competing resource demands of these programs, NRCP program officers have rationalised their NRCP activities.

The effectiveness of Health's records management practices is limited.

23. Health's records management practices require strengthening to more effectively support the department's demonstration of due process and to support decision-making within the Program.

Monitoring Program Performance (Chapter 5)

Health requires extensive reporting from funded organisations, although limited detail and breadth of reported information lessens its usefulness.

24. Health has established comprehensive NRCP reporting processes for funded organisations so that it can manage the Program soundly and to ensure

accountability for public funds. However, the monitoring system does not provide balanced information to inform Health of the extent to which NRCP is meeting its objectives. For example, Health does not seek carers' and care recipients' comments on the quality and appropriateness of service provision. As well, monitoring systems do not provide Health with sufficient information to enable it to determine whether funded organisations are complying with funding agreements, including compliance with the required National Service Standards. These Standards are important safeguards for people receiving respite services.

Program monitoring is based primarily on self-reporting, with limited verification of information provided in reports.

25. Health's monitoring system relies primarily on self-reporting, with limited activity from the department to verify the accuracy or quality of information within these reports. The number and frequency of reports also place a considerable workload on Health administrators and funded organisations.

There are problems with the quality of data provided by funded organisations and the way in which this data has been interpreted by Health.

26. The accuracy of data provided to Health by NRCP funded organisations is affected by confusion in some organisations over important data principles, such as the definition of some terms. Further, the way in which Health has interpreted service delivery data has the potential to distort the level of service delivery reported under NRCP. Health has sought to improve its interpretation of NRCP data through recent guidance to its officers.

Health is introducing a quality monitoring system for NRCP.

27. Health is working to improve the coverage of its monitoring regime through implementation of a system to better monitor the quality of services provided to carers under NRCP. Health envisages that the system will comprise a three-step process, involving services self-reporting against uniform quality standards every three years and Health officers carrying out a desk audit and a validation visit.

Overall audit opinion

28. While Health's administration of NRCP supports the delivery of respite, information and counselling services to carers, opportunities exist for Health to improve the effectiveness of its administrative practices.

29. The significance of weaknesses in administrative practices has increased as the Program has grown in size and complexity. This growth has been primarily driven by government policy initiatives, with complexity arising from the creation of separate components within NRCP.

Notwithstanding, the ANAO considers that Health should adopt a more structured, integrated and planned approach to implementation and future expansion of NRCP.

30. Health has acknowledged problems with the administration and delivery of community care services in general, and more specifically its administration of NRCP. It is currently working to resolve a number of these problems.

31. The Minister's review of community care services, which resulted in the publication in 2004 of a report entitled *A New Strategy for Community Care—The Way Forward*, has identified a number of areas where a more consistent and coordinated approach across all of Health's community care programs, including NRCP, is necessary. Health has already commenced the implementation of review initiatives and is well advanced with some.

Health's response

32. Health advised the following overall comment on the audit:

> The Department is supportive of the audit report and agrees to the recommendations. The Department welcomes the ANAO's acknowledgement of the reforms and initiatives already in hand that will address many of the matters raised in the audit report.

33. In addition, Health provided a response to each of the recommendations. The relevant responses appear immediately following each recommendation in the body of the report.

Recommendations

The ANAO's recommendations are listed below with report paragraph references. To improve Health's administration of NRCP, the ANAO has made six recommendations. The ANAO considers that Health give priority to Recommendations 1 and 2.

Recommendation No.1
Para. 3.6

The ANAO recommends that Health develop a longer term strategy for NRCP that:

- provides a statement of strategic directions and priorities;
- describes key Program aims and approaches; and
- establishes an integrated performance measurement framework, against which the achievement of Program objectives can be assessed.

Health's response: Agreed.

Recommendation No.2
Para. 3.26

The ANAO recommends that Health implement a needs-based planning methodology to underpin NRCP service provision, comprising:

- a methodology, incorporating a common assessment tool, for determining carers' needs; and
- regional planning, incorporating program data from relevant community care programs.

Health's response: Agreed.

Recommendation No.3
Para. 4.22

The ANAO recommends that, in order to improve the efficiency of its funding activities, Health:

- monitor both open and targeted funding rounds to inform future funding activities; and
- ensure that funds are allocated sufficiently early to allow considered expenditure over the full financial year.

Health's response: Agreed.

Recommendation No.4 Para. 4.42

The ANAO recommends that, in order to ensure consistent implementation of NRCP nationally, Health issue an up-to-date national NRCP policy and procedures manual and ensure that staff are aware of the manual.

Health's response: Agreed.

Recommendation No.5 Para. 4.67

The ANAO recommends that Health, in order to better inform its decision-making and to demonstrate due process, ensure that its record keeping processes and practices are aligned to better practice.

Health's response: Agreed.

Recommendation No.6 Para. 5.21

The ANAO recommends that Health review the number, type and timing of reports it requires from funded organisations to ensure that they support Health's monitoring requirements.

Health's response: Agreed.

Audit Findings and Conclusions

1. Introduction

This Chapter provides an introduction to the role of carers, with a focus on the National Respite for Carers Program. It also introduces the audit, including the audit rationale, objective, scope and methodology.

Carer environment

1.1 One in five people in Australia (almost 4 million) reported a disability in 2003.[5] Of these people, 3.4 million had a specific limitation or restriction in the core activities of self-care, mobility or communication.[6] While some disabled people live in residential facilities, the majority live in the community.

1.2 The Australian Institute of Health and Welfare (AIHW) estimated that the amount of unpaid assistance provided by family and friends (carers) to people with a disability who are living in the community is the equivalent of almost one million full-time employed persons. The estimated value of this work is $19.3 billion.[7] The Carer Snapshot below summarises statistical data on carers.

1.3 According to Carers Australia (the peak body for carers), carers commonly attribute a range of health problems to their caring responsibilities, including anxiety, depression and physical injuries. Many carers are chronically tired and need unbroken sleep, a day off, or an extended period with no caring responsibilities so they can regain a sense of wellbeing. Carers Australia has identified carer support services as one of three key requirements of carers[8], especially the provision of flexible respite care and counselling.

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5 The Australian Bureau of Statistics defines disability as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision.

6 Australian Bureau of Statistics, *2004 Disability, Ageing and Carers: Summary of Findings*, 2004, Canberra, p.4.

7 Australian Institute of Health and Welfare, *Carers in Australia—assisting frail older people and people with a disability*, 2004, Canberra, p.1.

8 The other two are financial support and income security, and workforce participation and flexibility.

Carer snapshot

- 2.6 million Australians identify as carers[9]
- 474 600 of these are primary carers[10]
- 71 per cent of primary carers are female
- 78 per cent of primary carers care for a person in the same household
- Primary care is mostly for a partner (42 per cent), child (26 per cent) or parent (23 per cent)
- Even though the majority of primary carers are of workforce age (75 per cent are aged 18 to 64 years), paid work is usually not possible. 61 per cent are not in the workforce
- 55 per cent of primary carers receive a government pension, benefit or allowance as their principal source of cash income
- 55 per cent of primary carers spend on average 20 hours or more per week providing care, of which 37 per cent spend 40 hours or more per week
- 33 per cent of primary carers have been providing care for a decade or more, and 60 per cent for more than 5 years

Source: Australian Bureau of Statistics.

1.4 Respite care is defined as an alternative or supplementary care arrangement with the primary purpose of giving the carer:

- a short-term break from the usual caring role; and/or
- assistance with the performance of the caring role.

1.5 Respite care is divided into direct respite services and indirect respite services, which are defined as follows:

- direct respite services provide the carer with quality alternative care for the person for whom he/she is the primary carer. Alternative care may be provided in the home, suitable temporary accommodation or an appropriate community setting; and

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[9] A carer is a person such as a family member, friend or neighbour who provides regular, sustained care and assistance to another person without payment other than for possible receipt of a pension or a benefit.

[10] A primary carer is a carer of any age who provides the most assistance to the care recipient.

- indirect respite services provide the carer with assistance which relieves the carer of tasks other than the caring role, for example, provision of a shopping, gardening or cleaning service.

1.6 In its 2004 report on carers in Australia, the AIHW stated that 87 per cent of primary carers in 1998 had never made use of respite care services. Eleven per cent of primary carers indicated that they needed respite but had not received it, with a further 30 per cent of carers stating that they had no fall-back carer.[11]

Government support for carers

1.7 There is a range of government support services for carers (see Table 1.1 for further information on funding levels and Appendix 1 for an overview of these services). These are designed to assist both the carer and the care recipient. They include:

- basic care services, for example, those provided under the Home and Community Care Program (HACC) and the Veterans' Home Care (VHC) Program;
- coordinated services for those with complex needs, for example, those provided under the Community Aged Care Packages (CACP) Program and Extended Aged Care at Home (EACH) Program;
- financial support, for example, the Carer Allowance and Carer Payment;
- general information services, for example, services provided through the Commonwealth Carelink Program; and
- carer-focused respite services and information, including services provided through the Carer Information and Support Program (CISP) and NRCP.

[11] AIHW, op. cit., p.66. This report uses statistics derived from the ABS's 1998 *Disability, Ageing and Carers* survey as data from the 2003 survey were not available.

Table 1.1

Public sector support for carers in 2003–04[a]

Type	Agency	Program[b]	$ (million)
Respite			
	Australian Government		
	Department of Health and Ageing	*Home and Community Care Program*	131.0
	Department of Health and Ageing	*National Respite for Carers Program*	98.7
	Department of Health and Ageing	*Residential Respite*	84.0
	Department of Health and Ageing	*Community Aged Care Packages Program*	Unavailable[c]
	Department of Health and Ageing	*Extended Aged Care at Home Program*	Unavailable[c]
	Department of Health and Ageing	*National Palliative Care Program*	3.0
	Department of Veterans' Affairs	*Veterans' Home Care*	14.2
	Department of Family and Community Services	*Respite Support for Carers of Younger People*	5.2
	Department of Family and Community Services	*Commonwealth State/Territory Disability Agreement*	4.4
	State/Territory governments[d]		
		Commonwealth State/Territory Disability Agreement	180.4
		Home and Community Care Program	87.3
		Total Respite	***608.2***
Income Support			
	Australian Government		
	Centrelink	*Carer Allowance*	965.4
	Centrelink	*Carer Payment*	921.0
		Total Income Support	***1,886.4***

Continued over page…

Type	Agency	Program[b]	$ (million)
Information Services			
	Australian Government		
	Department of Health and Ageing	*Commonwealth Carelink Program*	13.7
	Department of Health and Ageing	*Carer Information and Support Program*	2.1
		Total Information Services	***15.8***
		TOTAL[e]	**2,510.4**
		NRCP Expenditure as a Proportion of the Total Public Sector Support for Carers (per cent)	*3.9*

[a] More recent data is not yet available.

[b] Further information on the Programs included in Table 1.1 can be found at Appendix 1.

[c] Health does not collect data on hours of service provided by service type for these programs, that is, it does not collect sufficiently detailed data to enable it to determine how much funding is directed to respite under these programs.

[d] Table 1.1 includes State/Territory government funding through joint programs with the Australian Government. It does not include funding for the range of programs delivered independently by State/Territory governments.

[e] The total public sector funding to support for carers is understated, as it does not include State/Territory government funding for carer support, as noted above.

Sources: Productivity Commission, Report on Government Services 2005.
Department of Veterans' Affairs—Financial Reports (unpublished).
Health Financial Reports (unpublished).
Department of Family and Community Services—Annual Report 2003–04.
Department of Family and Community Services–Portfolio Budget Statements 2003–04.

NRCP overview

NRCP's objective

1.8 The objective of NRCP is to contribute to the support and maintenance of caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances, and those of the people for whom they care.

1.9 NRCP is one of several Australian Government initiatives designed to support and assist relatives and friends caring at home for people who are unable to care for themselves because of chronic illness, disability or frailty. It offers:

- information and support for carers;
- counselling; and
- assistance to help carers take a break from caring, or respite.

1.10 The Program Snapshot below provides an overview of NRCP.

Program snapshot

- 2005–06 funding for NRCP is $134.8 million (projected to be $168.4 million in 2006–07)
- NRCP has separate parts, with the following three major components: Commonwealth Carer Resource Centres (9 Centres), Commonwealth Carer Respite Centres (89 Centres and outlets) and Respite Services (432 providers)
- 42 627 carers were assisted by Commonwealth Carer Resource Centres in 2003–04
- 47 800 carers were assisted by Commonwealth Carer Respite Centres in 2003–04
- 28 000 carers were assisted by Respite Services in 2003–04

Source: Health.

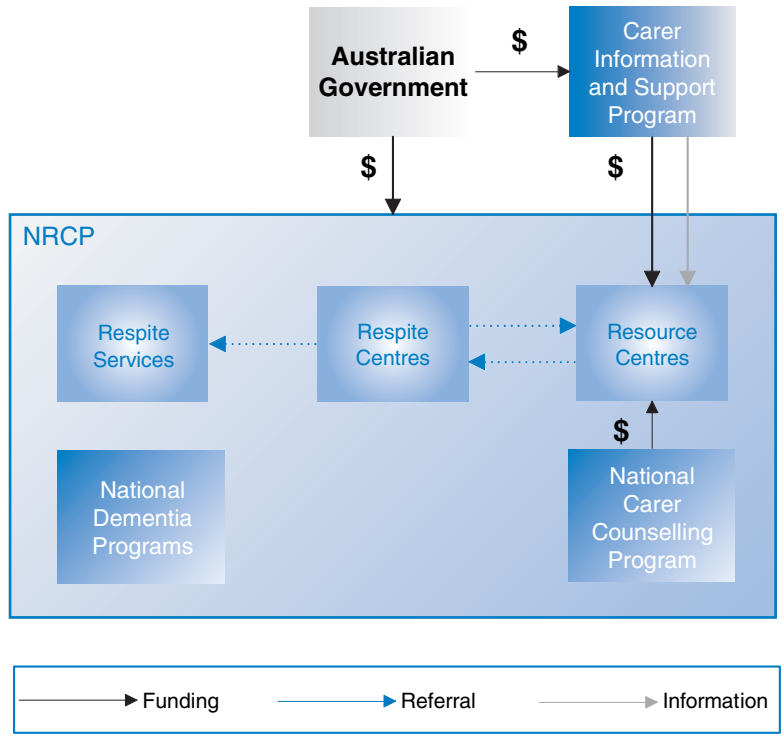
Program structure

1.11 NRCP is a collection of disparate components arising from successive Australian Government policy and funding initiatives with the aim of supporting carers in the community. It comprises three major components, several minor programs and a related carer information program (see Figure 1.1).

1.12 While Health administers the Program on behalf of the Government, it does not deliver services directly to carers. To provide these services, Health contracts a range of organisations, including community organisations, charitable organisations, State and Territory governments, local government, religious organisations, and private sector organisations.

Figure 1.1

NRCP structure



Source: ANAO.

Commonwealth Carer Resource Centres

1.13 There is a National Commonwealth Carer Resource Centre located in Canberra, as well as a Commonwealth Carer Resource Centre (Resource Centre) in each State and Territory. These Centres act as points of contact for carers seeking **information and advice** about services and other support and assistance. Resource Centres are operated by the respective carer association in each State and Territory, and by Carers Australia[12] for the National Resource Centre.

Commonwealth Carer Respite Centres

1.14 There are 61 Commonwealth Carer Respite Centres (Respite Centres) and 28 additional outlets[13], which have the capacity to **arrange short-term or emergency respite for carers through existing services**. In addition to

[12] Carers Australia is a body comprising members from each State and Territory carers' association.

[13] These outlets are operated by Respite Centres, but from different geographic locations to the latter.

operational funding, Health also allocates brokerage funding for these Centres to: purchase or subsidise (broker) flexible respite care; provide emergency respite services; and link carers to residential respite services (see Figure 1.2). Additional funding is allocated to Respite Centres by Health's National Palliative Care Program (NPCP) to assist carers of people with a life limiting illness ($3 million each year), and by the Department of Family and Community Services (FaCS) to assist carers of young people with severe and profound disabilities ($5 million each year). Some State and Territory governments also contribute funding to Respite Centres.

Figure 1.2

Example of Respite Centre activity

In Hobart, a Respite Centre has put in place an arrangement where, about every six weeks, a care worker in a wheelchair accessible bus collects six carers and their care recipients from their homes in relatively isolated rural areas. The carers and care recipients are taken to a local hotel where the Centre has arranged for them to receive a counter lunch. This is the only respite option available to these carers because there are no accessible day centres in the area, and the care recipients have very high needs including for care of dementia. These breaks provide the carers with a change from their usual care routine and an opportunity to socialise and gain support from each other.

Source: Health.

Respite Services

1.15 Respite Services, including Commonwealth Respite for Carers (CRC) Program services that now form part of NRCP[14], **deliver respite** to carers and the people they care for in a variety of settings (see Figure 1.3), including in-home, day centre, host family and other appropriate short-term respite accommodation. They include 169 Services specifically targeted at carers of people with dementia.

[14] The Australian Government established this Program in 1992. It comprised a package of assistance that expanded centre-based and home-based respite care services, and it developed information kits to help carers with issues and concerns in relation to caring.

Figure 1.3

Examples of Respite Service activity

Example 1

In Melbourne, care recipients who require frequent personal assistance have the opportunity to holiday with other people with similar needs. A metropolitan Respite Centre has entered into an arrangement with a local personal care agency to ensure that there is an adequate staff-to-client ratio for these holidays. This arrangement ensures that carers are able to get a break while the care recipient receives care in a supported environment. It also helps to reduce the cost of providing care.

Example 2

A carer on an outback station was not able to leave her aged mother. The Respite Service brought a caravan to the property and used it to accommodate the care recipient. The accommodation arrangement was also reversed, with the carer taking a break by staying in the caravan while the care worker stayed in the house and cared for the carer's mother. The mobile respite van is used to provide respite in rural/remote Queensland.

Example 3

The Northern Territory has a responsive Respite Service that provides respite without sending the care recipient away from the community. The Northern Territory Carers Association has been funded for two four-wheel drive Troop Carriers, camping and picnic gear if needed, fuel, and top-up wages for community-based workers when required. The vehicle and equipment is loaned to remote communities to enable them to take care recipients into the bush for respite. One of the vehicles was based at the one location for two months and the other has been to four different locations. Initial indications are that between 30 and 40 clients were assisted at each location.

Source: Health.

National Carer Counselling Program

1.16 The National Carer Counselling Program (NCCP) is a 2002 Budget Initiative delivered through Resource Centres to give carers access to specialised professional counselling. The Counselling Program addresses issues specific to carers such as carer stress, grief and loss, coping skills and transition issues. There is a single contract between Health and Carers

Australia for the delivery of this Program, with Carers Australia sub-contracting State and Territory carer associations to deliver parts of it.

National dementia programs

1.17 There are three National Projects funded under NRCP and delivered through Alzheimer's Australia:

- National Dementia Behaviour Advisory Service ($1.5 million);
- Carer Education and Workplace Training Project ($1.1 million); and
- Early Stage Dementia Support and Respite Project ($400 000).

Carer Information and Support Program

1.18 CISP was established in 1997 to develop and distribute information and practical advice about Australian Government programs in support of carers. These products include the *Carer Information Pack*, the *Aboriginal and Torres Islander Peoples Carers Kit* and activities related to *Carers Week*. In 2003–04 $2.1 million was allocated to the program, from which funding is provided to Resource Centres in each State and Territory ($1.5 million in 2003–04). The remainder is retained by Health for central product development and distribution.

Funding

1.19 NRCP is funded by Health as part of *Outcome 3: Aged Care and Population Ageing*. The aim of Outcome 3 is to ensure that high quality, cost-effective care is accessible to frail older people, and their carers are supported.

1.20 The 2005–06 Budget Estimate for Outcome 3 for administered items[15] is $6.5 billion[16], comprising:

- $4.7 billion for Residential Care;
- $1.4 billion for Community Care and Support for Carers, of which $134.8 million relates to NRCP;
- $222.3 million for Flexible Aged Care;
- $59.8 million for Aged Care Assessment;
- $37.4 million for Ageing Information and Support;
- $32 million for Aged Care Workforce;
- $25.6 million for Dementia; and
- $20.2 million for Culturally Appropriate Aged Care.

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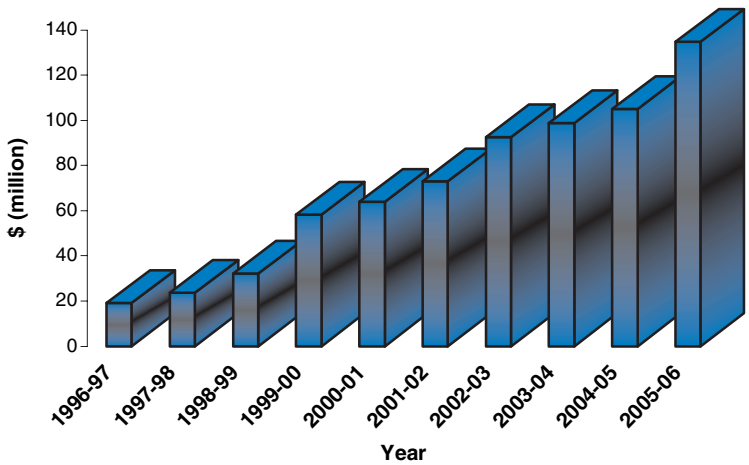
[15] Administered items are those assets, liabilities, revenues and expenses controlled by the Government and managed or overseen by agencies or authorities on behalf of government.

[16] This figure has been rounded.

1.21 In 1996–97, the Australian Government commenced funding NRCP, with the original CRC funds subsumed into the NRCP base funding. Program funding has increased from $19 million in 1996–97 to $134.8 million in 2005–06 (see Figure 1.4). This increase comprises a series of Budget measures (see Appendix 2), predominantly with initiatives addressing dementia and challenging behaviour, and the reallocation of unused budgeted residential respite subsidy to NRCP.[17]

Figure 1.4

NRCP funding growth



Source: ANAO from Health's data.

1.22 The 2005–06 NRCP budget, $134.8 million, is allocated to components as follows[18]:

- Resource Centres—$4.7 million;
- Respite Centres—$46.2 million; and
- Respite Services—$59.5 million.

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[17] In the 1998 Budget, the Australian Government agreed to the cashing out of unused residential respite subsidies allocated to residential aged care homes, and use of those funds for community-based respite care. This was in response to the continued low levels of respite provided by aged care homes compared to available allocations. Also, it was consistent with a policy decision to provide carers with more flexible community-based options as an alternative to residential care.

[18] The amount of funds allocated across the three major Program components is less than the annual budget because some funding announced in the 2005–06 Budget, which is included in the annual NRCP budget, is yet to be allocated to components.

Health's program management structure

1.23 Health's Community Care Branch is responsible for the administration of community care programs. This responsibility includes policy development and management of programs for carers. Health's State/Territory Office (STO) staff administer NRCP at the local level, including liaison and communication with service providers and State and Territory government departments. They also contribute to national policy development.

1.24 Health seeks Ministerial approval for administered expenditure under the Program, ranging from funding for new Centres and Services, expanding existing Centres and Services, allocation of surplus funds, Program related consultancies, and Program support for conferences. Ministerial approval is also sought for Program publications and materials, for example, carer kits, consultancy reports and guidelines.

Program developments

Community Care Review

1.25 In response to community and industry concerns that the community care system was too complex and that older people and their carers had difficulty in finding and accessing help, in 2002, the Minister for Ageing initiated a review of Health's 17 community care programs (including NRCP).

1.26 The aim of the review was to identify reforms that would deliver community care in a consistent manner across all programs. It sought to establish common:

- points of access;
- assessment processes;
- eligibility requirements;
- standards of service provision;
- user fees;
- accountability processes; and
- information systems across all similar programs.

1.27 Health's Community Care Branch conducted the review, with the resulting report, *A New Strategy for Community Care—The Way Forward* [19], published on 3 August 2004. This report proposed significant changes to the way in which community care services are delivered. It is in this context that

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[19] Department of Health and Ageing, *A New Strategy for Community Care–The Way Forward*, 2004, Canberra. Available from Health's website: <http://www.ageing.health.gov.au>.

Health has advised that it is working to streamline and improve administrative arrangements for NRCP in association with administrative reform in other community care programs. Implementation of reforms may involve consultation with industry and/or State and Territory governments where appropriate, pilot testing and evaluation prior to full implementation. Health is already well advanced on some initiatives stemming from the review.

Audit approach

1.28 The audit was identified as part of the ANAO's strategic planning and was included in the Audit Work Plan for 2004–05 as an audit topic. The topic was subsequently brought forward, because several audits planned for that year were re-scheduled.

Audit objective and criteria

1.29 The objective of the audit was to assess the effectiveness of Health's administration of the National Respite for Carers Program.

1.30 The audit assessed the effectiveness of Health's administration of NRCP against the following criteria:

- does Health effectively plan Program delivery;
- has Health established appropriate systems/processes to guide Program administration; and
- does Health effectively monitor Program delivery?

Audit methodology

1.31 The methodology included:

- interviewing Health officers in Central Office and four STOs (New South Wales, Victoria, South Australia, and Tasmania);
- reviewing Health data and documentation, including business plans, performance information and funding agreements;
- reviewing Health's business support systems;
- reviewing relevant literature;
- interviewing Resource Centre, Respite Centre and Respite Service provider personnel;
- interviewing State and Territory government officers; and
- meeting with key stakeholders.

1.32 Audit fieldwork was conducted over the period August to November 2004. The audit was conducted in accordance with ANAO Auditing Standards at a cost of $325 000.

Audit scope

1.33 This audit focused on Health's administration of NRCP, with a particular focus on the impact of administrative arrangements on provision of respite and information services to carers. While the audit reviewed coordination between NRCP and other community care programs, it did not include FaCS, DVA or Centrelink. The audit also excluded a review of the CRC program and related programs such as CISP.

1.34 The ANAO is aware of the underutilisation of Australian Government allocated residential respite days in aged care homes. The Australian Government subsidises respite in residential aged care homes so that carers of eligible recipients can rest from their usual caring role. This support is legislated under the *Aged Care Act 1997*. In 2003–04, days used by homes represented 58 per cent of those allocated. Residential aged care homes appear to prefer using places for long-term residents even though they have applied for and received an allocation of respite days. Health is aware of this issue and is acting to improve utilisation. While this is an important issue impacting the level of residential respite available for carers, the administration of residential aged care is outside NRCP, and as such this issue is beyond the scope of this audit.

Other relevant audits

1.35 The ANAO has not previously audited NRCP. However, the ANAO has completed the following related audits:

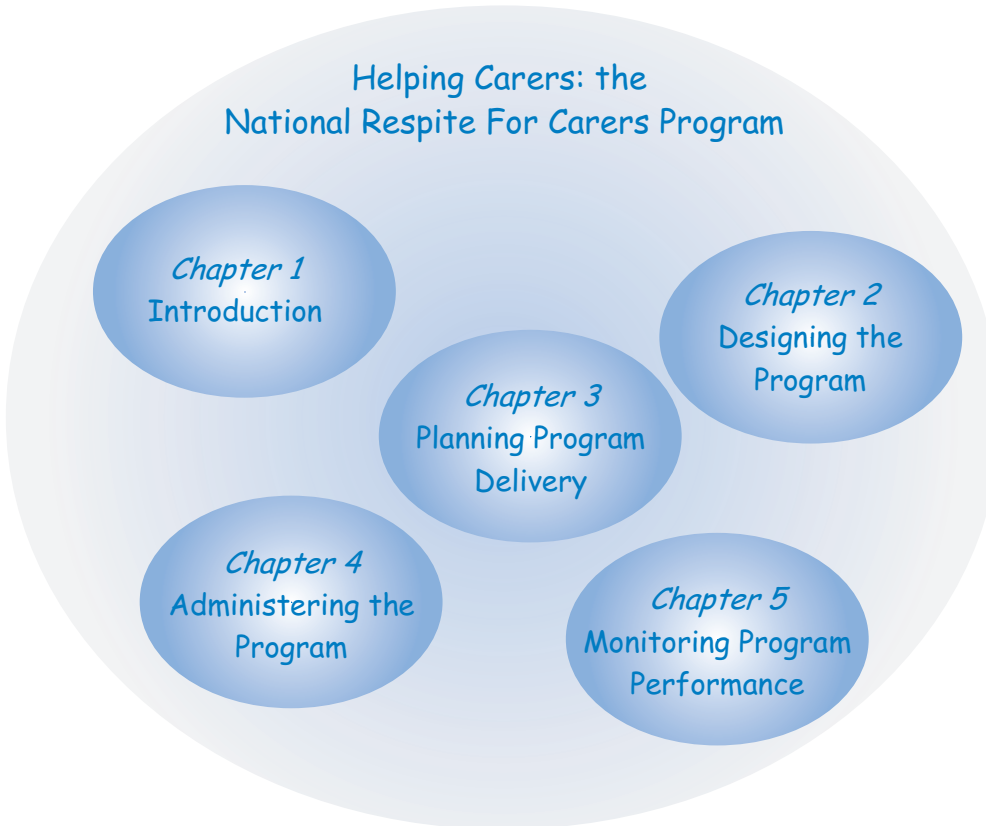
- *Veterans' Home Care*, Department of Veterans' Affairs, Audit Report No.43, 2004–05;
- *Home and Community Care Follow-up Audit*, Department of Health and Ageing, Audit Report No.32, 2001–2002; and
- *Home and Community Care*, Department of Health and Aged Care, Audit Report No.36, 1999–2000.

Report structure

1.36 The Report is organised into five Chapters. The structure is depicted in Figure 1.5.

Figure 1.5

Report structure



2. Designing the Program

This Chapter examines the way in which NRCP has been designed by Health in light of the Government's policy objectives.

Introduction

2.1 Sound program design by public sector agencies is essential in order to support the achievement of the Government's policy objectives in an efficient, effective and ethical manner.[20] It also provides the basis for important administrative functions, such as planning, risk management and performance monitoring—these functions are discussed in later chapters. Key elements of program design include a clearly defined program objective, identification of the intended recipients of program services—target group(s)[21], the scope of services and service delivery approach—essentially determining what will be provided to whom and how this will be done.

2.2 The role of agencies in the design of programs is influenced by the way in which the Government establishes a program. Some programs are established by legislation, with the key elements of program design prescribed. Under this arrangement, agencies have little flexibility. Other programs are the result of policy announcements of government, with greater flexibility afforded to the relevant Minister and/or implementing agency.

2.3 In assessing the effectiveness of Health's administration of NRCP, the ANAO first reviewed the role of Health in the design of NRCP and its design decisions. In support of this review, the ANAO examined the way in which NRCP was established, and it also assessed the extent to which Health's implementation of NRCP was consistent with the Government's objectives.

Program structure

2.4 Nine separate policy initiatives have shaped the structure of NRCP since its establishment in 1996 (see Appendix 2 for details of these initiatives). These predominantly related to funding announcements outlined in Federal Budgets, but also included key policy platforms such as the *National Carer*

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[20] Section 44 of the *Financial Management and Accountability Act 1997* requires Chief Executives of FMA agencies to manage the affairs of the agency in a way that promotes proper use of Commonwealth resources. Proper use means efficient, effective and ethical use.

[21] Target groups are sub-sets of a program's stakeholders. While stakeholders include recipients of program services, they also include service providers, government agencies and the general public.

Action Plan[22] and the *Staying at Home: care and support for older Australians Program*.[23]

2.5 Health noted that NRCP is not the direct result of one single policy decision, but rather is the umbrella title for many disparate programs arising from successive government policy and funding initiatives to support carers in the community. These policy announcements generally specify target groups for funding, with resulting policy specific objective(s). This process has resulted in the creation of:

- separate program components, for example, Respite Centres that were proposed in NCAP and funded under the *Recognising Older Australians* policy initiative; and
- targeted service provision within components, for example, the establishment of 169 dementia-specific Respite Services.

2.6 To support policy objectives within this environment, Health has established component-specific:

- funding approaches (further information on funding approaches is provided in Chapter 4);
- guidelines (guidelines are discussed in further detail in Chapter 4); and
- reporting formats (further information on reporting formats is provided in Chapter 5).

2.7 Health has also established separate teams within its Carer Support Section with responsibility for each major component, with minor Program components, such as NCCP, allocated across these teams.

2.8 Although the structure adopted for NRCP is aligned to government policies, it does pose challenges for administration. Where, within a program, there are varied service delivery approaches and administrative practices, administration becomes more complex. It can also become more costly since increased resources are required to manage increased complexity. Further, the targeting of program funding to specific models of service delivery or particular types of carers limits the flexibility required to meet the varied needs of carers, for example, an elderly person caring for a spouse with dementia will have significantly different needs to a young parent caring for a disabled child.

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[22] The Liberal and National Party coalition (the Coalition) developed the Plan as part of its 1996 election platform. Once elected, the Coalition proceeded to implement the Plan. In the 1996–97 Budget, funding of $36.7 million was announced for the introduction of the *National Respite for Carers Programme*. A review of existing respite arrangements was also undertaken in 1996.

[23] This Program was introduced in 1998 to provide more services for the elderly and disabled, and their carers.

2.9 Health has recognised the need to standardise administrative practices and further develop its planning processes for NRCP. It is also seeking to move the disparate components of NRCP into a more cohesive and integrated program, primarily through initiatives stemming from the Community Care Review. The ANAO is supportive of this direction and encourages Health to continue its commitment to improving the efficiency and effectiveness of its administrative structures and practices.

Program objective

2.10 Health has stated that NRCP is:

> …an element of the Australian Government's strategy to achieve an enhanced quality of life for older Australians, Australians with moderate, severe or profound disabilities, and their carers. It is a part of a group of programs which seek to support healthy ageing for older Australians and quality, cost effective care for frail older people and support for their carers. In particular, the NRCP is part of a group of programs which provide support for carers of frail, older Australians and Australians with moderate, severe or profound disabilities with the aim of assisting people to remain in their homes as long as possible.

2.11 NCAP, which was the foundation on which NRCP was constructed, stated that the objective of the proposed program was *to ensure that those full-time carers who desire it are entitled to an adequate and minimum break from their responsibilities, and that carers are not treated as a subordinate client group in community care*. NCAP outlined that the focus of the program's resources would be directed to *care at home and in the community*, reflecting that, for the vast majority of carers, residential-based respite was the least preferred option. The current NRCP aim is:

> To contribute to the support and maintenance of caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances, and those of the persons for whom they care.

2.12 While this aim is more detailed than the objective originally stated in NCAP, it is in keeping with its intent—that is, to provide carers with a rest from their caring responsibilities. However, the current aim focuses on the provision of *appropriate* respite in line with individual need, as opposed to the concept of a *minimum* level of respite outlined in the earlier objective. The concept of appropriate respite in line with individual need is discussed in further detail later in this Chapter under *Eligibility criteria*.

Target groups and eligibility criteria

Target groups

2.13 A clearly defined target group is an important part of program design because it:

- guides the distribution of funding and services;
- provides information to carers on their eligibility for services; and
- enables funded organisations to plan service delivery and promote programs appropriately.

2.14 Where a target group includes more than one type of recipient, clear guidance to funded organisations on the distribution of services across types is essential. This is particularly important where programs are designed to complement existing programs, and where target groups overlap those in other programs.

2.15 The ANAO noted that the Government's NRCP policy initiatives have included broad descriptions of intended beneficiaries of respite and information services. However, these initiatives have not established a consistent, consolidated target group for the Program. Often, policy initiatives focus on a particular condition, such as dementia and challenging behaviour. Policy descriptions include:

- *By caring on a full or part-time basis for a parent, loved one or friend, carers make an untold contribution to the life of our community;*
- *…Carers play a vital role in our community and particularly in support of the frail aged ;*
- *…A carer is any person who, through family relationship or friendship, looks after a frail older person or someone with a chronic illness or disability;*
- *...innovative services that meet the individual needs of carers, including carers of people with dementia and difficult behaviour, people with a mental illness and people with a disability…a particular priority will be respite services for carers in rural and remote areas*; and
- *…The Coalition is committed to ensuring carers receive the recognition, reward and support needed to enable them to continue caring for older Australians at home and in the community*.

Health has developed target groups for the following parts of the Program:

- Resource Centres;
- Respite Centres;
- Respite Services; and
- the National Carer Counselling Program.

2.16 Health's development of these target groups has been informed by the broad descriptions of intended beneficiaries outlined in various policy initiatives, and it is also based on the target population established for HACC.[24] Health adapted the HACC target population to maintain consistency for service providers, as original CRC funding (now part of NRCP) was allocated to *top up* existing HACC providers. It also acknowledges similarities in the recipients of community care services.

2.17 The target groups for each part of NRCP, while similar in intent, differ in wording. It is, therefore, not possible to refer to a single target group for the Program. For the purposes of this report, the ANAO will use the Respite Centre target group, which is:

> Carers of:
>
> - people with dementia;
> - people with dementia and challenging behaviour;
> - frail older Australians (65 years or over, or 50 and over if Indigenous);
> - young people (under 65 or under 50 if Indigenous) with moderate, severe or profound disabilities; and
> - people with a terminal illness in need of palliative care;
>
> who are living at home.

2.18 The ANAO reviewed the broad descriptions of intended beneficiaries outlined in the Government's policy and funding initiatives and compared these to the target groups established by Health. The ANAO concluded that the NRCP target groups that Health established were consistent with the

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[24] The HACC target population is provided at Section 6 of the *Home and Community Care Act 1985*. It is defined as:

- persons living in the community who, in the absence of basic maintenance and support services provided within the scope of the program, are at risk of premature or inappropriate long term residential care, including:
  - frail or at-risk aged persons, being elderly persons with moderate or severe disabilities;
  - younger disabled persons, being persons with moderate or severe disabilities; and
  - such other classes of persons as agreed upon by the Commonwealth Minister and the State Minister; and
- the carers of those persons.

Government's policy initiatives. Health has also clearly communicated target groups to funded organisations through component guidelines, which are attached as a schedule to each funding agreement (further information on guidelines is provided in Chapter 4).

2.19 Subsequently, the ANAO sought to determine whether Health had provided guidance to funded organisations on the allocation of services to different recipient types within target groups. For example, the Respite Centre target group contains five types of recipients ranging from carers of people with dementia through to carers of younger people with disabilities. As noted earlier, clear guidance on the allocation of services across target groups is important, particularly where programs are designed to complement existing programs and where recipient types overlap with other programs. In the case of NRCP, recipient types are shared with several other community care programs. Further, responsibility for the delivery of services to carers of younger people with disabilities is shared across Australian Government departments—Health and FaCS—and across jurisdictions, including Australian Government, State/Territory government and local government. In this environment there is the possibility of cost shifting between programs and departments or across different levels of government. Cost shifting occurs where, for example, the Australian Government funds activity that should be funded by a State and Territory government.

2.20 Respite Services are generally established to provide respite to one or more recipient types of the Respite Service target group, for example, carers of people with dementia and challenging behaviour. These arrangements are documented in funding agreements and specify the intended recipients of NRCP services. Health's data indicates that Respite Services have been established to deliver services to each recipient type of the target group, with:

- 28.1 per cent of services provided to carers of people with dementia;
- 21.9 per cent of services provided to carers of frail aged people;
- 21.6 per cent of services provided to carers of people with dementia and challenging behaviours;
- 21.2 per cent of services provided to people with disabilities; and
- 5.5 per cent of services provided to carers of people receiving palliative care.[25]

[25] A further 1.7 per cent of services are allocated to carers of people with other conditions, such as chronic illness, children with disabilities, financially disadvantaged people and those with psychiatric disorders. The percentages shown here have been rounded.

2.21 Health advised that policy initiatives generally dictate the allocation of Respite Service funding across the NRCP target group, and thus Health's capacity to influence the allocation of funding is limited.

2.22 Health has provided Resource Centres and Respite Centres with the flexibility to allocate services across the different types of recipients for their respective target groups. However, Health has also sought to guide the allocation decisions of Centres to ensure that services are in accordance with policy priorities and carer needs. This involves a balance between devolved and centralised decision making. To be effective, this approach requires clear parameters within which funded organisations are required to operate, while also allowing sufficient flexibility to respond to local conditions.

2.23 The ANAO reviewed Health's guidelines and interviewed Health officers and representatives from Resource Centres and Respite Centres to determine whether Health had established clear parameters to guide the allocation of services by Centres. The ANAO found that Program guidelines did not provide the required level of guidance. Health has, on a case-by-case basis, provided advice to Centres on the allocation of services. It has not, however, consolidated these decisions into an overall set of parameters. In interviews with representatives from Resource Centres and Respite Centres, the ANAO found that the absence of clear guidance has led to some confusion.

2.24 The ANAO suggests that Health develop and disseminate a set of parameters to inform the allocation of Program services within established target groups for Resource Centres and Respite Centres. This would serve to document Health's funding priorities and ease confusion within funded organisations. It would also provide the means for Health to communicate changed funding priorities to service providers. The parameters should allow sufficient flexibility to support Health's devolved model of decision-making. Adherence to the parameters should be monitored through Health's existing reporting arrangements. The ANAO also considers it timely for Health to integrate the components of NRCP through the establishment of an overarching target group for the Program.

2.25 Health has since advised that it is currently in the process of refining performance targets for Respite Centres and that, once complete, these targets will provide greater assistance in the allocation of resources.

Eligibility criteria

2.26 Once target groups have been identified, criteria would generally be established to assist in determining who is eligible for services under the Program. The funding or policy agency then includes the criteria in an assessment instrument or an assessment tool for use by service providers. Health has not established an assessment tool to determine carer eligibility for

NRCP services. Currently, funded organisations are responsible for developing appropriate assessment criteria, within a broad framework outlined in the applicable set of component guidelines.[26] Health does not, however, vet the appropriateness of the assessment criteria adopted by funded organisations.

2.27 The ANAO acknowledges that experienced service providers, given their detailed understanding of the service delivery environment, are well placed to develop appropriate assessment criteria for carers and care recipients. However, a consistently applied assessment tool is an important element in the equitable delivery of services for national programs. Differences in assessment practices for NRCP have led to access and equity issues for carers. Respite Centres advised the ANAO that carers located at regional borders and those that move between regions have experienced differences in service provision due to the different interpretations and approaches adopted by Respite Centres. In response to this issue, Respite Centres have taken steps to try and ensure consistent and equitable service provision between regions, including the development of regional protocols.

2.28 Health has also identified common assessment as a key initiative stemming from the Community Care Review. The aim of this initiative is to ensure that *access to care will be based on assessed need and level of dependency that is determined consistently across the country.*[27] The ANAO strongly supports the implementation of a standardised assessment tool for NRCP as a priority. Where possible, this should be incorporated into the planned Community Care Review initiatives. However, delays in implementation of the Review's findings should not unreasonably delay the development and adoption of an appropriate tool for NRCP.

2.29 Health has since advised the ANAO that a discussion paper is currently being prepared by a consultant to inform the development of a standard eligibility and assessment tool for NRCP. It is intended that this work also inform the development of standard eligibility assessment across community care programs. However, in the first instance, Health's intention is to standardise assessment across NRCP as soon as practicable, depending on the conclusions of the consultancy.

Applicable services

2.30 Specific types of services provided under NRCP have not, generally, been prescribed either by legislation or by the policy initiatives that established

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[26] The framework includes information on key definitions within the target groups, carer assessment, the assessment framework, care plans and referral.

[27] Department of Health and Ageing, *A New Strategy for Community Care–The Way Forward*, 2004, Canberra, p.29. Available from Health's website: <http://www.ageing.health.gov.au>.

the Program. This is in contrast to other community care programs, for example, HACC, which has 11 services prescribed in the HACC Act. For NRCP, Health is responsible for establishing the scope of service delivery, within policy parameters.

2.31 The ANAO noted that the extent to which services are prescribed by Health is dependent upon the component under which they are delivered. This is because organisations funded under each component perform different roles. Respite Services are generally funded to provide a particular model of service to carers, for example, an extra day of centre-based care to complement existing HACC funded days. Funding agreements generally specify the details of service provision.

2.32 In contrast to Respite Services, Health has adopted a decentralised, flexible approach to service delivery by Respite Centres, within the following principles:

> …carer focused, flexible and holistic approach to providing respite services within the context of the carer's and care recipient's home environment, cultural preferences and the provision of other services.[28]

2.33 The flexibility of service provision by Respite Centres was highlighted by a State Office of Health:

> The guidelines are non-prescriptive and general in many respects. NRCP services are funded to provide direct and/or indirect respite, but the exact nature of the service is not detailed, although funding agreements usually specify expectations about models of service. Over the history of the program there has been much debate nationally about what types of service provision fall within the scope of the program.

2.34 The concept of relative need[29] underpins the NRCP assessment framework, particularly services brokered by Respite Centres. Centres are able to respond to carers by asking them about their needs, as opposed to telling them what services can be provided. Stakeholders considered that this flexibility was a key strength of NRCP, as respite options were not limited to a particular one size fits all model of service. There are, however, limits to the level and type of services that Respite Centres are able to offer. For example, the maximum amount of brokerage funding that may be applied to a carer respite package in any one year is $11 500. Further, Respite Centres are restricted to providing short-term or emergency respite. These limits facilitate the allocation of limited funding to as many carers as possible.

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[28] This information is sourced from Health's Respite Centre guidelines. Health has not made its NRCP guidelines publicly available.

[29] The tailoring of respite services to the individual needs of carers and care recipients within available resources.

2.35 While strongly supporting this flexible approach to service delivery, Respite Centres indicated that it can pose difficulties, particularly in justifying the level of services provided to carers. Some carers expressed equity concerns to Respite Centres such as when carers observed other carers with what they perceived to be a similar role receiving different respite assistance from them. Issues have also arisen over the interpretation of what constitutes respite. Respite Centre representatives, interviewed by the ANAO, indicated that there were differences in the interpretation of respite across the Program, with some Centres interpreting broadly and others interpreting narrowly.

2.36 These interpretation issues have affected access to, and equity of services for carers. For example, some Respite Centres provided carers with subsidised weekend retreats and massages. The purpose of these activities was to encourage carers to take time for themselves. Health did not consider that these activities were equitable, that is, they were mainly available to metropolitan carers, nor did they provide a longer term benefit to the carer. In response, Health provided further guidance to Respite Centres, through the *Commonwealth Carer Respite Centre Newsletter*, on appropriate brokerage expenditure.

2.37 Health has sought to further clarify the types of acceptable services provided by Respite Centres, with a range of examples of respite included in the NRCP Minimum Data Set (MDS) Data Dictionary (see Chapter 5 for more information on the MDS and Data Dictionary). Health has also directed Respite Centres to seek advice from their STO where there is uncertainty as to the appropriateness of a service.

2.38 The Minister for Ageing has determined, from time to time, services that are outside the scope of NRCP. An early example related to the provision of overnight respite in cottage style accommodation. Health records indicated that the then Minister considered that the required regulation of these facilities would replicate the existing processes for residential aged care homes.[30] Recent examples related to exclusion of respite options that involved overseas travel and payment of the costs of carers taking a break, that is, travel costs or accommodation. Health has advised that it intends to provide additional advice on the use of brokerage funds in the next scheduled revision of the guidelines.

2.39 The adoption of a flexible approach to service delivery through Respite Centres is administratively challenging for Health, and poses some difficulties for Respite Centres. Under this approach, regular monitoring of service delivery is required to ensure that funded organisations are working within

[30] Due to the preference of carers for this type of respite, this decision was recently reversed, with the latest policy including funding of $40.8 million for overnight respite in community homes.

the broad principles established for the Program. This is underpinned by the requirement for effective working relationships between Health's STO program staff and staff of funded organisations through which issues of interpretation can be resolved. There is also an increased risk of non-compliant service delivery due to issues of interpretation. However, Health considers that the effectiveness of this model of service delivery, including responsive, tailored respite services, warrants the additional administrative resources required to implement this approach. Health did not consider that traditional service delivery models, such as an entitlement-based model where all carers receive the same service irrespective of needs, would be as effective. This view was strongly reinforced by service providers.

Summary

2.40 The design of NRCP reflects the influences of a series of policy initiatives that have shaped the Program since its inception in 1996. These initiatives have created separate components and targeted services within them. As a consequence, NRCP has a number of components, each with its own administration team, guidelines, model of service delivery and reporting processes. This structure, while aligned to the Government's policies, poses challenges for administration and increases costs.

2.41 Health has established an objective for NRCP. This objective has evolved from that originally established for the Program and, while more detailed, it is in keeping with the intent of the earlier objective.

2.42 The target groups for NRCP are based on the policy initiatives that have shaped the Program and the adaptation by Health of the target groups from HACC. While Health has established target groups for each major component of NRCP and communicated these to funded organisations, it is yet to develop sufficient guidance for Respite Centres, and to a lesser extent Resource Centres, to inform the allocation of services to different types of recipients within target groups. This guidance is particularly important for programs like NRCP that were designed to complement a range of other programs. It is also an important approach to limit potential cost shifting between programs, departments and different levels of government. Health has advised that refinements to performance targets, once complete, will provide greater assistance to Respite Centres in the allocation of resources.

2.43 A consistently applied assessment tool is an important element in the equitable delivery of services under national programs. Health is yet to establish a common assessment tool to determine eligibility for NRCP services. Differences in assessment practices for NRCP have led to access and equity issues for carers. Health has, however, identified common assessment as a key

initiative stemming from the Community Care Review and has commenced work on development of an NRCP assessment tool.

2.44 The degree to which Health has prescribed applicable NRCP services is dependent on the component under which the services are delivered. For some components, the types of services provided are prescribed in the funding agreement. Whereas for other components, funded organisations have the flexibility to develop tailored respite options within broad principles outlined in the applicable guidelines.

2.45 Health's adoption of flexible service delivery under the Program facilitates the achievement of policy objectives, supports a carer focus, and is strongly supported by service providers. However, it is more administratively challenging than other delivery models. Health has acknowledged these challenges and is working to limit their impact.

3. Planning Program Delivery

This Chapter examines Health's planning arrangements, with a focus on planning approaches, funding allocation, performance measurement and integration of planning with other community care programs.

Introduction

3.1 Planning provides a map of how an agency will get to where it wants to be. It sets out the necessary steps and processes, identifies what resources are needed, and how they will be used. It also determines relevant objectives and targets and establishes a mechanism to enable administrators to assess and report the extent to which individual components and the overall program are meeting their objectives. Planning also helps to ensure consistency between strategic and operational objectives, and identifies risks to the achievement of these objectives and timely ways of dealing with risks.

3.2 The ANAO's review of Health's planning processes considered Health's:

- program planning—those plans, such as strategic plans, and planning approaches, such as regional needs-based planning, that guide the deployment of program resources; and
- business planning—those plans that establish what Health will achieve, when it will be achieved and what resources are required.

3.3 The ANAO also examined the extent to which Health established appropriate performance information for NRCP, with a focus on compliance with the applicable requirements and guidelines.

Program planning

Strategic planning

3.4 The ANAO expected Health to have established a strategic or longer term plan to guide its administration of NRCP, that established program priorities and provided a means to measure their achievement. The ANAO found that Health has not established a strategic plan for NRCP. Health summarised its views on strategic planning in the following response to the ANAO:

> NRCP planning is, in the greater part, directed by the target and purpose of each funding initiative. Service provision is responsive to identified carer needs, and to a significant extent reflects service delivery models advanced by regional providers to meet local needs in response to advertised funding initiatives. This responsive and flexible funding allocation increases the risk of

perceived inequities when compared with more structured planning models, such as through the ACAR [Aged Care Approvals Round[31]].

3.5 The ANAO acknowledges the complexity of longer term planning in an environment of policy uncertainty and responsive service delivery. It also recognises the benefits derived from a clearly defined future direction for programs. A strategic plan would assist Health to inform policy development, particularly where the plan is provided to the Minister for endorsement. It would also serve as a mechanism to support Health's stated goal of improving the Program's cohesiveness and integration.

Recommendation No.1

3.6 The ANAO recommends that Health develop a longer term strategy for NRCP that:

- provides a statement of strategic directions and priorities;
- describes key Program aims and approaches; and
- establishes an integrated performance measurement framework, against which the achievement of Program objectives can be assessed.

Health's response:

3.7 Health agrees with this recommendation. The NRCP is made up of a series of policy initiatives, each with its own specific aims, priorities and administrative requirements. These policy initiatives were necessarily established through separate program components and these historic arrangements have limited the need for (and usefulness of) a longer term program strategy.

3.8 However, the increasing scale of the program, coupled with requirements arising from *A New Strategy for Community Care—The Way Forward (The Way Forward),* has provided the opportunity to develop longer term strategic program arrangements for the NRCP. The recent open competitive Request for Application (RFA) processes for the functions administered under the NRCP represent the first step to defining and implementing consistent arrangements.

3.9 Further development is being undertaken through the development of common arrangements as *The Way Forward* is implemented across community care programs (including NRCP).

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[31] The Aged Care Approvals Round is the mechanism used by Health to distribute Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages, residential aged care places, and capital grants for residential aged care services. Appendix 1 provides further information on these programs.

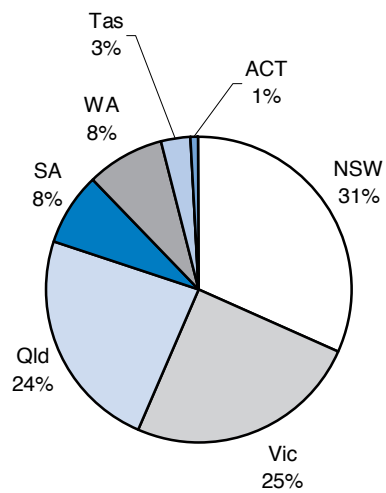
Identifying need

3.10 The assessment of need is an important element of sound program planning. It allows funding providers to target the provision of respite services. It also provides baseline information against which the performance of programs can later be assessed.

3.11 Health's primary source of data on carer need is the ABS's *Survey of Disability, Ageing and Carers*,[32] which includes information on the number of primary carers in each State and Territory (see Figure 3.1). Health uses this information as a key indicator of need and, subsequently, to allocate Program funding to each State and Territory.

Figure 3.1

Distribution of primary carers by State/Territory



* Estimates for the Northern Territory are not shown separately, as Health does not consider them to be reliable.

Source: Health (derived from ABS information).

3.12 Health's STOs are responsible for determining needs within their jurisdictions. However, the ANAO was unable to find evidence of a consistent and systematic approach to determining needs for each of the States and Territories. The establishment of consistent and systematic approaches ensures that services target those areas most in need of funding, consistent with the Government's objectives. While some program officers had undertaken limited data analysis, this activity was not replicated by other program officers within

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[32] Australian Bureau of Statistics, *2004 Disability, Ageing and Carers*, 2004, Canberra.

the same STO or in other STOs. Further, the ANAO found that approaches developed by program officers were not necessarily adopted by their successors. Therefore, approaches used to determine need differ across the program and over time. This variation limits Health's ability to determine whether Program funding is being targeted appropriately and in accordance with policy objectives.

3.13 In addition to the quantitative data sourced from the ABS and the Program knowledge of STOs, Health has also sought to build its understanding of carer needs through a variety of sources, including surveys, market research, peak body meetings, and reports from funded organisations.

3.14 While Health is building its understanding of the needs of target groups for NRCP, its current understanding is limited. At present, Health does not have data on the numbers of carers in particular regions, nor does it possess a well-developed understanding of the capacity of other providers on a regional basis.

3.15 This limited understanding has practical implications for Program delivery. The ANAO noted that Health is using a service provider's capacity to spend as a substitute measure of need when reallocating funding within the Program. That is, Health transfers funds from Centres/Services that are unable to spend their funding allocation to Centres/Services that can. An inability to expend funds is not necessarily a reflection of a lower level of need. It could represent more difficult service delivery conditions, for example, rural and remote areas where there is a dearth of service providers. It could also represent a timing issue, where an initiative is in the early stages of development and is yet to reach full capacity.

3.16 Without sufficient data on the needs of the NRCP target groups and those of recipient types within target groups, Health is not in a position to adequately assess the appropriateness of resource allocations. Further, the development of appropriate performance targets in funding agreements is more difficult.

Planning by region

3.17 While some components of NRCP are structured around geographic regions, such as Respite Centres, the Program as a whole is not planned on a regional basis. This is partly due to limited data on carer need within regions—the ABS's primary carer data is not sufficiently detailed to enable Health to identify primary carer numbers by region. An added complication is Health's limited knowledge of the level of service provision by other community care programs on a regional basis (this issue is discussed in more detail later in this Chapter).

3.18 Respite Centres are regionally located, with a defined geographic coverage. These regions were originally aligned with HACC regions. However, over time, amendments to HACC boundaries have not necessarily been reflected in NRCP regional boundaries.

3.19 Centres advised the ANAO that boundary changes, which have resulted in overlapping boundaries, have increased administration. For example, time devoted to liaison and coordination is increased where an NRCP region overlaps two HACC regions. The ANAO acknowledges the effect of overlapping boundaries on service delivery. It also recognises the difficulties in maintaining aligned boundaries particularly where responsibility for complementary community care programs rests with other jurisdictions. An example is HACC, which is delivered by State/Territory governments. Simply adopting boundary changes implemented by other programs could have a marked effect on NRCP, for example, it could lead to the closure of Respite Centres and the expansion of boundaries for existing providers. This may not be in the best interests of the Program or its clients.

3.20 The distribution of Respite Services is not determined on a regional basis. New Respite Services are selected through an open tender process, with the quality of application determining the selection, and ultimately location, of these Services.

NRCP Regional Mapping Project

3.21 Recently, Health completed a Regional Mapping Project. This project involved Health's Central Office collecting and collating service provider information in each State/Territory and HACC region for:

- NRCP Centres and Services;
- HACC funded respite services;
- residential respite services; and
- Carelink Centres.

3.22 The information that Health collated differed for each program, but included: provider contact details; funding details; hours of service provided in the previous financial year; and number of carers assisted in the previous financial year. Health advised the ANAO that it will use the information collected as part of this project to inform future planning considerations. The value of activities such as the Regional Mapping Project would increase if they took account of all service provision within a particular area because this would better inform the department of gaps in service provision. The inclusion of respite services delivered by State/Territory governments would further enhance the value of future mapping exercises. Regional consultation with stakeholders would also contribute to the usefulness of mapping data. While

desirable, these steps must be balanced with the costs of conducting such exercises.

Integrated planning

3.23 The ANAO found limited integration of NRCP planning with that of other community care and carer support programs. Further, the ANAO noted that there is minimal sharing of planning data and performance information between programs. The absence of this information reduces the effectiveness of Program delivery, because it increases the risk that:

- gaps in service delivery are not identified;
- areas of duplication are not identified; and
- administrative efficiencies are not realised.

3.24 The ANAO found that other community care programs, particularly HACC, have a profound impact on NRCP service delivery. In particular, Respite Centres indicated that extended HACC waiting lists result in an influx of carers seeking support. This places additional pressure on Centre resources and adversely impacts their ability to plan service delivery. Additional information on coordination between NRCP administrators and other community care administrators is in Chapter 4.

3.25 Health has added to its understanding of complementary programs through the recent completion of the Regional Mapping Project, as discussed earlier. The ANAO also noted that Respite Centres are working with other service providers in order to develop a better understanding of the capacity of mainstream services.

Recommendation No.2

3.26 The ANAO recommends that Health implement a needs-based planning methodology to underpin NRCP service provision, comprising:

- a methodology, incorporating a common assessment tool, for determining carers' needs; and
- regional planning, incorporating program data from relevant community care programs.

Health's response:

3.27 Health agrees with this Recommendation and, prior to the ANAO's conduct of this audit, had put in place arrangements to improve needs based planning.

3.28 During 2004, Health had put in place arrangements to develop a common assessment tool for determining carers' needs. This was called the

"Carer Eligibility and Needs Assessment for the NRCP Research Project". In November, 2004, Health advertised for a consultant to undertake the development work and the Centre for Health Services Development (CHSD), University of Wollongong, was the successful tenderer. This work is underway.

3.29 During 2004, as part of *The Way Forward* reform agenda, the process of establishing regional planning arrangements across community care programs commenced. In November 2004, a Commonwealth/State Working Group was established to develop integrated planning across community care programs, including the NRCP. Prior to this, Health undertook a regional mapping exercise for the NRCP, focusing on carer specific information, which will assist in informing the work that is now underway.

Business planning

3.30 Health's business units, including STOs, prepare annual business plans. Responsibility for development of plans for the delivery of Health's national programs is shared between Central Office and STOs. In effect, there are nine business plans governing the delivery of NRCP. The reporting formats for these plans differ between Central Office and STOs, due to the different roles performed. While a common planning format has been developed for STO reporting, each STO plans its delivery of elements of national programs depending on local conditions.

3.31 The ANAO considers that sound business planning should clearly state what will be achieved, when it will be achieved and what resources are required. The ANAO reviewed Health's business plans against these criteria and found that, overall, they were compliant. However, the ANAO did identify issues with the specificity of performance information, in particular the appropriateness of targets. Further, the ANAO found limited financial information in some plans, with no apparent link between planned activities and the resources required to achieve them.

Performance information

3.32 Performance information is evidence about performance that is collected and used systematically to guide the implementation of programs. It allows program administrators to determine the extent to which planned objectives have been achieved. The Department of Finance and Administration's guidance to public sector agencies on the development of performance information recommends performance indicators that reflect the:

- effectiveness of contributions to outcomes;
- price, quality and quantity of outputs; and
- desired characteristics of relevant administered items.

3.33 These indicators help external parties evaluate the agencies and their work. They also help agency managers in the evaluation and design process, at both a policy and an administrative level.[33]

Service delivery performance information

Performance measures

3.34 Health introduced performance measures and targets into funding agreements for Resource Centres and Respite Centres in 2003. Targets were subsequently removed in 2004, because Health considered that they required further development and refinement. Health has advised the ANAO that it has appointed a consultant to review performance targets. Health anticipates that this work will be finalised prior to the issuance of new funding agreements on 1 July 2005.

3.35 The ANAO reviewed the performance measures in Respite Centre agreements and found that they were structured around seven objectives and 20 measures, which spanned both quantity and efficiency. Health advised that it still used the performance measures, despite the removal of targets. The ANAO considers that it is harder to determine performance and movements without performance indicators and targets to provide points of comparison. An example of a Health measure is:

> Total number of carers assisted, by target group (i.e. all advice, referrals, bookings and/or purchases).

3.36 Health officers commented on the complexity of developing an appropriate range of information for inclusion in funding agreements. A particular area of concern related to the inclusion of funding targets and whether to use maximum or minimum funding targets. Health was conscious of the impact of inappropriate measures and the behaviours that could be driven within funded organisations and the resulting effects on service delivery.

Service standards

3.37 NRCP National Service Standards are incorporated into all Program guidelines (see Appendix 3 for the NRCP National Service Standards). These Service Standards comprise broad statements aimed at ensuring that an appropriate level of service is provided to carers. The Standards are not, however, aligned to performance information. As a consequence, services are not reporting against the Service Standards (this issue is addressed in more detail in Chapter 5).

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[33] Department of Finance and Administration, *The Outcomes & Outputs Framework—Guidance Document*, 2000, Canberra. Available from the Department of Finance and Administration's website: <www.finance.gov.au/GF/>.

Health's Portfolio Budget Statements

3.38 Health's NRCP performance indicator in its 2004–05 Portfolio Budget Statements (PBS) was *the number of National Respite for Carers services funded*. This indicator is termed a quantity indicator. As noted above, the Department of Finance and Administration's guidelines recommend agencies develop price, quantity and quality indicators on outputs for their PBS and annual reports. The absence of a balanced set of NRCP indicators in the 2004–05 PBS limited the ability of stakeholders to assess Program performance. The ANAO noted that Health has included two quantity indicators and one quality indicator covering NRCP in its 2005–06 PBS.

Summary

3.39 Health's planning requires further strengthening to support the current size and complexity of the Program.

3.40 Health has not developed a strategic plan for NRCP to guide the deployment of resources. The development of a plan of this type would assist Health to integrate the various components within the Program and guide development and expansion. It would also facilitate the establishment of a set of NRCP performance measures against which the performance of the Program could be assessed.

3.41 The absence of an effective needs-based planning approach for NRCP, incorporating service delivery data from other community care programs, has limited Health's ability to target funding to areas of greatest carer need. The assessment of need is an important element of sound program planning. It allows funding providers to target the provision of respite services. It also provides baseline information against which the impact of programs can later be assessed.

3.42 Business planning for NRCP, as is the case for Health's other national programs, is split between Health's Central Office and STOs, resulting in nine business plans guiding Program administration. These business plans include a variety of information, however, the limited detail and specificity of some of this information, for example, targets, restricts its usefulness.

3.43 Health's use of performance information to inform Program delivery and future expansion is limited. This is partly due to the complexity involved in developing performance information of sufficient detail and appropriate coverage. The performance information that Health has established for the Program is not sufficiently integrated, nor does it support comprehensive monitoring of Program performance. Health is, however, working to improve the quality, quantity and appropriateness of performance information for NRCP.

4. Administering the Program

This Chapter considers practical aspects of administering NRCP.

Introduction

4.1 The ANAO's review of Health's implementation of NRCP focused on: the distribution of funding to service providers; the policies and procedures that guide administration; day-to-day coordination between NRCP and other community care administrators; the support that Health provides to funded organisations; the maintenance of service delivery; and the way in which Health records its administrative decisions and actions.

Distributing funds

Funding policy and procedures

4.2 The ANAO initially sought to review Health's policies and procedures for the allocation of funding. In particular the ANAO was interested in assessing the soundness of Health's funding formulae/methodologies. However, Health has not documented administrative procedures nor guidelines governing the allocation of funding under NRCP. In addition, the department has not documented a funding formula or funding methodology. This makes it difficult for Health to explain its funding decisions to stakeholders. It also makes it difficult for new staff to understand funding procedures and practices and introduces variation into funding approaches. This complicates efforts to determine the rationale underpinning Health's Program funding. In the absence of documentation, the ANAO gathered information on Health's funding allocation practices from interviewing Health officers and reviewing Health's records.

Funding sources

4.3 NRCP funding results from policy initiatives and associated funding, the reallocation of unused budgeted residential respite subsidies, indexation, and growth funding attributed to the original CRC component of the Program. Funding is also provided to Respite Centres by FaCS and under Health's National Palliative Care Strategy.

4.4 While not constituting additional Program funding, Health reallocates uncommitted funds within the Program on an annual basis.[34] This occurs where a Centre/Service is unable to commit its full funding allocation (this

[34] In 2003–04, recouped uncommitted funds totalled $4.4 million.

issue is discussed in more detail in Chapter 5). Then, Health reallocates funds to other activities within the Program, which may include:

- additional funding to other Centres/Services that can demonstrate a capacity to spend; or
- national projects (such as consultancies).

4.5 Where the purpose of additional funds has not been specified by policy, the Minister and/or Health have the discretion to assign priorities. The ANAO noted that the Minister and Health have exercised this discretion, with funding priorities including innovative respite approaches and rural and remote respite services. Health also determines the amount of funding required for NRCP national projects, such as consultancies. Funding is then allocated to States and Territories on the basis of primary carer numbers (see Table 4.1). Health advised that funding levels for the Northern Territory and Tasmania were increased to ensure that they received sufficient funds.

Table 4.1

2004–05 allocation of NRCP funding[a]

State/Territory	Allocation (million)
New South Wales	33.5
Victoria	22.5
Queensland	18.0
South Australia	9.2
Western Australia	8.4
Tasmania	3.6
Northern Territory	2.6
Australian Capital Territory	2.1
NATIONAL	0.2
NCCP	2.2
OTHER	2.6
TOTAL	104.9

[a] The 2005–06 NRCP budget is yet to be allocated to States and Territories.

Source: ANAO from Health's information.

4.6 Once the purpose of the funding and the State and Territory allocation is determined, Health must then decide where the funding will be allocated within the Program, that is, Resource Centres, Respite Centres or Respite

Services. Within these Program components, there are four expenditure types.[35] Respite Centre funding is also split between operational funding (those funds required to operate the Centre) and brokerage funding (those funds used to purchase/broker respite services).

Funding rounds

4.7 Once Health has determined the amount of funding that will be distributed for service delivery, Health allocates these moneys through:

- open funding rounds, where Health invites applications from suitable providers through national advertisements; and
- targeted funding rounds, where Health requests existing providers to apply for funding for specific purposes.

4.8 Health generally uses open funding rounds to distribute new moneys that accompany Budget measures. This is particularly the case where Budget measures call for an expansion of existing Program components, for example, the increase in the number of Respite Services that occurred in 2002–03. The ANAO reviewed the most recently completed open funding round, and found that Health's Central Office adopted a structured approach with application documentation, evaluation criteria and assessment documentation developed for use by STOs in selecting providers.

4.9 Health primarily uses targeted funding rounds to distribute growth funding and the unused budgeted residential respite subsidy. These rounds are also used to distribute funding recovered from service providers unable to fully use the previous year's allocation. Targeted funding rounds are generally less structured than the open funding rounds, that is, the ANAO noted that consistent application and assessment documentation was not generally developed by Health's Central Office for this type of round. STOs were usually responsible for handling these rounds. This less structured approach reflects the lower funding levels allocated this way.

4.10 Health invites providers to apply for funds on a number of occasions each year, with up to four funding rounds in some years. The amount of work generated from these rounds, particularly open funding rounds with large

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[35] These are:

- capital items—relates to funding provided to purchase capital items, such as safety fencing for dementia services;
- one-off—relates to the reallocation of underspent funds to services that demonstrate a capacity to expend the funds;
- fixed term—relates to pilot programs; and
- ongoing—base funding.

numbers of applications, results in a heavy administrative workload within the department and within organisations seeking NRCP funding. The ANAO recognises that Health has limited control over the number of funding rounds stemming from policy initiatives, as the release of this funding is a decision of government. However, these particular government initiatives represent only one source of funding. Therefore, the ANAO suggests that Health consolidate funding rounds that result from other sources, such as growth funding or the reallocation of the residential respite subsidy, to achieve administrative efficiencies.

Appropriate levels and cost of respite models

4.11 In assessing the appropriateness of applications for funding, it is important for program administrators to understand the service level required to meet a defined need, and the cost of providing that service: for example, the appropriate hourly charge for the provision of home help and how much of this help is required to meet a carer's needs. This knowledge assists administrators to assess funding applications and alerts administrators to those services outside the normal range of service delivery. It also informs the development of performance information.

4.12 Health advised the ANAO that this is a complex issue. This complexity arises primarily as a result of the basis on which NRCP services are delivered. As noted earlier, NRCP service delivery is assessed against relative need, not entitlement. There is also considerable flexibility in the types of respite packages developed by Respite Centres, with variation between packages. This approach can result in a wide range of respite models.

4.13 The ANAO noted that Health is aware of the importance of developing level and cost benchmarks for respite models. Over recent years, Health has commissioned consultancies to gather data and information on this matter. An example is the recently completed stocktake of all Respite Services that collected information on staffing levels and unit costs of respite.[36] Given the importance of this information in implementing and further developing the Program, the ANAO encourages Health to continue its efforts in this area.

Timing of funding rounds

4.14 Health's Central Office develops plans for open tender rounds, which include commencement dates and conclusion dates for each phase. The time allocated by Health's Central Office for the 2004–05 round was approximately three to four months in total, with the following major phases:

- three weeks for applications to be completed;

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[36] The usefulness of this data is limited due to quality issues. These issues are discussed in further detail in Chapter 5.

- three weeks for application assessment; and
- two weeks for preparation of a Ministerial minute and approval by the Minister.

4.15 The ANAO sought information from Health to determine the method it used to allocate time to each phase of its funding rounds. While Health endeavoured to structure funding rounds to allow sufficient time for each phase, ultimately the time available was governed by the date on which the funded activity was to commence, for example, the beginning of a financial year or within a current financial year.

4.16 The ANAO's review of funding round records and interviews with STO staff and service providers identified concerns about the time Health allowed for the application and assessment phases of funding rounds. The majority of Respite Centres interviewed by the ANAO advised that the time allowed for the preparation of applications, some involving the development of innovative approaches to service delivery, ranged between one day and four weeks and that the time allocated was generally insufficient. It was not possible, as part of the audit, to determine whether the time allowed for applications deterred potential service providers from applying for funds. However, the ANAO did note correspondence from an STO to Central Office outlining that a well-qualified service provider considered that Health had allowed insufficient time for the preparation of applications and that, as a consequence, it was discouraged from applying for funds.

4.17 Correspondence from Health's STOs to Central Office was critical of the time allocated by Central Office for the assessment of applications. STOs considered that the time allocated was neither commensurate with the complexity of the task nor with the workload, particularly for funding rounds that generated large numbers of detailed applications.

4.18 It was unclear from Health's records whether the time allocated to each phase for these rounds was adhered to. For example, the ANAO's review of a recent funding round noted that assessment information was provided by STOs prior to established deadlines, but was later amended through a series of additions to the earlier information. The ANAO did not find evidence in Health's records of a documented approach to monitoring compliance with the plans. The ANAO considers that monitoring of this type would inform Health's management of its funding activities and indicate where amendments to its schedule may be warranted for future rounds. This information could also contribute to policy advice regarding the time required to implement policy initiatives.

4.19 Similarly, the ANAO found limited information in Health's records to enable it to determine the time allowed for each step of targeted funding rounds. This was generally due to the nature of targeted funding rounds, that

is, these rounds were less structured with administration normally devolved to STOs.

4.20 The ANAO noted that Health seeks Ministerial approval for all funding rounds under NRCP, which is an additional step in the process. The ANAO suggests that Health seek authorisation from the Minister for the department to reallocate funding for certain Program components or for funding decisions below certain thresholds. This would reduce the number of steps required for some funding processes, thus allowing more time for the remaining steps.

4.21 The ANAO identified a related timing issue involving the allocation of funding late in the financial year. The ANAO found that Program funds were often allocated in the latter part of the financial year, particularly in May and June. The allocation of current year funding late in the second half of the financial year is problematic as it does not allow sufficient time for organisations to commit funds in a considered manner prior to the end of the financial year.

Recommendation No.3

4.22 The ANAO recommends that, in order to improve the efficiency of its funding activities, Health:

- monitor both open and targeted funding rounds to inform future funding activities; and
- ensure that funds are allocated sufficiently early to allow considered expenditure over the full financial year.

Health's response:

4.23 Health agrees with this recommendation, and notes that it already has appropriate practices in place.

4.24 Health currently monitors both open and targeted funding rounds to inform future funding activities. For example, formal arrangements have been put in place to monitor current open competitive processes (RFA), which will include a comprehensive report to assist in informing the development of future funding rounds both for the NRCP and other community care programs.

4.25 NRCP funding rounds are started in the first half of the financial year. However start dates are generally in the second half of the financial year (usually 1 January) due to the timing of Budget decisions and lead times required to undertake development work associated with new initiatives. It is not possible (nor desirable) in these circumstances to allocate funding across a full financial year. Part year effects are included in first year estimates, with full year effects in the second year.

Funding agreement term

4.26 Prior to 2002–03, Health established four year funding agreements for NRCP service providers, subject to government funding decisions and satisfactory service performance by providers. While the duration of agreements was consistent, each component of the Program had funding agreements that ended at different times, with some of the earlier CRC agreements not having end dates (perpetual contracts).

4.27 In 2002–03 Health sought approval from the Minister to have all funding agreements end at the same time by proposing short-term extensions to expiring agreements. The justification for the alignment of agreement dates was that it would ensure continuity of services and consistency in funding agreements. The majority of agreements were extended until 30 June 2004. As part of this process, Health worked with service providers to implement new agreements, which also ended on 30 June 2004, to replace the earlier CRC versions. At this point, Health had achieved its objective of aligning the end dates of NRCP funding agreements.

4.28 In December 2003 Health sought Ministerial approval to extend for a further twelve months (pending the outcome of the Community Care Review implementation processes) funding agreements with community care service providers that were previously extended until 30 June 2004. Uncertainty of funding was creating concern among service providers, as they were unable to plan for the longer term. In particular, organisations informed Health that they would be unable to retain staff who thought that their jobs would not continue beyond 30 June 2004. The Minister approved the extension for six months (until 31 December 2004). Health announced, in *The Way Forward*, a further six month extension through to 30 June 2005.[37] The purpose of the six month extensions was *to ensure sufficient flexibility for service providers to take into account the opportunities presented by a more simplified system*.[38]

4.29 The impact of short-term funding agreements was raised in the ANAO's correspondence with Health during the 2003–04 financial statements audit. The ANAO's letter recommended the establishment of longer term (three-year) funding agreements for another Health program in order to reduce the administrative workload for the department and funded organisations. Further, the ANAO suggested that Health could achieve efficiencies if it implemented the agreements in a staged process over three years so that it would process only one-third of funding agreements at any one time.

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[37] Department of Health and Ageing, *A New Strategy for Community Care–The Way Forward*, 2004, Canberra, p.37. Available from Health's website: <http://www.ageing.health.gov.au>.

[38] ibid, p.37.

4.30 While Health's reasons for the series of six-month extensions were sound, that is, to align the terms of its funding agreements and to incorporate initiatives stemming from the Community Care Review, the impact on funded organisations and Health's administration staff was considerable. The issuance of four successive six-month contract extensions significantly increased workloads in STOs. This is particularly problematic where limited administrative resources for Health's smaller programs are shared across a number of programs (this issue is discussed in more detail later in this Chapter). As well, these short-term funding agreements increased uncertainty faced by service providers. The ANAO appreciates that there was a range of competing objectives in determining the length of NRCP funding agreements. However, in seeking to balance these, Health could give more emphasis to the impact on funded organisations and administrative staff.

Developments

4.31 Since audit fieldwork was completed, Health informed the ANAO of funding agreement developments. The ANAO subsequently completed limited fieldwork to verify this information. Health records indicated that on 9 December 2004 the Minister for Ageing advised Health of her approach to achieving efficiencies and streamlining in a number of community care programs, as indicated in *The Way Forward*. This included the Minister's decision to test the market through a competitive tender process for the delivery of a number of community care programs, including NRCP, with a view to having new providers in place by 1 July 2005.

4.32 On 20 January 2005, the Minister sent a letter to peak organisations informing them of the tender process. Health sent a further letter to funded organisations in late January 2005 to advise them of its requirements.

4.33 On 22 February 2005, Health sought Ministerial approval for its approach to the tender process, including the timing, objectives and the services sought. Health also proposed the engagement of a procurement company to provide probity and procurement advice throughout the tender process. Health advised that Ministerial approval was provided on 28 February 2005.

4.34 The tender was subsequently advertised on 5 March 2005, with applications closing on 1 April 2005. Health envisages that new three-year agreements will be in place by 1 July 2005. Health has established transitional arrangements until September 2005 to allow newly funded organisations to become operational, and for those whose funding is discontinued to maintain services where needed while winding down operations.

Policies and procedures

4.35 Clear, consistent and well-documented program policies and procedures are an important part of effective program administration. A single reference source for policy guidance, administrative procedures, monitoring requirements, evaluation strategies and standard forms helps to ensure consistent and efficient administration. This is especially important in networked programs, such as NRCP, where responsibility for day-to-day administration is decentralised.

4.36 In July 2002, Health's Central Office requested STOs to provide their views on a draft NRCP procedures manual being developed and to identify issues that should be included in the final version. However, at the time of audit, there was no up-to-date NRCP procedures manual.

4.37 The absence of an up-to-date procedures manual has led to inconsistent administrative practices between STOs. Areas with inconsistencies included:

- the recovery or rollover of surplus monies at the end of the financial year;
- the suspension or otherwise of payments to defaulting services; and
- planning approaches.

4.38 A national program needs consistent administrative practices. Otherwise, carers' access to services may differ according to the State or Territory in which they live, thus preventing the equitable distribution of services. Further, large community care organisations that operate in several States and Territories are faced with a variety of administrative practices from the one agency implementing a national program. The absence of an up-to-date procedures manual also makes the induction of new program officers more difficult.

4.39 Where procedures are not documented, STOs have either developed their own procedures or sought a precedent from Central Office or other STOs on a case-by-case basis. This results in less efficient, reactive management. An example identified by the ANAO was the lack of guidance to STOs on the removal of funding from poorly performing services.

4.40 STOs have also produced, on an ad hoc basis, their own procedural documents on specific aspects of Program implementation. STOs developed these in an attempt to apply appropriate and consistent practices. Although the ANAO welcomes these efforts by STOs to document procedures and facilitate training and induction of new staff, the development of such materials on a stand-alone basis does not ensure the completeness, accuracy, or consistency of operating procedures nationally.

4.41 While Health acknowledges the absence of an up-to-date national NRCP procedures manual and differences in administrative practices between STOs, it advised the ANAO that program manager teleconferences are held every two months and two day program manager meetings are held every six months. Program administrative practices are discussed and agreed at these forums. Health further advised that it conducts a wide range of staff development programs addressing common program management issues, such as contract management and accounting for government funds.

Recommendation No.4

4.42 The ANAO recommends that, in order to ensure consistent implementation of NRCP nationally, Health issue an up-to-date national NRCP policy and procedures manual and ensure that staff are aware of the manual.

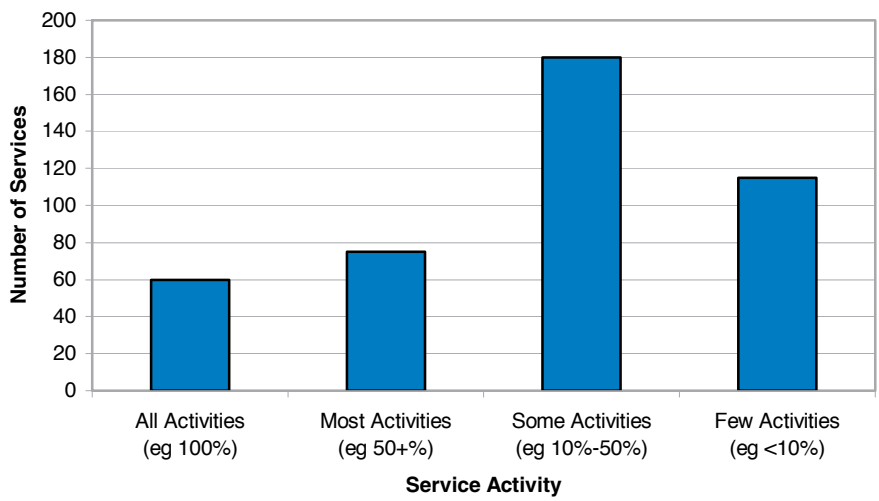
Health's response:

4.43 Health agrees with this recommendation.

Community care coordination

4.44 A number of services specifically designed for carers, such as respite services and support services, receive funding through various government funded programs. In fact, a number of NRCP Services receive more funds from other programs—predominantly HACC (see Figure 4.1 for the percentage of Respite Service activities provided by NRCP).

Figure 4.1
Level of NRCP support



Source: ANAO from Health's information.

4.45 The ANAO found that, although program officers are aware of other community care programs, they generally have a limited understanding of the services being provided and their impact on NRCP. The relationship between various program officers (such as those from State/Territory governments, HACC, VHC and NRCP) is generally informal. Detailed planning and service delivery information is not routinely exchanged between programs unless initiated by individual program officers.

4.46 STOs are, however, taking steps to build their understanding of the impact of other community care programs on NRCP. In one STO visited, the program officer, since early 2003, has liaised with State government counterparts regarding regional respite needs. This liaison helps to identify funding gaps and inequities, and facilitates coordinated approaches to respite planning and funding. The capacity for this liaison depends on workloads and the level of staffing in each STO—further information on staff resourcing for NRCP is provided later in this Chapter.

4.47 A consequence of limited coordination of community care programs is the potential for carers to access multiple sources of funding for the same requirement. Health does not collect information from funded organisations that would allow it to determine whether NRCP service recipients are also receiving services from other community care programs. Funded organisations may or may not collect this information as part of their assessments.

4.48 The ANAO was advised that Health's senior managers regularly meet with senior managers of other community care programs, both Australian Government and State and Territory government, to discuss program implementation. However, these meetings were generally informal and did not include the exchange of detailed program information.

4.49 Health acknowledged the importance of coordinated planning with other community care programs, but advised the ANAO that the opportunity for joint planning is dependent on the willingness of State and Territory government counterparts to participate. Notwithstanding, there is progress in joint planning of community care programs, with Health advising that joint planning is an action item with HACC Officials[39] as part of the implementation of *The Way Forward*.

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[39] The primary mechanism for HACC coordination both between States and between Health and the States is the HACC Officials' Committee. This group is a subcommittee of the Standing Committee of Community Services and Income Security Administrators, which reports to the Ministers responsible for income support and community services portfolios. Membership of HACC Officials comprises officers of Health and each State or Territory department responsible for HACC.

Day-to-day administration

4.50 The ANAO did not conduct a comprehensive review of Health's allocation of staff resources to NRCP as part of the audit, but did note from interviews with Health officers and stakeholders that staff resourcing was an issue within the Program.

4.51 In order to deliver a range of national programs, STOs allocate staff resources across a number of programs. The ANAO observed that NRCP project officers are regularly called upon to assist other areas of the STO cope with peak workloads. This assistance can be required for lengthy periods (up to two months). Further, NRCP program officers maintain responsibility for several community care programs, such as the Psychogeriatric Unit Program.

4.52 In response, one STO has set administrative priorities to assist it to manage competing resource demands. It ranked the most important NRCP administrative activities into four categories, with limited capacity to respond to other matters. While most STOs have not formalised their resource management approaches in this manner, most officers interviewed by the ANAO said that they were rationalising their NRCP activities. A number indicated that: they had reduced their attendance at meetings with funded organisations; ceased activities, such as visiting new Respite Services (some Services have never been visited) and conducting regional information exchange sessions where STOs identify regional needs; reduced their scrutiny of reported information; and limited their analysis of Program performance data.

4.53 In support of its administrative resourcing decisions for NRCP, Health stated:

> …while the Australian Government has placed a high priority on the needs of carers, including by rapidly increasing funding from around $19 million in 1996–97 to $104.9 million in 2004–05, the NRCP remains one of the smaller programs that the Department administers. In this regard, the residential aged care programs pose more significant risk to the welfare of residents and factors such as this bear on the prioritisation of available administration funds.

4.54 The ANAO recognises that Health has set administration priorities for its STOs and that this approach ultimately determines the level of resources applied to smaller programs. However, the ANAO considers that, as part of this process, Health should determine a desirable resource allocation across its smaller programs to facilitate the completion of critical functions, such as planning and monitoring, in a timely and effective manner.

Supporting service providers

4.55 While Health does not have an up-to-date NRCP procedures manual for its own staff, as noted earlier, it has developed Program guidelines for service providers. Separate guidelines have been established for Resource Centres, Respite Centres, Respite Services and the National Carer Counselling Program. Health seeks Ministerial approval for all Program guidelines.

4.56 The guidelines are comprehensive and represent key operational documents for funded organisations. They do not, however, include information on administrative practices and therefore do not supplement the need for Health to issue and maintain an up-to-date NRCP procedures manual for the use of program administrators. The format for each of these guidelines differs, mostly in content but also in layout. They are provided to each funded organisation as a schedule to the funding agreement. They provide a range of information, including an overview of the Program, general conditions of funding, financial management and reporting. The ANAO found that the guidelines were consistent with the Government's policy objectives for the Program.

4.57 The ANAO identified some issues with the guidelines, particularly discrepancies between the guidelines in areas of Program implementation, such as target groups.

4.58 As noted above, Health has developed guidelines for the major components of NRCP. These guidelines all include similar information on the Program, coupled with activity specific information. The ANAO considers that it would be more efficient for Health to roll the existing guidelines together into one document, with activity-specific information attached as schedules. This would simplify management of the guidelines and present uniform Program documentation to funded organisations.

Maintaining service delivery

4.59 In implementing the Program, Health must decide on the way in which it will allocate limited resources to provide maximum benefits to NRCP target groups. Often this will require the delivery of services in areas where there are few service providers, particularly rural and remote areas and some outer metropolitan areas. In many cases, services in these regions are delivered by smaller not-for-profit organisations.[40] The Auditor-General for Western Australian commented on the problems confronted in working with organisations of this type in a 2003 audit report on the contracting of

[40] Health funds a range of organisations to operate NRCP Centres/Services, including community organisations, charitable organisations, State/Territory governments, local government, religious organisations, and private sector organisations.

not-for-profit organisations (NFPOs) for the delivery of health services. The report stated that:

> The funding of NFPOs can on some occasions involve significant financial risks…as not all NFPOs are well managed, financially secure or fully capable of consistently delivering contracted outputs.[41]

4.60 In addition to smaller NFPOs, Health also relies on the expertise and knowledge of larger organisations that have been operating Resource Centres and Respite Centres over many years to deliver appropriate services to carers.

4.61 Health's ability to achieve the policy objectives of government is reliant on these service providers. Therefore, Health must maintain services to carers either through existing providers, or through alternative arrangements where this is not possible. An important element of these processes is the identification and management of risks to service delivery. This allows Health to anticipate potential service delivery problems and put in place arrangements to limit the impact on carers.

4.62 The ANAO found that Health's documentation of risks to service delivery is limited, with no evidence of a systematic and consistent approach to managing them. While the ANAO did not find evidence to suggest significant service delivery problems within NRCP, it did identify some examples where more rigorous assessment would have better informed Program implementation. For example, the ANAO found that Health did not identify as a high risk the breakdown in service delivery caused by a key funded organisation experiencing significant administrative difficulties. As a consequence, Health was placed in a reactive situation where it required considerable resources to resolve the issue. Had Health identified this risk early, it would have been in a better position to implement strategies to reduce it, such as by developing a comprehensive monitoring regime, or to respond to it.

4.63 The ANAO considers that a structured approach to managing risk increases the rigor and quality of analysis. The ANAO found only limited evidence of a structured approach to risk management at the Program delivery level. Yet there were some examples of good practice identified during fieldwork, for example, risk analysis to determine the level of monitoring of services. This allowed the STO to allocate limited administrative resources to those areas that presented the greatest risks to delivery of services to carers. The ANAO considers that Health could apply risk analysis techniques more

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[41] Auditor-General for Western Australia, *Contracting of Not-For-Profit Organisations for the Delivery of Health Service*s, 2003, Australia, p.16. Available from the Auditor-General for Western Australia's website: <http://www.audit.wa.gov.au/reports/report2003_02>.

broadly within the Program, for example, when determining funding strategies, monitoring processes, and Program resourcing.

4.64 Health advised the ANAO that the Quality Reporting Framework and the financial acquittance form (more information on these two items is provided in Chapter 5) will assist in the adoption of a risk management approach, especially in highlighting provider performance and financial anomalies.

Records management

4.65 Sound records management assists organisations to meet their legal obligations, demonstrating that due process was followed in actions and decisions. It also assists the achievement of business objectives by better informing decision making and capturing corporate knowledge.

4.66 The ANAO reviewed the extent to which Health's records management supported its administration of NRCP. The ANAO found that Health's practices were not consistent with relevant standards, such as the Australian Standard for Records Management (*AS ISO 15489*), or Health's procedures. Further, the ANAO was not confident that the records management practices adopted by Health safeguarded Commonwealth records and facilitated sound administration. The ANAO formed this opinion after reviewing records management practices in Health's Central Office and STOs. This review identified a number of problems, including:

- incomplete file lists (local area lists) used to manage program records;
- records management systems could not be relied upon to locate some records, for example, physical location and/or responsible officer data were incorrect;
- local area file lists were not current, with inconsistencies between these lists and Health's central records database;
- related files generally were not cross-referenced;
- there were significant gaps in records series with records missing from files; and
- the reasons for some administrative decisions were not documented and recorded.

Recommendation No.5

4.67 The ANAO recommends that Health, in order to better inform its decision-making and to demonstrate due process, ensure that its record keeping processes and practices are aligned to better practice.

Health's response:

4.68 Health agrees with this recommendation.

Summary

4.69 There is an absence of documented policies and procedures on Health's approach to the distribution of Program funding. Health has not documented administrative procedures or guidelines governing the allocation of funding under NRCP. In addition, the department has not documented a funding formula or funding methodology. The absence of procedures, methodologies and formulae makes it difficult for Health to explain its funding decisions.

4.70 There are timing issues for funding rounds with NRCP moneys often allocated and required to be committed late in the financial year. Increased service delivery at the end of the financial year can build carer expectations that cannot be met once funding levels return to normal. Further, Health does not have a documented approach to the monitoring of its funding rounds. In particular, Health does not analyse information that would allow it to determine the appropriateness of the time allowed for each phase of its funding rounds. Therefore, it is not in a position to inform future funding activities or to advise the Government of the optimal time required to implement policy initiatives.

4.71 Health has issued a series of short-term funding agreements to streamline its existing agreements and allow for the introduction of revised contractual terms stemming from the Community Care Review. These short-term agreements have created uncertainty for providers and increased the workload for Health's administrators. Health is working, however, to address this issue, with the implementation of new three-year agreements for funded organisations from 1 July 2005.

4.72 The absence of an up-to-date NRCP policy and procedures manual has resulted in inconsistent administrative practices between STOs as well as less efficient, reactive management. While Health has recognised the need for a Program procedures manual, and commenced preliminary work, an up-to-date manual was not in place at the time of audit. Health does, however, hold regular program manager meetings, at which NRCP administrative practices are discussed.

4.73 There is insufficient communication and coordination between NRCP and other community care programs. As a consequence, the exchange of planning and service delivery information between programs is limited and is not a routine part of implementation. While NRCP program officers are aware of other community care programs, they generally have a limited understanding of the services being provided and their impact on NRCP. This hinders the identification of gaps and inequities in, and the duplication of, service provision. This issue is discussed in *The Way Forward*, with proposed initiatives aimed at creating a simple, streamlined, responsive and better coordinated community care system.

4.74 Health allocates its limited administrative resources across its programs on the basis of size and risk. As such, NRCP as one of Health's smaller programs, shares administrative resources with a number of other programs. In meeting the competing resource demands of these programs, NRCP program officers have rationalised their NRCP activities.

4.75 Health's records management practices require strengthening to more effectively support the department's demonstration of due process and to support decision-making within the Program.

5. Monitoring Program Performance

This Chapter examines performance monitoring arrangements for NRCP, including a discussion of the key reports, the quality of Health's data, and Health's compliance management processes.

Introduction

5.1 An effective monitoring regime is an important element in the administration of government programs, particularly those where public sector agencies contract private sector organisations to deliver services. It allows program administrators to determine the extent to which funded organisations are complying with funding agreements, while also providing important information to enable agencies to assess and report program achievements. This monitoring represents a key element of management, providing an assurance of the efficient and effective use of public funds.

5.2 The ANAO's review of NRCP monitoring arrangements focused on: the type and number of reports required by Health; the balance between reporting and service delivery; the quality of information included in reports; the usefulness of reports in managing compliance; and way in which Health monitors the use of program funds by service providers.

Reporting

5.3 Health collects a variety of information from funded organisations to enable it to monitor Program implementation. These information requirements are in funding agreements.

5.4 The amount and type of information required by Health is dependent on the type of activity, that is, Centres are required to provide more comprehensive information than Dementia-specific Respite Services, that are, in turn, required to provide more information than general Respite Services. Therefore, the amount of information Health asks for is generally in line with the amount of funding it provides.

Centres

Resource Centres

5.5 Health requires the following information from Resource Centres:

- a quarterly financial statement;
- a quarterly report detailing the use of NRCP and CISP funding;
- a quarterly report detailing the use of NCCP funding;

- a quarterly Minimum Date Set (MDS) report[42]; and
- an annual audited financial acquittal statement.

Respite Centres

5.6 Health requires the following information from Respite Centres:

- a quarterly financial statement;
- a quarterly narrative report;
- a quarterly MDS report; and
- an annual audited financial acquittal statement.

5.7 Reports produced by Resource Centres and Respite Centres are generally prepared on a standard form developed by Health's Central Office and submitted to the relevant STO for review and follow-up, where required. However, the MDS report is submitted electronically to Central Office. At the time of fieldwork, STO program officers did not have regular access to this data. The restricted access limited the capacity of STOs to monitor the performance of Resource and Respite Centres. Health has since advised the ANAO that all STOs now have access to all NRCP MDS data and have received training in interpreting the reports.

Respite Services

General Respite Services

5.8 Health requires the following information from general Respite Services:

- a quarterly financial expenditure statement; and
- an annual audited financial acquittal statement.

5.9 In addition to financial information, the quarterly financial expenditure statement also collects data on the number of carers assisted and the number of service hours provided. Health has advised the ANAO that it has developed a standardised reporting form that it will implement as part of the introduction of MDS data collection for Respite Services (more information on the MDS and Reporting System is provided later in this Chapter). This will improve the efficiency of STOs' quarterly financial reporting since, presently, each STO has developed its own reporting format.

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[42] Information on the MDS and Reporting System is provided later in this Chapter.

Dementia-specific Respite Services

5.10 Health requires the following information from Dementia-specific Respite Services:

- a quarterly financial expenditure form;
- a quarterly data collection form; and
- an annual audited financial acquittal statement.

NRCP Minimum Data Set (MDS) and Reporting System

5.11 Health developed the NRCP MDS and Reporting System to provide Resource Centres, Respite Centres and the Australian Government with an enhanced and shared understanding of who carers are, of their needs, and to better inform government policies and programs. While Respite Service data are not currently part of MDS, Health anticipates that they will be incorporated by 2005–06.

5.12 The basis for the MDS and Reporting System is the NRCP MDS Data Dictionary. It was initially developed from the HACC Data Dictionary and also relates to the National Community Services Data Dictionary. It defines the standard measurement to be used in classifying and reporting carer respite data, and carer and care recipient need.

5.13 Health introduced processes for the collection, collation and transmission of MDS information to a central repository. It introduced these processes for Respite Centres on 1 January 2002 and for Resource Centres on 1 July 2002. During fieldwork, regular reporting from this data was yet to commence, as Health was continuing to refine its data collection and reporting systems.

5.14 The ANAO acknowledges the significant effort that Health has contributed to the development of the NRCP MDS, including aligning the NRCP MDS with the National Community Services Data Dictionary. However, due to delays in developing MDS reports, the ANAO was unable to assess the appropriateness of the MDS and Reporting System as a means of supporting program officers in their work or in furthering Health's understanding of the needs of its target groups.

5.15 Health has since advised the ANAO that MDS reports for Respite Centres are available and data from these reports are now used to inform Program implementation. For example, MDS data were used to inform recent performance reviews of Program components, and MDS data were used in Health's 2003–04 Annual Report.

Balancing accountability with service delivery

5.16 The balance between reporting and the achievement of program outcomes is discussed in the ANAO's Better Practice Guide on the *Administration of Grants*. The Guide states that:

> The goal should be to balance the requirements of accountability, the protection of the Commonwealth's interests and the achievement of value for money for public funds expended against facilitating the achievement of the outcomes of the grant program.[43]

5.17 Health has informed funded organisations of the importance of being accountable for public funds and has provided detailed information to these organisations on their obligations. This is highlighted by the Respite Centre guidelines, which state:

> Acceptance of public funding brings with it probity and accountability requirements over and above that normally applying to other commercial relationships. In essence, it is important that the use of public funds be, and be seen to be, effective and efficient, equitable and fair, and reasonable and responsible.

5.18 Funded organisations interviewed by the ANAO acknowledged the need for sound accountability processes when public funds are involved, and accepted the need for regular reporting. However, these organisations also commented on the significant administrative workload created where funding is provided by a number of community care programs with different reporting formats.

5.19 As the number and complexity of reports increase, the resources required to ensure satisfactory performance and compliance with program requirements also increases. For a Program such as NRCP with over 500 funded Centres/Services, this can result in a significant workload for program administrators. As noted in Chapter 4, some STOs are not reviewing NRCP reports. Therefore, it can be asked that if Health does not review some reports, why does it require them?

5.20 The ANAO recognises that NRCP has grown significantly since its inception in 1996 and that monitoring systems suitable for smaller programs may become impractical as programs grow in size and complexity. As such, the ANAO now considers it timely for Health to review its reporting requirements in light of the Program's current size and complexity, and the administrative resources able to be dedicated to a program the size of NRCP.

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[43] ANAO *Better Practice Guide—Administration of Grants*, May 2002, Canberra, p.49.

Recommendation No.6

5.21 The ANAO recommends that Health review the number, type and timing of reports it requires from funded organisations to ensure that they support Health's monitoring requirements.

Health's response:

5.22 Health agrees with this recommendation. Health notes that a streamlined Respite Services Quarterly Activities Report and a Quality Reporting tool have been developed and will both be implemented from 1 July 2005. Health will review other reporting requirements.

Reporting developments

5.23 Health has noted the impact of multiple reporting formats on funded organisations and is working to align financial reporting obligations under its community care programs. Health has engaged a consultant to simplify and standardise financial reporting obligations for its community care programs through the development of a common financial report. Health advised that a common financial report will be used to monitor compliance and service delivery from 1 July 2005.

5.24 The ANAO also notes the efforts of Health and FaCS in rationalising reporting by the use of a common quarterly financial expenditure statement for funding provided to Respite Centres.

5.25 These developments underpin the broader objective of streamlined Australian Government funded community care programs outlined in *The Way Forward*. A key initiative in support of this objective is the development and adoption of common arrangements for community care programs.

Data quality

5.26 Health relies on the data collection and collation practices of funded organisations to inform its implementation and reporting activities. Poor data quality can adversely impact Program implementation and the development of policy advice. The ANAO found that funded organisations have provided poor quality data to Health, particularly for the activities of Respite Services.[44] The ANAO reviewed Respite Service data collected by Health in a recent survey (2003–04) and found considerable discrepancies in cost and resource data provided by Services. Health's consultants who analysed the data supported this view. They found extensive data quality issues, including:

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[44] The ANAO did not review the quality of data submitted by Centres as part of the MDS and Reporting System because the system was still under development during fieldwork.

- some Services had difficulty in understanding the concept of demand/unmet need; and
- some Services did not have an understanding of the process of calculating unit costs, and therefore a consistent method was not applied to calculating unit costs.

5.27 This confusion has resulted in some Services furnishing inaccurate data to Health. As Health's survey was the first of its kind, it is unknown for how long Respite Services have been providing inaccurate data. These data quality issues have a significant impact on Health's ability to inform Program delivery and policy development.

5.28 The ANAO also found problems with data interpretation by Health's program officers during visits to STOs. In one STO, episodes of respite care were being confused with numbers of carers assisted. Therefore, the number of carers assisted was overstated in Health's reports. Health has since advised the ANAO that this issue has been resolved, with further guidance provided to STOs.

Compliance management

5.29 Health uses reports from funded organisations as the basis of its compliance management practices. They provide Health with information, to varying degrees, on service delivery and financial expenditure. Health uses this information to assess the extent to which funded organisations are meeting the obligations established under funding agreements. Health also visits funded organisations to discuss service delivery. These visits, do not, however, involve a comprehensive assessment of the accuracy of information provided in reports.

Monitoring report submission and review

5.30 The ANAO found that most STOs visited had implemented manual processes to monitor the submission of reports. The ANAO also noted that some program officers implemented processes to verify that they reviewed reports. These processes ranged from the completion of a *Report Assessment Form* that assisted in determining whether further action was required, through to the initialling and dating of reports once reviewed. These practices were not, however, replicated in other STOs with limited evidence available to confirm whether reports were reviewed.

Usefulness of reports

5.31 In general, STOs indicated that Program reports provided sufficient and timely information to enable them to form opinions on whether services were being delivered in accordance with agreements. However, the ANAO

considered that the information requested and analysed by Health was not balanced, with a focus on quantity measures, such as numbers of carers assisted and numbers of episodes of care. This was particularly the case for Respite Service reporting. The ANAO suggests that Health consider requesting information from Respite Services, through existing reports, that would provide an insight into the quality of services, for example, the number of complaints received or results from carer questionnaires.

5.32 Further, the ANAO found that current reporting did not provide Health with an assurance that funded organisations were complying with the National Service Standards. This is particularly problematic as Health's guidelines state that non-compliance with the Standards may result in withdrawal of NRCP funding. These Standards are important safeguards for people receiving respite services.

5.33 Health is working to improve the coverage of its monitoring regime through implementation of a system to better monitor the quality of service provision under NRCP. In the 2004–05 Budget, the Australian Government announced funding of $13.7 million over four years for a quality reporting system for CACP, EACH and NRCP. Health envisages that the system will comprise a three-step process, involving services self-reporting against uniform quality standards every three years and Health officers carrying out a desk audit and a validation visit.

5.34 Health advised the ANAO that the size, financial allocation and comparative risk of a program may affect the speed with which it develops and implements a quality assurance or quality monitoring system. Health now considers NRCP to be sufficiently large to require the implementation of such a system and, as such, the quality monitoring system outlined above is being implemented.

Identifying non-compliance

5.35 Health officers advised the ANAO of a limited number of cases where Health's monitoring systems had not detected the misuse of Program funds by service providers. These cases were referred to Health by whistleblowers. The ANAO was also advised of situations where funded organisations were allocating hours of service to the wrong program. Health detected this misallocation when additional information was provided inadvertently.

5.36 As noted above, Health visits providers, but does not assess the accuracy of reported information during these visits. Nor does Health directly seek carers' and care recipients' comments on the quality and appropriateness of service provision. As a consequence, the probability of Health detecting the misuse or inefficient use of Program funds by funded organisations is low.

5.37 Health, however, advised that:

> STOs may not routinely seek out additional information to identify non-compliance. However, the STO review of performance and financial data [from funded organisations] results in remedial action with particular organisations, including several instances in recent months.

5.38 The ANAO suggests that Health consider:

- improving the utility of annual audited financial acquittal statements to provide increased assurance of service provider compliance; or
- altering its current monitoring process to include an assessment of the accuracy of reports from funded organisations during visits. Where resource issues limit Health's capacity to monitor all service providers in this manner, the ANAO suggests that Health use a combination of risk management and random selection to determine Centres/Services to be monitored. This level of monitoring would also assist Health to identify data quality issues within funded organisations.

Acting on non-compliance

5.39 The most common form of non-compliance relates to the delayed submission of reports. STOs generally inform funded organisations that a report is overdue and that failure to provide the report by a certain date will result in suspension of payments. Where the report is not submitted by the agreed date, Health suspends payments until it receives the overdue report.

5.40 As noted above, Health has also taken action on non-compliance relating to the misuse of Program funds. In response to information received from whistleblowers, STOs alerted Central Office and involved Health's Audit and Fraud Control Branch and other relevant areas of the department, such as the Legal Services Branch. Subsequently, Health took remedial action, including the recovery of funds. The ANAO's review of Health's response to one such example found that Health's actions were appropriate.

Financial monitoring

5.41 In accordance with annual Parliamentary appropriations, Health has adopted an annual funding cycle for NRCP Centres/Services, with STOs monitoring expenditure via quarterly financial statements. As noted earlier, where annual funding amounts are not committed by Centres/Services, Health recovers and reallocates some moneys. Therefore, these funds remain within the Program.

5.42 The ANAO noted a history of annual underspending within the Program. For example, in 2003–04 Health spent $94.3 million of a budgeted $98.7 million. This represents a $4.4 million underspend that was reallocated

within the Program. There was considerable variation in the levels of underspending between States and Territories. The causes of underspending are varied, but include:

- delays in implementing initiatives;
- funding received late in the financial year; and
- difficult service delivery environments, for example, rural and remote locations.

5.43 While levels of underspending recently exceeded 15 per cent in one State, the ANAO noted that, overall, the level of variation has reduced over recent years. Health has worked with service providers to address areas of underspending to maximise the Program's impact.

Informing program design

5.44 The ANAO found that Health uses Program information gained through its monitoring activities to inform policy advice and policy initiatives. This information is derived from a number of sources, including:

- pilot evaluations to inform policy development;
- information from Centres, through narrative reports on innovations and improvements; and
- consultants' reviews of aspects of Program delivery.

5.45 The ANAO identified initiatives that stemmed from Program innovations, including the cluster model approach to respite[45] and cottage style accommodation.

Summary

5.46 Health has established comprehensive NRCP reporting processes for funded organisations so that it can manage the Program soundly and ensure accountability for public funds. However, the monitoring system does not provide balanced information to inform Health of the extent to which NRCP is

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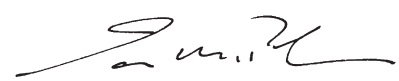
[45] This approach is being trialled under NRCP to encourage greater utilisation of respite beds within residential aged care homes. It is built around five main elements: financial support; carer/care recipient support; facility cluster; service enhancement; and Respite Centre support for aged care homes. A cluster model approach to residential respite is operating in Melbourne through a partnership between a Respite Centre and four aged care homes. Under the model, the Respite Centre provides support services to the aged care homes, including the coordination of respite bookings, carer support in all aspects of the respite stay, additional funding, streamlined processes and related support. The Respite Centre also provides pre-entry and post-respite support to the carer and care recipient. The aged care home provides a respite focus (cluster), with each cluster containing a minimum number of high care places for respite use.

meeting its objectives. For example, Health does not seek carers' and care recipients' comments on the quality and appropriateness of service provision. As well, monitoring systems do not provide Health with sufficient information to enable it to determine whether funded organisations are complying with funding agreements, including compliance with the National Service Standards. These Standards are important safeguards for people receiving respite services.

5.47 Health's monitoring system relies primarily on self-reporting, with limited activity from the department to verify the accuracy or quality of information within these reports. The number and frequency of reports also place a considerable workload on Health administrators and funded organisations.

5.48 The accuracy of data provided to Health by NRCP funded organisations is affected by confusion in some organisations over important data principles, such as the definition of some terms. Further, the way in which Health has interpreted service delivery data has the potential to distort the level of service delivery reported under NRCP. Health has sought to improve its interpretation of NRCP data through recent guidance to its officers.

5.49 Health is working to improve the coverage of its monitoring regime through implementation of a system to better monitor the quality of services provided to carers under NRCP. Health envisages that the system will comprise a three-step process, involving services self-reporting against uniform quality standards every three years and Health officers carrying out a desk audit and a validation visit.



Canberra ACT
29 June 2005

Ian McPhee
Auditor-General

Appendices

Appendix 1: Public Sector Support for Carers

Support for carers through community care services

The Australian Government and State and Territory governments jointly fund community care services through the Home and Community Care Program (HACC), with State and Territory governments setting priorities for funding across their jurisdictions. Services include delivered meals, home help, respite, personal care, gardening, home modification and transport. Carers are listed as a specific target group of HACC, needing support, recognition and assistance in their role. The Australian Government provides 60 per cent and the States and Territories provide 40 per cent of HACC funding. In 2005–06, the Australian Government will contribute $857.8 million, with total funding of $1.4 billion when all State and Territory matching contributions are included.

Coordinated care is provided through the Australian Government funded Community Aged Care Packages (CACPs) Program and Extended Aged Care at Home (EACH) Program that provide a level of community care equivalent to low or high residential aged care. They provide similar services to HACC, but are coordinated through a case management approach and aim to provide a flexible mix of services. The 2005–06 budget for the CACP Program is $368.3 million, with $82.3 million budgeted for the EACH Program.

Information about regional community care services is provided through Commonwealth Carelink Centres, reached through a FREECALL™ number (1800 052 222). Australian Government funding for Carelink Centres in 2005–06 is $15.7 million.

Support for carers through respite provided in residential aged care facilities

The Australian Government subsidises the cost of long-term and respite care in residential aged care facilities. The subsidy depends on whether the care recipient has been assessed by an Aged Care Assessment Team (ACAT)[46] as having high or low care needs. While respite recipients must not use more than 63 days respite within any year, unless an extension has been approved, most stays are for approximately 21 days. Around one million resident days of respite are used each year, at a cost of around $84 million in 2003–04.

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[46] The Australian Government provides annual funding to each State and Territory government to manage and administer the Aged Care Assessment Program through which ACATs are funded across Australia. ACATs are teams of care professionals who provide expert assessment and advice regarding the long term care needs of the frail aged and assess eligibility for appropriate services to meet those needs.

Financial support for carers

Australia has two payments, administered through Centrelink, that are specifically for carers:

- Carer Payment; and
- Carer Allowance.

The Carer Payment is means tested and provides financial support to carers that is equivalent to other Australian Government benefits. It is paid to carers who meet assessment criteria (related to the care needs of the care recipient) who are unable to work because of their caring responsibilities. Around 84 000 carers receive the Carer Payment.

The Carer Allowance is not means tested and is a smaller payment in recognition of the extra expenses that a carer may have. Again, assessment for the Carer Allowance relates to the care needs of the person cared for, among other criteria. Approximately 340 000 people receive the Carer Allowance.

In 2005–06, the Australian Government has budgeted approximately $2.1 billion in funding for Carer Allowances and Carer Payments.

Other support for carers

While Health is responsible for services for the aged, including their carers, the Department of Family and Community Services (FaCS) is responsible for services for families with children, people with disabilities and their carers.[47]

FaCS support for disability services is channelled primarily through the Commonwealth State/Territory Disability Agreement (CSTDA).[48] CSTDA provides the national framework for the delivery, funding and development of specialist services for people with disabilities. The Australian Government, through FaCS, will provide $605 million in 2005–06 to fund the States and Territories in meeting their responsibilities under the CSTDA, with the States and Territories contributing $2.4 billion. The responsibilities of State and Territory governments include the provision of respite.

In addition to these funds, the Australian Government is also implementing the following carer-focused programs through FaCS[49]:

- Respite Support for Carers of Young People ($22 million over four years);

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[47] Commonwealth Administrative Arrangements Orders, 16 December 2004. Available from the Department of Prime Minister and Cabinet's website:<http://www.pmc.gov.au/parliamentary/index.cfm>.

[48] The ANAO is currently undertaking a performance audit of FaCS' administration of the CSTDA.

[49] A proportion of FaCS funding is delivered through NRCP Respite Centres.

- Carers—Increased Access to Respite for Older Carers ($72.5 million over four years, conditional upon matching funds being provided by the States)[50]; and
- Carers—Respite and Information Services for Younger Carers ($26.6 million over four years).[51]

State and Territory government support

As mentioned above, State and Territory governments are responsible under the CSTDA for services to people with disabilities, including respite services. State and Territory community care services also provide additional support directly to carers including transition care services from the hospital to the home, outreach support, in-home and drop-in support, recreation/holiday programs, counselling and information through both area health groups and non-government organisations. These services are in addition to the services provided by States and Territories under HACC and CSTDA.

A number of States and Territories have issued policy statements under which carer programs are delivered. These include the *NSW Government Carers Statement* issued by the New South Wales Ageing and Disability Department in 1999; and *Caring for Carers in the ACT—A Plan for Action* issued by the Australian Capital Territory Government in 2004.

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[50] Financial information on this initiative is not included in Table 1.1 in Chapter 1 because it commenced after 2003–04.

[51] Financial information on this initiative is not included in Table 1.1 in Chapter 1 because it commenced after 2003–04.

Appendix 2: NRCP Program Growth

National Respite for Carers Program – Budget Growth			
Year	**Budget Initiative**	**Key Features**	**Package Amount**
1996–1997	***National Respite for Carers Program (NRCP)***	▪ Part of National Carers Action Plan ▪ Establishment of 58 Respite Centres and 8 Resource Centres ▪ Now incorporates the Commonwealth Respite for Carers Program	$36.7 million over 4 years
1997–1998	***Carer Information and Support Program (CISP)***	▪ Carer support and information–ongoing development and distribution of resource materials for carers	$8.2 million over 4 years
1998–1999	***Staying at Home*** ***Cashing out Unused Residential Respite***	▪ Expansion of Carer Respite–new Centres and outlets established, bringing the total number of Respite Centres and outlets to 82 ▪ A National Carer Resource Centre established ▪ Additional Respite Services for carers of people with dementia–26 dementia specific Services developed ▪ Unused residential places *cashed out* and funds made available to Carer Respite Centres to use purchase respite services (i.e. brokerage funding)	$41.2 million over 4 years $16.0 million over 4 years

National Respite for Carers Program – Budget Growth			
Year	**Budget Initiative**	**Key Features**	**Package Amount**
1999–2000	***Dementia and Challenging Behaviours (includes Carers Education and Workforce Training)***	▪ Enhancement and expansion of Carer Respite Centre–specific operational and brokerage funding for Centres to focus on carers of people with dementia and challenging behaviours ▪ 82 new and expanded Respite Services focussing on carers of people with dementia and challenging behaviours ▪ Additional operational funding for Centres ▪ Two national dementia projects with Alzheimers Australia	$82.2 million over 4 years
2000–2001			
2001–2002			
2002–2003	***Support for Carers*** ***Additional Estimates***	Additional support for: ▪ Carers of older Australians (and carers in rural and remote regions) ▪ Carers of people with dementia ▪ Ageing carers of people with disabilities ▪ *Cashing out* Residential Respite	$80.0 million over 4 years $29.6 million over 4 years

National Respite for Carers Program – Budget Growth			
Year	**Budget Initiative**	**Key Features**	**Package Amount**
2003–2004	***Dementia & Challenging Behaviours***	▪ Continuation of lapsing Dementia & Challenging Behaviours Initiative (formerly known as *Enhanced Respite Services*) ▪ Continued funding to increase the provision of respite care for people with dementia and challenging behaviours	$90.6 million over 4 years
2004–2005	***Support for Carers***	▪ Rolling out of 2002–03 Budget Initiatives ▪ *Cashing out* of residential respite adjustment	

Source: Health

Appendix 3: NRCP National Service Standards

National Respite for Carers Program

National Service Standards (Respite Centres)

Under the National Respite for Carers Program (NRCP), Commonwealth Carer Respite Centres have a responsibility to provide services in accordance with the following standard:

1. Access to Services

To ensure that each carer's access to a service is decided only on the basis of relative need.

2. Information and Consultation

To ensure that each carer is informed about his or her rights and responsibilities and the services available, and consulted about any changes required.

3. Efficient and Effective Management

To ensure that carers and the person(s) for whom they care receive the benefit of well-planned, efficient and accountable service management.

4. Coordinated, Planned and Reliable Service Delivery

To ensure that each carer and the person for whom they care receive coordinated services that are planned, reliable and meet their ongoing specific needs.

5. Privacy, Confidentiality and Access to Personal Information

To ensure that the rights to privacy and confidentiality of each carer and the person for whom they are respected, and that the carer and person cared for have access to personal information held by the agency.

6. Complaints and Disputes

To ensure that each carer and person cared for has access to, and knows about, fair and equitable procedures for dealing with complaints and disputes.

7. Advocacy

To ensure that each carer has access to an advocate of his or her choice.

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