VICTORIA

Auditor General

Victoria

Delivery of home and community care services by local government

Ordered to be printed by Authority.
Government Printer for the State of Victoria

No. 69, Session 2003-2004

ISSN 1443 4911
ISBN 0 9750755 8 6

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Legislative Council
Parliament House
MELBOURNE

The Hon. Judy Maddigan MP
Speaker
Legislative Assembly
Parliament House
MELBOURNE

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance audit report on *Delivery of home and community care services by local government.*

Yours faithfully

JW CAMERON
Auditor-General

25 May 2004

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Foreword

As they grow older and less able to look after themselves, many Victorians face the prospect of moving into residential care. The Home and Community Care (HACC) program provides services to frail aged people, and people with disabilities, so that they can continue to live independently at home. This way, they can continue to enjoy the comforts and security of their own homes, as well as local community life.

In 2003, the program helped over 200 000 Victorians, about 65 per cent of whom were 70 and older. In 2002-03, the Commonwealth and state governments provided $317 million for the program, and local government Councils about $48 million. Program clients paid another $30 million in fees.

This audit examined the comprehensiveness of Department of Human Services and Council HACC planning processes. It also examined the adequacy of Councils' systems for delivering HACC services.

We found that the department's and councils' planning processes were generally sound, however, there was room for improvement in some areas, particularly in performance assessment.

We found that Councils' service delivery systems were generally adequate. We have made a number of recommendations which we believe would improve the monitoring and review of clients, demand management, staff skills and the use of volunteers.

We encourage Councils to further develop processes to assure the quality of services and to improve the reporting of program data to the department.

All the demographic evidence suggests that demand for HACC services will continue to grow strongly. This will test the capacity of a system already facing substantial client demand. It is most important that departmental and Council planners, and those who deliver services, build on the many good aspects of the HACC program and address the issues we have identified.

JW CAMERON
Auditor-General

25 May 2004

1. Executive summary

1.1 Introduction

The Home and Community Care (HACC) program provides a range of coordinated maintenance and support services for the frail aged, people with a disability and their carers. These services help to support people to be more independent at home and, thereby, prevent their premature admission to long-term residential care.

The HACC program operates in a complex environment that involves Commonwealth, state and local governments, and a vast number of other service providers. Local government (Councils) receives around 40 per cent of state HACC funding and is the largest single provider of HACC services in Victoria.

Demand for HACC services has increased over the past decade as the population continues to age. Longer life expectancies, coupled with higher levels of disability, will result in increasing client demand and ongoing pressure on funding levels.

In this context, the need for coordinated planning is crucial. The Commonwealth and state governments, Councils, and other key stakeholders need to ensure that the planning, funding, and delivery of HACC services reflect identified community needs, that services are targeted to meet those needs, and that there is equitable access to HACC services.

This audit examined HACC planning process at the Department of Human Services (DHS) and at Councils. The audit also examined the adequacy of Councils' service delivery systems.

1.2 Were DHS and Council HACC planning processes comprehensive?

1.2.1 Were DHS planning processes sound?

DHS' planning processes are sound and are evidence-based. It uses population, demographic and service use data to determine:

- trends in the target HACC population
- the impact population trends will have on future demands for HACC services for the frail aged and people with disabilities, including the special needs of people of culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) communities
- the allocation of growth funds between and within the DHS regions
- the allocation of funds to deliver service expansion and ministerial priorities.

Population growth estimates, and cost and service usage data show that there will be significant pressure on demand for basic HACC services and on the total cost of the HACC program in the future.

DHS needs to ensure that the HACC minimum data set is more reliable given its importance for planning the HACC program.

1.2.2 Were Council planning processes sound?

Planning processes in Councils visited by audit were sound. They were based on population, demographic and service use data, and this data was analysed to identify future needs for HACC services.

However, our survey results showed that the extent to which Councils used such data to plan HACC services varied. This variation mainly occurred in small and large shire Councils. The limited use of such data may not enable these Councils to determine future community need for HACC services.

Better training, professional development and recruitment strategies could help smaller rural Councils to improve their capacity to plan strategically.

1. **The Department for Victorian Communities, in consultation with local government peak bodies should examine ways to improve the overall strategic planning capacity of Councils, particularly in rural areas.**
2. **DHS should determine how best to improve Council HACC planning through the provision of HACC demographic and service usage data, and the development of a common HACC planning framework for use by Councils as appropriate.**

1.2.3 Did DHS adequately consult stakeholders?

DHS adequately consulted stakeholders during the HACC 2003-04 planning process. This resulted in major reforms.

Development processes for triennial (2003-04 to 2005-06) regional HACC plans involved provider and client representatives and other stakeholders, with the result that the annual HACC plan was developed openly and transparently.

Recommendation

3. **DHS, together with agencies implementing the Culturally Equitable Gateways Strategy, should develop reporting and evaluation arrangements to assess the effectiveness of the strategy. In particular, identify the:**
    - **needs of newly-emerging culturally and linguistically diverse communities**
    - **take-up of HACC services against pre-established targets.**

1.2.4 Did Councils adequately consult stakeholders?

The amount of stakeholder consultation undertaken by Councils varied, but was generally adequate. However, those Councils in limited consultation with other Councils and primary care partnership members reduce the amount of information available for planning and for assessing the quality of service delivery.

Recommendation

4. **All Councils should ensure that they systematically consult with, and gather information from, stakeholders (including health care providers) that can be used for planning and to evaluate service delivery.**

1.2.5 Did DHS have an effective performance assessment framework?

DHS reports short-term output measures of HACC expenditure and services delivered. Through the HACC national standards survey instrument, DHS also has a process to assess the extent to which individual service providers comply with national HACC standards. However, DHS has not developed outcome indicators to assess the achievement of program objectives and priorities.

Recommendation

5. **DHS should work with the Commonwealth Department of Health and Ageing to develop indicators that can be used to assess the extent to which HACC program objectives, priorities and outcomes are achieved.**

1.2.6 Did Councils effectively measure program performance?

Councils are required by several Acts to measure and report their performance. Currently Council reporting of the achievements of the HACC program and its cost is not fully transparent.

Because they did not have the performance measurement tools, Councils were unable to fully assess the extent to which HACC program objectives and outcomes were achieved.

Recommendations

6. **All Victorian Councils which are yet to develop HACC-specific performance measures for outputs should develop them as soon as practicable.**
7. **In accordance with the "best value principles" required by the *Local Government Act 1989*, Councils publicly report:**
   - **against HACC program objectives and performance indicators for program outcomes**
   - **full details of the total cost of HACC services and the principal sources of funding**
   - **the total quantity of HACC services delivered by Council, split between DHS-funded and Council-funded services where appropriate and necessary.**

1.3 Were Councils' HACC service delivery systems adequate?

1.3.1 Was service coordination adequate?

Council policies and systems to assess people needing access to HACC services were adequate.

While DHS' *Better access to services framework* defines the different types of client assessment, the meaning of these assessments to the HACC program is not clear to Councils. There is no common understanding across Councils of the nature of the different types of assessments (particularly comprehensive assessments).

Around 95 per cent of Councils had started using the Service Coordination Tool Templates (SCTT) to assess client needs. Those Councils implementing the SCTT have noted the benefits of doing so, however, a majority of Councils were experiencing difficulties in implementing the tools.

The SCTT was mainly designed to meet the needs of frail older people. However, the SCTT does not meet the needs of children with a disability, carers and ATSI communities. Consequently, the needs of these groups may not be fully identified, and they may not get access to the support services they require.

A small number of Councils did not have processes to coordinate the assessment of clients with other service providers. This could result in clients being assessed on multiple occasions.

Recommendations

8. **DHS should clarify the definitions of all types of assessments in the *Better access to services framework* applied to HACC.**
9. **DHS and Councils should identify and resolve the barriers to implementing service coordination tool templates.**
10. **DHS and Councils should together review the applicability of SCTTs for young people with a disability, carers and ATSI communities, and modify the SCTTs as required.**

1.3.2 Were Council monitoring and review processes adequate?

Most Councils had processes in place to undertake routine reviews of client needs. However, they had difficulties in completing these reviews in a timely manner.

Despite the inability of some Councils to formally review clients by the set date, any risk to clients is perhaps mitigated by monitoring of clients by direct care staff. However, formal reviews are particularly important for clients with high level or complex needs to identify if they are receiving appropriate services.

Councils should use standard tools to conduct and record client reviews. This would standardise the conduct of reviews and the recording of results, and enable client needs to be consistently measured over time.

The systems used by Councils visited to update care and respite plans after client reviews were adequate.

11. DHS should develop clear guidelines for the conduct of client reviews. In developing these guidelines, DHS should investigate the feasibility of a standard tool for conducting and recording client reviews.

1.3.3 Were Council referral processes adequate?

Most Councils had adequate processes to coordinate the referral of clients to other service providers. These processes are likely to further improve over time, given the strong uptake of SCTTs.

1.3.4 Was demand adequately managed?

Most Councils have strategies to manage client demand for HACC services. Councils managed demand using a variety of strategies, but had not evaluated the adequacy of these strategies.

Most Councils had processes to prioritise client access to HACC services. These processes reflected demand pressures faced by each Council. However, a more consistent and evidence-based approach to setting priorities would lead to better client access to HACC services across the state.

A common set of tools based on a consistent set of principles would function as a decision-support aid to the professional judgement made by assessment staff. Versions of such a tool would need to be designed to take specific account of the differences between the major HACC service types.

Better information is needed about which methods and strategies to manage demand and prioritise clients are the most successful. Better information about client dependency would enable DHS and Councils to allocate resources according to client needs, and potentially provide the basis of understanding the impact of their demand management strategies on users of the service.

Recommendations

12. **DHS should develop common guidelines for prioritising client access to HACC services. These guidelines should be developed to support the decision-making process of assessment staff.**
13. **DHS should complete its evaluation of the HACC dependency data and move towards establishing this data collection as part of the quarterly minimum data set collection.**

1.3.5 Were in-house/contractor arrangements adequate?

Councils varied in how (and how much) they monitored contractors, in their reporting requirements and the level of quality assurance undertaken. Councils that relied only on infrequent customer satisfaction surveys would not be able to adequately ensure the quality of contracted services.

Councils need to ensure that they do not neglect their duty of care to HACC clients by allowing services to be delivered that do not meet the required standards. All Councils should have adequate quality assurance processes to minimise risk to their clients.

Recommendation

14. **Councils should develop quality control procedures over services delivered by contractors so that they do not compromise their duty of care to their HACC clients.**

1.3.6 Did Councils have adequate staff to deliver HACC services?

Recruiting and retaining staff to deliver HACC services is a challenge for many Councils. Failure to fully meet this challenge can reduce the quantity and range of services delivered to clients. With demand for HACC services projected to grow as the population ages, some Councils (especially rural and remote Councils) will find it increasingly difficult to meet the needs of their clients.

Councils are responsible for ensuring that qualified staff deliver HACC services. Councils not using appropriately qualified staff may place their clients at risk and compromise their duty of care to these clients.

At the time of the audit, there were no qualification or competency standards (units of competence) specifically for HACC assessment staff. Given their diversity of occupational backgrounds and specific training needs, competency standards need to be developed.

Recommendations

15. **DHS should work with Councils to identify and promote Council best practice in the recruitment and retention of HACC staff.**

16. **DHS should work with Councils to:**

    - **ensure that Councils have strategies and time lines to implement minimum qualifications for direct care staff**
    - **develop competency standards on which training for HACC assessment staff can be based.**

1.3.7 Did Councils adequately manage volunteers to deliver HACC services?

Volunteers are widely used to deliver some HACC services. The majority of Councils had adequate policies and procedures in place, but were experiencing difficulties in recruiting and retaining HACC volunteers.

Further reductions in volunteer numbers could cause some Councils to become less flexible and responsive in the way they deliver services or reduce the level of services delivered overall.

Recommendation

17. **The Department for Victorian Communities should work with Councils to identify and publicise best practice in the recruitment and retention of volunteers.**

1.3.8 Did Councils assure the quality of services?

Councils have used best value reviews, external accreditation and the HACC national service standards reviews to identify improvements required for their HACC services. Most Councils had processes to identify and manage the main risks to their HACC services.

Smaller Councils were much less likely to identify and manage risks, or systematically assure the quality of their services. Councils (mostly smaller ones) that do not have systems to manage client complaints may not be able to adequately respond to complaints, and will be less likely to use complaints data to identify and address weaknesses in their services.

Recommendation

18. **Councils should ensure that they have, and use, systems to manage client complaints so that client feedback is used to continuously improve service delivery.**

1.3.9 Was program performance accurately reported to DHS?

A number of Councils did not fully meet DHS' HACC reporting requirements for both financial and client data. Data being reported to DHS may not be accurate or complete, because some Councils do not have adequate information systems or/and do not assure the quality of their data (particularly small shire Councils).

Steps taken by DHS to improve the quality of data submitted by Councils are useful, but they are not a substitute for Councils checking their data and identifying errors before they send it to DHS.

By mid-2005, Councils will be required to report HACC client dependency data to DHS. This data can only be collected through the SCTTs. As a number of Councils are not fully using the SCTTs for service coordination, they will need to update their client information systems to enable them to report this data.

The current multiplicity of software systems present ongoing risks to collection of program and client data by Councils. Centralised systems such the Client Information Management System (CIMS) and the Client Relationship Information System for Service Providers (CRISSP), both maintained by DHS, may reduce data collection risks. In its second phase, CIMS could be made available for use by Councils.

Recommendations

19. **DHS, together with Councils, should develop minimum quality assurance procedures for data reported to DHS.**
20. **DHS should explore the use of CIMS and CRISSP to manage HACC client information and reporting of HACC program data currently collected through the quarterly and annual data collections.**

2. The Home and Community Care program

2.1 Introduction

The Home and Community Care (HACC) program was established in 1985 when several Commonwealth, state and territory programs were consolidated. HACC supports frail aged people over 70 and people with disabilities of any age to live at home who otherwise would not be able to do so, and would need to be admitted to long-term residential care[1]. The program also supports their carers.

The program's goals and objectives, and financial and administrative arrangements, are set out in a bilateral agreement between the Commonwealth and Victorian Governments. The agreement was implemented on 1 July 1998.

The Department of Human Services (DHS) manages the HACC program in Victoria. DHS is responsible for state-level policy setting, program management, service development, service approval and funding allocation. In 2002-03, the Commonwealth and State Governments funded the HACC program for $317 million. The program provided services to 204 450 clients in Victoria.

In Victoria, Local Government (Councils) is the biggest single provider of basic HACC services. These are home care, personal care, respite care, property maintenance, delivered meals, and assessment and care management[2]. Other HACC providers are the Royal District Nursing Service, community health centres, ethno-specific and other community-based, not-for-profit organisations.

DHS administers HACC funding by determining prices for services, and then purchasing specific volume of units from agencies at the prices determined[3]. These arrangements are formalised in service agreements between the department and providers. A service agreement identifies funding amounts, administrative requirements, service performance measures and targets, service standards and data collection requirements.

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[1] Victorian Home and Community Care Manual, February 2003, Department of Human Services, Victoria.

[2] Submission to the House of Representatives Standing Committee on Economics, Finance and public Administration into local government and cost shifting, September 2002, Municipal Association of Victoria.

[3] Other HACC services such as meals are subsidised, and assessment services are block funded.

The DHS r*elative resource equity formula (*RREF), is used to distribute HACC growth funding between DHS regions[4]. It is used to calculate a base population by local government area[5] which includes people aged 0-69 years-old with a profound, severe or moderate disability, and people aged 70 and over, who are not living in institutional care. The base population is then weighted to allow for probable variations in prevalence and intensity of need, using 5 variables: socio-economic status; health status; rurality; indigenous status; and ethnicity.

The RREF calculates regional shares of the total weighted population, expressed as percentages; these are the regional growth shares. These percentages are applied to the total Victorian base population to give regional target populations. These represent a best estimate of the HACC target population at a regional level[6].

Figure 2A illustrates how the HACC system operates. It shows:

- the relationship between the Commonwealth and state governments
- how the program is funded
- the service delivery relationship between the Victorian Government and the service provider.

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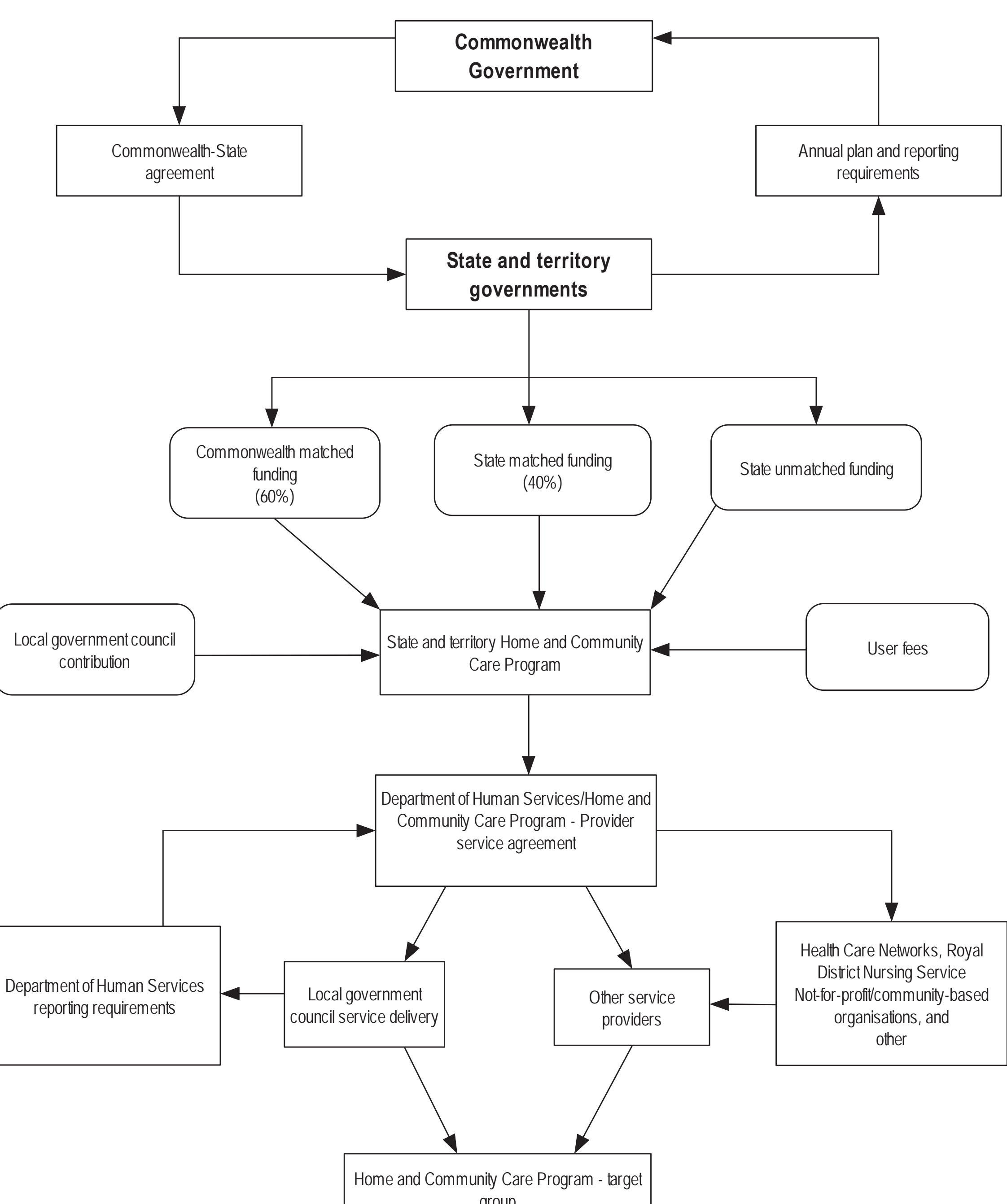
[4] There are 9 Department of Human Services regions across Victoria.

[5] There are 79 local government areas (Councils) across Victoria.

[6] HACC Program, *Victorian Annual Program Plan 2003-2004*, Department of Human Services. p. 22.

FIGURE 2A: THE HACC SYSTEM



Source: Victorian Auditor-General's Office.

2.1.1 Funding the HACC program

Under the *Home and Community Care Act 1985*, Commonwealth, state and territory governments fund the HACC program. HACC is funded through a formula of matched Commonwealth and state contributions and unmatched state government funding. For the matched component, the Commonwealth contributes 60 per cent of the total and Victoria contributes 40 per cent.

The state's annual HACC plan[7] specifies the funding to be provided to each DHS region, and is allocated on the basis of service priorities[8]. The annual plan is approved by the Commonwealth and state ministers responsible for the HACC program.

In Victoria, Councils and other agencies also fund and resource the delivery of HACC services, as do consumers through fees for services.

Figure 2B shows HACC program funding between 2000-01 and 2002-03. In 2002-03, DHS funding for HACC services in Victoria was $317 million. Councils contributed approximately a further $48 million and user fees totalled $30 million. About 37 per cent of DHS funding went to Councils, with the balance being provided to other service providers.

FIGURE 2B: HACC FUNDING ($ MILLION)

Funding source	2000-01	2001-02	2002-03
Commonwealth matched (a)	158	167	179
State matched	97	104	111
State unmatched	19	26	27
Total DHS funding of the HACC program (b)	274	297	317
Commonwealth/state allocation to councils (c)	101.5	108.6	117.1
Local government contribution (d)	38.9	42.5	48.0
(% change)		(+9.3)	(+12.9)
User fees (e)	26.0	28.5	30.4
(% change)		(+9.6)	(+6.7)

Source: (a) Provided through the state appropriation system to DHS.
(b) and (c) Department of Human Services.
(d) and (e) Auditor-General's survey of councils, 2004. These figures are not publicly reported and have been supplied by councils and have not been verified.

[7] The Commonwealth/state amended agreement requires, under section 10 (3), for the state to produce an annual plan specifying program outputs by DHS region.

[8] Service priorities for 2003-04 include expansion of HACC basic services, and services to culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities.

2.1.2 Victorian Government triennial HACC plan

After extensive consultation with HACC agencies and stakeholders, DHS changed planning and funding arrangements from 2003-04 to streamline HACC processes, set annual services priorities and allocate growth funds[9]. DHS' regional plans for 2003-04 to 2005-06 changed from annual to triennial plans, and aim to:

- simplify the process of allocating funds, and give service providers more funding certainty
- allocate growth funding to areas of greatest demand for services
- more evenly distribute HACC funds across and within regions
- improve the consistency of planning across regions, and involve the community and agencies more in regional planning processes[10].

The priorities of the Victorian Minister for Aged Care for expanding HACC services and allocating growth funds for 2003-04 to 2005-06 are to:

- increase the supply and improve the responsiveness of HACC basic services and consolidate the HACC basic service system around the key local government and health sector providers[11]
- increase the quantity and quality of HACC basic services for people from culturally and linguistically diverse backgrounds (CALD), and develop new collaborative direct service delivery arrangements between mainstream, multi-cultural and ethno-specific organisations
- increase the quantity and quality of HACC services for Aboriginal and Torres Strait Islander (ATSI) communities[12].

2.1.3 Audit objectives and scope

The objectives of the audit were to:

- determine whether there were effective planning and reporting processes at the state and local government levels to support the delivery of HACC services by Councils; and
- determine whether Councils had systems in place to ensure the timely and appropriate delivery of HACC services.

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[9] The DHS HACC triennial planning and funding reforms are detailed in *Better planning and funds allocation for the home and community care program in Victoria, Final Report*, Department of Human Services, March 2003.

[10] Department of Human Services, Aged Care, *Home and Community Care Program, Victorian Annual Program Plan, 2003-2004, (Revised February 2004)*. pp. 4-5.

[11] HACC basic activities are home care, personal care, nursing, allied health, delivered meals, property maintenance, and assessment and care management.

[12] Department of Human Services, Aged Care, *Home and Community Care Program, Victorian Annual Program Plan, 2003-2004, (Revised February 2004)*. p. 7.

We did not examine the planning for or delivery of HACC services by other service providers.

The audit was conducted at the DHS head office and at 2 of its regional offices. A number of Councils were visited as part of our preliminary work. The planning and service delivery processes of 4 councils were audited in-depth. All 79 Victorian Councils responded to a survey about delivery of HACC services and council planning processes, and some Councils were followed-up in person.

The audit was performed in accordance with the Australian auditing standards applicable to performance audits and, accordingly, included such tests and procedures considered necessary in the circumstances.

We thank staff of the Department of Human Services head office and regional offices, of the Department for Victorian Communities, of the Municipal Association of Victoria and of Victorian Councils for their support and assistance to the audit.

3. Were DHS and Council HACC planning processes comprehensive?

3.1 Were DHS planning processes sound?

In assessing whether the Department of Human Service' (DHS') planning processes were sound, we examined whether:

- population, demographic and service use data was collected, analysed and used
- analysis was undertaken to identify future needs for Home and Community Care (HACC) services, and the mix of services to be provided.

DHS develops regional triennial HACC plans, and an annual HACC plan for submission to the Commonwealth.

DHS' head office collects and analyses population, demographic and service use data. This data is provided to agencies and DHS regions to use to identify changes in HACC target populations and to plan future service provision. Data provided were:

- population data from the Department of Infrastructure, which identified trends in the ageing of the population
- Australian Bureau of Statistics data from the survey of disability, ageing and carers, which enabled an estimate to be made of the likelihood of disability at different ages
- HACC service use data from the HACC minimum data set[1] (MDS) and the DHS quarterly output data collection, which was combined with population data to estimate future demand for HACC services.

DHS' projections were that between 2003-04 and 2005-06, most growth in demand for HACC services would come from frail people over 70 and ageing people with a disability. DHS expects most growth in demand for in-home support and health care services (home care, personal care, nursing, allied health, delivered meals, property maintenance, and assessment and care management).[2]

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[1] The HACC minimum data set is a collection of data about HACC clients and the amounts and types of HACC services provided to them.

[2] This data and projections were developed by the DHS and used by all DHS regions in the development of their regional HACC plans.

The delivery of personal care and home care services are 2 HACC services essential for helping to keep HACC clients living in their own homes and out of residential care. They provide intensive support including individual hygiene and domestic services. Already, there is significant pressure on these services and many Councils have rationed supply to manage existing demand.

Figures 3A shows that HACC clients aged 70 and over are the highest users of home care and personal care services. Figure 3B shows that the cost per client for the use of these services is high for the users in this group.

FIGURE 3A: HACC SERVICE USAGE, HOME AND PERSONAL CARE, 2003

Age cohorts	Number of clients	Home care (hours)	Hours per client home care	Personal care (hours)	Hours per client personal care
0-49	28 872	218 974	7.58	188 957	6.54
50-59	14 402	115 385	8.01	66 727	4.63
60-69	28 785	289 139	10.04	116 881	4.06
70-74	27 983	317 411	11.34	83 943	3.00
75-79	36 502	458 399	12.56	133 312	3.65
80-84	34 409	463 977	13.48	145 843	4.24
85+	33 497	463 011	13.82	227 738	6.80
Total	**204 450**	**2 326 296**	**11.38**	**963 401**	**4.71**

Source: Department of Human Services.

FIGURE 3B: AVERAGE COST PER HACC CLIENT, HOME AND PERSONAL CARE, 2003

Age cohorts	Number of clients	Home care ($)	Per client home care ($)	Personal care ($)	Per client personal care ($)
0-49	28 872	5 222 530	180.89	5 150 968	178.41
50-59	14 402	2 751 932	191.08	1 818 978	126.30
60-69	28 785	6 895 965	239.57	3 186 176	110.69
70-74	27 983	7 570 252	270.53	2 288 286	81.77
75-79	36 502	10 932 816	299.51	3 634 085	99.56
80-84	34 409	11 065 851	321.60	3 975 680	115.54
85+	33 497	11 042 812	329.67	6 208 138	185.33
Total	**204 450**	**55 482 158**	**271.37**	**26 262 311**	**128.45**

Source: Department of Human Services.

Figure 3C shows that there will be strong growth in the population 70 years and older to 2021.

FIGURE 3C: VICTORIAN POPULATION CHANGE, 2001 TO 2021

Age cohorts	2001	2021	Change	% Change
0-49	3 390 865	3 306 829	-84 036	-2.5
50-59	561 744	714 403	152 659	+27.2
60-69	375 242	643 886	268 644	+71.6
70-84	375 669	579 634	203 965	+54.3
85+	66 894	114 364	47 470	+71.0
Total	**4 772 414**	**5 359 116**	**588 702**	**+12.3**

Source: Victoria in Future, the Victorian Government's population projections 1996-2021, Department of Infrastructure, 2000.

The group aged 70-84 is estimated to increase by nearly 204 000 (54.3 per cent) and those aged over 85 are estimated to increase by over 47 000 (an increase of 71 per cent over this period).

People from these 2 age groups represent heavy and high cost users of personal care and home care services. Given this anticipated strong growth in this portion of the Victorian population to 2021, there will be significant demand pressure for personal care and home care services, and considerable growth in the total cost of the HACC program.

An additional demand and cost pressure on the HACC program arises because of the limited availability of other Commonwealth and state-funded community care programs that also target the HACC population[3]. Given their limited availability, compared with HACC services, many high-service and high-cost clients remain in the HACC program.

Figure 3D shows the impact these high needs users have on the HACC program. The proportion of high and very high-cost clients represent 1.1 per cent of the total HACC client base, however, they consume 20 per cent of the total cost of the program. The average cost per client is $16 732 and $66 785, respectively. By contrast, a typical HACC client in receipt of basic services has an average cost per client of $940.

[3] These programs include Community Aged Care Packages and HACC Linkages.

FIGURE 3D: DISTRIBUTION OF HACC CLIENTS BY COST OF SERVICE PROVISION 2002-03

	Proportion of HACC clients (%)	Average cost per client ($)	Proportion of cost (%)	Total cost ($)
Very high cost (>$40 000)	0.1	66 785	5	12.2
High cost ($10–40 000)	1	16 732	15	35.5
Low cost (<$10 000)	98.9	940	80	186.0
Total	**100**		**100**	**233.7**

Source: "Response to issues raised by the Commonwealth's community care review"', Victorian Departmental Advisory Committee on the Home And Community Care Program, October 2003.

This issue is recognised widely in the community care sector. In response, the Commonwealth Government has initiated the Community Care Review in March 2003. The review aims to explore options to rationalise the number of community care programs and to target program funds to meet user needs. DHS is currently formulating its response to this review.

DHS has identified that people from culturally and linguistically diverse (CALD) backgrounds are much less likely to use HACC services compared with the broader community[4].

DHS has also identified that people from Aboriginal and Torres Strait Islander (ATSI) communities have a much higher level of ill-health, and premature death, than other people and consequently a greater need for HACC services[5].

Regions use quarterly output data to determine their service provision targets. Regions considered this data to be more reliable, and provided a more accurate picture of HACC service provision[6]. Information from the HACC minimum data set[7] (MDS) collection is not yet fully used for HACC planning. DHS regions believe that the data did not provide an accurate picture of services because of low response rates to requests for information, and data errors. DHS has established processes to improve the quality of MDS data.

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[4] Ibid.

[5] Ibid, p. 10.

[6] Department of Human Services, Home and Community Care (HACC) program, Draft Grampians Regional Plan 2003-06, June 2003, p. 22.

[7] The HACC minimum data set (MDS) is a collection of data about HACC clients (such as their age and living arrangements) and the amount and types of assistance being provided to them.

Conclusions

DHS' planning processes are sound and are evidence-based. It uses population, demographic and service use data to determine:

- trends in the target HACC population
- the impact population trends will have on future demands for HACC services for the frail aged and people with disabilities, including the special needs of people of CALD and ATSI communities
- the allocation of growth funds between and within the DHS regions
- the allocation of funds to deliver service expansion and ministerial priorities.

Population growth estimates, and cost and service usage data show that there will be significant pressure on demand for basic HACC services and on the total cost of the HACC program in the future.

DHS needs to ensure that the HACC minimum data set is more reliable given its importance for planning the HACC program.

3.2 Were Council planning processes sound?

In assessing whether Council planning processes were sound, we examined if:

- population, demographic and service use data was collected, analysed and used
- sufficient analysis was undertaken to identify future needs for HACC services, and the mix of services to be provided.

In response to our survey, most Councils reported that they used population and demographic data in their HACC planning processes[8]. However, the 4 field audits showed that the use of population and demographic data varied between Councils.

The more sophisticated Council planning processes included long-term (10 year) population projections, movements in age groups (with indications of strong growth in the number of people over 75) and changes in the number of one-person households.

Some Councils also used service use data to estimate the impact that an ageing population would have on demand for HACC services.

[8] Sixty-four councils responded to the HACC planning section of the audit survey. Fifteen councils (19 per cent of all councils) did not respond to this part of the survey. These were 2 large inner metropolitan councils, 4 large shire councils and 9 small shire councils.

The audit survey of Councils showed that:

- nearly 40 per cent of small shire Councils did not use population and demographic data in their HACC planning
- 71 per cent (56) of Councils had access to, or used, HACC MDS information for planning, and 29 per cent (17) of Councils did not. About 50 per cent of small shire Councils did not use HACC MDS for planning purposes
- 43 per cent (34) of Councils estimated the needs of special needs groups, including people from CALD and ATSI communities.

Strategic planning, whether for the HACC program or for other programs, requires skills and experience that is not always readily available to smaller rural shire Councils. It can also be hard for staff of Councils of all sizes to find the time to plan, given the pressure to deliver services and recruit appropriately trained staff. In consultations, the Municipal Association of Victoria suggested Councils needing to improve their strategic planning could be helped through:

- adoption of a common planning template that would provide a framework for the inclusion and analysis of population and demographic and service usage trends in local government areas
- better links between Councils and regional DHS staff to help Council staff understand and use population, demographic and service usage data.

Conclusions

Planning processes in Councils visited by audit were sound. They were based on population, demographic and service use data, and this data was analysed to identify future needs for HACC services.

However, our survey results showed that the extent to which Councils used such data to plan HACC services varied. This variation mainly occurred in small and large shire Councils. The limited use of such data may not enable these Councils to determine future community need for HACC services.

Better training, professional development and recruitment strategies could help smaller rural Councils to improve their capacity to plan strategically.

Recommendations

1. **The Department for Victorian Communities, in consultation with local government peak bodies should examine ways to improve the overall strategic planning capacity of Councils, particularly in rural areas.**
2. **DHS should determine how best to improve Council HACC planning through the provision of HACC demographic and service usage data, and the development of a common HACC planning framework for use by Councils as appropriate.**

RESPONSE provided by Secretary, Department for Victorian Communities

Recommendation 1

DVC agrees to continue working with relevant peak bodies to continue to improve the strategic capacity of Councils generally. The improvement in the local government accountability framework introduced by the Local Government (Democratic Reform) Act 2003 will also assist in resolving issues regarding councils' planning.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 2

DHS makes available to all Regions, and to service providers on request, relevant demographic and HACC service provision data at the local government area level. The Department will make this data routinely available by publishing it on its website as part of the annual process of planning the distribution of new services.

The Department will work with local governments through the Municipal Association of Victoria to identify what effective support it can offer for service planning, without constraining councils' discretion and legitimate scope for a flexible approach. The Department is of the view that local councils should consider their HACC services in the context of the varying mix of services for which they have responsibility; not all councils will choose to do this in the same way.

3.3 Did DHS adequately consult stakeholders?

In assessing whether DHS adequately consulted stakeholders during the HACC planning process, we examined if DHS had established mechanisms to involve organisations representing consumers and service providers, to advise on service needs and HACC program priorities.

The current Commonwealth-state amending agreement for HACC services states[9]: “The Commonwealth Minister and the State Minister shall from time to time jointly agree arrangements for advisory and/or consultative mechanisms at regional and state level whereby consumers and service providers are consulted on needs and priorities under the program”.

From September 2002 to February 2003, DHS consulted with HACC agencies and stakeholders, including peak bodies representing the aged, disabled, ethnic groups, Councils about the proposed triennial HACC planning and funding reforms. Almost half of Victoria’s 500 HACC service providers came to regional consultation sessions, and DHS received 17 written submissions[10].

Workshops were also held with the Municipal Association of Victoria, the Departmental Advisory Committee on HACC[11], the Victorian Association of Health and Extended Care, and DHS’ regional HACC staff and managers.

Many sector issues and concerns were addressed following implementation of the DHS triennial HACC planning process in 2003-04, including:

- a simpler and more transparent planning and funding process
- enabling Councils to concentrate on the planning and delivery of HACC services.

In previous planning processes, there were no consultations about governmental priorities. In the new triennial planning and funding process, the Departmental Advisory Committee on HACC represented all major consumer and provider groups. They identified areas of future demand for services[12].

DHS guidelines for the development of regional HACC plans required the HACC sector to be given the opportunity to comment on, and amend, regional planning proposals. Each region had a consultation program. All HACC service providers, planners, and consultative groups for clients and carers were encouraged to contribute to the development of regional plans. Draft regional plans were also published on DHS’ website for public comment.

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[9] Amending Agreement, Commonwealth and Victoria, for the Home and Community Care Program, p. 11.

[10] *Better planning and funds allocation for the home and community care program in Victoria, Final Report*, March 2003, Department of Human Services, p. 1.

[11] The Departmental Advisory Committee on HACC represents the major consumer and provider groups involved in the program.

[12] Ibid, p. 10.

DHS regional offices established strong links through primary care partnerships. This was reflected in the development of HACC regional plans[13]. For example, DHS Northern Metropolitan Region used community care plans developed by partnership members to identify service issues that were then addressed in the HACC regional plan[14].

Also as part of its HACC planning process, DHS consulted widely about governmental priorities with peak organisations representing CALD and ATSI communities. This was consistent with government's Culturally Equitable Gateways Strategy. From 2003-04 to 2005-06, 39 organisations representing CALD communities and targeted Councils in metropolitan Melbourne and Geelong will be funded with $6.2 million under the Culturally Equitable Gateways Strategy to improve access to mainstream HACC services for people from CALD backgrounds[15].

Conclusion

DHS adequately consulted stakeholders during the HACC 2003-04 planning process. This resulted in major reforms.

Development processes for triennial (2003-04 to 2005-06) regional HACC plans involved provider and client representatives and other stakeholders, with the result that the annual HACC plan was developed openly and transparently.

Recommendation

3. **DHS, together with agencies implementing the Culturally Equitable Gateways Strategy, should develop reporting and evaluation arrangements to assess the effectiveness of the strategy. In particular, identify the:**

   - **needs of newly-emerging culturally and linguistically diverse communities**
   - **take-up of HACC services against pre-established targets.**

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[13] The Primary Care Partnership strategy aims to create a coordinated primary care service system to improve outcomes for consumers and reduce preventable use of hospital services. This strategy is underpinned by partnerships between communities, local government, consumers, carers and service providers. Through the Primary Care Partnership strategy, community health plans are implemented to identify priority health and well-being needs of communities and describe how the providers in the partnership will work with each other and other key stakeholders to respond to these needs.

[14] HACC Program, Draft Northern Metropolitan Regional Plan 2003-06, June 2003, p. 15.

[15] Media Release, Minister for Aged Care, 5 December 2003.

RESPONSE provided by Secretary, Department of Human Services

The Department is currently developing an evaluation strategy for implementation early in the 2004-05 financial year, and for the rest of the life of the strategy.

The aims of the evaluation are to measure the extent to which the mix of people receiving HACC services resembles the mix of these groups in the relevant target population; the effectiveness and efficiency of the process; and consumer satisfaction.

Planned activity group function.

3.4 Did Councils adequately consult stakeholders?

In assessing whether Councils adequately consulted stakeholders in their HACC planning processes, we examined if they involved organisations representing consumers and service providers, to advise on service needs and HACC program priorities.

Stakeholder involvement in HACC planning varied considerably among Councils. Figure 3E shows the results of our survey of Councils about how they consult stakeholders as part of HACC planning[16].

[16] A maximum 66 councils (or 83 per cent of all councils) responded to these questions. The extent of consultation undertaken by 17 per cent of councils is not known.

Figure 3E shows that:

- 94 per cent of Councils consulted with HACC service users and 91 per cent with providers
- about a quarter of Councils did not consult with neighbouring Councils
- 16 per cent of Councils did not consult with primary care partnership members.

FIGURE 3E: STAKEHOLDER CONSULTATION BY COUNCILS IN HACC PLANNING

Stakeholder consulted	Councils consulting with stakeholders	Councils not consulting with stakeholders
	(%)	(%)
HACC service users	94	6
HACC service providers	91	9
Community groups	84	16
Primary care partnerships members	84	16
Regional DHS offices	81	19
Neighbouring Councils	73	27
Commonwealth Department for Health and Ageing	48	52
Other	68	32

Source: Survey of councils undertaken by the Victorian Auditor-General's Office in 2004.

While the planning processes of some Councils were more sophisticated than others, most Councils had (and used) local knowledge to plan services.

Our council audits identified examples of good practice in the plans of some of the large inner metropolitan and outer metropolitan Councils. These Councils undertook:

- wide-ranging consultative processes with service providers
- consultation with older adult groups and clubs
- household ageing surveys
- client satisfaction surveys.

Conclusion

The amount of stakeholder consultation undertaken by Councils varied, but was generally adequate. However, those Councils in limited consultation with other Councils and primary care partnership members reduce the amount of information available for planning and for assessing the quality of service delivery.

Recommendation

4. **All Councils should ensure that they systematically consult with, and gather information from, stakeholders (including health care providers) that can be used for planning and to evaluate service delivery.**

3.5 Did DHS have an effective performance assessment framework?

One goal of the HACC program is “to enable regular and systematic consumer-focused monitoring of the effectiveness and efficiency of the program and the assessment of priorities”[17].

The current Commonwealth-state HACC agreement indicates that the DHS HACC plans should identify:

- measurable program outputs to be provided in each region, with detail about the mix, level and quality of services
- desirable client outcomes, which determine the mix and level of services to be provided in regions.

Outputs are products and services that government funds departments to deliver through programs. Outcomes are the desired effects of government decisions and programs on the community. Outputs should be clearly linked to program outcomes, which should be linked to departmental objectives.

Effective performance measurement is a hallmark of a well-managed organisation. Performance measurement helps agencies and program managers to improve their performance by:

- allowing them to better understand the impact of different strategies, activities and processes on the achievement of organisational objectives and government outcomes
- enabling them to continuously improve service delivery by identifying activities and processes that lead to successes and failures
- ensuring they focus on priorities and examine and address areas of poor performance.

[17] Amending agreement in relation to the provision of financial assistance by the Commonwealth of Australia to the State of Victoria, for the Home and Community Care Program, 1999. Amending agreement for the provision of financial assistance by the Commonwealth to the states and territories. p. 7.

Agencies will also establish arrangements to measure program outputs and outcomes because:

- they are accountable for the delivery of outputs that help achieve outcomes
- government needs information to help it decide which outputs to fund in order to achieve its policy objectives.

In assessing whether DHS had an effective performance measurement framework for the HACC program, we examined if DHS had short-term output measures and long-term outcome indicators to assess the achievement of program objectives and priorities.

DHS performance reporting mechanisms provide information about the cost of HACC outputs. It has started to report on service quality and is in the early stages of developing a framework for reporting on the mix of services. DHS does not report against outcomes.

3.5.1 HACC expenditure and service reporting

DHS currently reports HACC performance through the Victorian budget papers, the DHS annual report, the HACC annual plan, and the annual HACC business report to the Commonwealth Government. The budget papers and the DHS annual report contain information on:

- total cost of outputs and services
- the quantity of HACC service delivered
- the proportion of the HACC target population receiving services
- the quantity and cost of HACC service development projects.

The DHS business report is submitted to the Commonwealth annually under the Commonwealth-state HACC agreement. The 2001-02 report certified the expenditure of HACC funds against expenditure and service delivery targets. The report provides information about HACC outputs and services delivered (by activity) against regional and state targets. The business report does not provide information about program outcomes.

3.5.2 HACC service quality reporting

The HACC national standards survey instrument (NSSI) is used to assess the extent to which individual service providers comply with national HACC standards[18]. The NSSI was started in Victoria in May 2003 and is expected to be completed by June 2004. Councils are required to have their home care and personal care services assessed.

DHS planned to conduct a post-implementation review of the NSSI in 2005 and to:

- collect baseline data on the service delivery performance of Councils and other service providers
- use the first round of data collection to assist HACC providers improve their delivery of services
- analyse all service delivery data to undertake projects to improve service delivery
- reassess the service delivery performance of one-third of HACC service providers over a 3-year cycle.

3.5.3 HACC service mix

DHS planned to improve the way HACC resources are allocated, to enhance the mix of services to clients and so better meet their needs. DHS' data on service users showed the types and quantities of HACC services received by clients, according to their demographic characteristics.

The national HACC program does not have a method to determine the ideal mix and level of services that would result in the best outcomes for clients. In the absence of such a method, DHS gathers evidence about the value that particular services offered to clients.

At the time of the audit, DHS was testing and refining client dependency data items to be introduced into the HACC minimum data set for all clients by mid-2005. The combination of dependency data about HACC clients with data about family care-giving arrangements and about the use of alternative sources of home care will enable DHS to monitor and describe more accurately the extent to which HACC services meet the needs of clients.

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[18] The HACC National Standards Survey Instrument (NSSI) is a quality improvement tool developed to measure the extent to which individual agencies are complying with the standards through a service appraisal process. The NSSI measures the quality of services as defined by the HACC National Service Standards.

The dependency data collection, intended to be part of version 2 of the HACC MDS, is a joint Commonwealth-State Government initiative. Given that the Commonwealth Government is also the major funder of the HACC program, its cooperation is required for Victoria to progress this work.

3.5.4 Conceptual framework for measuring HACC program performance

Figure 3F illustrates a conceptual framework developed by our Office for measuring HACC program performance.

FIGURE 3F: HIERARCHY OF HACC PERFORMANCE REPORTING

Source: Victorian Auditor-General's Office.

Such a model offers a structured and comprehensive approach to integrating the various aspects of performance measurement into one system. DHS reporting already covers several aspects of this model. We suggest it consider this type of approach to improve its performance reporting.

DHS' performance measurement framework is evolving. Its resource allocation mechanism should enable benchmarking the mix and level of HACC services delivered, to determine the extent to which they meet client and carer needs.

We recognise that it is not easy to measure outcomes. The cause-and-effect relationships between outputs and outcomes can be difficult to establish and measure, especially where outcomes are achieved through a combination of outputs from different programs and agencies.

3.5.5 HACC outcome indicators

The DHS performance measurement framework does not currently include outcome indicators to assess the extent of achieving program objectives or priorities. Such a framework does not exist at the Commonwealth level either.

Conclusions

DHS reports short-term output measures of HACC expenditure and services delivered. Through the HACC national standards survey instrument, DHS also has a process to assess the extent to which individual service providers comply with national HACC standards. However, DHS has not developed outcome indicators to assess the achievement of program objectives and priorities.

Recommendation

5. DHS should work with the Commonwealth Department of Health and Ageing to develop indicators that can be used to assess the extent to which HACC program objectives, priorities and outcomes are achieved.

RESPONSE provided by Secretary, Department of Human Services

It is expected that the Commonwealth Government will approach States and Territories to renegotiate the Home and Community Care Agreement over 2004-05. This issue will be raised with the Department of Health and Ageing in the context of those negotiations.

3.6 Did Councils effectively measure program performance?

Councils are required to account to DHS for the expenditure of funds received and for services delivered. Under the best value legislation[19], Councils are required to report performance to ratepayers. Under the *Local Government Act 1989*, requires Council:

- budgets to contain separately identified key strategic activities to be undertaken during the financial year and performance targets and measures in relation to each key strategic activity
- performance statements to include the key strategic activities and performance targets and measures specified in the budget and the actual results achieved for that financial year.

[19] Best value principles and particularly the development of quality and cost standards for councils services are stated in the *Local Government Act 1989*.

In assessing whether Councils effectively measured the performance of their HACC programs, we examined if:

- they had established measures of outputs and long-term indicators of performance against objectives
- Councils publicly reported HACC expenditure, the delivery of HACC services and the achievement of HACC objectives.

There were significant variations in the use of performance measures by Councils. Some Councils we visited used performance measures to monitor HACC program outputs, and to report on them in their annual report. Others were in the process of developing HACC-specific performance measures for outputs. These performance measures were generally developed out of Councils' best value processes and were:

- a mix of quantitative and efficiency based (timeliness) indicators
- indicators of client satisfaction.

All Councils surveyed said that they received HACC client feedback through a range of methods, including client satisfaction surveys. Councils should, therefore, be in a position to develop HACC-specific performance measures.

All Councils visited had HACC program plans. These plans clearly stated the vision for the program, its objectives and service delivery strategies.

Council visits and the audit survey of Councils both found that no council had performance indicators for programs outcomes or objectives.

A majority of Councils set cost and timeliness benchmarks for service delivery. They did this by comparing work processes and the delivery of services against another Council or Councils with similar processes and services. Our survey of Councils showed that:

- about 70 per cent of Councils benchmarked their HACC services against those of other Councils
- 15 per cent of Councils did not have benchmarks, but were partnering with other Councils to develop them
- 15 per cent of Councils did not benchmark their services, and were not in partnership arrangements to do so.

Councils that had benchmarks used them to identify process and service gaps. Councils were also benchmarking through the "best value principles" and using benchmarking processes developed by the Municipal Association of Victoria and the LG PRO[20] Benchmarking Project.

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[20] LG PRO is an organisation that specialises in the training and professional development of Council staff.

The survey indicated that nearly 90 per cent of Councils used their performance measures or benchmarks to continuously improve service delivery. All Councils said they used client feedback to improve service delivery.

Councils reported information about HACC services and expenditure to DHS. However, Councils did not report on:

- the total cost of delivering HACC services (including Councils' own contribution)
- dissection of the source of HACC funds (into the state grant, Councils' own funds and user fees)
- the quantity of HACC services delivered in total
- any qualitative measures.

There is scope for Councils to report HACC performance in a more transparent manner through the "best value principles" requirements in the *Local Government Act 1989*. These requirements include describing how the objectives of the HACC program are achieved, the use of performance measures, and the cost of the program.

Conclusions

Councils are required by several Acts to measure and report their performance. Currently, Council reporting of the achievements of the HACC program and its cost is not fully transparent.

Because they did not have the performance measurement tools, Councils were unable to fully assess the extent to which HACC program objectives and outcomes were achieved.

Recommendations

6. **All Victorian Councils which are yet to develop HACC-specific performance measures for outputs should develop them as soon as practicable.**

7. **In accordance with the "best value principles" required by the *Local Government Act 1989*, Councils publicly report:**

   - **against HACC program objectives and performance indicators for program outcomes**
   - **full details of the total cost of HACC services and the principal sources of funding**
   - **the total quantity of HACC services delivered by Council, split between DHS-funded and Council-funded services where appropriate and necessary.**

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4. Were Councils' HACC service delivery systems adequate?

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

4.1 Was service coordination adequate?

4.1.1 Introduction

The framework for home and community care (HACC) service coordination by Councils is shown in Figure 4A. The main stages of service coordination are:

- initial identification and assessment of client needs
- provision of services
- monitoring and reviewing client needs
- referral of client to other services.

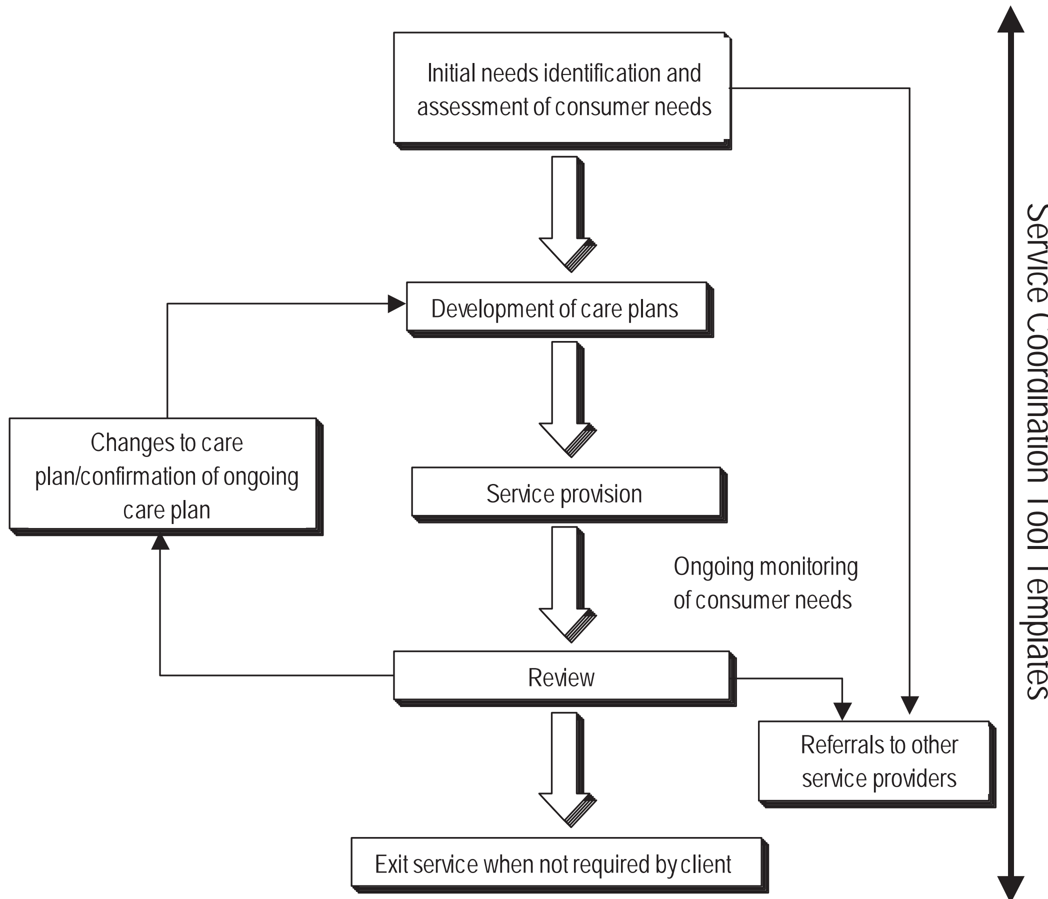
Councils are also responsible for:

- planning HACC service delivery
- managing demand for HACC services
- assuring service quality
- choosing the right service delivery model, including the use of volunteers
- reporting HACC program and client service usage data to the Department of Human Service (DHS).

Since 1999-2000, the community care sector has mainly used primary care partnerships to coordinate services. These partnerships are voluntary alliances of local government, HACC service providers, aged care assessment teams, community health services, primary mental health services and alcohol and other drug services. Partnerships usually involve agencies from 2 or 3 local government areas. The agencies in a partnership usually agree on common ways of dealing with public inquiries, collecting the same information about clients at the time of their initial presentation, referring clients and providing services.

DHS has developed Service Coordination Tool Templates (SCTTs) to help improve service coordination and client referral, particularly at the point of initial client contact, and reduce multiple assessments of the same person by different agencies. These templates provide common standards for assessing and referring clients. Since 1 July 2002, all HACC providers have been required to use these tools, which replaced the Client Information and Referral Record (CIARR).

FIGURE 4A: FRAMEWORK FOR HACC SERVICE COORDINATION BY COUNCILS



Source: Victorian Auditor-General's Office.

4.1.2 Were Council assessment practices adequate?

In determining whether Council assessment practices were adequate, we examined if Councils:

- had processes in place to assess the differing needs of clients
- had policies to ensure that care and respite plans[1] were developed for clients after assessment
- used the SCTTs to initially identify client needs
- had procedures to coordinate assessments with other service providers.

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[1] Care and respite plans specify the particular types and levels of service and support provided through HACC for the client and their carer.

DHS' *Home and Community Care Program Manual* requires that a person, to receive HACC services, must be:

- assessed as being in the HACC target group[2]
- in need of HACC-funded services
- prioritised for services.

The HACC assessment process identifies a person's need for HACC services, and whether they can live independently at home with HACC support. Assessment also involves the development and implementation of a care plan, and a calculation of fees the client will be required to pay, in line with the HACC fees policy.

All 4 Councils visited had policies and procedures to assess people referred to them, or who asked for HACC services. All visited Councils screened people for eligibility, had processes to identify consumer and carer needs, and processes to develop care and respite plans.

Almost all Councils (97 per cent of survey respondents) had a single assessment process for their HACC services, and multiple assessments were rare. The extent and nature of assessments varied across Councils.

As part of the audit survey, Councils were asked to indicate their capacity to conduct service-specific, specialist and comprehensive assessments[3]. Survey results indicate that the capacity of Councils to conduct these assessments varied significantly. All Councils reported that they could conduct basic service-specific assessments for HACC services. Thirty-three per cent of Councils reported that they conducted specialist assessments and 78 per cent of Councils conducted comprehensive assessments.

The Councils visited had differing interpretations of the types of assessments they were required to conduct. For example, one council defined all face-to-face assessments as comprehensive. Another conducted comprehensive assessments for all clients, regardless of the complexity of the clients' circumstances.

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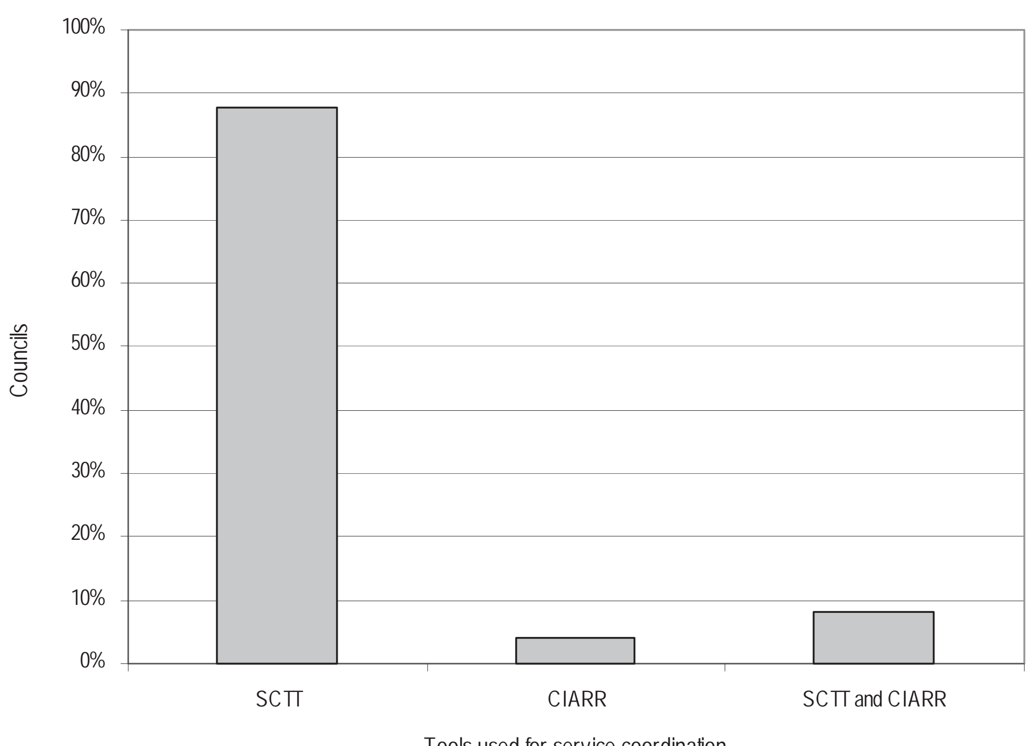
[2] The target group is people living in the community who, in the absence of support services provided through HACC, are at risk of premature or inappropriate long-term residential care. The group includes:

- older and frail people, with a moderate, severe or profound disability
- younger people with a moderate, severe or profound disability
- carers of the people above.

[3] These types of assessments are specified in DHS' *Better access to service framework*.

The use of SCTTs is designed to make Councils' initial screening and needs identification of clients more uniform across the state. Figure 4B shows that most Councils use the SCTT tools. Use ranged from complete integration of the tool with council information technology systems, assessment policies and practices, to limited integration and continuing use of both the client information and referral record and the service coordination tool templates.

FIGURE 4B: PERCENTAGE OF COUNCILS THAT USED SERVICE COORDINATION TOOL



Source: Victorian Auditor-General's Office audit survey of Councils, 2004.

The benefits of SCTT were widely acknowledged by Councils, with 95 per cent considering the SCTT tools beneficial. However, 73 per cent of Councils reported that the need to change work practices and procedures, train staff and overcome information technology problems were significant issues in implementing the SCTTs.

Councils reported that the SCTTs did not apply to all client groups, and that they primarily focused on the needs of older people and not children with a disability, Aboriginal and Torres Strait Islander (ATSI) communities or carers.

Coordination of client assessment reduces multiple assessments of the same person by different agencies. Nearly 90 per cent of Councils stated they coordinated assessments with other service providers. These included processes for conducting joint assessments of clients, for sharing and using assessment results (with clients' consent) with other service providers, and for coordinating the development of care plans. Assessment coordination was driven by the need to reduce the impact of multiple assessments on clients.

Conclusion

Council policies and systems to assess people needing access to HACC services were adequate.

While DHS' *Better access to services framework* defines the different types of client assessment, the meaning of these assessments to the HACC program is not clear to Councils. There is no common understanding across Councils of the nature of the different types of assessments (particularly comprehensive assessments).

Around 95 per cent of Councils had started using the SCTT. Those Councils implementing the SCTTs to assess client needs have noted the benefits of doing so, however, a majority of Councils were experiencing difficulties in implementing the tools.

The SCTT was mainly designed to meet the needs of frail, older people. However, the SCTT does not meet the needs of children with a disability, carers and ATSI communities. Consequently, the needs of these groups may not be fully identified, and they may not get access to the support services they require.

A small number of Councils did not have processes to coordinate the assessment of clients with other service providers. This could result in clients being assessed on multiple occasions.

Recommendations

8. **DHS should clarify the definitions of all types of assessments in the *Better access to services framework* applied to HACC.**

9. **DHS and Councils should identify and resolve the barriers to implementing service coordination tool templates.**

10. **DHS and Councils should together review the applicability of SCTTs for young people with a disability, carers and ATSI communities, and modify the SCTTs as required.**

RESPONSE provided by Secretary, Department of Human Services

Recommendation 8

DHS is currently undertaking work to synthesise the research and development effort on assessment in home and community care that has occurred at a national, state and regional level over the past five years. Our aim is to develop a framework for assessment in Victorian HACC services. As part of this exercise, and before implementation, the Department will consult extensively with practitioners. The framework for assessment in HACC will take as its point of departure the Better access to services *framework and will clarify the definitions of types of assessment as they apply to HACC.*

Recommendation 9

To gain the benefits of the service coordination tool templates, the experience of DHS has been that agencies need to go through a change management process concerning work practices, staff training, and information technology. Local government agencies have correctly identified that these steps are necessary in order to achieve successful implementation.

The HACC program in DHS has been closely involved with Primary Care Partnerships to identify actions that can support agency implementation. Implementation of service coordination is supported in a number of ways. Funding is provided to Primary Care Partnerships for Service Coordination Orientation Train the Trainer programs and a Service Coordination self-paced learning module.

The Department has regular meetings with members of the Municipal Association of Victoria through a HACC and Primary Health standing committee. This committee has provided important advice on the capacity of local government to implement the service coordination tool templates and will continue to be a vehicle for identifying issues which require action by the Department.

One of the roles of DHS regional HACC contact officers is to monitor implementation of the service coordination tool templates by local government and to identify actions which can assist with implementation.

Recommendation 10

The Department is proposing to revise the current suite of service coordination tool templates, recognising that the current version does not adequately identify the needs of the full range of consumers, as identified in the Auditor General's report. The revision will be done in consultation with provider agencies, relevant DHS programs, and an expert practitioner advisory group. The process is likely to take up to two years.

This will be an opportunity for agencies and Departmental programs to propose the inclusion of new or revised tools. Modules and accompanying guidelines relating to ATSI communities, carers and young people with a disability could be developed and piloted. If accepted, the new material would be included in the next version of the service coordination tool templates, guidelines, data dictionary and data standards.

However, it must be recognised that the service coordination tool templates are being used by providers delivering a wide range of DHS-funded services. As such, it is unlikely that sector-specific or program-specific revisions will be adopted unless they can be shown to enhance the usability of the tools for all potential users.

On the specific question of applicability to Aboriginal communities, DHS is currently engaged in a project with Aboriginal HACC agencies to map the data items in the existing Aboriginal Client Information and Referral Record (the CIARR) to the corresponding items in the Service Coordination Tool Templates (SCTT). This will identify where changes are required. This project recognises that some of the questions in the SCTT tools may not be culturally relevant to Aboriginal elders and Aboriginal HACC agencies. Aboriginal agencies are not required to use the SCTT tools until this project is completed.

4.1.3 Were Council monitoring and review processes adequate?

In assessing whether Council processes to monitor and review client needs were adequate, we examined if:

- Councils had adequate processes to review clients
- Councils had processes to update client care and respite plans to reflect their changing needs.

Councils funded by DHS to provide HACC services are required to regularly monitor and review clients' needs, and assess how effectively HACC services are meeting them. Formal client reviews identify whether the level and type of services delivered suit the client, and allow clients to comment about the quality of services.

Eighty-four per cent of Councils surveyed said they routinely reviewed clients. All 4 Councils visited decided how regularly clients should be reviewed as part of the initial assessment process, and aimed to review higher-priority clients more regularly. However, Councils stated that they often did not complete client reviews by the set date. Councils said that screening and assessing new clients took precedence over reviewing existing clients.

The audit survey of Councils showed that about one-third of clients had their services changed after being formally reviewed, and that:

- services were increased for 22 per cent of clients
- services were reduced for 5 per cent of clients
- services were stopped for 5 per cent of clients.

Council views on what constituted a formal review of a client, and the comprehensiveness of review, varied considerably. What was considered a formal review ranged from a comprehensive face-to-face reassessment to a telephone discussion. The time elapsed between reviews, and the use of formal tools to conduct a review, also differed.

The audit survey showed large differences in the time between reviews of clients. Home care clients were, on average, reviewed about once a year, but some Councils could take up to 2 years. In some cases, home care clients had not been reviewed for up to 5 years. This extent of variation is similar for all types of services. The *Home and Community Care Program Manual* does not specify a standard review period. It only requires funded agencies to "regularly monitor and review consumers' conditions" and circumstances and does not define "regular" or suggest what is an appropriate time between reviews.

The 4 Councils visited had trained HACC staff who regularly monitored clients as part of delivering services. The Councils believed this to be an important method of client monitoring. All had procedures for staff to report any issues identified through monitoring, and to initiate a formal review if required.

Councils visited varied in their use of tools to review clients. Two of the 4 Councils visited used formal tools such as the SCTT or CIARR to record the results of the review. The review arrangements of the other 2 Councils were ad hoc.

Councils visited also had procedures requiring assessment staff to update care and respite plans as part of the review.

Conclusion

Most Councils had processes in place to undertake routine reviews of client needs. However, they had difficulties in completing these reviews in a timely manner.

Despite the inability of some Councils to formally review clients by the set date, any risk to clients is perhaps mitigated by monitoring of clients by direct care staff[4]. However, formal reviews are particularly important for clients with high level or complex needs, to identify if they are receiving appropriate services.

[4] Direct care staff deliver home care, personal care and respite care services.

Councils should use standard tools to conduct and record client reviews. This would standardise the conduct of reviews and the recording of results, and enable client needs to be consistently measured over time.

The systems used by Councils visited to update care and respite plans after client reviews were adequate.

Recommendation

11. DHS should develop clear guidelines for the conduct of client reviews. In developing these guidelines, DHS should investigate the feasibility of a standard tool for conducting and recording client reviews.

4.1.4 Were Council referral processes adequate?

Service providers should have processes for the referral of clients to other appropriate agencies when the client's needs can no longer be met under the HACC program. The referring agency should makes sure that all relevant information on the client and their needs are forwarded to the new agency.

To assess whether referral processes were adequate, we examined if Councils:

- had procedures to coordinate the referral of HACC clients to other service providers
- used the SCTTs for referrals.

Over 90 per cent of Councils surveyed said that they had procedures to refer HACC clients to other service providers. Almost all respondents (91 per cent) had procedures to prioritise clients according to whether their needs were urgent or not urgent. However, 26 per cent of small shire Councils did not have procedures to prioritise referrals. This meant that they could not give other service providers information about the urgency of their client's needs.

The four Councils visited had protocols or service agreements to refer clients and coordinate service delivery with other service providers such as the Royal District Nursing Service, post-acute care services and aged care assessment services. The protocols helped Councils and these other service providers to assess HACC clients and coordinate services for them.

Common standards and tools for the referral of clients have been developed through the primary care partnerships[5]. Use of these referral tools by agencies should be beneficial and lead to greater efficiency in the referral of clients.

The 4 Councils visited said that variable levels of participation by other partners, the lack of widespread use of the SCTTs by partners and the need to ensure the privacy of client information were the main challenges they faced in coordinating services through primary care partnerships.

This was supported by the survey results. They show that while half of the Councils had gained significant benefits from primary care partnerships, the other half were either unsure of the benefits, or had had limited or insignificant benefits from participating in the partnerships.

Conclusion

Most Councils had adequate processes to coordinate the referral of clients to other service providers. These processes are likely to further improve over time, given the strong uptake of SCTTs.

4.2 Was demand adequately managed?

The likelihood of disability increases with age. Older people are most likely to use HACC services because of their:

- increased frailty and vulnerability
- reduced mobility
- lower incomes
- greater instances of living alone, and dependence on informal carers
- chronic ill-health and general deterioration of health.

In 2002-03, clients aged 70 and older received 64 per cent of all HACC service hours. Client's aged 50-69 received 18 per cent of services, and clients aged 49 and younger received 18 per cent of services[6]. The average client aged 70 and older received more home care, personal care, delivered meals and nursing services than younger clients, and also spent more time in planned activity groups. Councils, as major providers of most of these services, are going to face growing demand pressures.

[5] Partnerships are usually between agencies in 2 or 3 local government areas and are the mechanism to coordinate the delivery of primary health care services.

[6] Data source, Department of Human Services.

As Figure 4C shows, predictions are that the 50-69 and 70 and over age groups will have the biggest percentage increases between now and 2021. Accordingly, the greatest pressure on HACC services is likely to be on the services most used by these age groups, which are the HACC basic in-home support and health care services (home care, personal care, nursing, allied health, delivered meals, property maintenance, and assessment and care management).

FIGURE 4C: PROJECTED CHANGES IN VICTORIA'S POPULATION, 2001 TO 2021

Source: Department of Infrastructure, *Victoria In Future*, 2000.

There is also pressure on demand for HACC services because of problems that clients with high-level needs face moving from HACC basic services to higher support services (such as HACC linkages[7] and Commonwealth age care packages[8]). There are long waiting lists for these services and complicated transitional arrangements from HACC basic services. As such, clients with high-level needs often remain on HACC services, which reduces the availability of basic HACC services to others.

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[7] HACC linkages is a case-managed, intensive package of services available to people who need more support than is provided with HACC basic services.

[8] Community Aged Care Packages (CACPs) provide case management and brokerage to help older people remain living in their own homes. CACPs are funded by the Commonwealth Government.

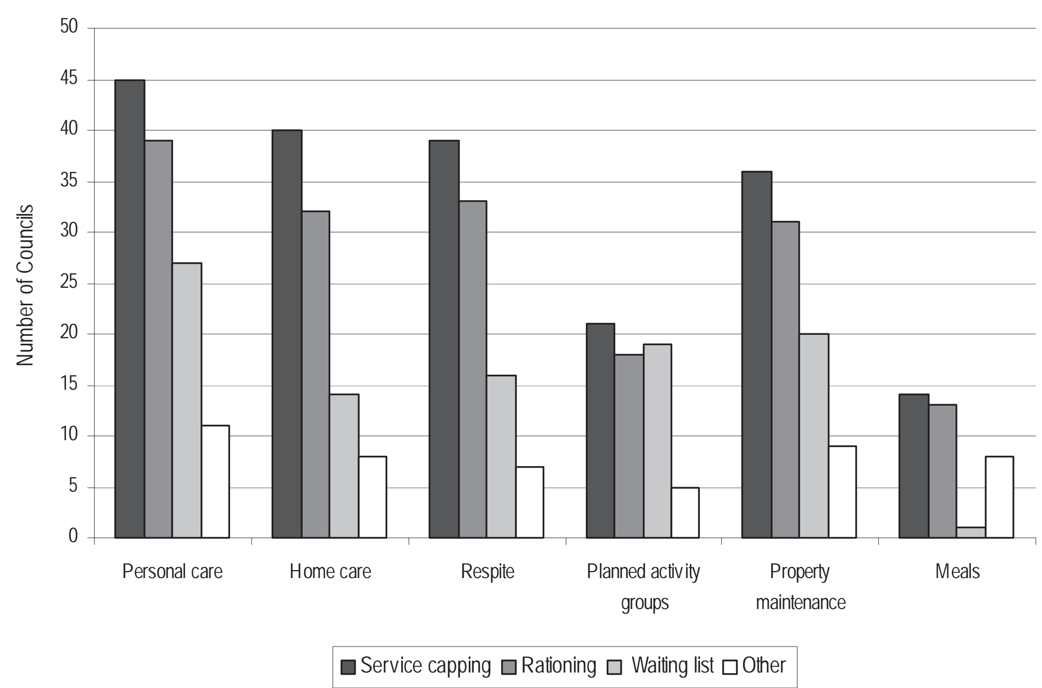
In assessing whether Councils managed demand adequately, we examined if they:

- had adequate strategies to manage demand
- had processes to prioritise client access to HACC services.

HACC service agreements between DHS and service providers require providers to prioritise client access to a service when demand for the service exceeds its availability.

Our audit survey found that almost 90 per cent of Councils had a strategy to manage client demand, when demand for HACC services exceeded available resources. Figure 4D shows the 3 main types of demand strategies, and the number of Councils using each strategy. The strategies were to establish limits to hours of services provided (service capping), to ration services so that a greater number of people got a lesser volume of service, and to establish waiting lists for services. Councils generally used a combination of strategies.

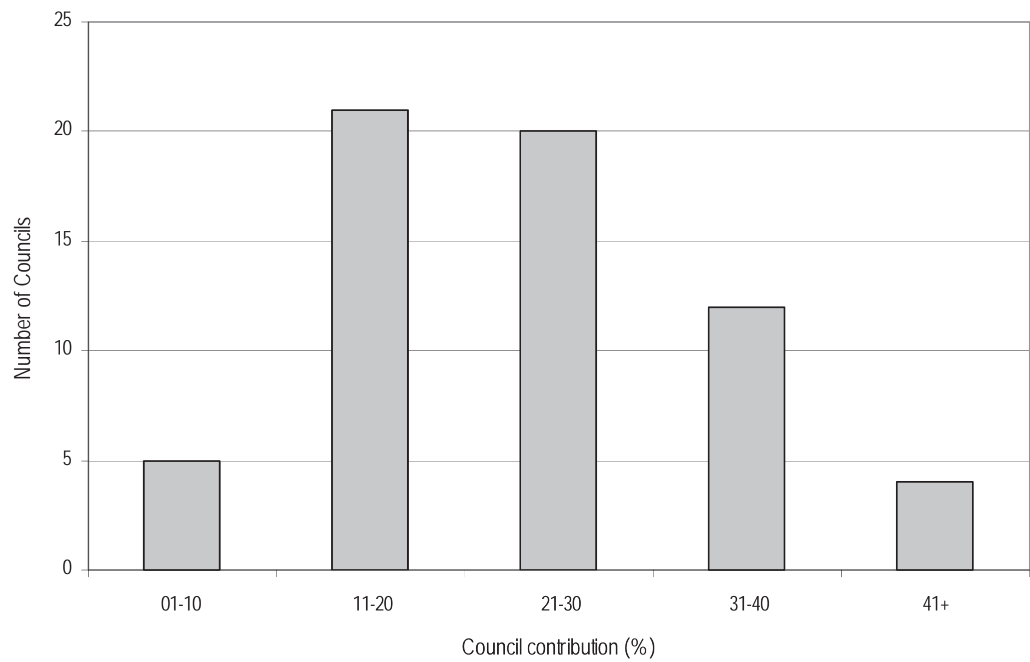
FIGURE 4D: DEMAND MANAGEMENT STRATEGIES, BY TYPE OF SERVICE



Source: Victorian Auditor-general's Office survey of Councils, 2004.

Councils receive funding DHS and user fees for their HACC programs. Most Councils also provided extra funds from their own resources to deliver HACC services, allowing them to increase the availability of HACC services. Figure 4E shows reported spending of their own funds by Councils surveyed, banded by percentage, in 2002-03. Some Councils met 4 per cent of HACC expenditure, while the highest was at 47 per cent. The average of reported amounts was 24 per cent of total expenditure on HACC services. Currently, it is not possible to verify the value of these contributions.

FIGURE 4E: COUNCIL FUNDING OF HACC SERVICES AS A PROPORTION OF TOTAL COUNCIL EXPENDITURE ON HACC SERVICES, 2002- 03



Source: Victorian Auditor-General's Office survey of Councils, 2004.

To allocate resources to people most in need, DHS requires Councils to prioritise client access to HACC services, and has "common indicators of higher level need" that should be referred to when prioritising a person for service.

Most Councils (94 per cent) used criteria (such as difficulty with tasks of daily living, social and geographic isolation, and lack of carers) to prioritise people for service. The Councils visited had incorporated the common indicators of higher level need into their criteria. They prioritised clients both at initial assessment and when clients were reviewed. Most Councils surveyed had 3 levels of priority (low, medium and high), based on groupings of their criteria. Some Councils used scores and formulas to rank people for access. Others had broad guidelines that could be interpreted by assessment staff, using their clinical judgement.

At the time of audit, DHS was trailing the collection of information about HACC client dependency[9]. DHS plans to use this information to better manage demand for HACC services. It expected the information would tell it more about the services required by clients. It also intended to provide this information to Councils.

Conclusion

Most Councils had strategies to manage client demand for HACC services. Councils managed demand using a variety of strategies, but had not evaluated the adequacy of these strategies.

Most Councils had processes to prioritise client access to HACC services. These processes reflected demand pressures faced by each Council. However, a more consistent and evidence-based approach to setting priorities would lead to better client access to HACC services across the state.

A common set of tools based on a consistent set of principles would function as a decision-support aid to the professional judgement made by assessment staff. Versions of such a tool would need to be designed to take specific account of the differences between the major HACC service types.

Better information is needed about which methods and strategies to manage demand and prioritise clients are the most successful. Better information about client dependency would enable DHS and Councils to allocate resources according to client needs, and potentially provide the basis of understanding the impact of their demand management strategies on users of the service.

Recommendations

12. **DHS should develop common guidelines for prioritising client access to HACC services. These guidelines should be developed to support the decision-making process of assessment staff.**
13. **DHS should complete its evaluation of the HACC dependency data and move towards establishing this data collection as part of the quarterly minimum data set collection.**

[9] Dependency is a measure of a client's ability to carry out everyday tasks.

RESPONSE provided by Secretary, Department of Human Services

Recommendations 11 and 12

DHS agrees that this recommendation is an important one for the HACC program. As noted above, the Aged Care Branch is therefore developing an assessment framework for the HACC program. The possibility of developing a standard tool for conducting and recording client reviews will also be investigated.

This project will identify at what stage of the intake and assessment process it is most appropriate for agencies to assess clients' risk and/or priority for receiving a service, and how to improve the consistency of these decision making processes. At least one Region has already developed a priority of access tool whose suitability for wider use will be considered as part of the assessment framework process.

Recommendation 13

Agreed. It should be noted that changes to the HACC MDS can only be made by agreement between the Commonwealth, States and Territories. DHS has received the final draft report on its trial of the dependency data items and is using the results of the study to inform the national debate about the issues involved. The issues raised cover both the content of the dependency measures and the business rules that should accompany the collection of the measures in order to ensure the data is reliable, up to date and accurate.

Workman installing a hand rail.

4.3 Were in-house/contractor arrangements adequate?

4.3.1 Was Council monitoring of HACC contractors adequate?

While Councils directly provide some services, a number of Councils have contracted-out certain services, particularly the provision of meals and property maintenance.

In assessing whether Council monitoring of HACC contractor services was adequate, we examined if:

- Councils had contracts or service agreements that required contractors to comply with the DHS service standards and reporting requirements
- Councils monitored the performance of contractors and assured the quality of contractors' services.

DHS requires Councils to ensure that contracted HACC services complied with HACC service standards and guidelines. HACC national standards also require HACC providers (including Councils) to show that they monitored the quality of services purchased from third parties. Councils were also subject to the *Local Government Act 1989*, which establishes tendering procedures to be followed by Councils when contracting-out services valued at more than $100 000[10].

Many Councils use contractors to deliver HACC services. As Figure 4F shows, the most commonly contracted services were preparation and delivery of meals and property maintenance. Councils also purchased services as-needed (e.g. to help in peak demand periods or to replace staff on leave or doing training), most commonly to deliver direct care services (such as homecare, personal care and respite services).

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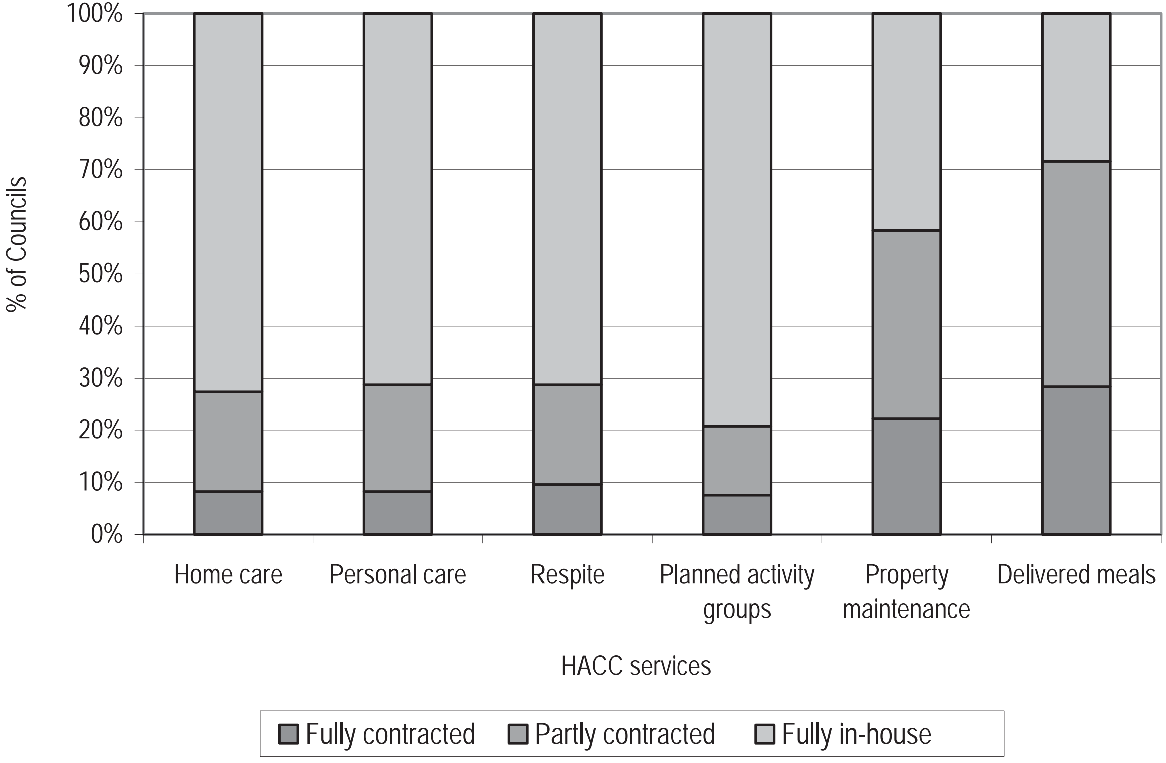
[10] Before a Council enters into a contract for the purchase of goods or services to the value of, or greater than, $100 000, the Council has to give public notice of the purpose of the contract and invite tenders or expressions of interest.

FIGURE 4F: USE OF CONTRACTORS TO DELIVER HACC SERVICES



Source: Victorian Auditor-General's Office survey of Councils, 2004.

Councils that contracted-out HACC services had followed the legislated tender and evaluation processes and had contracts with contractors to provide services. Most contracts required that contractors comply with HACC service delivery guidelines. The contracts also established monitoring and quality assurance procedures.

Councils used external staff on an as-needed basis, and in these cases had a service agreement or a preferred provider policy in place.

In response to the audit survey, 95 per cent of the Councils that contracted-out service delivery reported that they measured the performance of their contractors. However, levels of monitoring varied considerably between Councils in:

- the frequency of monitoring
- the standards the Council used to measure contractor performance
- the processes to assure the quality of services delivered by contractors.

At the minimum, Councils required contractors to report on the levels of services delivered. More sophisticated contracts included:

- performance indicators for the quality and timeliness of service delivery
- requirements that work practices and systems such as contractor's complaints mechanisms and occupational health and safety practices be audited.

The quality assurance processes used to ensure that services were delivered in line with HACC standards also varied between Councils. Some Councils conducted their own quality assurance testing (e.g. by testing the temperature or taste of purchased meals). All Councils used customer surveys or complaints processes to get feedback about the quality of the services delivered. Most commonly, surveys were done annually.

Conclusion

Councils varied in how (and how much) they monitored contractors, in their reporting requirements and the level of quality assurance undertaken. Councils that relied only on infrequent customer satisfaction surveys would not be able to adequately ensure the quality of contracted services.

Councils need to ensure that they do not neglect their duty of care to HACC clients by allowing services to be delivered that do not meet the required standards. All Councils should have adequate quality assurance processes to minimise risk to their clients.

Recommendation

14. **Councils should develop quality control procedures over services delivered by contractors so that they do not compromise their duty of care to their HACC clients.**

RESPONSE provided by Secretary, Department of Human Services

Recommendation 14

Councils are required under their service agreements with DHS to provide their HACC services in line with the HACC Program National Services Standards. It is a requirement under Objective 3 (Efficient and Effective Management), Service Standard 11, that Agencies practise accountable management procedures, including demonstration that the agency "monitors the quality of services purchased by the Agency from a third party".

4.3.2 Did Councils have adequate staff to deliver HACC services?

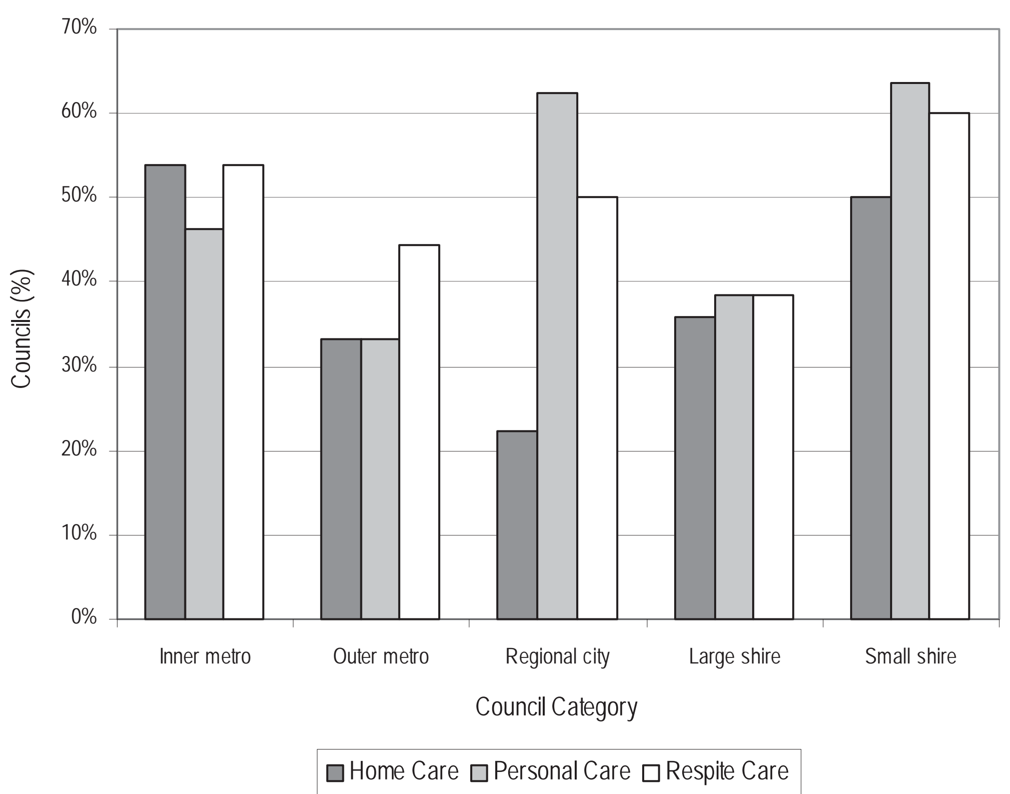
In assessing whether Councils had adequate staff to deliver HACC services, we examined if:

- Councils were able to recruit and retain sufficient staff to deliver HACC services
- the staff employed to deliver services had appropriate qualifications.

Nearly half the Councils surveyed reported difficulty in recruiting and retaining staff qualified to deliver HACC services. Councils cited the lack of full-time employment opportunities, the low status of direct care work, an ageing work force, occupational health and safety concerns, and staff turnover as the main issues affecting the availability of HACC staff.

These results are similar to a study of the HACC work force by the Brotherhood of St Lawrence in 2002. Figure 4G shows that study's findings that outer metropolitan Councils and large shire Councils found it less difficult to recruit staff than other Councils. Regional city Councils and small shires appeared to have had the most difficulty recruiting home care staff, while small shire Councils and inner metropolitan Councils had the greatest difficulty attracting staff for all direct care services.

FIGURE 4G: PERCENTAGE OF LOCAL COUNCILS WITH RECRUITMENT DIFFICULTIES, BY COUNCIL TYPE



Source: Who Will Care? The Recruitment and Retention of Community Care (Aged and Disability) Workers, The Brotherhood of St Lawrence, 2002.

A similar pattern emerged with the Councils visited by audit. Three of the Councils could not recruit and retain enough direct care staff. This affected the frequency, amount and timeliness of services the Councils delivered. One inner metropolitan Council could not attract enough suitable staff to deliver services to clients from culturally and linguistically diverse communities. A small shire Council had difficulties finding staff to help clients who were geographically isolated.

Visited Councils had HACC assessment staff from a variety of occupational backgrounds. There were no competency standards for the conduct of HACC assessments. Large inner and outer metropolitan Councils visited had enough assessment staff with a wide-enough range of skills, and were better able to meet the needs of clients with varying backgrounds. The small shire Council found it hard to recruit and retain adequately-skilled assessment staff.

DHS' *HACC program manual* requires funded agencies to make sure that direct care staff have specified qualifications for the work they do[11]. HACC service providers are required to analyse the training needs of their staff, and develop and implement training plans for them. All 4 Councils visited had analysed their staff's training needs, either as part of a DHS regional training needs analysis or as a separate council activity.

Not all direct care staff employed by Councils met the minimum qualifications required by DHS. However, Councils were willing to provide training to staff to ensure that these staff met these requirements. However, while all 4 Councils recruited non-qualified staff and expressed a willingness to train them, only 2 had developed a strategy to do so.

Conclusion

Recruiting and retaining staff to deliver HACC services is a challenge for many Councils. Failure to fully meet this challenge can reduce the quantity and range of services delivered to clients. With demand for HACC services projected to grow as the population ages, some Councils (especially rural and remote Councils) will find it increasingly difficult to meet the needs of their clients.

Councils are responsible for ensuring that qualified staff deliver HACC services. Councils not using appropriately qualified staff may place their clients at risk and compromise their duty of care to these clients.

At the time of the audit, there were no qualification or competency standards (units of competence) specifically for HACC assessment staff. Given their diversity of occupational backgrounds and specific training needs, competency standards need to be developed.

[11] The minimum qualification for HACC program-funded community care workers is the Certificate III in Home and Community Care.

DHS comment on conclusion to section 4.3.2 re assessment staff

Whilst the Auditor General's observation (p.64, conclusion, last para) that 'no qualification or competency standards (units of competence) specifically for HACC assessment staff' is correct, there are statements in the HACC Program Manual which establish an expectation that agencies to employ staff appropriately qualified for the functions they undertake.

The HACC Program Manual does not specify any single qualification that is required for assessment staff. Instead, the Manual states that 'funded agencies are responsible for ensuring that ... staff have the relevant qualifications to undertake the activities they are allocated to do.' (pg 51).

The Manual also states that '… assessment staff must have the necessary skills, experience and training to ensure a high standard of assessment practice' (p.80).

DHS agrees that the HACC Program Manual could be made more specific about the type of qualifications that are relevant to the assessment and care management activity. DHS believes that the assessment activity is best carried out by staff with tertiary qualifications in the nursing, allied health and social science professions. Embedded in the training for these professions is training in assessing and understanding client needs and care planning. If, as is currently the case, HACC-funded agencies employ these professions, such staff bring to the position of HACC assessor an understanding of the skills and expertise required to carry out an assessment of need.

Recommendations

15. DHS should work with Councils to identify and promote Council best practice in the recruitment and retention of HACC staff.

16. DHS should work with Councils to:

- **ensure that Councils have strategies and time lines to implement minimum qualifications for direct care staff**
- **develop competency standards on which training for HACC assessment staff can be based.**

RESPONSE provided by Secretary, Department of Human Services

Recommendation 15

Since 2001 DHS has being undertaking the HACC Workforce Development Strategy which focuses on recruitment, retention and training of staff employed by HACC funded agencies, recognising that quality service provision is critically dependent on a stable and appropriately qualified work force. Improving recruitment, retention and training will both increase the supply of Community Care workers and increase the diversity of the workforce to match the increasing diversity of the HACC target group.

Some of the work already undertaken in the last two years includes:

- *Developmental work on the Certificate III in Home and Community Care and Certificate IV in Service Coordination (Ageing and Disability) in the December 2002 National Community Services Training Package;*
- *Collaboration with the Vocational Education and Training (VET) system and HACC agencies to facilitate the implementation of the December 2002 Training Package;*

In 2003–2004 the Strategy has:

- *Participated in the Victorian Home Care Industry Occupational Health and Safety Project;*
- *Implemented the HACC New Entrant Development Project which examined the issues that affect the supply of the community care workforce (i.e. non-professional direct care staff);*
- *Planned three pilot projects, to be conducted in 2004-05, which will trial different methods of attracting a more diverse field of applicants for community care work.*
- *Through the HACC Culturally Equitable Gateways Strategy, DHS has funded three multicultural recruitment projects and training scholarships for bilingual staff.*

Recommendation 16

With regard to the first dot point on direct care staff, Victoria's HACC Program Manual states that: "All paid staff delivering personal care … must have completed appropriate registered vocational training before delivering personal care (page 93)". The range of appropriate training is explained in sub-section 3.8 of the Manual.

The second dot point in this recommendation could give a confusing message to the sector. The Vocational Education Training Sector bases its training on assessment of competencies. The Victorian HACC Program Manual requires assessment and care management staff to have an appropriate qualification, such as social work or nursing. Tertiary qualified professionals are not assessed on a competency based system, but in accordance with a professional framework. It would be inappropriate for the VET sector to develop competency based assessment courses for HACC staff who already have, as required, a tertiary qualification.

As noted above, the Department is currently developing a client assessment framework for the HACC program. DHS agrees that it would be desirable to work with Councils on this. One of the primary aims of the framework is to specify roles, responsibilities and best practice in HACC assessment. Once the framework has been developed (in consultation with key stakeholders including Councils) the workforce implications and educational requirements will be identified and addressed.

4.3.3 Did Councils adequately manage volunteers to deliver HACC services?

Volunteers provide assistance to Councils in the delivery of HACC services. Volunteers are mainly involved in the delivery of meals, the transportation of HACC clients and involvement with planned activity groups.

In assessing whether Councils adequately managed volunteers to deliver HACC services, we examined if Councils had adequate policies and procedures to recruit and retain volunteers.

Volunteers were used by around 90 per cent of respondents to the audit survey to deliver meals, help with activity groups and transport clients. Large inner metropolitan Councils were more likely to use paid staff and were least likely to use volunteers, with only 30 per cent doing so.

Councils responding to the survey noted that volunteers made a significant and valuable contribution to the delivery of HACC services. Councils largely indicated that volunteers were a cost-effective means of delivering services, allowing Councils to be more responsive in service delivery (allowing some Councils to provide flexible services such as delivering meals on the weekends); deliver a greater quantity of services (such as complementing paid staff in planned activity groups); and in some instances, allowing the Council to sustain the delivery of services which they would not otherwise be able to deliver.

Most Councils (80 per cent) had policies and procedures to recruit and retain volunteers. Small shire Councils (28 per cent) were least likely to have had recruitment and retention policies.

Many Councils responding to the survey noted that they were having difficulties in recruiting and retaining their volunteers. Most Councils that used volunteers were concerned that the average age of their volunteers was increasing, that they were not recruiting enough new volunteers and that they were not retaining their current volunteers.

Three of the 4 Councils visited used volunteers to deliver HACC services, and each managed volunteers differently. Two of the 3 Councils had detailed policies and procedures for volunteer recruitment, training and management that were in line with HACC guidelines. The third Council had a community volunteers policy, which had subsequently lapsed, and did not have a volunteer recruitment and retention strategy.

Conclusion

Volunteers are widely used to deliver some HACC services. The majority of Councils had adequate policies and procedures in place, but were experiencing difficulties in recruiting and retaining HACC volunteers.

Further reductions in volunteer numbers could cause some Councils to become less flexible and responsive in the way they deliver services or reduce the level of services delivered overall.

Recommendation

17. The Department for Victorian Communities should work with Councils to identify and publicise best practice in the recruitment and retention of volunteers.

RESPONSE provided by Secretary, Department for Victorian Communities

DVC will consider the most appropriate way to do this as part of the development of its Volunteering and Community Enterprise strategy.

4.4 Did Councils assure the quality of services?

In assessing whether Councils assured the quality of HACC services, we examined if they had:

- adequate quality assurance systems for HACC services
- policies and processes to monitor and respond to client complaints.

Councils are required to meet national standards for the delivery of HACC services. Councils are assessed by DHS-appointed reviewers who ensure that they comply with the standards under the HACC national standards survey instrument[12]. Under the *Local Government (Best Value Principles) Act 1999*, Councils are also required to review their service delivery processes.

Eighty-five per cent of Councils said they had reviewed their HACC services (mostly as part of a best value review or of getting external quality accreditation) in the last 2 years.

About 80 per cent of Councils said that they had processes in place to assure the quality of their HACC services. Thirty-seven per cent of small shires and 21 per cent of large shire Councils did not have these processes.

[12] See footnote 18, page 36 of this report for a description of the HACC national standards survey instrument process.

Eighty-five per cent of Councils developed risk management strategies for the delivery of HACC services. However, only 47 per cent of small shire Councils had developed such strategies.

Almost all Councils (92 per cent) said they had a complaints policy. However, 22 per cent did not systematically record and monitor complaints by clients. Three of the 4 Councils visited had a complaints register and a review process for complaints, while the other Council was not systematically recording or dealing with complaints.

Conclusions

Councils have used best value reviews, external accreditation and the HACC national service standards reviews to identify improvements required for their HACC services. Most Councils had processes to identify and manage the main risks to their HACC services.

Smaller Councils were much less likely to identify and manage risks, or systematically assure the quality of their services. Councils (mostly smaller ones) that do not have systems to manage client complaints may not be able to adequately respond to complaints, and will be less likely to use complaints data to identify and address weaknesses in their services.

18. Councils should ensure that they have, and use, systems to manage client complaints so that client feedback is used to continuously improve service delivery.

4.5 Was program performance accurately reported to DHS?

The DHS HACC service agreement requires that all service providers provide data for the DHS quarterly output data collection and for the quarterly HACC minimum data set (MDS). The quarterly output collection records, for each type of activity, the number of clients and the number of hours of service received. The MDS records summary details of each client's demographic characteristics, and of the type and number of hours of service received. Agencies are required to submit an annual financial statement for the DHS HACC grant, and an annual service data acquittal that relates to fees collected and the HACC services delivered in a financial year. This client-based service usage data obtained through these collections is important to DHS because:

- it is used by service providers to reporting client and program data to DHS

- it enables DHS to meet its reporting obligations to the Commonwealth Government
- it is used to identify HACC service usage by the target population at the regional and local government area levels
- it is used to plan the future provision of services.

DHS is planning to merge the 2 collections and phase out the quarterly output data collection in the first quarter of 2004-05. During the phase-out, Councils that have met HACC MDS reporting requirements will cease to report to the quarterly output collection. Councils unable to meet MDS requirements will continue to provide client service usage data to the quarterly data collection.

Data from the 2 collections is used by DHS to prepare reports for its management, the Department of Treasury and Finance, and to the Commonwealth Government. HACC program reports were also given to service providers.

In assessing whether Councils accurately reported HACC program performance to DHS, we examined if:

- Councils complied with the reporting requirements of their service agreements with DHS, specifically the quarterly output data collection, the HACC MDS, and the annual service data acquittal regarding HACC services delivered and fees collected
- Councils assured the quality of data reported to DHS
- Council information systems captured the data required to meet DHS' reporting requirements.

In response to our survey, more than 80 per cent of Councils reported that they met MDS reporting requirements. However, 22 per cent of inner metropolitan Councils and 29 per cent of small shire Councils could not fully meet MDS reporting requirements. The reporting rates for the quarterly output returns and annual service data acquittal were much higher, at over 95 per cent. The most common reason for not meeting reporting requirements was inadequate client management information systems.

Of the Councils visited, 3 fully met their reporting obligations to DHS. The fourth was implementing information systems to enable it to fully meet the requirements.

Nearly 60 per cent of Councils surveyed had procedures to assure the quality of data reported to DHS. About 13 per cent of Councils stated they were developing data quality control processes. These included data controls built into Council computer systems and the conduct of data audits. Small shires were most likely not to assure the quality of their data, with over 70 per cent not doing so.

To improve the quality of the data reported by Councils, DHS published guidelines about interpretation of data items, provided feedback to Councils about the data they submitted and offered individual advice to Council staff through the HACC data help desk.

Councils used a variety of software to deliver HACC services. Our audit identified 6 different systems. Each system was developed and supported by small vendors and needed to be modified whenever HACC program reporting requirements changed. A common concern of, and risk faced by, Councils was that these vendors might cease to operate, or might be unable to meet future data and client information requirements.

The use of a variety of software was not particular to HACC, but occurred with several DHS programs. To resolve this issue, DHS has had 2 major developments underway for client/patient record management in health and primary care services. They are the Client Information Management System (CIMS) and Client Relationship Information System for Service Providers (CRISSP).

CIMS is a patient or client administration system. It will allow some HACC providers (such as community health centres) to report their HACC data. However, local Councils are not included in the first phase of CIMS.

CRISSP is a web-based client and case management system. It is expected to replace some current DHS reporting requirements, and will also incorporate the HACC MDS.

Conclusion

A number of Councils did not fully meet DHS' HACC reporting requirements for both financial and client data. Data being reported to DHS may not be accurate or complete, because some Councils do not have adequate information systems or/and do not assure the quality of their data (particularly small shire Councils).

Steps taken by DHS to improve the quality of data submitted by Councils are useful, but they are not a substitute for Councils checking their data and identifying errors before they send it to DHS.

By mid-2005, Councils will be required to report HACC client dependency data to DHS. This data can only be collected through the SCTTs. As a number of Councils are not fully using the SCTTs for service coordination, they will need to update their client information systems to enable them to report this data.

The current multiplicity of software systems present ongoing risks to collection of program and client data by Councils. Centralised systems such as CIMS and the CRISSP, both maintained by DHS, may reduce data collection risks. In its second phase, CIMS could be made available for use by Councils.

DHS comments on conclusion to section 4.5

The process of phasing out the HACC Quarterly Output Collection will begin in the first quarter of 2004-05, but is likely to span several quarters, due to the differences in agency business practices regarding client and service information management, and the time-lines for modifications to IM systems.

The conclusion states that 22 percent of metropolitan and 29 percent of rural councils could not fully meet HACC Minimum Data Set (MDS) reporting requirements. However, it should be noted that the participation rate for councils was actually higher (see table below). These figures are from the Victorian HACC Data Repository.

Proportion of councils participating in HACC MDS across 4 quarters to April 2004

	Participation rate (percent of councils)	*Compliance rate (percent of councils)*
Metro councils	*98.5*	*98.0*
Non-metro councils	*90.6*	*86.5*
All councils	*94.6*	*91.9*

The participation rate refers to the proportion of councils who sent a quarterly MDS file to the data repository; some of these files are rejected because of invalid data, coding errors, etc, which cannot be fixed before the closing date. The compliance rate is the proportion of councils whose MDS files successfully passed the validation process; this rate is always a little lower than the participation rate.

It can be seen that 98 percent of metropolitan councils sent valid data for the last four quarters. It is not clear what the Auditor-General's survey results mean in this regard. Most likely some councils meant that they were not able to collect complete data on all their HACC-funded services: missing client records cannot be detected by the data repository, and missing answers to some questions (e.g. source of referral) are not considered fatal to the validation process.

Recommendations

19. DHS, together with Councils, should develop minimum quality assurance procedures for data reported to DHS.

20. DHS should explore the use of CIMS and CRISSP to manage HACC client information and reporting of HACC program data currently collected through the quarterly and annual data collections.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 19

Agreed. The DHS Aged Care Branch is working on a series of measures to improve HACC data quality: training for agency staff (particularly as part of the implementation of version 2 of the HACC MDS); electronic feedback to councils on the data they supply to the HACC data repository (including Web-based feedback via the DHS Funded Agency Channel); encouragement to agencies to participate in user groups for particular software products; and advice to software developers on the interpretation of data-collection guidelines.

Recommendation 20

Agreed. Whatever information management systems are used by councils to collect HACC client data, DHS will continue to assist councils to transmit full and accurate data to the DHS HACC repository.

The Client Relationship Information System for Service Providers (CRISSP) system will be offered to local government authorities who provide services to people in the CRISSP target groups, i.e. child protection placement & support, disability services, early childhood intervention services and juvenile justice post-release services. CRISSP may be used to collect and report the HACC client information. It will replace the QDC tool used by some agencies with HACC funding that fall into the CRISSP target group. CRISSP functionality will include the Service Coordination Tools.

Regarding the Client Information Management System (CIMS), the DHS HealthSMART strategy 2003-2007 does not include the upgrade of systems in local councils. However, it is believed that HACC providers in the community health setting will in all probability utilise the data collection systems which will be installed in these centres over the strategy period.

It is envisaged that the next strategic period will see a roll-out of systems to include HACC providers who offer services in settings beyond the community health environment.

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(a) This report is included in Part 3.2, Human Services section of the *Report on Ministerial Portfolios*, June 2001.

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