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Submission to the Productivity Commission

Public Inquiry on

Caring for Older Australians

Northside Community Forum Inc

27 July 2010

Background

Northside Community Forum Inc. ('NCF') works for the benefit of people who are aged, people with disabilities and carers who live in the Northern Sydney region. The Northern Sydney region includes the eleven local government areas of Hornsby, Ku-ring-gai, Ryde, Hunters Hill, Lane Cove, Willoughby, Mosman, North Sydney, Pittwater, Manly and Warringah. The region's boundaries coincide with the Northern Sydney Aged Care and Home and Community Care (HACC) Planning Regions.

Vision

A just and inclusive community is a vibrant and healthy community.

Mission

To build dynamic community care in the Northern Sydney region that expands opportunities for carers, older people, and people with a disability, their families and friends.

Aims

In pursuing its mission Northside Community Forum Inc. aims to enhance and enrich the quality of life of people and relieve poverty, sickness and distress in the Northern Sydney region by ensuring high quality community care services are available in the region and by linking people with information, advice and support services.
Working collaboratively with partners and stakeholders, NCF builds the capacity of the Northern Sydney region community care sector by:

- Linking carers, older people, and people with a disability, their families and friends to information, advice and services.
- Linking community care organisations to information, advice, training, and support and networking opportunities.
- Supporting and resourcing community care organisations
- Coordinating information and consultation within the community care sector
- Participating in the planning and development of the community care sector
- Responding to government initiatives, actions and policies that affect the Northern Sydney region
- Working collaboratively with individuals, partners, funding bodies and other stakeholders.

Focus of submission

This submission is based on the knowledge and experience of the Northern Sydney service providers gathered through a local community care forum meeting for the purpose of this submission. The submission focuses on community care.

1. Strengths of HACC Services

Under the current HACC service types there are definite strengths that have developed over 25 years of HACC Services in NSW which need to be maintained in order to maintain the quality of service when the Commonwealth take over the administration of HACC services.

1.1 Person Centered Approach

To maintain IMPACT as underpinning principle of Community Care:

- Person-centred
- Culturally-appropriate, socially inclusive,
- Flexible & responsive
- Supportive & enables the positive relationship between consumers and carers.
- Recognised as a fundamental and valued part of society that grows and develops to meet the changing expectations of consumers, carers, funders & the workforce.
- Innovation is constant and aims to increase capacity & improve outcomes for consumers.
- Management of programs ensures effective allocation of resources to attract and retain the appropriate calibre of staff.
- Pathways for access are clearly identified through service promotion.
- Accountability measures focus on services' ability to deliver consumer outcomes rather than service system outputs.
- Collaborative relationships challenge the assumptions of existing care models.
- Training & development is ongoing and provides staff and volunteers with appropriate skills and knowledge to meet all levels of need.
- Service providers see the need to preserve the person centred care approach to Community Services which is seen as a highly valuable and essential part of HACC services. It has a preventative aspect to frail age as well as being rehabilitative and has long been a model of best practice in disability support services.

1.2 Sector Development

Sector development in the community aged care system should focus on continuous improvement in the knowledge, skills and good practice of the workforce through forums that promote networking and information-sharing, as well as enabling accessible, relevant training and development opportunities at individual and organisation levels. Partnerships and collaboration should benefit both service providers and their clients.

Strengths of the current HACC system in NSW include:

- The 25-year history of the Program has created best practice by a skilled workforce, including many paid workers, volunteers and managers who have been involved for more than 10 years.
- Clear lines of communication with Project Officers from Ageing, Disability and Home Care (NSW funding body), who are easily accessible to answer questions and initiate service

- Community development workers who canvass issues with service providers, assist with structural issues and capacity building, including: HACC DOs, Aboriginal HACC DOs, Local Government Workers, Multicultural Access Projects, Carer Support Projects, Dementia Advisory Services.
- HACC DOs and HACC-funded local government workers facilitate HACC/Community Care Forums that provide opportunity for strategic discussion and action.
- Funding for community and sector development projects, both recurrent and one-off in nature encourage and enable provider agencies to work together for clients.
- Peak Organisations such as NCOSS and networks work across service types and the whole sector.

1.3 Service Delivery

- The range of service types available: HACC is able to provide a service mix to meet individual needs and recognises that some clients need just one service and not a whole package e.g. social support services can be just as important as domestic assistance or personal care in assisting people.
- Service types like Social Support and Centre Based Day Care, and even Community Transport, address issues around social isolation; they enable clients to maintain lifestyle, establish/maintain contact with the community.
- Partnerships and joint client care arrangements between providers
- The mix of small, medium and large providers
- The use of volunteers creates financial efficiencies in service types like Social Support in NSW and adds an important community dimension to service management and delivery.
- The number of existing providers who use models to promote client independence

1.4 Communication with Government organisations

- Service providers have valued the presence, availability and interaction of ADHC personnel at Community Forums and at the community organisation service level. It is hoped that this level of interaction will be maintained with DoHA Personnel.

1.5 Advantages of Keeping services Local

- Localised services for local needs - Local knowledge. Frail aged and disabled people often can't leave their own area - just for a day trip – it is too exhausting. They need local events.
- Rather than isolating people - HACC services take people out of home and do things with volunteers - strength of HACC is connecting with community.
- Keeping Community Services based locally within the area it services has the advantage of having Specialist knowledge which is often lacking in centralised service models that are located away from the area for whom they are providing services.
- Having centralised organisations providing multiple services under one umbrella also means travel time by staff is unproductive lost time.
- Smaller organisations through the networking forum process can ensure that clients have access to a wide range of local services through referral processes.
- One central body in control of all systems doesn't work but one central phone number where people can access information on where (suburb, phone number) potential clients can obtain the information, referral or services they need could be helpful.
- From smaller NGO perspective, there's the need to maintain the advantages of small medium local services and not be "swallowed up".
- Older clients have more complex needs but prefer local support.
- Localized cases need to cut out centralized systems and reconnect with the community

- Community care organisations and their staff and volunteers are generally locally based; this creates efficiencies in not wasting resources in travel time and helps address social isolation of people requiring support living in their own homes.
- Local, community based organisations have knowledge to be relevant and responsive to need, and to create appropriate services:
- Local community organisations have a local presence which makes them attractive to people who find it difficult or embarrassing to access support services.
- "No wrong door" system where the person can get assistance from anyone organisation in the system whether they are information and assessment or a direct service provider. The service providers need to be funded to take on more of this responsibility with regards to making a referral to another service which often entails several phone calls to different services and filling out forms.

1.6 Individual Needs

- Currently each service provider assesses the client without funding parameters per client; potentially HACC clients can receive all service types they need. Maintain individualised case plans and goals that are not limited by HACC service type restrictions.
- Brokerage funds and other arrangements that cover the cost of (and thereby enable use of) interpreters for assessments.

2. Challenges:

Challenges of the current community aged care system include:

2.1 MDS (Minimum Data Set) Reporting:

HACC services worry about the role of HACC Minimum Data Set (MDS) in planning and determining new funding; services are only asked to report time spent on direct, individual client contact, not group activities, organisational planning, staff support and development etc.; it measures quantity of services given, not quality or outcomes for clients.

- If this is the tool for determining future funding arrangements by the Commonwealth then it needs to be modified to ensure that all service activities are captured including the organisational administrative. Currently a 5% administrative component is allowed. There is no research or evidence to support this figure and it does not accurately reflect an organisational activity.
- MDS data was not originally intended as a funding mechanism determinant – inaccuracies and narrowness of its scope of reporting may adversely affect smaller organisations.
- A true reflection of the costs are not measured e.g. A worker might have to drive for 25 minutes to see a client, but the only time accounted for is the time spent with the client.
- The reporting mechanism needs to account for ALL time (not just time with client)
- Outputs do not accurately reflect how many service types a client receives e.g.: 2 hours of care/1 meal is often 1 output
- There is a need for outcome based measurements to complement outputs.
- MDS Outputs are down because it takes more time to deliver services to people with increasingly complex needs – this is not adequately reflected in MDS reporting.

2.2 Single Point of Access

There are concerns about the single point of access and single point of entry into HACC services. This makes it more difficult for many eligible clients to make contact and receive services. Refers to Hunter Access Point Pilot.

2.3 Affordability of Community services in the future

- That those who cannot afford private community care continue to have access to affordable community care in the future
- Keeping services affordable i.e. utility rate rises last week. Pensioners are delaying putting the heating on. Buying less fresh fruit because of the costs. We need to make sure people are still willing to contact services because we are local.
- Looking after older and more disadvantaged people through Homecare or equivalent. HACC users contribute 5%. There is a concern that HACC may change average contribution to 20%.
- Lack of a nationally-consistent HACC fees policy and the need to provide clearer and more specific guidelines (e.g. for assessing financial disadvantage and capping/ reducing fees), while catering to diverse circumstances.

2.4 Aged care/ Person with disability

- When does an aged person become disabled? When will they be classified as a client with a disability - needing a chairlift? Are you looking after the person because they are disabled/ aged? Will clients with a mental illness be classed as having a disability?
- What is the situation if a person is under 65 with an intellectual disability?
- Double administrative work for co coordinators under the new Commonwealth State arrangements for HACC services is of concern.
- In regards to mental health: getting referrals for mental health clients not coping e.g. meals. But in the new system they won't be counted.
- Separating between aged care and disability care needs more detail.
- GAPS – Interface – issues of health and community services – how will they work more closely together.
- Where does one responsibility stop and another start? Concern over transition from under 65 to over 65 years service –There needs to be clear policy and guidelines.
- A streamlined system so that all services involved in providing services will know for example when a client has been admitted into hospital. I.e. delivering meals/wheels - informing Food Services that the client is in hospital.
- Organisations in place need to be granted a degree of flexibility so they can be responsive. Flexibility taken away will be very detrimental and distressing

2.5 Transport Issues

- Public Transport on weekends does not meet the needs of frail; aged & people with disability
- Buses don't always cater for wheelchair users. There are wheelchair accessible buses, but sometimes the person may need a carer to safely access the bus service.
- Buses often don't run on weekends and this may be the only means of transport for HACC eligible clients.
- Community Transport services are overwhelmed by demand created by insufficient transport provisions by other programs and jurisdictions, such as health-related transport (NSW Health).

2.6 Challenges/weaknesses of a centralised system

- There are extra costs with a centralized agency.

- Local councils are more inclined to support local services. Economies of scale - Good will of local area is really important for funding. Large services don't have local support. $20 million service - council won't provide good will. (printing/brochures) hidden costs that people don't benefit from.
- Local community supports shouldn't be taken for granted.

2.7 Volunteers

- Centralised services would result in a loss of volunteers who generally volunteer in their local area for HACC services.
- Currently certain HACC service types such as Neighbour Aid depend heavily on volunteer HACC services. There is a danger that HACC Community Services will lose volunteers if local services are no longer available.
- The need to keep the value of the volunteer by providing worker support for them
- The financial value of volunteers is huge to the industry and cannot easily be replaced with paid workers.
- Australian Government community care programs do not utilise and promote volunteer workforce the way HACC does.

2.8 Funding

- Planning and funding: competitive tendering
- Transparency and not politics in selection of tender application is required
- Need for someone local who knows the organisation and what they are doing in reviewing funding
- Smaller agencies having to work longer and beyond normal business hours- more support is needed
- Performance management of organisations and better support systems for management.
- The successful tender trend in the last lot of tenders all the larger organisations who can afford to pay for a consultant to write a tender received the funding. Only one small community organisation that received funding - that was in the CBD. More transparency in criteria would be fairer and more equitable.
- Often an organisation successfully providing a HACC service type misses out on a tender to increase funding for the same HACC service type it already provides. Instead it goes to another orrganisation who has not previously provided the service and who then spend the funding on infrastructure whereas the funding could have gone into directly service through the existing local service. This is an inefficient way of servicing the local need and is a significant disadvantage with competitive tendering. "With more players it takes a longer time to 'start up'"
- Department Veteran Affairs (DVA) clients come off DVA because they do not give the same services/ social support as the HACC Program
- The Change to Commonwealth will impact on who gets funding and could disadvantage smaller NGO A spread of organisation models of delivery from small/medium to larger will ensure that client needs are met.
- Funded providers question some of the unit costing accuracy on which funding allocations and organisations' funding agreement outputs are based.
- Lack of understanding of 'full cost recovery' requirements when using certain HACC service types (such as Food and Transport) by providers or clients already funded for the same service type/s through other programs; some clients are inappropriately receiving a HACC-subsidised service because of the failure of the other program to meet their needs or pay the purchase fee.

- Competitive tendering has removed the incentive for services to work together, as they once did.
- Current planning and funding processes assume HACC is only addressing low needs and CACP/EACH is for higher needs; actually, some personal care and case management providers in NSW are providing support above the limits of CACP/EACH and certainly Veterans Home Care
- It is vital to consult the local community in planning and funding allocation processes and that decisions are based on solid information about how local services interact with existing community networks. Many times agencies have been selected by a National selection panel – that does not have any idea of the local issues – or how a particular service provider would perform in relation to other services; as a result, the services have failed or struggled to get referrals.

2.9 Workforce:

- The pay rise in QLD has drawn people into the community sector. This would support the sector in NSW and across Australia.
- There is a great need for training and career pathways.
- Portability of experience; skills; qualifications and long service leave
- CALD – Difficult working with candidates who have no car/ no license/ speak another language.
- need to maintain and develop the workforce to retain staff: financially linked

2.10 Increase of people with dementia

- The sector is not yet ready for increased dementia.
- Change is needed for delivering services: a holistic approach – health/aged care: with a continuum of care.
- Existing clients require increasingly more services and one on one care as dementia increases

2.11 Medical General Practitioner involvement

There is a lack of consistency in referrals by GP's across the sector. Referral from GP's helpful to clients but it should not become necessary to have a referral from anywhere to access services such as the 1800 052 222 Carelink contact number.

There needs to be streamlining process with a single phone number that will provide access to many services.

- Local services are often able to establish local networks with local GP's
- GP get financial incentives. GPs – often don't explain to CALD patient what they are actually doing. Patient requires more support i.e. interpreter services to be provided.

2.12 Social issues.

- The issue of large/expensive residences where people are asset rich but cash poor needs to be examined in terms of access and eligibility of clients to HACC services given that there are already waiting lists for complex needs and as the life span of the population increases so too will the demand for services. We are looking at eligibility and means testing whilst maintaining affordability.
- There are often OH&S issues with regard to providing Home Maintenance & Home Modification. Some dwellings need extensive renovations that are outside the Home Mods eligibility. Other services need to be brought in. Will this flexibility of referral and service be maintained?

- Homeless people are eligible for HACC services and need to be considered in the transition process.

2.13 Flexibility of service delivery

- keeping member of the community independent - we will lose the local community perspective
- There is a concern that with two different funding bodies for over 65 years and under 65 years:
- The current system will lose it flexibility resulting in people not having access to services.
- Co coordinators then looking after the system, have to do the work twice reporting to - community government and state.
- Access to private hospitals referral rate from private hospitals can be higher than public: 35-15%. 15% in a region in North Sydney. The reality is that for some patients the days of looking after ourselves are long gone.

2.14 Informed Choice for clients'

- People need to know their options so that people can pick the most suitable choices for themselves.
- For people in the community to have a local centre to go to for advice is what people want.
- People need advice but also need to talk about their issues until they know what they want or need and find out what is available.
- A preferred client based approach rather than a bureaucratic approach.
- Carelink gives options but allows people to make the final decision. This is important to maintain. Health relies on a streamlined system provided by Carelink. It is very client based - Disability pension - aged care pension.

- **2.15 Individual Needs**

Assessing the individual needs of the current community aged care system include:

- Without a central register, service level assessors rely on clients to know and declare which services they are already using; even when questioned thoroughly, some clients double-up on service (whether through confusion or deliberate misinformation)
- Clients have multiple assessments which is distressing to many clients and not time well spent for service providers.
- The Australian Government community care programs do not allow a focus on social support the way HACC does; prioritisation of limited funding allocations per client in CACPs and EACH means many clients are not assessed for (and do not receive) essential socialisation, in favour of Personal Care and Domestic Assistance, which may be the choice of the budget-conscious assessor rather than the client.

3. Possible Solutions:

3.1 No Wrong Door Policy

- A no wrong door policy through localised community service organisations captures more enquires and allows anyone can come in any door and receive the services they need rather than having a single access point through a referral process and local services.
- Universal Access to anyone who needs assistance due to functional disability. In accordance with HACC's stated aim, we should describe prospective service users as "*older people*

requiring support to enable them to live at home and participate in the community safely and independently", not just sick people exiting hospital if we move toward a clinical model.

- A socially inclusive approach that is sufficiently broad to take into account all people requiring support whether they have a medical condition or not.
- At access point/s, the system should channel people to short term wellness/restorative approaches, where appropriate, rather than long-term supports they may not need. Access points need to be open beyond business hours, including weekends and Public Holidays, to respond when crises occur and/or when working carers are able to access support. Access points need to be visible in communities and well-promoted directly to the community through community development as information campaigns are not sufficient to explain the complexity and responsiveness of Community Care to the greater community as awareness of Community Care is poor therefore something more than just information needs to be done.
- A reformed community aged care system should have an Information and Referral hotline, with national/state multilingual phone lines similar to Centrelink which provide specialist culturally and linguistically appropriate service that liaises with regional access and information services.
- Any new referral and assessment pathway/s should be clear and easy to understand and follow. "A no wrong door system" where the person can get assistance from anyone organisation in the system whether they are information and assessment or a direct service provider. The service providers need to be funded to take on more of this responsibility with regards to making a referral to another service which often entails several phone calls to different services and filling out forms.

3.2 Wellness

- HACC provides services for people when they are already less able physically and mentally.
- The recently developed Wellness approach is working with ageing from the perspective of wellness, promoting activities and services connected with improving and maintaining the quality of life and health rather than waiting till a huge proportion of the older population is already in the early stages of dementia.
- Include in future budgeting for wellness activity and a change in emphasis from the existing HACC target group to add keeping people well and independent for as long as possible.
- The health aspect of Health and Ageing could think about its contribution to wellness just as much or more than home care and the role of the existing funding devoted solely to HACC.
- HACC is already looking at its role in working with clients earlier and keeping them independent longer. This needs to be maintained.
- The eligible Target group could extend to all the over 65s by promoting wellness and thus preventing people becoming HACC clients at risk of institutionalisation.
- Existing positions would need to be funded to work with the existing HACC and new 'wellness' target groups.
- Dept Health and Ageing should fund coordination of services involved with hoarding directed at dealing with the behaviour rather than the symptom - the acquisition of things. Local Councils need advice not to use public health regulations to totally clear sites but to involve health services appropriately as early as possible. I understand wholesale clearing of sites has occasionally resulted in suicide.

3.3 Transition in Client needs from low need to high need

- From Low need to complex need with clear pathways and guidelines and criteria that support Home and Community Care and makes a clear distinction between HACC and Health services whilst maintaining a smooth transition when needs change and become more complex.

3.4 Industry Benchmarks

- At the moment we have a loose monitoring system -there needs to be Improved measurements to properly monitor with Industry benchmarks
- A licensing system. – Meeting standards every 3-5 years.

3.5 Transition Phase from State to Commonwealth administration:

- To provide sustainability for organisations to transition by assurance that funding will continue using
- Pre qualifying strategies to prepare for 2015.

3.6 Hospital discharge

- In some areas discharge has been handled well with arrangements for discharge care organised in advance by social workers.
  A more consistent policy and procedure to avoid last minute arrangements would support Respite and Carelink so that there is no late Friday calls asking for Personal care (short term) or referral to a client who is not eligible for HACC services. This would involve funding to support the re-establishment of both short-term personal care and domestic assistance services, which are in high demand.
  Also increased funding for ADHC Case Management services so that they are able to manage their own clients well, without resorting to Carer Respite (when it is not appropriate).
- Joint training for health and community staff on the discharge process and options for post-hospital care.
- Inability of HACC services to provide short-term care, including gap-filling during periods of crisis due to episodic conditions or increased frailty due to illness; transitional care is only available from hospitals.

3.7 Centralised Referral System and Assessment

In order to provide a better information and referral system there is a need for

- More regular assessment (quarterly) and the resources to do this.
- A Centralised IT system that would support information/referral sharing (CIARR) –
- It would be a great advantage to have a more transparent system. Keeping access to client's easy.

3.8 Waiting Lists

- There is currently no policy requirement in the HACC Guidelines for waiting lists. Each organisation has its own policy on waiting lists.
- Some individuals are on more than one waiting list for the same service types; this can distort reporting on unmet need, as some clients are double-counted and/or becoming 'lost' in the system.

- If a waiting list is developed it needs resources to be managed and administered in a way that:
  - ensures clients receive services;

- that there is equity for all clients;
- Means testing;
- raising fees;
- making different requirements

3.9 Transitioning Into a New System

Current community aged care providers are concerned with:

- Uncertainty about the future of HACC;
- Lack of information from governments to enable workers to plan their lives and inform clients.
- Uncertainty about organisational survival
- Ability to recruit and retain staff due to poor pay levels, low morale, lack of career pathways etc.

The transition process could be supported by:

- Retention of HACC development workers and other local sector development workers and their products which include: client brochures, HACC orientation packs, websites/intranets,
- Newsletters, workforce training, individual advice to service providers and users, community education, research and development, advocacy, targeted initiatives, among others.
- Community care provider networks and their products, including regular forum meetings, protocols/agreements for collaboration.
- Simplified reporting to funding bodies and incentives and rewards for quality service delivery and collaborative practice.
- Well-promoted, flexible choice for clients, including self-directed care models
- Continuity of access and service delivery as clients age and needs change, including transitions for people under 65 years old with disability who experience early onset of age-related conditions, episodic conditions etc.

Input from Carelink Information and Intake Team, for submission by Northside Community Forum Inc.

The Northern Sydney Commonwealth Respite and Carelink Centre receive between 400 and 500 calls a month from clients and service providers in our region. The nature of these calls, and feedback received from callers, places us in a position to provide input regarding key issues which we believe need to be addressed with regard to our community of care. Many of these issues overlap into the Health sector.

We believe there is a need for:

- Increased funding for personal care, domestic assistance and ongoing respite services. These services are consistently among the top five requested services via Carelink each month, and clients continue to wait weeks, sometimes months, before receiving assistance.
- Provision of short term services. Many callers only require services for a month or two; a service system which *only* allows clients to access long term services is not an efficient system. This is particularly the case with regard to personal care and domestic assistance services.
- Increased funding for Transpacs and Compacks to enable patients being discharged from hospitals in our region to have adequate care post-discharge. This need is reflected in the number of requests for in-home respite made by hospital social workers at time of discharge, when the real need is adequate support from HACC services.

- Much greater communication and reciprocal support between the Health and Community Services sectors, including joint training activities.

In addition, we suggest the following:

- Other improvements could be made to the hospital discharge process, in terms of linkage to appropriate community services (when Transpacs or Compacks are not appropriate or available). This could involve joint training for hospital staff and staff of relevant community service providers, for example, providers of personal care services.
- In conjunction with discharge planning, assistance for potential HACC clients in understanding the *risks* associated with turning down specific services (e.g. clients who do not accept care packages because they do not think they need them at the time, yet a few days or weeks later phone in desperation. In addition, more assistance for people to understand their options, such as Transpacks, Compacks, Community Options, CACPS, EACH, with an emphasis on eligibility (that is, not all clients meet eligibility criteria, which raises another issue: greater funding equals greater eligibility).
  Encourage more private hospitals to use packages of post-hospital care, with appropriate financial support.
- The re-establishment of regional referral and intake points not centralised. For example, many callers to our service have great difficulty accessing Home Care services due to the demand on one entry point. Another example of this is the Catholic Community Services RAC, and Veterans' Affairs Assessment agency.
  In conjunction with this, acknowledgement of the value and role of locally-based services is important. Many of our clients place a great emphasis on linking up with local services.
- Smaller regional area health services e.g. split Central Coast from Northern Sydney.
- Greater networking between service providers to ensure equitable access to services e.g. managing waiting lists. This has been addressed to some extent due to a collaboration between ADHC, regional service providers, and CCCRC, however further improvements could be made.
- Increased funding for in-home palliative care and education/support about dying in conjunction with services such as Hope Healthcare and Home Hospice.
- National standards and core skills for community care workers e.g. tertiary qualification such as minimum Certificate IV (Northern Sydney Commonwealth Respite and Carelink Centre receives many complaints about quality of service and unskilled community workers, and the vulnerability of persons being cared for in their own homes).
- Greater information provision throughout the community service field regarding services available, especially services for the elderly (for example, a recent client phoned about a woman living in squalor who was a DVA gold card holder, who had NO idea about services available.) This would include greater emphasis on people in need in our community who are *not carers* and therefore not able to access support via this avenue.
- Education for General Practitioners about community and support services available for their patients to enable a holistic approach to care. For example, practice staff could attend education and training (Carelink receives an occasional call from practice staff and GPs).
- Increased learning opportunities for workers in the Community Services and Health sectors regarding the *roles* of various services, such as Carer Respite, ADHC, Centrelink, etc.
- Financial acknowledgement of the important role of the community services workforce. Greater pay will attract better staff, and investigation into possible improvements to career pathways within the community services sector.
- Greater emphasis on service provision for clients with mental health issues, and disabilities.

The following individuals represented their organisations in the discussions that resulted in the development of this submission. Further discussions took place with other organisations as well.

Name	**Organisation**	**Position**
Amanda Worgan	Christian Community Aid	Community Worker
Adelaide Collisson	Christian Community Aid	Food Services
Kate Skinner	DARTS	Manager
Irena Liddell	NCF	EO
Zena Maxwell	MWPCAS	CEO
Phil Katopau	NCF	HACC Resource Officer
Jenny Yule	NCF	Team Leader, Intake & Information
Grace Chan	NSCCAHS	Northern Sydney Multicultural Access Project
Barbara Lewis	NSCC Health	Carer Support
Helen Battellino	Easy Transport	Manager
Susan Heyne	LNSCT	EO
Jacqueline Martimer	Wesley	Program Coordinator
Tricia Meers	Ku-ring-gai Neighbour Aid	Manager
Janice Poynton	HHRCS	EO
William Davies	City of Ryde Council	Access & Equity Coordinator
Tim McGovern	Northside Community Forum	HACC Development Officer