Draft Carer Support Framework

Integrated Carer Support Service (ICSS)

DRAFT Version 0.1, 26 October 2018

Contents

Overview

The guidance materials contained in this document are collectively referred to as the Carer Support Framework[1] (the framework). The Carer Support Planning Process (part of the framework) is a business process designed for use by Carer Gateway regional delivery partners (RDPs) – its purpose is to ensure a consistent and effective experience for clients of the Integrated Carer Support Service (ICSS).

The framework was tested as part of a pilot undertaken by the Department in September 2019. The framework is currently in a draft format and will be finalised through further co design and consultation with the sector prior to the implementation of Carer Gateway regional delivery partners (RDPs) in September 2019.

Carers Star™

A central component of the Carer Support Planning Process is the Carers Star™, an evidence-based tool that supports and measures change when working with people[2]. The Carers Star is particularly used in the Needs Assessment and Support Planning stages.

The Carers Star™ was developed in the UK specifically for use with carers, both full-time and part-time, and covers seven key areas[3]:

1. Health
2. The caring role
3. Managing at home
4. Time for yourself
5. How you feel
6. Finances
7. Work

Activities undertaken to design the framework

The Department has undertaken the following in the design of the framework:

- *User Research:* Working with carers and staff at carer support organisations to understand their needs, in context – **Complete.**
- *Ideation:* Exploring ideas to provide a guided, consistent approach to understanding the needs of carers and then connect them with support – **Complete.**
- *Concept development:* Creating an initial version of the framework for discussion with members of the sector – **Complete.**
- *Consultation:* Presentation of the framework to members of the sector for validation, feedback and iteration – **Complete.**
- *Development of an alpha version:* Preparation of the framework for use by carer support organisations in a limited pilot. Includes consultation with experts to successfully incorporate the Carers Star™ into the support planning process – **Complete.**
- *Pilot (September 2018):* Use of the alpha version of the framework with real carers to evaluate suitability and inform improvement– **Complete.**
- *Development of a beta version:* Creation of a framework version that is ready for broader use by the sector in preparation for live deployment from September 2019 – **Still to come.**

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[1] Formerly referred to as the *Carer Pathway Navigator*.

[2] ©Triangle Consulting Social Enterprise Ltd. 2018. *About the Star – Triangle*. [ONLINE] Available at: http://www.outcomesstar.org.uk/about-the-star/. [Accessed 27 June 2018].

[3] ©Triangle Consulting Social Enterprise Ltd. 2018. *Carers Star – Triangle*. [ONLINE] Available at: http://www.outcomesstar.org.uk/using-the-star/see-the-stars/carers-star/. [Accessed 26 October 2018].

Principles underpinning design of the framework

The user research and subsequent consultation input from sector stakeholders informed the following as key principles to guide design of the framework:

Principle	Description
Holistic approach	Assessment needs to be comprehensive and holistic, considering all relevant aspects of the carer's circumstances.
Engage carers in a conversation	The most effective way to understand the needs of a carer is through a natural conversation between them and a Carer Support Worker.
Collect only what's relevant	To provide an efficient experience, only the information that is most useful should be captured when needed, building carer and care recipient records over time.
Outcomes for carers	The process of identifying services for a carer must consider their aims, as they relate to their caring role and support outcomes that are in line with their needs as a carer.
Empower carers to self-manage	Enable carers to direct and manage their own support arrangements, empowering them to choose how and when supports are utilised.
Inclusive support	Planning supports for a carer must accommodate needs and preferences for service delivery that are specific to their cohort (including but not limited to Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) and Lesbian, Gay, Transgender, Intersex and Queer (LGBTIQ) people).
Sustainable outcomes	Supports must enable caring arrangements to be maintained in the long term. Measuring carer outcomes is required to confirm and respond, where adjustments are needed.
Nationally consistent, locally adjusted	The framework needs to support a common way of working for all RDPs but still allow variations that support carer needs and service arrangements specific to the region they live in.

Components of the framework

The following components have been developed to support use of the framework by Carer Support Workers, who work for an RDP:

- **Carer Support Planning Process:** This process defines the steps that RDPs will be expected to follow to enable delivery of a consistent and effective experience for carers who require the supports available via the ICSS. The support planning process also defines the inputs and outputs at each stage in the carer's journey.
- **Support Planning Process Guidance**: Defines the criteria that should be met when supporting a carer through the process of accessing supports available under the ICSS.
- **Needs Assessment Guiding Questions:** Designed as a non-prescriptive point of reference for Carer Support Workers when working through the seven Carer Star™ outcome areas to understand a carer's needs and circumstances.
- **Action Plan Guiding Questions:** Designed as a non-prescriptive point of reference for Carer Support Workers to guide creation of a Carer Star™ Action Plan.
- **Service Matching Table:** Assists with the identification of appropriate ICSS services to address the needs of carers.

Carer Support Planning Process

The process model (refer page 6) sets out the process for RDPs to follow to ensure that carers receive a consistently good experience when seeking support. The Carer Support Worker will facilitate the process for each individual carer, including the following stages:

- **Intake:** Initial contact with a carer when they present with an enquiry or request. Includes:
  - Identifying the carer;
  - Understanding what has prompted them to seek assistance;
  - Determining their **eligibility** to access carer support services, by confirming their role as a carer and confirming they are located in the RDPs service region;
  - Assessing the **urgency** of their request, based on their request timeframe and if they have any emergency circumstances; and
  - Educating the carer about the RDP's role and available services.

- **Registration:** Capture of a carer's identifying information and basic information[4] about the person they care for, where required. Registration establishes a record of the carer in the RDP's system to support ongoing management of support services and monitoring of carer wellbeing, post-delivery of services.

- **Needs Assessment (incorporating the Carers Star™) :** Undertaken to understand a carer's aims, responsibilities, care load, living circumstances, support network (including both current paid services and informal support from others) and general relationship with the person they care for. The process identifies the carer's needs and is the key input to successfully completing the support planning process.

- **Support Planning:**
  - Identification of the types of supports/services that will benefit the carer, in line with their needs, as assessed.
  - Development of an individual action plan to document the carer's goals and the actions that will be undertaken (by the carer and others) to support them.

- **Coordination:**

  Activities to put services in place for the carer either via:

  - Referral to appropriate providers;
  - Direct brokerage of services on the carer's behalf; or
  - Information to enable the carer to self-refer.

- **Support:** Delivery of services to the carer by appropriate service provider(s).

- **Monitoring:** Reconnecting with the carer to:
  - Check they have sustainable supports in place[5].
  - Measure support outcomes by checking their wellbeing against their baseline Carers Star™ reading.

  Return to Needs Assessment Stage to revise Carers Star™ based on new circumstances.

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[4] The term "basic information" refers to a simple note or direction regarding the person receiving the care. An example might be – "*Provides care for* – Robert (Spouse). *Condition* – Dementia"

[5] Checks may initially be scheduled close to the end of the carer's first round of services and then, with the carer's agreement, every three to six months, thereafter, by default.

Carer Support Planning Process

Carer contacts the RDP with a request for assistance

START

ENQUIRY

SUPPORT REQUEST

Information
Provide/Refer to information

Emergency Process
Immediate Arrangements
- Basic Registration Details
- Carer & Recipient Needs
- Schedule Post Emergency Assessment

The Carer Support Framework sets out the process that Carer Gateway regional delivery partners (RDPs) follow to ensure that carers receive a consistent experience when seeking support. Directed by a Carer Support Worker for each individual carer, the process includes the following stages:

Intake: Initial contact with a carer when they present with an enquiry or request. Includes:
- Identifying the carer;
- Understanding what has prompted them to seek assistance;
- Determining their **eligibility** to access carer support services, by confirming their role as a carer and confirming they are located in the RDPs service region;
- Assessing the **urgency** of their request, based on their request timeframe and if they have any emergency circumstances; and
- Educating the carer about the RDP's role and available services.

Registration: Capture of a carer's identifying information and basic information about the person they care for, where required. Registration establishes a record of the carer in the RDP's system to support ongoing management of support services and monitoring of carer wellbeing, post-delivery of services.

Needs Assessment: Undertaken to understand a carer's aims, responsibilities, care load, living circumstances, support network (including both current paid services and informal support from others) and general relationship with the person they care for. The process identifies the carer's needs and is the key input to successfully completing the support planning process.

Support Planning:
- Identification of the types of supports/services that will benefit the carer, in line with their needs, as assessed.
- Development of an individual action plan to document the carer's goals and the actions that will be undertaken (by the carer and others) to support them.

Coordination:
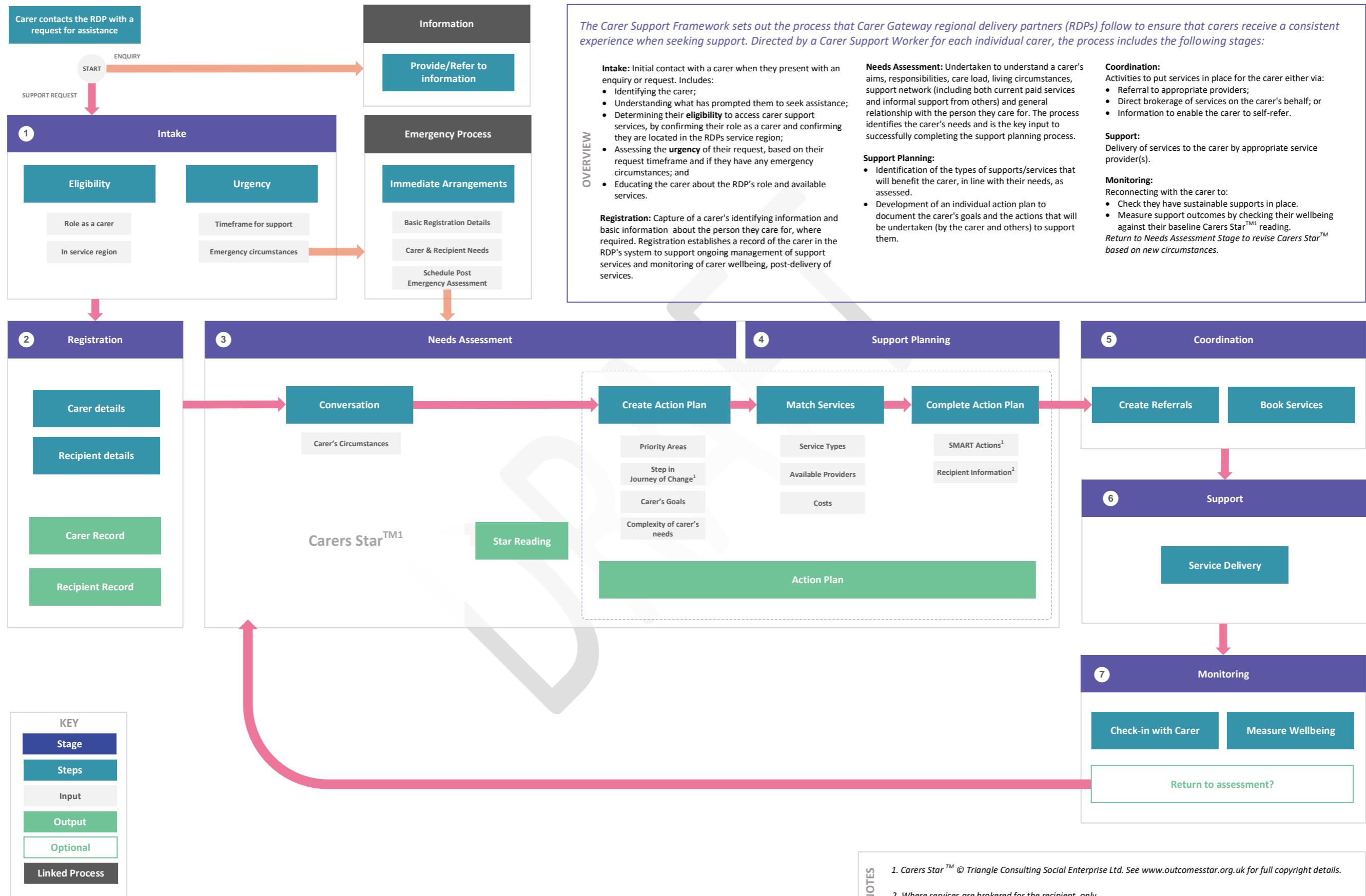Activities to put services in place for the carer either via:
- Referral to appropriate providers;
- Direct brokerage of services on the carer's behalf; or
- Information to enable the carer to self-refer.

Support:
Delivery of services to the carer by appropriate service provider(s).

Monitoring:
Reconnecting with the carer to:
- Check they have sustainable supports in place.
- Measure support outcomes by checking their wellbeing against their baseline Carers Star[TM1] reading.
Return to Needs Assessment Stage to revise Carers Star[TM] based on new circumstances.

OVERVIEW

1 Intake
Eligibility
- Role as a carer
- In service region

Urgency
- Timeframe for support
- Emergency circumstances

2 Registration
Carer details

Recipient details

Carer Record

Recipient Record

3 Needs Assessment
Conversation
- Carer's Circumstances

Carers Star[TM1]

Star Reading

4 Support Planning
Create Action Plan
- Priority Areas
- Step in Journey of Change[1]
- Carer's Goals
- Complexity of carer's needs

Match Services
- Service Types
- Available Providers
- Costs

Complete Action Plan
- SMART Actions[1]
- Recipient Information[2]

Action Plan

5 Coordination
Create Referrals

Book Services

6 Support
Service Delivery

7 Monitoring
Check-in with Carer

Measure Wellbeing

Return to assessment?

KEY
Stage
Steps
Input
Output
Optional
Linked Process

Support Planning Process Guidance

1. Intake

Step		Criteria	Actions

A.	Eligibility	• Has taken responsibility for the care of another person who:
		    ○ has a disability
		    ○ has a mental health problem
		    ○ has a medical condition (including a terminal or chronic illness
		    ○ is frail aged
		• Has ceased being a carer within the past 12 months
		• Lives within the service area of the RDP
			If the person meets these criteria, complete registration if required.

B.	Urgency	EMERGENCY: The care relationship is under high stress and breakdown has either occurred or will occur, if support is not received within 72 hours.	• Understand the driver for the contact • Assist immediately • Follow your organisation's emergency process
		Registration should be completed immediately, where possible. In the event the contact is not an emergency and cannot be addressed immediately:	
		HIGH: There is a high level of stress in the care relationship and there is a risk of breakdown if support is not received in the next 7 days (for less than 72 hours see 'EMERGENCY' above).	Contact carer for registration and/or assessment within 24 hours
		MEDIUM: The care relationship is under moderate stress and support is needed within the next 14 to 21 days.	Contact carer for registration and/or assessment within 48 hours
		LOW: The care relationship is under low stress.	Contact carer for registration and assessment within 72 hours

2. Registration

Step		Need to collect	Collect to support service delivery (Optional)
C.	Carer details	- Given name - Family name - DOB - Gender - Residential address - Phone - Indigenous status - Country of birth - Main/preferred language - Consent (includes consent to act on recipient's behalf) - Carer status (Primary/Shared/Other) - Alternate carer's name - Alternate carer's phone	- Preferred name - Disability/health condition (if any) - Employment status - Employment type (Full-time/Part-Time/Casual/Volunteer) - Current Payment Type (Pension/Carer Payment) - Carer status (Primary/other) - Care recipients: - Name of recipient 1 - Name of recipient 2 - Name(s) of other recipient(s) - Relationship to recipient(s)
D.	Recipient details	- Given name - Family name - DOB - Gender - Residential address - Phone - Disability/health condition - Pension Type - Indigenous status - Country of birth - Main/preferred language - Consent (for each carer to act on their behalf) For each carer: - Carer's name - Carer's phone - Relationship to carer	- Preferred name - Program (My Aged Care / NDIS / Other) - Type of funded plan/package

3. Needs Assessment

Step		Guidance
E.	Conversation	• Ideally, the Carers Star^{TM} will be introduced to the carer and a copy of the Star Chart and Scales provided to them before the assessment, to support a guided, joint discussion. If the carer is not ready to engage with the Carers Star^{TM} the Star reading can be completed by the Carer Support Worker only, and in this instance a notification of 'Worker Only', should be recorded. • Utilise the guiding questions below, capturing the information required to complete the Carers Star^{TM} reading. • Identify Outcome Areas in the Carers Star^{TM} with scores indicating change is required to improve the carer's circumstances, to input into support planning. • *Example* – The reasons for a carer scoring a 2 out of 5 in "How you feel" should be understood and translated to appropriate supports and have corresponding actions set out in their Action Plan. A driver that influences a lower score in a specific area may include the carer grieving for a significant change in the person they care for. In the case of this example, referral to a counselling service may be an appropriate support to set out in the carer's Action Plan.
F.	Create Action Plan	• Take the carer's needs that were identified in each Carers Star^{TM} outcome area during assessment (see above) and prioritise. • Identify the goals/aims of the carer. • Create an Action Plan for actions that are needed to support the care. The carer is responsible for completing these actions and recording them (see also *Action Plan Guiding Questions*, below). NOTE: Completion and finalisation of the Action Plan requires further steps, see below.

4. Support Planning

Step		Guidance
G.	Match Services	Utilise the service matching guidance below (see Service Matching Table) to identify the ICSS services the carer will benefit from and record these in the carer's Action Plan.
H.	Complete Action Plan	• Finalise the Action Plan, including: o Services that the carer has chosen to use. o Actions for referral and/or purchase of the services. • Provide Carers Star™ Star Chart and Action Plan to the carer for their review and acceptance.

5. Coordination

Step		Guidance
I.	Create Referrals	If the carer intends to organise services themselves, the Carer Support Worker creates/provides the appropriate referrals and contact details.
J.	Book Services	• Carer Support Worker books services on behalf of the carer • Where brokerage of services for the recipient is required: o Capture consent to share carer recipient's and the carer's personal information with the provider, if required for the services. o Collect details of the recipient's Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) if required for the services. • Contact carer so they know what to expect • Provide a document that outlines the schedule of services organised for the carer (postal delivery is assumed, email is possible). Includes contribution payment details (only for services where a co-contribution payment is permitted and the carer has agreed to a co-contribution for their service).

6. Support

Step		Guidance
K.	Service Delivery	Services are delivered by the applicable service provider(s).

7.   Monitoring

Step		Guidance
L.	Check-in with Carer	Contact the carer prior to the conclusion of their scheduled services to: • Confirm the services were delivered as expected • Determine whether the services supported the carer • Understand whether additional services may be required.
M.	Measure Wellbeing	• Check the carer's latest Carers Star^{TM} reading against their previous baseline at assessment. • Record the latest scores for de-identified reporting.
N.	Return to needs assessment?	Where the carer's circumstances have significantly changed, it may be appropriate to revisit needs assessment and support planning.

Guiding Questions

Purpose

Guiding questions will be developed to inform Carer Support Workers who undertake needs assessments with carers for the ICSS. The intent is to enable Carer Support Workers to apply the Carers Star™ consistently. Sector stakeholders have identified a need for materials that provide guidance on:

- **Needs Assessment Guiding Questions:** Identification of appropriate topics to raise with a carer to understand their needs, in line with Carers Star™ outcome areas.
- **Support Planning Guiding Questions:** Explain how to correlate Carers Star™ outcomes with services to assist the carer.

The questions below are examples of the type of questions which may be used. They *are not intended to be read verbatim as a script* – their purpose is to prompt discussion about aspects of the carer's situation that inform a Carers Star™ reading and can be used in any order, based on the judgement of the Carer Support Worker conducting the assessment.

Examples of the Needs Assessment Guiding Questions

1. **Health**
- In general how would you say your health is?
- Do you currently have any health conditions?
- What overall impact is there on your physical health because of your caring role?

2. **The Caring Role**
- Any challenges for you in providing support? Are you able to support your person in all areas where they need support?
- Are there already any services in place (if not already asked)?
- Do family and friends provide support to assist you in your caring role (if not already asked)?
- Do you have any concerns about the future?
  - If you were unable to continue caring either in the short term or longer term what may be some of the options?
  - Have you discussed these options with the person or family?
  - Do you have any guardianship/power of attorney arrangements in place?

3. **Managing at Home**
- Overall how are you coping with day to day tasks in the home? Examples include cooking, cleaning and shopping.
- Is your/their home suitable at present? What would make it more suitable?

4. **Time for yourself**
- Do you feel like you currently get some time to yourself and are able to attend to your own needs?
- Do you get the chance to spend time with friends/family away from your caring role?
- Do you have any Hobbies and/or interests? Do you have time to do these?

5. **How you feel**
- What overall impact is there on your mental health because of your caring role?

- Do you feel supported by family and friends?
- Any stress on relationship with person you care for? Has caring caused any strain or impacted on your relationships with family or friends?

6. Finances

- Do you receive carer pension/allowance?
- Does your person receive a government pension/benefit?
- Has your caring role affected your financial situation?

7. Work

- Any paid employment? Status of employment?
- For carers who are employed:
  - Is your employer aware of your caring role? Are they supportive?
  - Does your caring role impact your work?
- Any volunteer work or study currently?
- Are you wanting to get back into the workforce and if so how can we support you?

Examples of Support Planning Guiding Questions

Key questions to guide the creation of an Action Plan for the carer are as follows:

- Are you able to identify any goals that you would like to achieve in the near future?
- What kind of support would make the biggest difference for you now or into the future?
- Is there anything in your overall health and wellbeing you would like to change?

Service Matching Table

To facilitate consistent support outcomes for carers, this table suggests ICSS services that may be appropriate to meet a carer's identified needs.

Area of Life	Need	Information	Peer Support		Counselling		Coaching		Carer Directed Support	Emergency Respite	Other Actions — Referral	Brokerage of Recipient Services	
		Online Resources	Online	In Person	Digital	In Person	Self-guided	Facilitated					
Health	Mental Health				●	●				Not Applicable – Refer to Emergency Process			
	Nutrition	●					●	●					
	Fitness	●					●	●					
The Caring Role	Practical support with care								●			●	
	Access to information/educational resources	●					●						
	Training	●					●	●					
	Caring advice/mentoring	●					●	●					
	Legal advice	●					●	●			●		
	Advocacy	●									●		
	Equipment/aids								●			●	
	Transport services								●			●	
	Contact/connection with other carers		●	●									
	Temporary planned respite care								●				
Managing at home	Home repairs or modification								●			●	
	Support with cleaning								●			●	
	Support with shopping								●			●	
Time for yourself	Activities away from caring								●				
	Short breaks (less than a day)								●			●	
How you feel	To feel:												
	Supported		●	●									
	Connected		●	●									
	Secure				●	●	●	●					
	Less stressed				●	●	●	●	●				
Finances	To apply for Carer Payment/Allowance	●									●		
	Funded services for care recipient										●	●	
	Legal advice						●	●	●				
	Financial advice						●	●	●				
Work	Support to return to work	●					●	●	●		●		
	Support reduction of work hours						●	●					
	Strategies to communicate/negotiate with employer	●	●	●			●	●	●				
	Support post cessation of employment	●	●	●		●	●	●	●				