

2013



**REVIEW OF HOME AND COMMUNITY CARE
(HACC) NON EMERGENCY AND COMMUNITY
TRANSPORT**

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EXECUTIVE SUMMARY

Community transport, including Home and Community Care (HACC) community transport, is an essential enabler of the social, health and wellbeing of people who require assistance and basic care to live independently. As the proportion of older Australians within the population increases, the challenge of providing support to those choosing to live independently is expected to increase. HACC community transport, given it is designed to meet the needs of a target group that might not otherwise be able to access other forms of transport, is an important element of a diverse and flexible community transport system.

In 2008, Banskott Health Consulting Pty Ltd recommended (Recommendation 53), as part of a wider suite of transport coordination recommendations, that the allocation and dispatch of community transport be coordinated from a central coordination centre, located within Ambulance Tasmania. This project was commissioned to test the recommendation in the current and emerging service system and to identify viable alternatives should those be needed.

To provide an evidence base upon which to evaluate the recommendation, the brief required a detailed survey of the use of HACC community transport (repeating a 2006 survey to enable comparative analysis across key use dimensions) and non-emergency patient transport (NEPT) over a four week period. The project brief also required wide consultation with HACC service providers and other key stakeholders to provide both quantitative and qualitative information on which to develop an understanding of the use of the HACC community transport system and issues faced in delivering the necessary client outcomes on which independence is predicated. From this understanding of both context and detail, conclusions in relation to key dimensions affecting the performance and productivity of the HACC community transport system, including the benefit of centralised coordination could be determined.

The survey identified that:

- Launceston, Devonport, Hobart, Burnie and Glenorchy are the major HACC community transport destinations;
- The origins of these trips were dependent upon purpose of the trip; Launceston and Hobart represented a high proportion of “medical” purpose trips and consequently a highly dispersed location of origin;
- Conversely Devonport, Burnie and Glenorchy represented a high proportion of “social” purpose trips and generally less dispersed origins;
- Social purpose trips (including essential travel such as shopping and other transactions) comprised 72% of trips overall, compared with 68% in 2006;
- There has been a significant increase in the proportion of social trips used to access day centres and for shopping/recreation; and

- The proportion of HACC clients requiring assistance when using HACC community transport has risen from 30.5% (2006) to 42% (2013), with HACC clients in the 65years and over age cohort having a greater need for assistance.

For the purpose of the survey, trips were defined as a return journey; the reason for this was to capture the key difference between such trips when compared with, for example public transport, where the transaction is normally associated with a one way journey.

There are fundamental differences between community transport and public transport. In effect community transport may be considered an interaction between the client and provider, one where the nature of the “trip” actively contributes to, and is focused on providing what is necessary for the social and physical wellbeing of the client, whereas public transport is arguably a transaction that provides a seat to carry a person from “A” to “B”. Community transport, and in particular HACC community transport cannot be described as analogous to public transport or in most cases compared with it. This often means that although travel distance may be short, time can be extensive. In the case of medical transport, this interaction may be day-long. Conversely HACC eligible clients utilising non-emergency patient transport, to a large degree experience a one-way trip between medical campuses and to a lesser degree to regional locations, while more aligned to the transaction, the trip is also characterised by a care level matched to the client condition.

Investment decisions within community transport should be based on broad benefit/cost approaches that are inclusive of the consideration of client outcomes; this is different to public transport models where the decisions are made on a return on investment model. Community transport enterprise models need to reflect this difference and principles in their governance and relationships with clients and funding agencies.

To achieve the HACC community transport outcome, the form of transport and selection of driver is critical. Of the almost 13,000 client trips provided during the four week survey period:

- 9,400 (73%) were provided to HACC clients in the 65 year old and over cohort, while 3,500 (27%) were provide to HACC clients in the under 65 years age cohort;
- 16% were provided by buses with a capacity of greater than 13 seats, a decline from the 35% in 2006;
- 12 seat bus utilisation has increased from 16% to 34% over the same period, in part identified as a result of the replacement of larger capacity buses with smaller vehicle on the basis of cost and regulatory change;
- Group travel has increased and individual transport decreased between 2006 and 2013
- In an attempt to cover peak loads and provide diversity of access some HACC providers have arrangements in place, including redeemable vouchers, to enable clients to access public transport such as taxis. Options to develop more integrated financial and transport links between the HACC community transport and public transport, in particular taxis, should be considered.

Tasmania's total target population for HACC community transport would not warrant the development of separate systems for the different age cohorts. Given the relatively low representation of the younger disabled cohort in the sample it is unlikely that the operation of separate transport systems for the younger cohort and the 65 and over cohort would be viable. It is essential that the system continues to provide support for both target groups.

In focus groups, Day Centre providers identified lack of access to suitable buses as a critical problem in enabling efficient client access to programs. Centres work around this problem by diverting resources from other programs to transport clients and have clients "wait" in the centre for the remainder of the group prior to commencing programs. They reported that they feel the "work around" solutions result in adverse consequences for clients and client outcomes; they result in some clients 'missing out', reduced client service levels within the day centre program and challenges to meet client target levels. Where the reduced access to a suitable bus is as a consequence of the HACC community transport provider decision to not provide a large capacity bus the cost saving to the transport provider is transferred as a cost to the HACC client in terms of reduced access to other support services.

'Specialist' buses, for example those with a capacity to transport wheel chairs, are a key element of the HACC community transport system. When changing over major fleet assets, the replacement decision should be considered within a benefit/cost framework rather than the current, straight financial model using commercial return on investment parameters. This benefit/cost approach is a means of ensuring that the financial savings to a HACC community transport provider of not providing the service optimum vehicle is not outweighed by the indirect cost to the HACC clients and the overall program. A further example of attempting to control direct costs is found in the reduced hours of transport coordination that one provider has instituted. HACC service providers indicate that this is highly problematic if there is an unplanned event prior to or during the trip; effectively leaving them to resolve the incident.

The coordination of volunteer, appropriate vehicle and client can be complex. From a HACC community transport provider perspective it is an interaction that benefits from "local knowledge" and from a client perspective the ability to contact someone easily and with confidence. The HACC eligible client population is widely dispersed within Tasmania, however the under 65 year old cohort tends not to be as "clustered" in specific suburbs as is the older age cohort. Both are subject to similarly broad variations in access to public transport and vehicles that match mobility characteristics and needs; it appears that clients and organisations develop effective work around solutions to resolve problems. While this flexibility is important, as identified above, it can have significant overall consequences in reduced client service and cross subsidisation between other support services and transport.

It was identified through the project that although HACC provider forums occur regularly in each region there is little knowledge of the community transport capability of other near and adjacent HACC providers and as a consequence little sharing of vehicles or consolidation of clients as appropriate in a vehicle travelling to a common destination.

From amongst the transport coordination options (including the Banskott recommendation) discussed with stakeholders, the provision of a real time fleet management system; based on centralised fleet information that would enable HACC service providers to both allocate their own vehicles and to identify spare capacity in other HACC service providers allocation received strong stakeholder support. This support was based on the balance of local coordination combined with up to date, centralised information.

Recommendation 53 of the Banskott (2008) review is not supported. However the underpinning centralised information base that would have been required to facilitate the recommendation is strongly supported as a strategic initiative to improve the productivity of the HACC community transport system. It is critical that the provision of real time information to service providers on fleet activity is considered as part of the HACC community transport system.

Given the role such consolidated transport data will play in ensuring the productivity of HACC community transport and in program evaluation, it is considered important that the system is hosted within an organisation that is separate from service delivery which is able to provide information to support the management of regional diversity and reflect differences in needs of the under 65 year old cohort from the 65 year and over age cohort.

It is recommended that the feasibility of a centralised information and fleet management system to enable flexible and efficient delivery of this critical client/community transport interaction be examined.

TERMINOLOGY

Home and Community Care (HACC) - is a key provider of community care services to frail aged people and younger people with disabilities and their carers. In Tasmania (and most other States and Territories) the Commonwealth Government funds and manages service delivery for the older target group and State Governments fund and manage the younger persons service system.

Community transport - transport services to people affected by disability, older people and other groups with a limited range of transport options provided by not for profit organisations or councils and others such as friends, relatives and volunteers.

HACC community transport – is an unscheduled, essentially door to door subsidised transport service provided to a HACC client driven by a HACC provider employee or volunteer or indirectly by, for example, taxi voucher or brokerage. HACC eligible clients pay a contribution to this transport which is not designed as a complete transport system negating people’s responsibility for meeting some of their transport needs. All fees collected remain with the service provider to be redirected back to client services.

Trip - for the purpose of the survey, trips were defined as a return journey.

Assistance – assistance is diverse in form and may range from assistance to carry groceries, to enter and exit a vehicle (or residence/business), to handle walking aids and wheelchairs.

Non Emergency Patient Transport (NEPT) – Ambulance Tasmania NEPT provides for the transport of patients requiring a basic level of care to, from or between Department of Health and Human Services (DHHS) medical services/facilities, where an appropriate health professional has determined that the person being transported is not suitable to travel by other means.

Group Transport – where a number of clients are transported in a single vehicle.

Individual Transport – Where a single client, at times with a carer is transported.

Contributors – people who contributed through the consultation in workshop sessions and face to face discussions.

INTRODUCTION

The Project

The brief required a two phase project as outlined below. Given the interdependency of the two phases and the relatively short time frame for the project, the phases were undertaken concurrently.

Phase 1

1. Update the September 2006 Home and Community Care (HACC) Community Transport Survey - data to include the disposition of community transport schemes, the type of transport activity and the client profile, details of provider organisations, their vehicle types and locations, which clients they carry and their needs – and any details of service level agreements. The survey collection period was for 4 weeks.
2. Broaden survey participants to include specific non HACC medical community transport providers such as Cancer Council Transport to Treatment and non HACC Red Cross transport. Also to consider the impact on or from Ambulance Tasmania Non-Emergency Patient Transport services.
3. Provide a map illustrating current community transport providers and systems in a form that can provide the Commonwealth and the State with information to assist each in their future responsibilities for setting policy and planning community transport arrangements for older and younger target populations respectively.

Phase 2

1. Consult with service providers and key stakeholders to determine the feasibility (efficiency and effectiveness) of the Banskott proposal in relation to HACC community transport (as was included in the Government's original response to the Banskott Review);
2. Provide a report of the outcome of consultation to Ambulance Tasmania and recommend on-going support for the Banskott HACC community transport approach or an alternative; and
3. The deliverables from this phase will include a recommendation as to whether or not to proceed with Phase 3. Phase 3, if it is undertaken will include developing and building a computerised community transport planning tool.

The HACC Context

HACC is a longstanding community based program which is undergoing major structural change. The program is designed to enhance the independence of people in the target groups and to avoid their premature admission to long term residential care. The target groups are frail aged and younger Australians affected by disability and their carers. In recent years maintenance of wellness and independence has gained increasing importance as program outcomes. Transport is an essential element of client mobility, one that is seen to be an important enabler of independence. It is reasonable to assume that HACC community transport is a key enabler of the target group's ongoing ability to remain at home living as independently as possible.

The community and in particular the HACC community transport system has been significantly affected by a number of external policy, demographic and practice changes that impact on the HACC target population, these are identified as:

- Split of HACC program along age lines;
- DisabilityCare Australia;
- A reduction in the availability of low care places in aged care facilities as these facilities; review their focus and business models;
- Increasingly centralised health care for critical, specialised and high cost procedures;
- An increase in day surgery procedures as an alternative to inpatient treatment;
- An increase in recurrent treatments for a range of conditions;
- People living longer but at times with the burden of chronic disease; and
- Fuel price and vehicle operating cost increases.

These factors combine to change the community transport utilisation profile in terms of demand and present a challenge in meeting client access and care levels. The macro overlay to this is the need for governments to be able to manage the budget implications of an ageing population and provide support to younger people with disabilities.

From 1 July 2012 the HACC Program funding, policy and operational responsibility was split between the Commonwealth and State – with the State Government assuming responsibility for clients under 65, or under 50 for Aboriginal and Torres Strait Islander People – 'younger target population', while the Commonwealth Government has taken responsibility for those 65 and over, or 50 and over for Aboriginal and Torres Strait Islander People – 'older target population'.

The system will undergo additional realignment with the introduction of the National Disability Insurance Scheme (DisabilityCare Australia) and the Commonwealth Ageing and Living Longer Living Better policy agenda. This will occur at 3 levels:

- Introduction of client choice and transparency in cost structures;

- Potential changes to the fleet capital management model for Commonwealth funded aged care transport services; and
- As mentioned previously, transition to a model where aged care is Commonwealth funded and for younger Australians affected by disability and their carers; care is both Commonwealth and State funded.

These changes in conjunction with expected demographic shifts and government challenges in controlling the cost and economic consequences of an increasing proportion of older citizens across the nation, provide the landscape in which this project was undertaken.

The Impact of Change

The North West HACC forum felt that HACC service providers are “specialists” in providing both the necessary mix of support in a manner reflective of the needs and values of the client group. It was concluded by the group that HACC service provision is holistic in scope; furthermore, community transport was identified by contributors as a critical part of this scope. The reliance of the HACC client group on HACC community transport as a key enabler of independence was reinforced.

HACC community transport is a sub-set of community transport. The regional HACC Forums and the face to face discussions with service providers have identified a complex socio-technical environment that provides transport in a manner that reflects client’s needs. HACC community transport for a large part must be, and is complemented with a level of service that reflects the specific needs of the client and their level of ability. As one contributor indicated, *“HACC transport is an accompaniment service that escorts people based on their need and may include escorting them from within their home to an appointment and in some instances waiting with them and subsequently escorting them safely back into their home”*. It became clear that HACC community transport is an “interaction” with the client as compared to public transport which is a “transaction” to take a person from “A” to “B”. This categorisation is reinforced by the following, additional benefits associated with this HACC community transport interaction:

- Personal touch – the accompaniment role;
- Observation of change in capacity and risk;
- Contact for the isolated;
- Decreased burden for client carers in their respite role; and
- Contribution to communities by enabling people to use services within them.

This distinction between community and public transport, and the need to understand client circumstances and the context of the transport required, reinforces the necessity for a “safe” outcome for the client. The need is particularly so given the increase in the level of demand for medical trips identified by contributors.

With this “safe” client outcome focus, unless private operators are prepared to invest in the necessary training to support such interaction and value delivery that ensures the private transport

option is comparable, the community sector is likely to maintain its position as a key provider of community transport to the HACC target population.

Notwithstanding this reported key dependency on community and HACC community transport, service providers express concern over the suitability of the current HACC community transport fleet profile and the communication and coordination interface between transport and service providers; in particular a perceived lack of their engagement with fleet management decisions. This concern may also be related to the somewhat isolated manner in which some HACC service providers operate and a lack of real knowledge of other provider's capacity on which coordination and collaboration between service providers can occur.

Approach

The project methodology combined quantitative and qualitative primary research with a review of key reports and discussion papers. The survey replicated and expanded the 2006 survey and included the following providers.

The 2013 survey was extended to include:

- The Cancer Council of Tasmania;
- Red Cross non HACC funded transport; and
- Ambulance Tasmania Non-Emergency Patient Transport Service.

All organisations and their staff and volunteers are thanked for their efforts

Organisation	Service Location/s
Aboriginal Elders Council	Launceston
Baptcare Ltd	East Devonport
Bruny Island Respite & Community House Inc.	Bruny Island
Bucaan Community House Inc.	Chigwell
Cancer Council of Tasmania	Statewide
Central Highlands Community Development Inc.	Ouse
Circular head Aboriginal Corporation	Smithton
Clarence City Council	Rosny Park
Community Based Support South Inc.	Moonah
Community care NESB Inc.	Launceston
Community Transport Services Tasmania Inc.	Statewide
Emmerton Park Inc.	Smithton
Family Based Care Association North Inc.	Launceston, Fingal, St Helens, Scottsdale, Westbury
GC Services Inc.	Latrobe
Glenview Community Services Inc.	Glenorchy
Good Neighbour Council of Tasmania Inc. (Launceston Branch)	Kings Meadows
Hobart District Nursing Service Inc.	Nubeena
Tas Independent Services	Riverside
Launceston VFC Services Inc.	Launceston
Kingborough Council	Kingston
May Shaw Health Centre Inc.	Swansea
Meercroft Care Inc.	Devonport
Mersey Community Care Association Inc.	Devonport
Polish Association in Hobart Inc.	New Town
Presbyterian Care Tasmania Inc.	Warrane
Australian Red Cross Society	Bridgewater, Launceston, Burnie, Hobart
South Eastern Nursing and Home Care Association Inc.	Sorell
St Helens Community Car Group	St Helens
St Johns Ambulance Australia (Tasmania) Inc.	Moonah, Launceston
Tandara Lodge Community Care Inc.	Sheffield
Uniting Aged Care – Southern Tasmania Inc.	Mornington
Wattle Group Inc.	Launceston
Womens Karadi Aboriginal Corporation	Goodwood
Wyndarra Centre Inc.	Smithton

The survey was conducted over a four week period of interaction. The specific four week window was captured between 25 March and 19 April and for Community Transport Services Tasmania (CTST), the largest HACC community transport provider, the period March 2013. This variation was applied for purely pragmatic reasons; given the data recording model utilised by CTST, it would not have been possible to achieve the collection of the required data within the Project overall completion date.

Ambulance Tasmania considered and approved this variation between periods which was adopted within the methodology.

The qualitative research was based on “workshops” with groups of HACC service providers as an adjunct to HACC forums and face to face discussions with a cross section of HACC community transport providers and other stakeholders. The group sessions utilised the regional HACC forums and also the Southern Day Centre Forum. The workshops and discussions reflected the following perspectives:

- Client demand for transport and scope/characteristics of requirement;
- Challenges in the provision of transport;
- The degree to which the challenges are addressed; and
- The necessary characteristics and performance requirements of HACC community transport coordination.

The forums, workshops and face to face, in-depth discussions were complemented by project management meetings and three Advisory Group meetings.

The organisations participating in workshop sessions and discussions included:

Advocacy Tasmania, Alzheimer’s Australia, Bapcare (Orana), Banksia Day Centre, Care Access, Community Transport Services Tasmania, Clarence Volunteers, Cottage Day Respite, Family Based Care N/W; CTST, Glenview, Healthwest, South Eastern Community Care, Community Based Respite, Hobart District Nursing Service, Home Care South, Huon Valley Respite Centre, Italian Day Centre, Lifeline, Presbyterian Care, Polish Welfare office, Central Highlands Day Centre, ILC Tasmania, Kincare, Migrant Resource Centre, Manor Gardens, Red Cross, TasCarepoint, Tasmanian Council of Social Services (TASCOSS), Wattle Group, Mersey Community Care, Wyndarra Centre.

HACC TRANSPORT USE PATTERNS

Survey: Focus and Fit to Other Transport

This section presents the data from the survey, together with associated commentary based on analysis and consultation input.

It is important to note that “HACC community transport” vehicles provided and/or operated through specific HACC funding to community organisations are only one of the transport options available to the HACC target client group. Not all HACC service provision funding includes a transport funding component; in this instance transport is often provided as part of, for example assistance with shopping, through support workers and volunteers using their own vehicle with the client contributing on a per kilometre basis. This mode of transport forms a significant component of some service provider’s support activity and as indicated by service providers is increasing in demand - *“clients are with us for a long time, firstly for transport, then Community Options and then HACC service bundles”*. This quotation reinforces the central role of HACC community transport as one enabler of people’s capacity to confidently and safely remain in their home.

When HACC community transport vehicles or volunteers are not available, some providers have arrangements with external parties such as taxi firms and hire car companies on a direct payment system, an internal “voucher” redeemable by the firm, in other instances HACC eligible clients arrange their own public transport, paying full commercial rates. Some service providers have in place arrangements where for example, hire car firms provide vehicles as a short term donation.

It is important to note that the following profile primarily includes HACC funded community transport vehicles plus non HACC vehicles such as those operated by The Cancer Council of Tasmania that were included to ensure a more comprehensive scope to the analysis.

Transport Profile Context

The transport profile must be considered in context. All providers indicated an increase in demand for transport from clients (although this cannot be validated between the 2006 and 2013 surveys because of their different survey period durations). The following reasons for increasing transport demand were proposed in forums:

- Clients with increasingly complex conditions are remaining in the home;
- Increasing isolation – perhaps due to families moving further afield or older people moving to Tasmania to retire;
- Decreased mobility as clients are remaining in their home longer;
- Lack of public transport, particularly in rural areas;
- Increase in long distance medical appointments;
- Mismatch of community transport availability and appointments in the public system; and

- Better knowledge in the community of what HACC community transport is available.

It was a universal observation from those consulted that the success of supporting people to remain in their homes longer has created an increase in the HACC client base and this rise is often compounded by a lack of family support and public transport options. Such isolation is at times exacerbated when the locational and capability profile of a client is consistent with:

- Rural regions where public transport options are limited;
- At times, limited client mobility and challenging behaviours create an environment that is incompatible with limited capacity of a volunteer based service; and
- Long term clients understand the system and book ahead whereas short term clients (such as those in an emergency) need transport immediately and it is not available.

Contributors indicate that there is a gap between client expectation and service provision and contend there is a case for considering ways to expand hours of operation and service delivery.

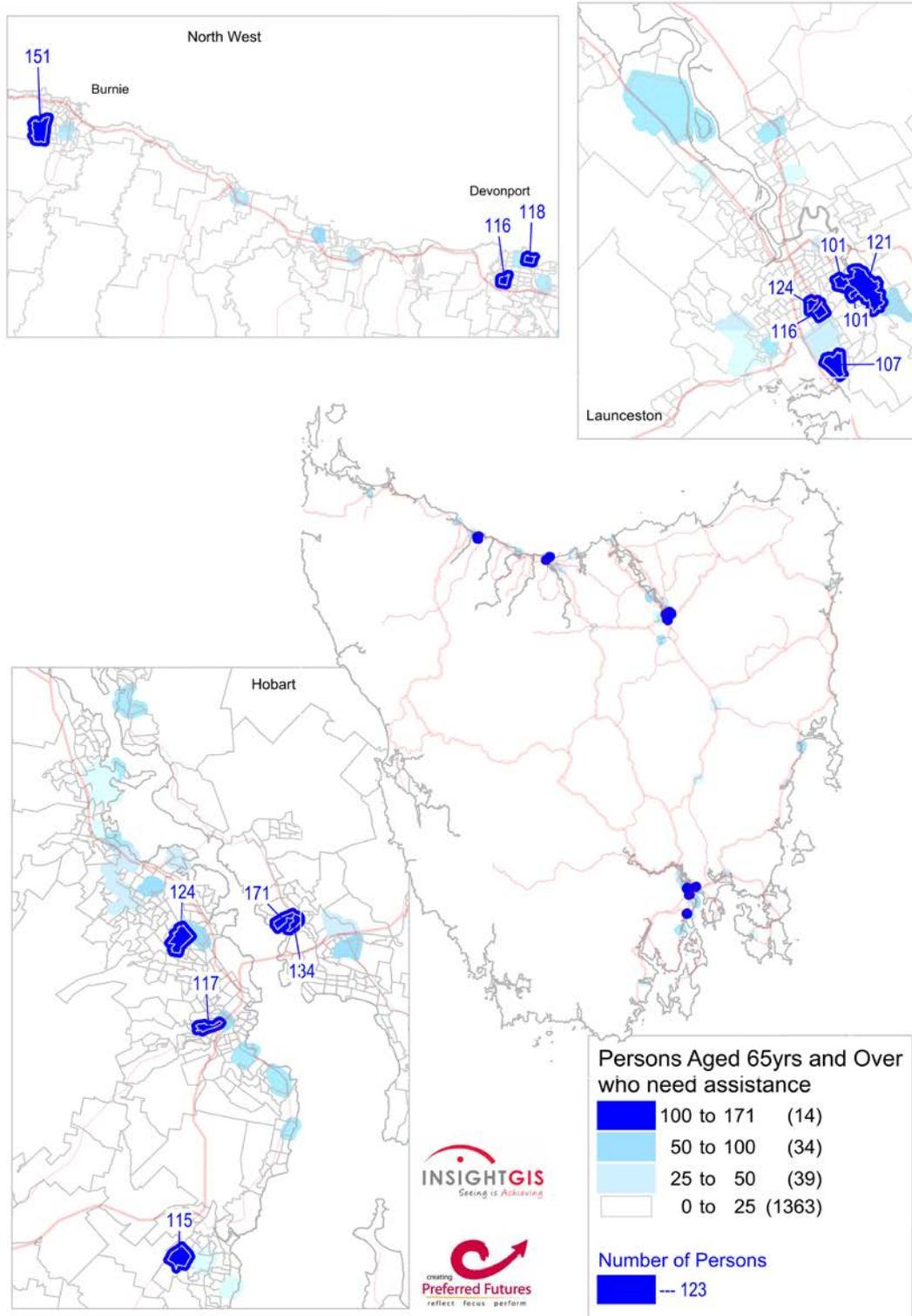
Service providers indicate that some clients face real hardship in paying their HACC community transport contribution; they reinforce the need to consider “what is affordable” from the lower socio economic viewpoint. Contributors further contended that HACC community transport is at times not used as the client is required to pay a transport fee they cannot afford when considered in the context of the need to pay for essentials such as food, power and medications; there may be a need to review the apportioning of fee waivers.

Maintaining independence and wellbeing as the basis for “at home” quality of life is also dependent on being able to leave the residence as required and desired. It was generally noted during consultation with service providers that the contribution provided by HACC community transport to client wellbeing is significant. This observation was based on factors such as:

- HACC Community Transport and broader community transport is important for social interaction and enhanced wellbeing;
- Social benefit cost – there is a poorer medical outlook without access to services. The facilitation of community transport to medical treatment has the potential to save money in terms of reduced readmissions and the facilitation of access to outpatient treatments; and
- Some HACC funded programs would not work as well without the transport component; it is effectively a lead service and enabler of the effectiveness of others.

Figures (1) and (2) highlight, by suburb/town, the location of the Tasmanian population (ABS 2011), that are highly probable to be currently or in the near future, users of HACC community transport. The maps show locational distribution, the darker the shade of colour represents more people in the area, the insets also identify the numbers of people requiring assistance in the key locations.

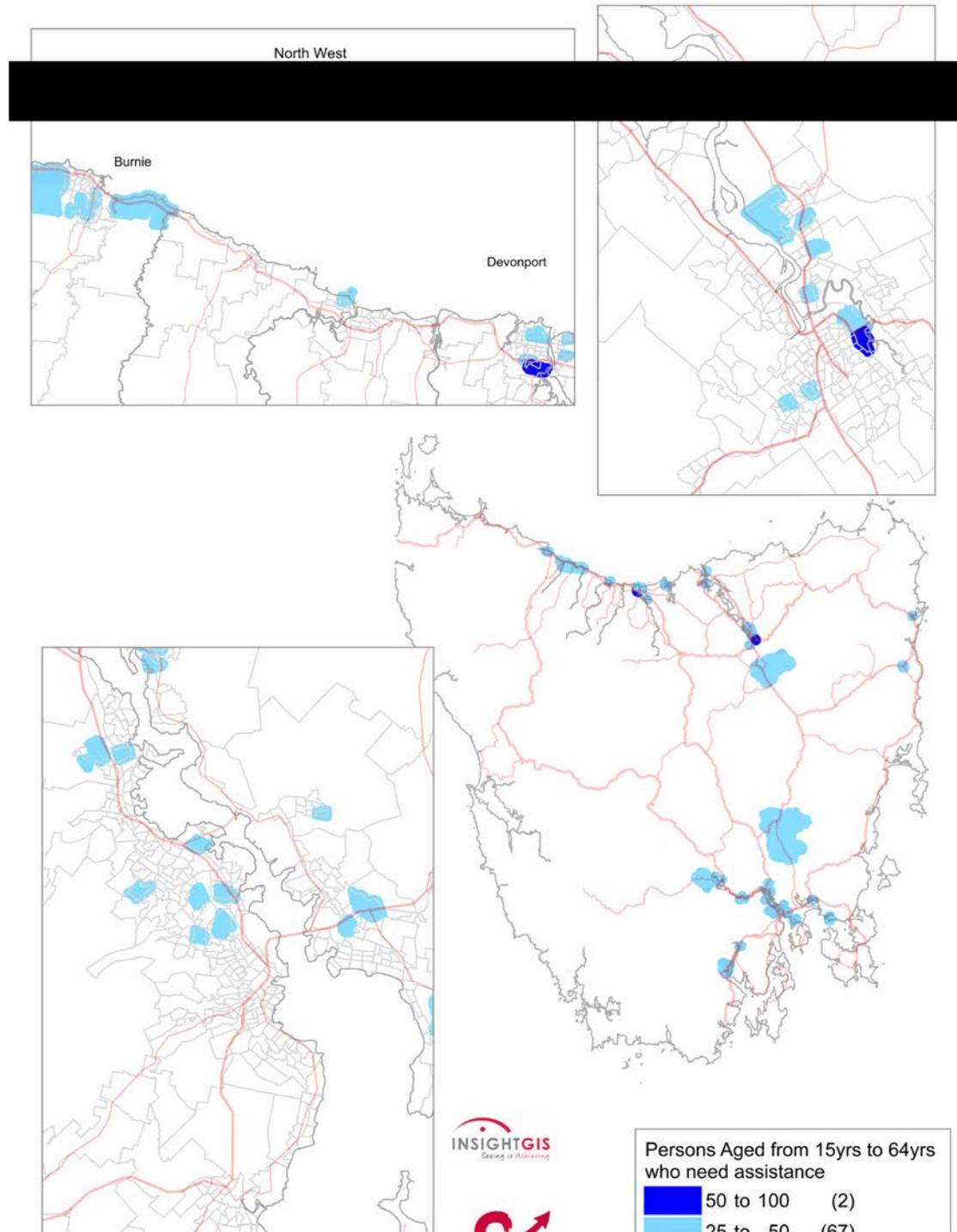
Figure 1. People aged 65 and over, requiring assistance to live independently - distribution



Source ABS 2011 Census

Figure (2) highlights the locations with highest numbers of the younger under 65 cohort who indicate they require assistance to live at home.

Figure 2. People under 65 years of age requiring assistance to live independently - distribution



Source ABS 2011 Census

It is interesting to note the geographic spread of the higher concentration clusters and to also note that the density of potential clients is much less than for the over 65 target population. Please note that ABS data categories do not match those differentiating the HACC population categories.

Importantly the survey provides an indication of the way in which HACC community transport penetrates areas where there is need.

Figure 3. Proportion of 65 and over (needing assistance) population utilising community transport

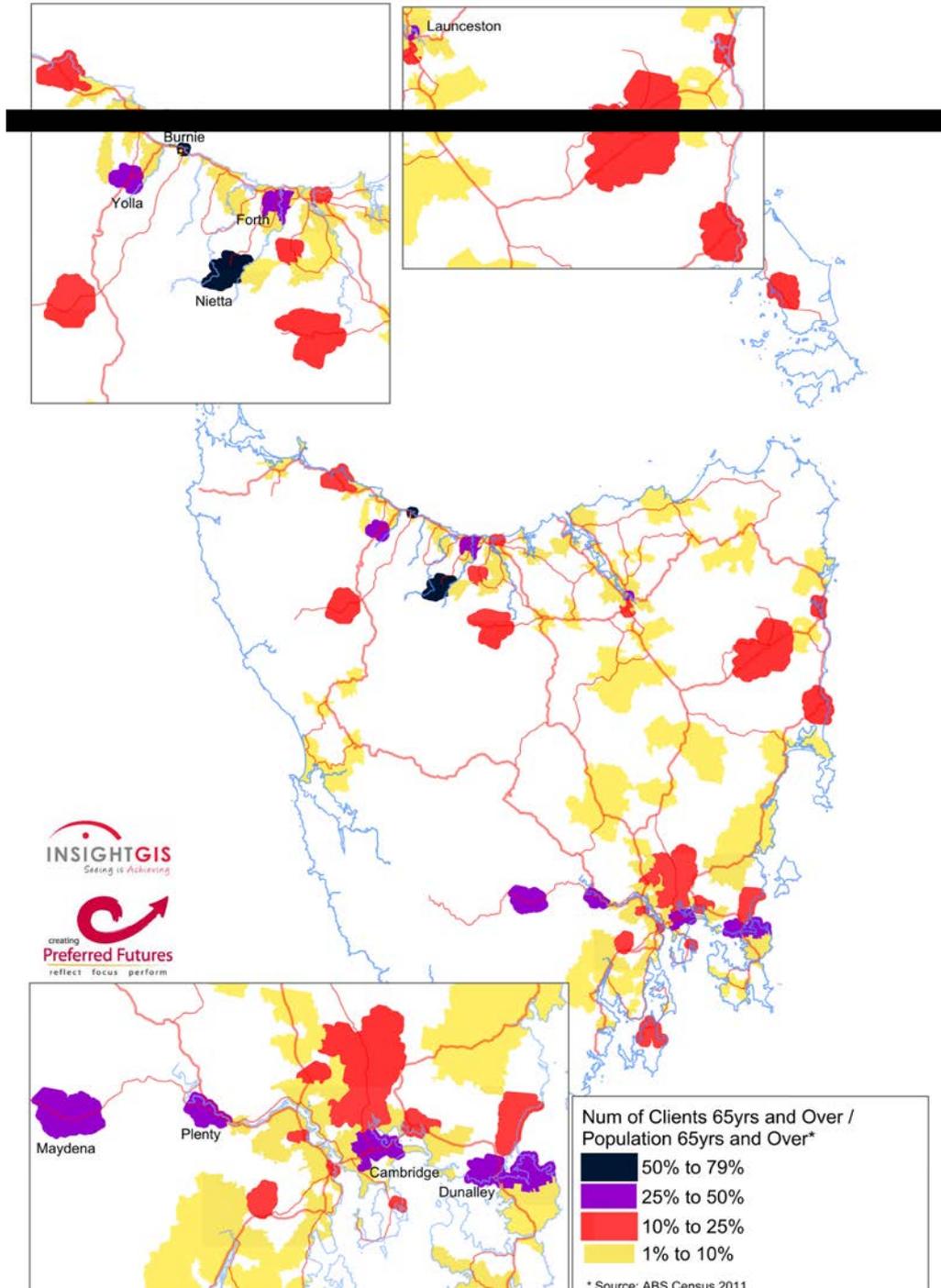
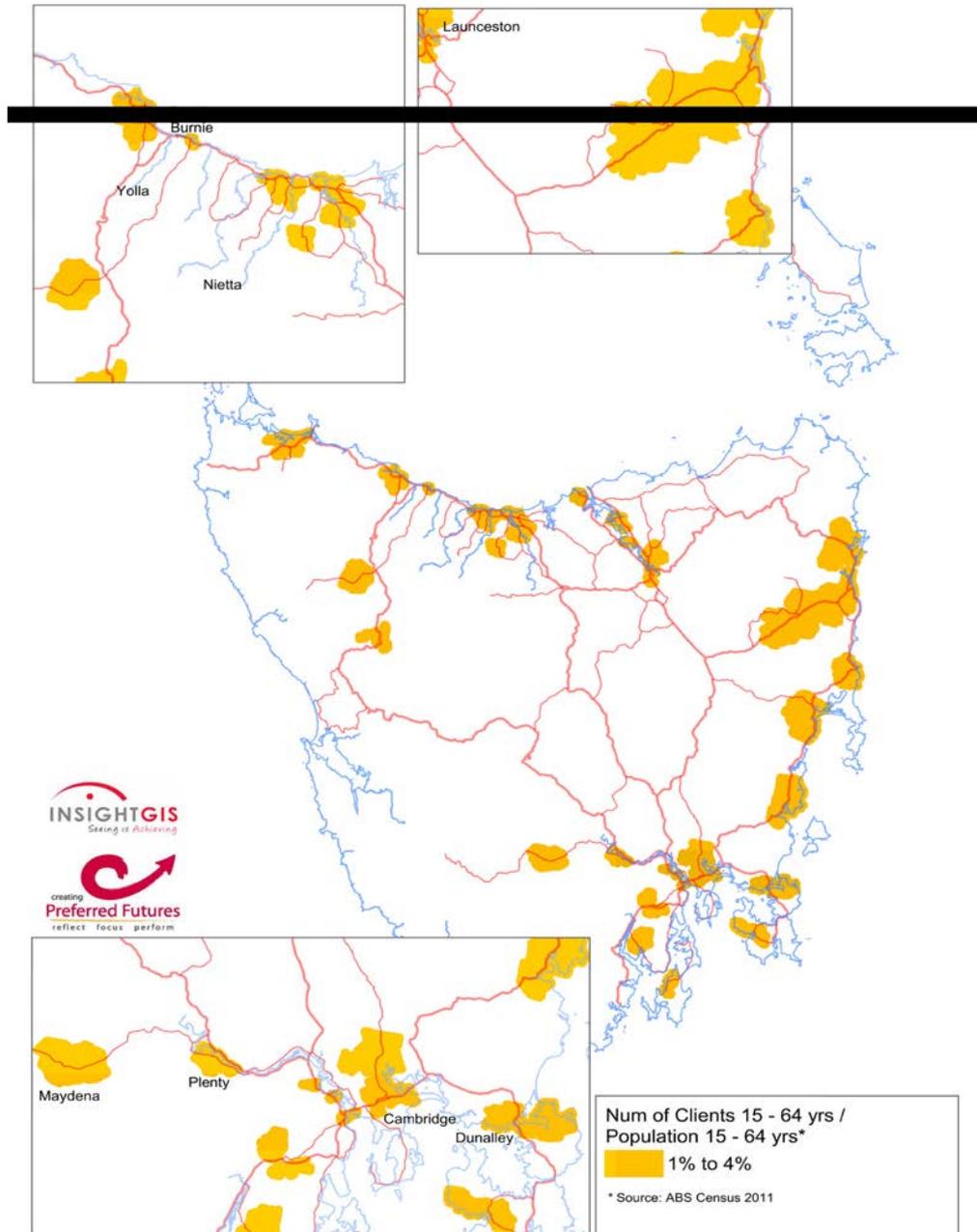


Figure 4. Proportion of under 65 (needing assistance) population utilising community transport



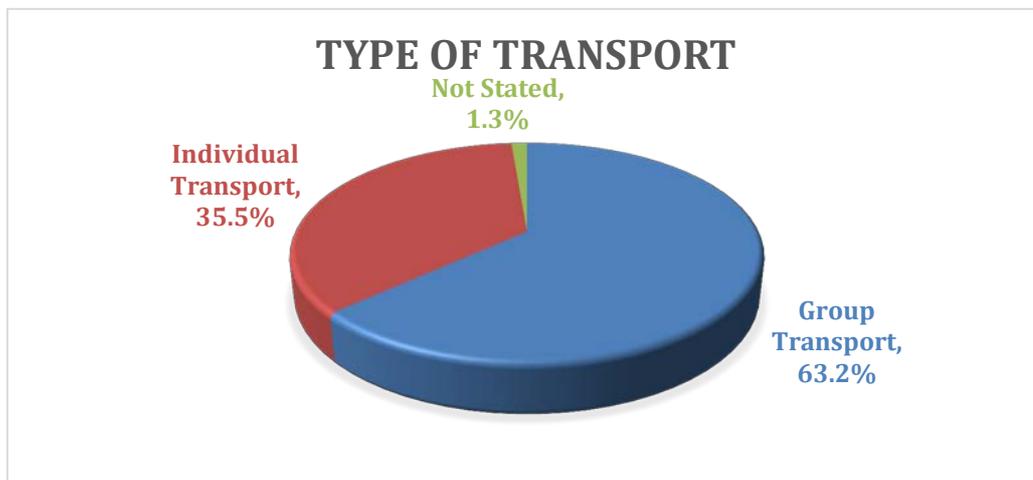
These maps provides an indication of where the HACC community transport “system” is penetrating the population that requires assistance to continue to live independently. Most areas, including isolated locations have very low levels of service penetration. Low levels of penetration are an indicator that over time the need for transport to support people to continue to live independently will increase in these areas challenging transport funders and providers. The following HACC community transport profile must be considered in the above context and also that established by provider observations.

TRANSPORT PROFILE

How Much HACC Funded Community Transport is Used?

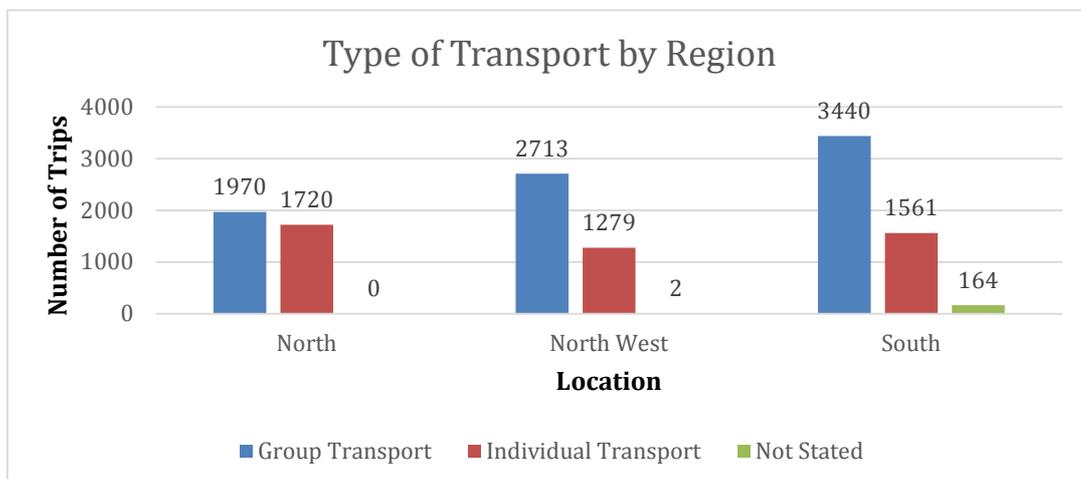
Demand for HACC community transport is significant, the four week period captured 12,849 individual trips (origin to destination) for HACC eligible clients of all ages; of these 9,344 (73%) were provided to the 65 years and over HACC cohort and 3,455 (27%) were provided to the under 65 years cohort. Of these HACC community transport movements 8,123 (63.2%) were group transport and 4,560 (35.5%) were individual transport movements, see Figure (5).

Figure 5. Type of HACC transport utilised by the total survey population



The regional distribution of trips is captured in Figure (6); it is relatively similar between the North and North West, with the northern half of the State showing relatively higher demand than the south of the State. This distribution is not related to overall population distribution and may reflect the more highly dispersed nature of the population across the north of Tasmania and relative lack of public transport options.

Figure 6. Type of transport utilised by region by number of trips



When compared with the 2006 survey, there are some significant differences in transport type utilised.

Table 1. Number of HACC Community Transport Trips by Type by Region 2013

	North	North West	South	Total
Group Transport	1970	2713	3440	8123
Individual Transport	1720	1279	1561	4560
Not Stated	0	2	164	166
Total	3690	3994	5165	12849

Table 2. Change in the number of HACC Community Transport Type by Region as % of Total - Variation between 2006 to 2013

	North	North West	South	Total
Group Transport	17.9 to 15.3	15.6 to 21.1	19.2 to 26.8	52.8 to 63.2
Individual Transport	15.6 to 13.4	21.7 to 10	9.2 to 12.1	46.5 to 35.5
Not Stated				
Total	34.2 to 28.7	37.4 to 31.1	28.4 to 40.2	

(Figures in Red indicate a reduction between the 2 survey periods)

When compared with the 2006 profile, it is identified that as a proportion of trips by HACC community transport type and total:

- The proportion of trips for the South has increased and for the North decreased across both group and individual community transport categories;
- The proportion of total community transport trips has decreased in the North West; the reduction in individual community transport is not offset by the increase in group trips; and
- Group community transport has increased as a proportion of trips statewide.

Tables 1 and 2 highlight significant changes in in the characteristics of HACC community transport between the two survey periods.

Similarly when compared to 2006, table 3 highlights that there has been a significant shift in the type of vehicle utilised:

- A move in group community transport from large buses to small buses (it is unclear whether this is because larger buses are not always available from within the fleet);
- More sedans are used for group community transport; and
- There is a reduction in individual trips with sedans.

It is unclear as to whether the move to group community transport is a planned operational transition to improve efficiency or a reflection on fleet profile. Day centre operators observe it occurs as a means of adapting to a lack of large bus availability.

Table 3. Vehicle type utilisation by region

Vehicle Type	Trip Type	North	North West	South	Total	2006 % of Total	2013 % of Total
Bus- 13 seats or greater owned by HACC funded organisation	Group	46	569	1436	2051	30.4	16
	Individual		2	1	3	4.8	
	Unknown				0		
Bus- 12seats or less owned by HACC funded organisation	Group	855	1587	1210	3652	13.8	28.4
	Individual	134	403	226	763	2.3	5.9
	Unknown		1	146	147		
Sedan owned by HACC funded organisation	Group	574	183	159	916	1.9	7.1
	Individual	243	513	682	1438	33.3	11.2
	Unknown		1	12	13		
Other wheelchair accessible vehicle owned by HACC	Group		2		2		
	Individual		21		21		
	Unknown				0		
Other owned by HACC funded organisation	Group	484	225	337	1046		8.1
	Individual	754	308	351	1413		11.0
	Unknown			2	2		
Bus charter hire	Group			59	59		
	Individual				0		
	Unknown				0		
Other vehicle hire	Group		68	38	106		
	Individual		9	3	12		
	Unknown				0		
Volunteer Vehicle	Group			7	7		
	Individual			105	105	0.8	1.5
	Unknown			3	3		
Other vehicle	Group	11	79	194	284		
	Individual	589	23	193	805	6.3	3.3
	Unknown			1	1		
Total		3690	3994	5165	12849		

To a large degree the profile matches expectations between group and individual community transport; however it also indicates significant sharing in sedan provided trips and individual trips with small buses, potentially indicative of the need for walking aid and wheelchair access.

It is important to gain insight into any differences in need between the two HACC populations, those aged under 65 years and those aged 65 years and above. The type of transport utilised by the older HACC age cohort is identified in Tables (4) and (5),.

Table 4. HACC Community Transport Type by Region – older age cohort number of trips 2013

	North	North West	South	Total
Group Transport	1292	1873	2899	6064
Individual Transport	1133	808	1157	3098
Not Stated	0	2	149	151
Total	2425	2683	4205	9313

Table 5. HACC Community Transport Type by Region – older age cohort % of trips 2013

	North	North West	South	Total
Group Transport	13.9%	20.1%	31.1%	65.1%
Individual Transport	12.2%	8.7%	12.4%	33.3%
Not Stated	0.0%	0.0%	1.6%	1.6%
Total	26.0%	28.8%	45.2%	100.0%

Table 6. HACC Community Transport Type by Region – younger age cohort number of trips 2013

	North	North West	South	Total
Group Transport	670	810	532	2012
Individual Transport	587	439	402	1428
Not Stated	0	0	15	15
Total	1257	1249	949	3455

In percentage terms, the profile is as follows.

Table 7. HACC Community Transport Type by Region – younger age cohort % of trips 2013

	North	North West	South	Total
Group Transport	19.4%	23.4%	15.4%	58.2%
Individual Transport	17.0%	12.7%	11.6%	41.3%
Not Stated	0.0%	0.0%	0.4%	0.4%
Total	36.4%	36.2%	27.5%	100.0%

The younger age cohort utilisation pattern demonstrates:

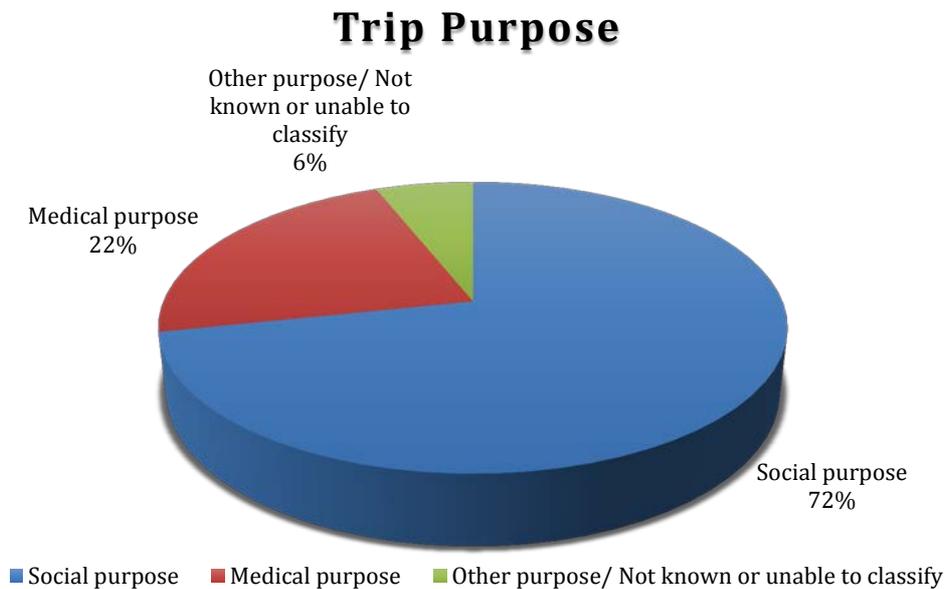
- A more even distribution of trips across the three regions;
- Slightly lower use of group transport overall; and
- The North West demonstrates a much higher use of group transport for younger HACC clients.

This observation may arise from the service profile available to younger people, in particular differences in the service mix to clients with, for example intellectual disability.

Who Uses HACC Community Transport and Why

In broad terms HACC community transport is categorised in the survey as either social or medical. Contributors to the consultation process perceive an increase in the number of medical related transport, however as a proportion of all trips medical transport remains consistent with the 2006 survey as identified in Fig (7).

Figure 7. Trip Purpose 2013



Social community transport is the dominant purpose, it should be noted that this category includes shopping activities, and business activities associated with living independently.

Figure 8. Number of Trips by Purpose and Region

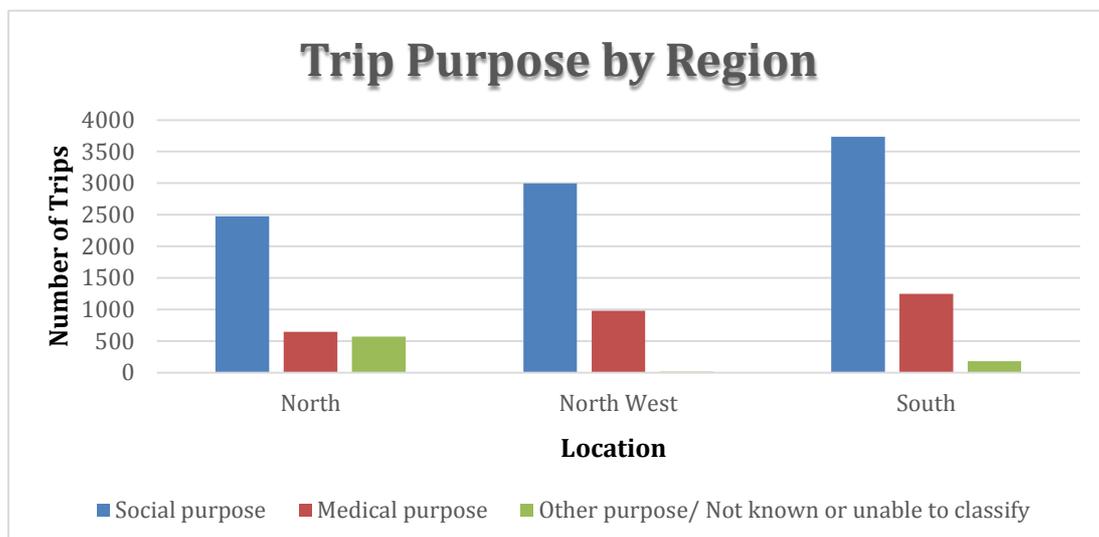
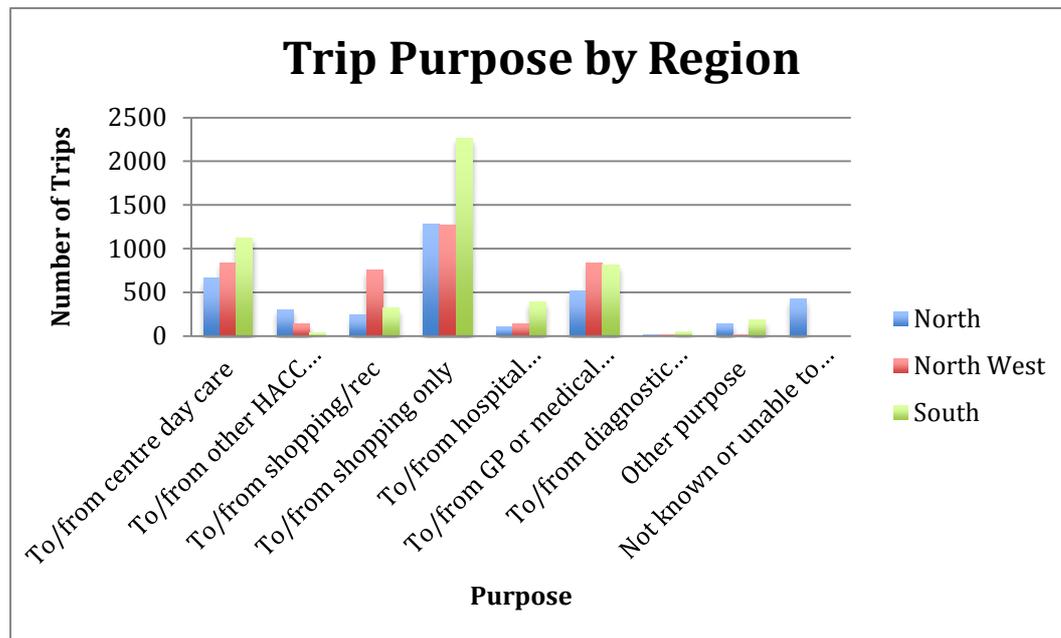


Figure (8) indicates the ratio between social and medical trips is similar between regions. Figure (9) provides a further level of detail by disaggregating the social and medical categories into sub-categories.

Shopping is a significant activity and its importance as a determinant of independence is shown in Fig (9) by the number of trips. Interestingly the similarity between GP/Medical and Day Centre as equal second “trip purpose” are reflective of the key health and social wellbeing determinants.

Figure 9. Detailed Trip Purpose by Region



When compared with the 2006 results significant change is identified.

Table 8. Trip Purpose Comparison 2006 to 2013

Trip Purpose	2006 %	2013 %
To/from centre day care	39.6	20.3
To/from other HACC service	0.2	3.7
To/from shopping or recreation	20.3	10.2
To/from shopping only	7.4	37.4
To/from hospital outpatient clinic	9.1	5
To/from GP or medical specialist	13.6	16.8
To/from diagnostic services (X-Ray, Blood Test or Pharmacy)	1.8	0.6
Other purpose	7.6	2.6
Not known or unable to classify	0.3	3.3
Total	100	100

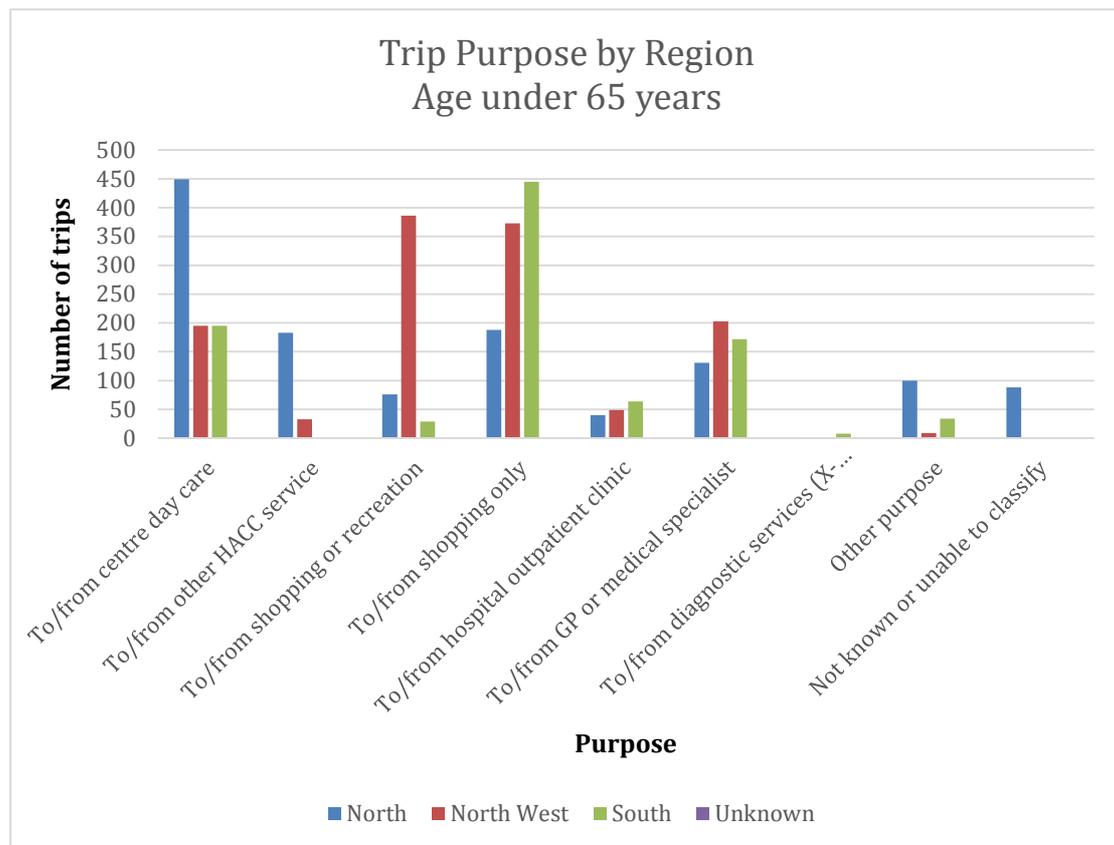
Day centre trips have declined significantly, as have shopping/recreation combinations whereas trips specifically for shopping have increased. As a percentage of trips by purpose; there is little significant

alteration in the proportion of medical trips; however, the distribution between the purpose of visited sites has shifted marginally between outpatient clinic and visits to GP/Specialists.

Slightly more than 40% of clients using HACC community transport required assistance to complete the trip, a significant increase from the 30% identifying the need for assistance in the 2006 survey.

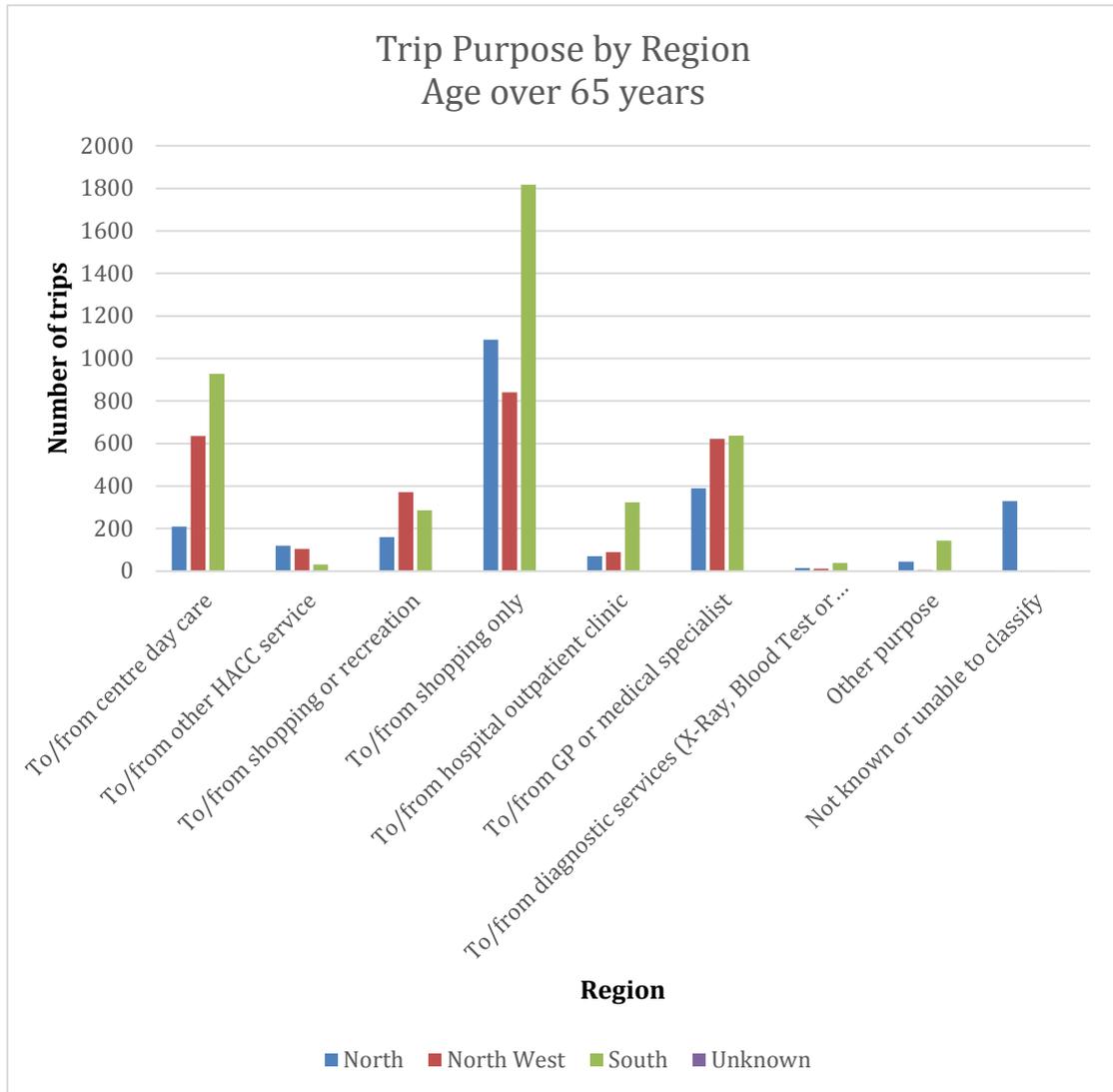
Again it is important to identify whether there is a difference in “trip purpose” between the two population age cohorts. The trip purpose by age cohort by region is identified in Figs (10) & (11).

Figure 10. Number of trips by purpose by region for younger cohort 2013



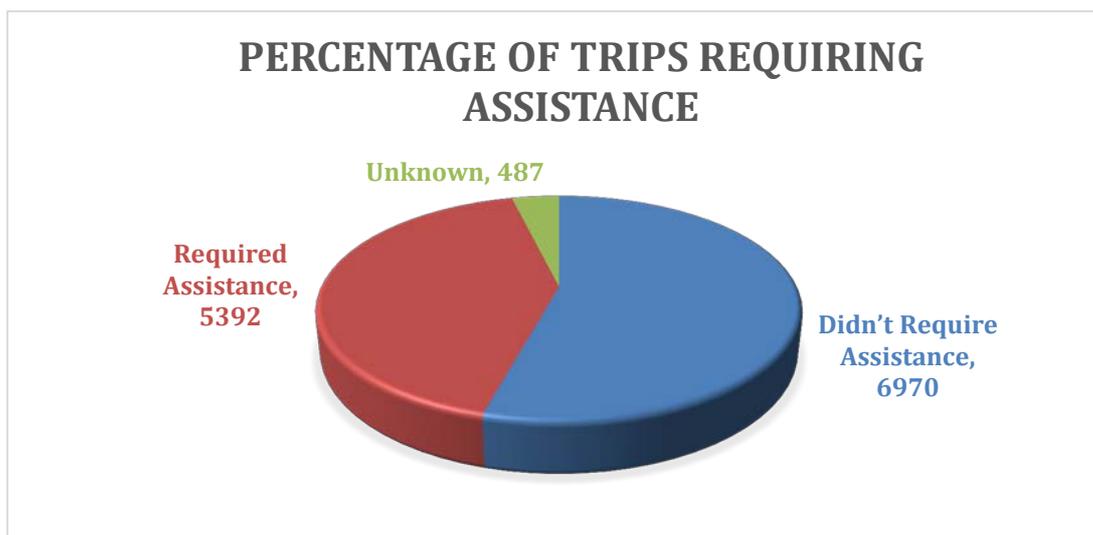
The two figures contain information that highlights the differences between trip purpose between the two HACC population cohorts and the sensitivity of purpose to the service availability. Clearly shopping is important for all groups, particularly across the southern region, however again, the day centre travel for the younger cohort in the North West is identified as a key determinant of travel purpose.

Figure 11. Number of trips by purpose by region for older cohort 2013



Of great importance to the HACC community transport program is the need clients have for assistance with their travel. Figure (12), identifies the proportion of trips where the client (from the total sample) required assistance. The data is later disaggregated into the younger and older HACC age cohorts.

Figure 12. Percentage of Trips Where Clients Require Assistance



This assistance, whether it be companion or carrying groceries is critical, it allows people to undertake daily living tasks outside the home and to access support services designed to enhance physical and social wellbeing.

Table 9. Detailed Trip Purpose by Assistance Required and Comparison 2006 to 2013

Trip Purpose	% of under 65 years old Requiring Assistance 2013	% of 65 years old and over Requiring Assistance 2013	% of Clients Requiring Assistance 2006	% of Clients Requiring Assistance 2013
To/from centre day care	34.7%	70.8%	40.9%	59.2%
To/from other HACC service	16.6%	52.7%	68.8%	36.2%
To/from shopping or recreation	46.8%	58.7%	26.6%	54.3%
To/from shopping only	57.9%	49.6%	50.2%	51.3%
To/from hospital outpatient clinic	2.0%	2.5%	13.6%	2.4%
To/from GP or medical specialist	13.8%	16.1%	11.4%	15.5%
To/from diagnostic services (X-Ray, Blood Test or Pharmacy)	9.1%	16.7%	9%	15.6%
Other purpose	20.3%	45.6%	23.2%	34.9%
Not known or unable to classify	0%	3.5%	73.9%	2.8%
Total	35.9%	44.2%	30.5%	42%

There is a clear demonstration of the different need for assistance between the younger and older HACC cohorts, in particular for travel to HACC services and for medical purposes.

People using HACC community transport for social purposes are identified as having a significantly higher need for assistance (50 % approximately) compared with those travelling for medical purposes, (approximately 15 %). Day centre and shopping clients group contain a significant proportion of

clients over 80 years of age. Between 2006 and 2013, the proportion of clients requiring assistance has increased from 30.5% to 42% of clients.

Where do People Travel to and Why?

The major HACC community transport client destinations are mapped in Figure (13). The top five HACC community transport client destinations identified in Figure (13) and as measured by number of client trips in descending order are Launceston, Devonport, Hobart, Burnie and Glenorchy, Tasmania's major urban and service centres. To compensate for the "clustering effect" (town/suburbs where there is a large population of the HACC target groups), the following analysis identifies trips "within" the destination (where the origin and destination are the same town/suburb and "between" where the origin and destination are a different town/suburb.

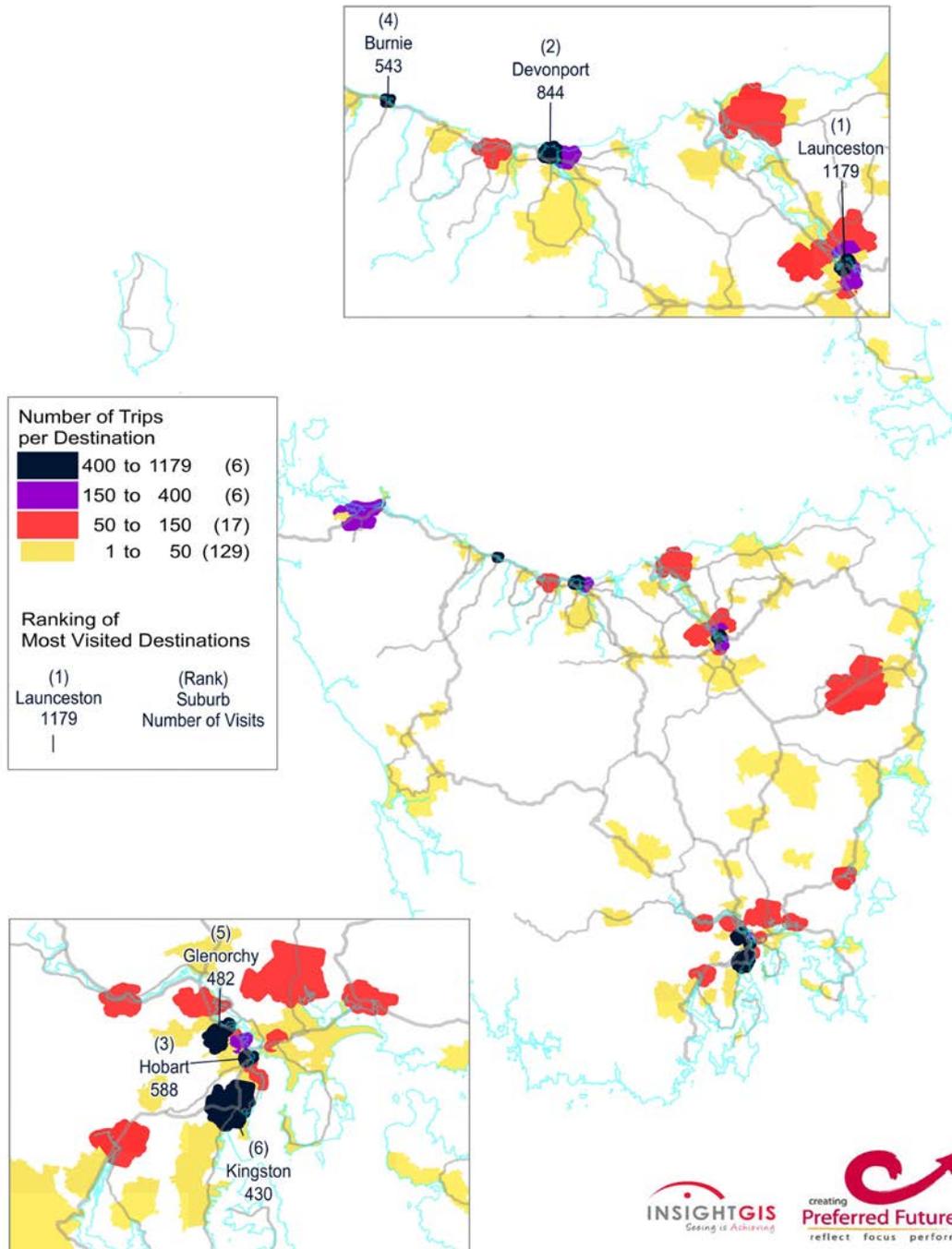
To provide additional information each of these major destinations has been analysed to identify:

- The major origin location – trips to the destination from both within the location itself and from outside the destination; and
- Primary purpose of the trip – medical or social (in some instances the "trip purpose" was not provided as a consequence of ensuring the total trips were recorded).

This more detailed analysis indicates different characteristics in terms of proportion of local and longer distance travel. However it is apparent from the broader analysis that as distance of trip increases, it is more likely to be for medical purpose.

The maps provide a mix of information. The spatial or "map" representation identifies the origins of trips to the destinations, locations represented by the darker shade indicates it as the origin of more trips and is defined in the gradient scale, lighter shading represents a low number of trips from that location. The small table inset identifies the number of trips from the major origins by medical and social purposes. To complete the picture, the total number of trips to the destination by medical and social purpose is included in the "pie chart".

Figure 13. Major Trip Destinations – Ranked (1) to (6) by Number of Trips



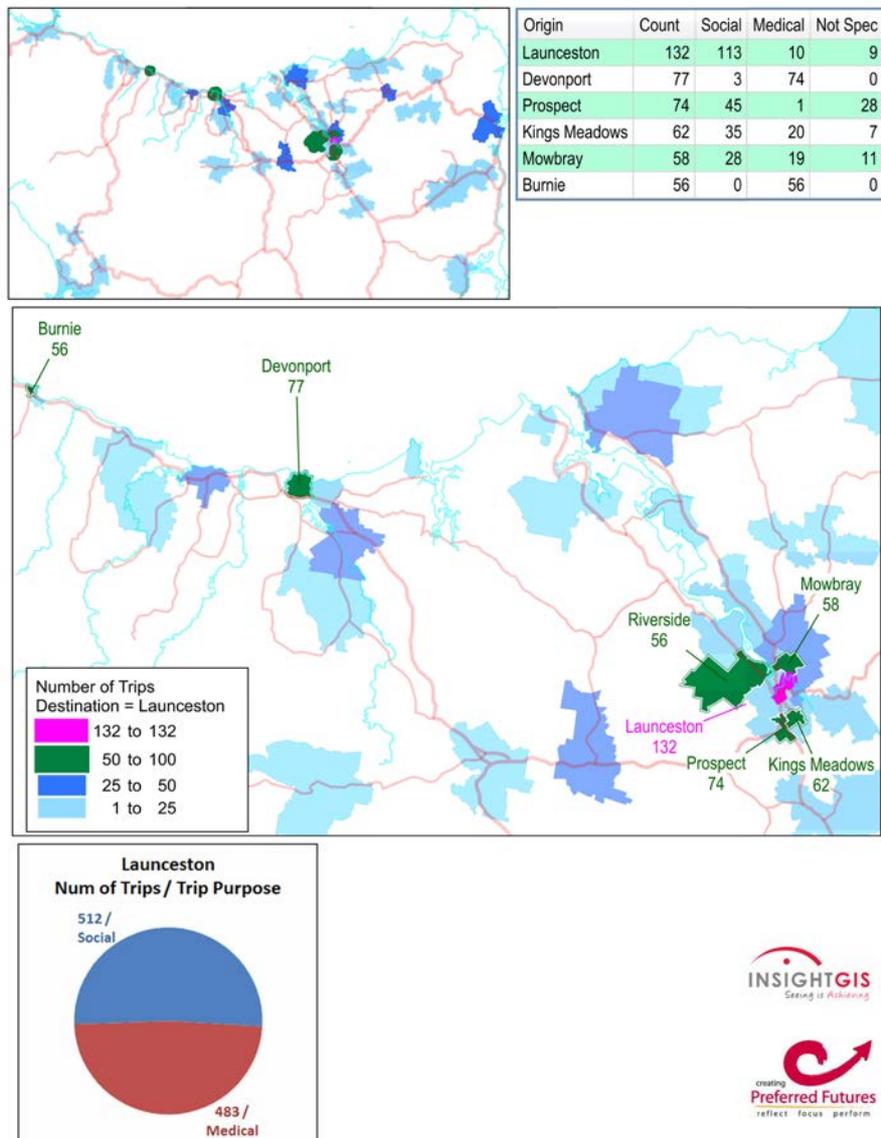
Origins and Purpose of Trips to Major Destinations

For each of the major destinations, the trip origins have been identified and mapped, the maps are ordered by ranking.

For Launceston; of the 1179 community transport trips, 132 are from within Launceston; the other major origins of community transport trips to Launceston are Devonport, Burnie and adjacent Launceston suburbs. Although the purpose of trips to Launceston is generally evenly split between social and medical, the trips from Devonport and Burnie are dominated by medical trips. Adjacent locations tend to reflect a significantly higher social purpose than medical.

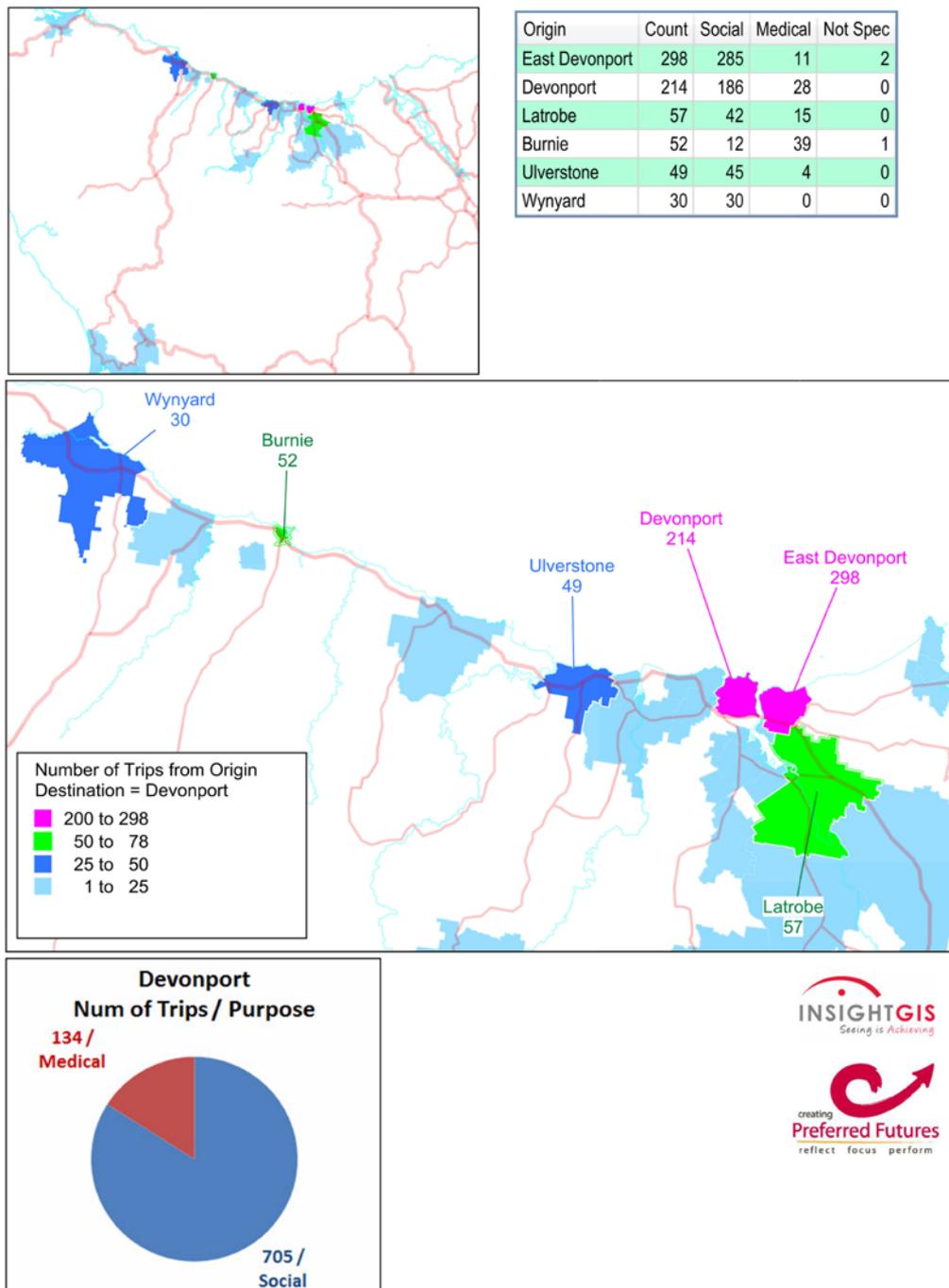
As shown in figure (14), there is some HACC community transport to Launceston from as far afield as the west coast of Tasmania, Wynyard and other rural centres surrounding Launceston.

Figure 14. Launceston Trip Origins and Purpose



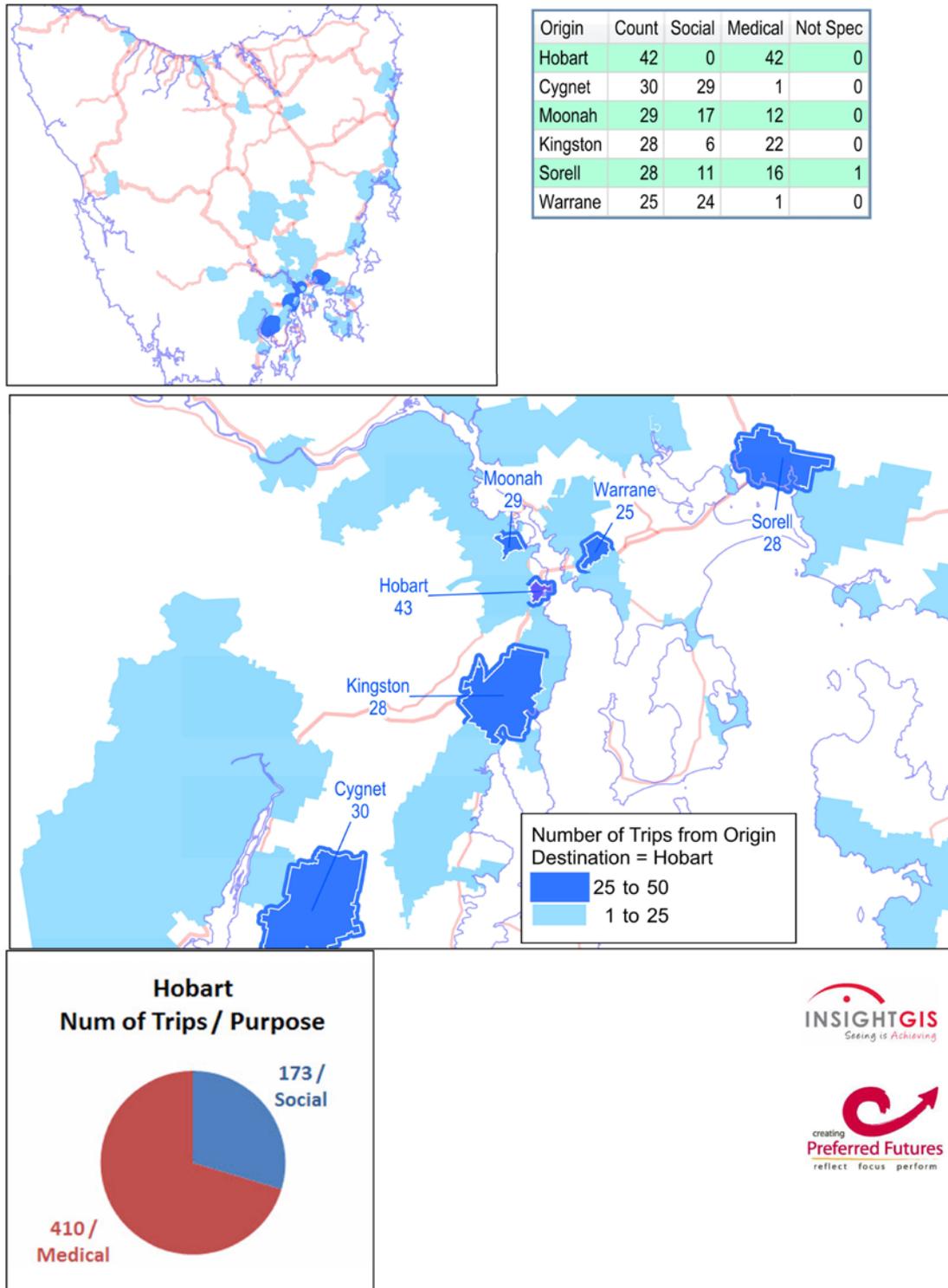
Devonport is the second most popular destination. While the majority of community transport trips are within Devonport and primarily social in purpose, there is a significant level of travel from other north-west coast settlements, again primarily for social purposes. Travel from Burnie is the exception showing significant HACC community transport for medical purposes. In overall terms Devonport is dominantly a social trip destination. Examination of figure (15) highlights visits from Wynyard, circular Head and the west coast.

Figure 15. Devonport Trip Origins and Purpose



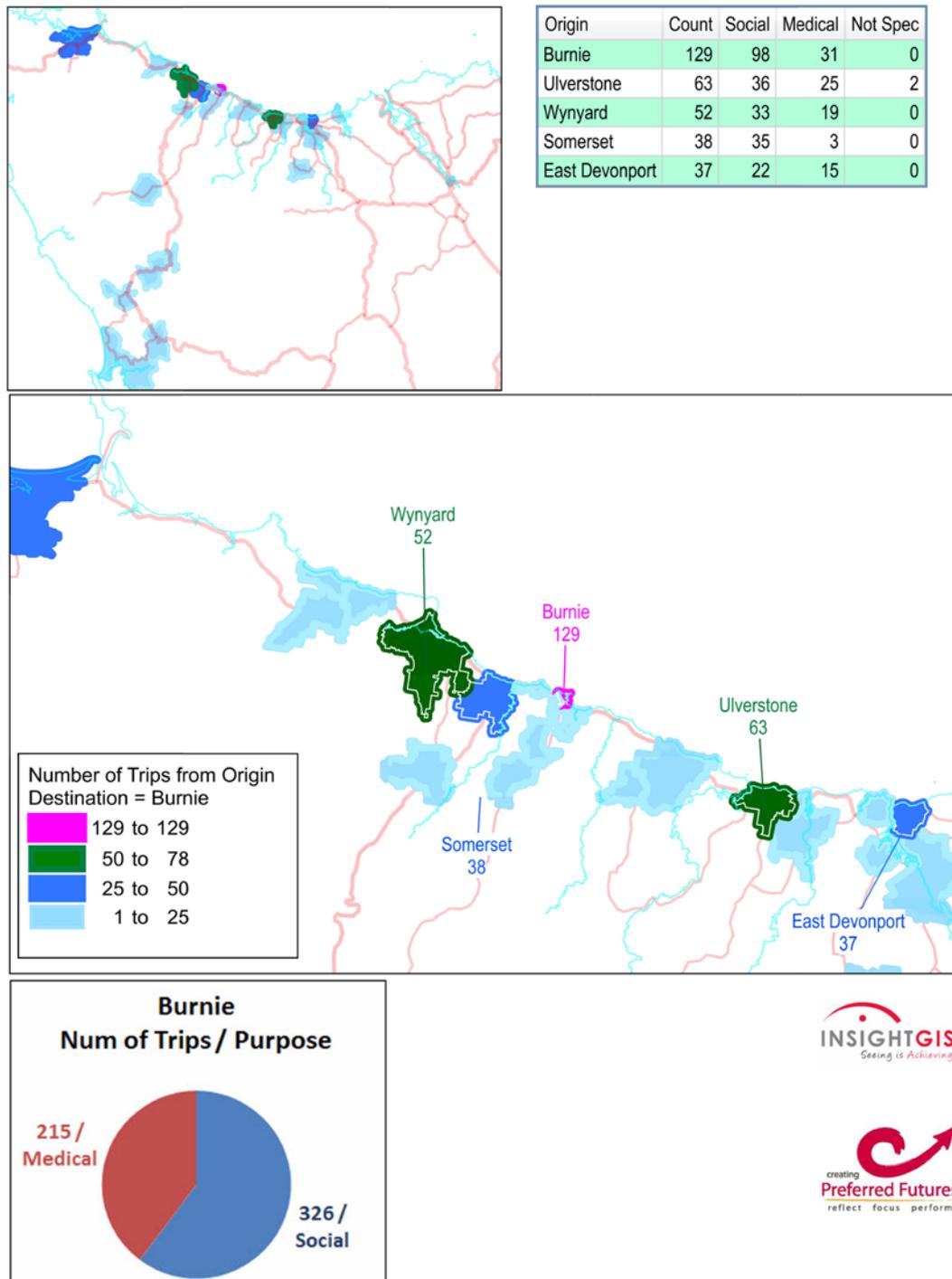
Hobart reflects a different pattern for trip purpose, dominated by around 70% medical travel. There is little travel from within Hobart and a significant spread of origins, although slightly dominated by a cross axis ranging from Sorell to Cygnet.

Figure 16. Hobart Trip Origins and Purpose



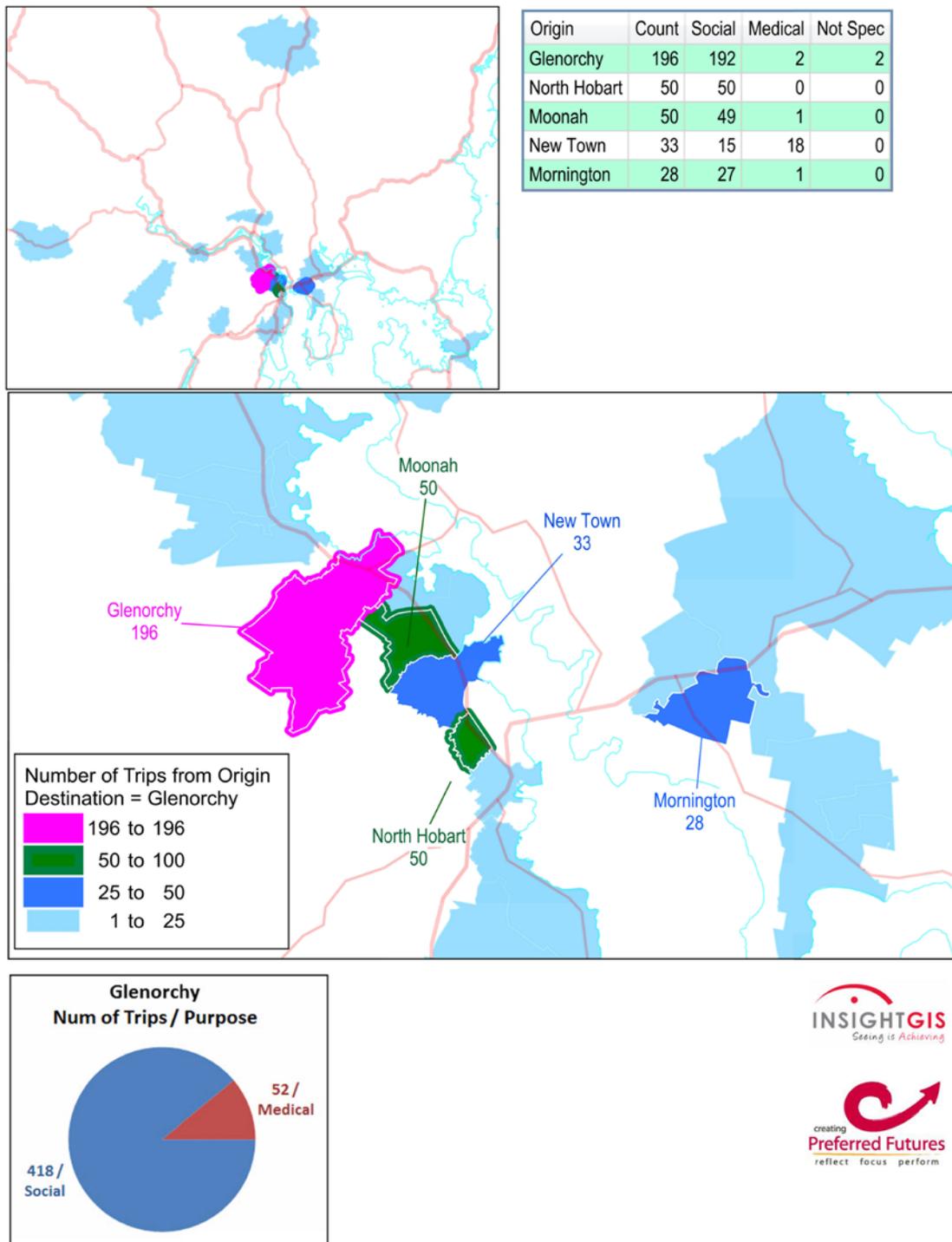
Slightly over 20% of trips to Burnie originated within Burnie, with the balance tending to be derived from adjacent north west coastal towns and the west coast. Burnie also shows significant transport movements within its boundaries; 240 of 719 HACC client visits, with a significant number originating from the towns spread along the coast and places wider afield such as the west coast (see smaller inset). The trips from within Burnie tend to represent a much higher level of social categorisation than medical, with around 30% of the externally sourced trips reflecting a medical purpose.

Figure 17. Burnie Trip Origin and Purpose



Glenorchy demonstrates a relatively high level of transport within its boundaries and although it attracts people from around the Derwent Valley and Southern Midlands, the key origins are adjacent suburbs. Glenorchy visits are predominantly social in purpose.

Figure 18. Glenorchy Trip Origin and Purpose



HACC NON-EMERGENCY PATIENT TRANSPORT (NEPT)

This service caters to the needs of disadvantaged HACC clients who, due to prohibiting factors such as mobility, are not able to use conventional HACC community transport services.

The following provides a summary profile for patients of both HACC age cohorts during April 2013.

HACC NEPT allocation is designed to ensure that the most appropriate and lowest cost transport option is provided and includes travel to, from and between DHHS facilities.

Over the survey period Ambulance Tasmania delivered the following profile of services to HACC eligible clients.

Table 10. NEPT Age Profile

Age Cohort	Client Numbers in Tasmania				Percentage of Total Clients			
	Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
0-49	11	16	0	27	1.9%	2.8%	0.0%	4.7%
50-64	30	8	0	38	5.2%	1.4%	0.0%	6.6%
65-79	68	72	0	140	11.8%	12.5%	0.0%	24.3%
80+	100	86	1	187	17.4%	15.0%	0.2%	32.5%
N/A	156	27	0	183	27.1%	4.7%	0.0%	31.8%
Total	365	209	1	575	63.5%	36.3%	0.2%	100.0%

Given the charter under which Ambulance Tasmania operates, as expected the most significant origins and destinations are locations from which medical campuses and care facilities operate. This is highlighted in figures (19) and (20), most trips originating from a campus location, with mirroring destinations.

Figure 19. NEPT Origin of Trip

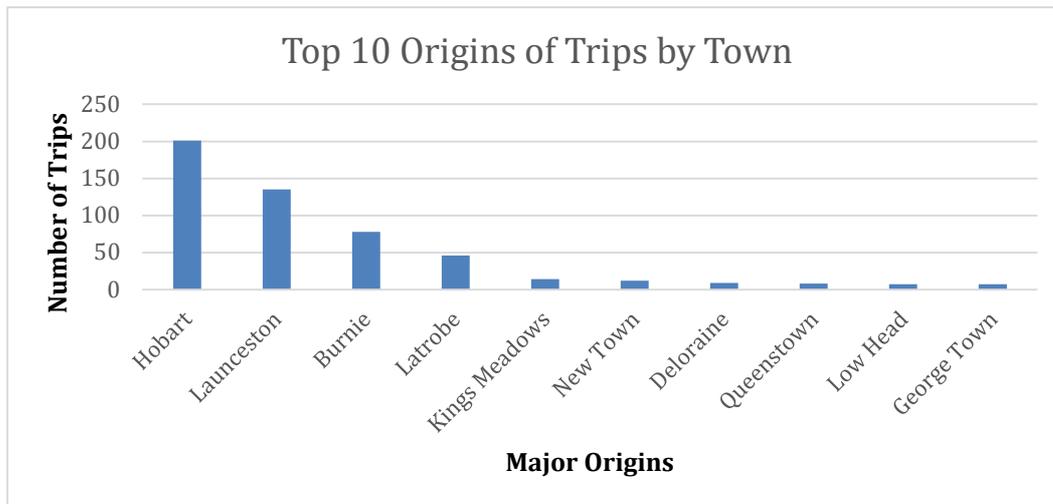
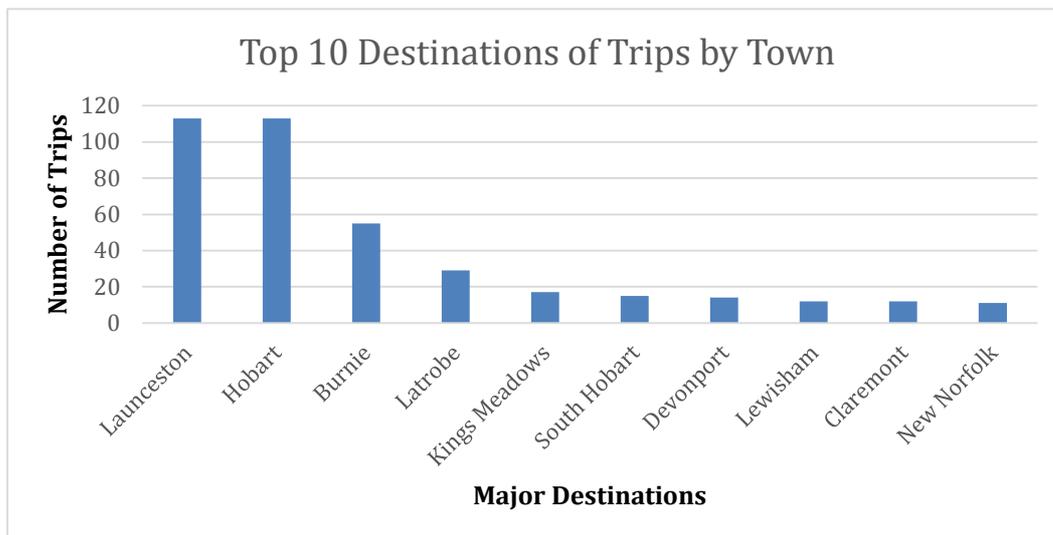


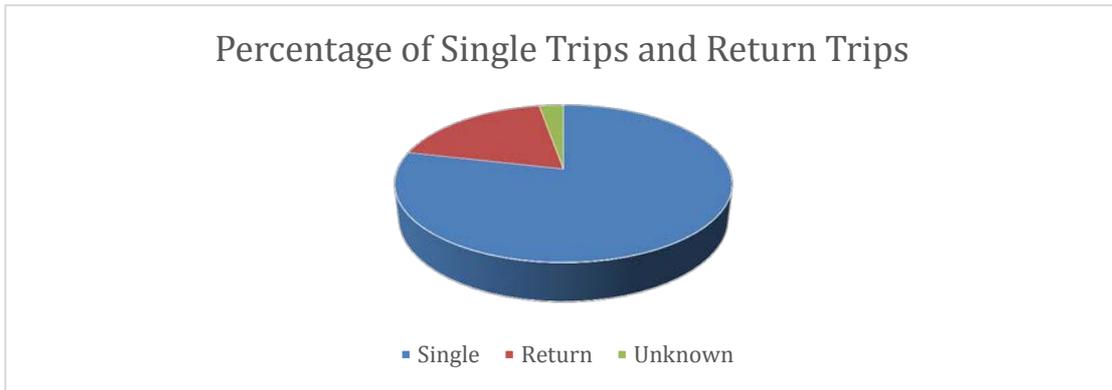
Figure 20. NEPT Destination of Trip



Both tables represent significant intercampus travel and then a significantly dispersed profile of origin and destination of locations reflective of low care centres (origins) and residential locations (destinations).

As indicated in Fig (21), the majority of trips are single direction, rather than return – a significant difference between HACC NEPT and HACC community transport. It should be noted that HACC NEPT trips can vary significantly from month to month; given this variation in combination with low numbers, an analysis of age by origin/destination was not performed.

Figure 21. HACC NEPT Percentage of Single Trip and Return Trips



HACC COMMUNITY TRANSPORT CHALLENGES

The consultation and data support the view that the community transport system, including the HACC funded system works, in that it ensures people reasonable access to support and services essential to enabling the choice to live “at home”; however it will need to work more effectively and efficiently if the ageing and younger disabled population is to be afforded appropriate access. Actual penetration of the potential “market” for transport support is very low (see Figure (3) and Figure (4)).

A key lesson from this project is that to a degree, HACC community transport works because organisations adapt to circumstances as they arise to seek positive outcomes for clients. In other words, service providers are acting in the solution focussed, flexible manner the program seeks. HACC community transport vehicles are operated by HACC service providers funded by the Program. Some service providers do not operate vehicles for some or all of their programs and utilise other HACC funded community transport providers and options such as vehicles provided by community and local service clubs. In other instances service providers utilise volunteer, employee and general operating vehicles as well as commercially provided taxis and buses.

The preceding transport profile provides a demonstration of use patterns and fit to demographics in broad quantitative and spatial perspectives. It does not however provide insight into the way in which the HACC community transport system works, its challenges and how the system adapts to meet client needs and social enterprise outcomes.

The following is presented to provide some insight into these challenges; how providers adapt, the consequences of these adaptations and suggested means to address potential adverse consequences.

HACC Service Providers

HACC clients access community transport services through a variety of means. This can be through direct contact with a funded community transport provider or through their existing HACC service provider requesting transport on their behalf from a funded community transport provider. Some providers also enable transport of their clients by their own workers with a kilometre reimbursement payment from the client.

There are also circumstances where the most appropriate vehicle (or a volunteer) for the purpose is not available and organisations create “work around solutions”. It is important that service providers are innovative and flexible in delivering services, however at times these responses have potential adverse consequences; namely the benefit (cost savings) to a transport provider of having less than optimum vehicles for the designated purpose is potentially outweighed by increased direct and indirect costs to HACC service provider organisations and HACC clients. Day Centres provide an example of this consequence:

“Day Centres are an important element of the support continuum, acting as a location for a wide range of support services as well as a “hub” from which outings and/or people are able to then undertake activities such as shopping. The period of time to transport and support clients is identified as quite small. The inability to access a bus that can both carry a significant number of clients and store wheelchairs and frames results in multiple trips for a smaller bus and/or the use of cars driven by support workers, subsidised use of taxis and at times nursing staff to transport clients to and from centres”.

Southern Day Centre Forum

Such adaptive practices have a range of potential consequences:

- clients are waiting in the centre for others to arrive before activities are commenced and the time given to active support is decreased overall;
- the average cost of transport increases by choosing to use higher value labour content and more trips for each group;
- the cost of transport is transferred to another support program because staff are diverted from core roles;
- the ability for other clients to access services such as nurse support is reduced as the transport activity is displacing another service/client interaction, and
- Day Centres are potentially less able to achieve their target utilisation rates due to logistical inefficiencies and increased transport costs, which in conjunction with the introduction of capping to service numbers, means that “new eligible” people cannot access the service.

Both Day Centres and Specialist Clinics bring people to a central facility for a support service or intervention that is generally scheduled on specified days each week between certain hours. Organisations such as the Cancer Council have addressed this specific transport need to create both a relatively efficient system and importantly one that is based on an understanding of client need and the characteristics of the service provider. Ambulance Tasmania NEPT reflects the same model with the transfer of non-emergency patients to, from and between medical facilities. In the context of a younger disabled and ageing population, the centralisation of procedures at specific campuses and the emergence of private clinics with particular areas of speciality, together with contemporary “outpatient” treatment regimes, leads to a conclusion that “patient” access could be considered as part of the clinic’s value proposition to their client base – a bundled service combining access, support and treatment. This option has both potential social and commercial benefits; it can provide appropriate transport and companion service while ensuring that the return on investment in transport is attractive in comparison to the establishment of satellite clinics. The funding of appropriate vehicles to optimise the effectiveness of day centre interactions with HACC clients is important to consider; the challenge is in reducing the transport and waiting times for clients and increasing the activity and social support time.

The day centre is one example of the challenge that faces all services in a rationed system; how to optimise the HACC community transport interaction to facilitate the required HACC outcomes.

The day centre example may be interpreted to reflect a HACC community transport system that is characterised by:

- Perceived/assumed lack of efficiency;
- Some hidden cross subsidisation although this is essentially program funded; and
- Service provider difficulty in meeting the needs of clients and potential clients.

However, the day centre example also highlights the adaptability and innovation of organisations operating within the HACC system, the mix of community transport options that can be utilised; albeit in this instance not necessarily conducive to overall client outcome and efficiency principles. The day centre example further highlights the need to identify critical elements of the HACC client community transport support system where the appropriate vehicle configuration and the business systems to place it appropriately should not be compromised and within which other transport options and models should be considered.

In part, the deficit situation arises because the internal decision making for significant fleet capital and recurrent investment is made on organisational financial parameters rather than broad benefit/cost analysis or social return on investment principles. Decisions to alter or change access to HACC community transport by providers and/or funders should be made in the context of the flow-on costs across the dependent organisations and communities – the impact of capital decisions on client outcomes. This is not an argument for inefficiency; rather it is one to support the productivity of the HACC program in light of the macro challenges facing Australia as a consequence of an ageing population. Narrow decision parameters will arguably work against the productive achievement of client outcomes. The framework for this benefit/cost analysis are defined in the context of client outcomes achieved (or conversely foregone) when a particular investment is made (or not).

Service providers use a wide range of mechanisms to manage both unmet demand and the event of an unplanned incident during a trip or an immediate transport need. The Wattle Group for example provide clients with vouchers for taxi usage which are redeemable from the group by the taxi firm. Contributors to this Report identify some taxi usage, however they also express concern that the cost of such usage erodes the capacity to meet their nominated target client numbers. The level of taxi subsidy use was not captured in this Project.

Some services provide needs based HACC community transport on weekdays within business hours, others include out of hours support. This variation between models is potentially also linked to the relative isolation that characterises HACC community transport providers. While there are significant linkages between HACC service providers, those providing transport do not appear to have an understanding of the capability profile of other providers and little collaboration appears to exist between them. This lack of understanding extends to both fleet profile and the level of service they are able to provide as a consequence of the capacity of their volunteer drivers.

The regional HACC forums have not been a mechanism utilised to address HACC community transport challenges and to strategically consider the role of community transport in enabling HACC client outcomes. This is considered to be a two part challenge; the communication, focus agenda and the apparent tension between service providers and business decision criteria.

Community Transport Providers

Two service providers are HACC funded to provide HACC community transport exclusively, Community Transport Services Tasmania (CTST) and the St Helens Community Car Group. There are a number of other larger HACC community transport providers that receive funding for transport and other HACC service types such as the Wattle Group, Mersey Community Care and Launceston VFC Services.

The profile of the service provided by these organisations is identified in Table (11).

Table 11. Major Transport Provider Summary Profile

	All Clients		65yo and over clients		clients under 65 yo	
	No of Trips	% state total	No of Trips	% state total	No of Trips	% state total
CTST	55478	23.4	46793	25.7	8685	15.9
Wattle Group	16597	7.0	5759	3.2	10838	19.9
Mersey Community Care	13532	5.7	9520	5.2	4012	7.4
Australian Red Cross	12713	5.4	9023	5.0	3690	6.8
Launceston VFC Services	9546	4.0	8146	4.5	1400	2.6
Total for 5 Providers above	107866	45.6	79241	43.5	28625	52.5
Total for balance of providers	128872	54.4	102962	56.5	25910	47.5
Statewide Total	236738	100.00	182203	100.00	54535	100.00

Source 2011/12 HACC Minimum Data Set (it is important to note that the MDS has a number of caveats as per the Annual Business report).

Major service providers account for around 46% of all trips, with a slight variation of distribution between younger and older cohorts, therefore a high degree of transport is provided by other providers.

Most HACC community transport providers operate within a region or area. Two operate statewide, Red Cross and CTST. The provision of transport in light vehicles occurs efficiently and relatively effectively within the current HACC management and funding model. The same does not appear to be the case for the provision of larger vehicles.

CTST for example, offers a statewide service with a fleet of 66 vehicles located in areas of demand, coordinated by eight part-time staff and by local council staff on the West Coast. CTST is the largest HACC community transport provider in Tasmania, providing 23.4% of all HACC community transport

trips (2011-12 MDS Reported Data) within Tasmania. CTST represents a transport provider model that interfaces with individual HACC clients and through other HACC organisations to eligible clients. CTST is subject to criticism from other providers in terms of service delivery when they are unable to access transport for their clients in a vehicle that the service provider sees as best for their client group. These “shortcomings” are recognised by CTST, (CTST Annual Report 2011-12. The manner in which larger vehicles are provided and the associated decision model could be reviewed.

As strategic changes both within the program and in the current transition phase are considered, the specific challenge of providing larger transport vehicles must be considered from the perspective of optimising client outcomes and ensuring productivity.

One example of adaptation is where CTST is trialling and investigating options in relation to “partnering” with enterprises within the public transport network and also considering a range of business models that, for example, better align the specialist clinic, the client and transport. This is an example of working from the destination/purpose back into the community catchment, as highlighted in the “Cancer Council” transport model. This does not preclude the vehicles location in the catchment to achieve logistical efficiency, indeed it combines this with ensuring the vehicle type and service characteristics match the need of the client. The enterprise is also actively trialling trunk route options with commercial bus providers as an option to increasing both service and efficiency. From a HACC Program perspective it is important to ensure that the needs of HACC clients take priority in this model.

Some other services, such as the Wattle Group and Mersey Community Care have developed specific responses to meeting needs by using other vehicle access options, for example redeemable vouchers, ad-hoc access to mini buses through hire car firms, however these do not necessarily address the challenges of providing larger, high capital vehicles that may also need drivers with particular licencing.

The transition to Federal funding for the aged population may provide the opportunity to develop a solution to ensure a fleet profile that is more capable of efficiently meeting specific service requirements such as the Day Centres noted earlier. Notwithstanding the funding challenges, it is considered important that all HACC community transport providers are connected to broader service providers in terms of strategically considering the changes in demand and service requirements of the client group, not only from an efficiency perspective but also in terms of meeting client outcomes and minimising the potential adverse outcomes identified. The use of benefit/cost analysis to optimise the fixed and recurrent costs around such models is an important measure to ensure enterprise and service viability.

Fleet

The fleet profile is identified as 'critical' by providers to the delivery of the necessary mix of efficiency and desired client outcomes. While it is acknowledged that *"there is no ideal vehicle"*, providers identify a transition to, for example Subaru Foresters, as a positive option given both the height of the vehicle and the extra door width to allow ease of entry and exit for clients. Day centre operators identify their ideal vehicle as a bus with around 14 seats, 2 wheelchair fittings, walker storage and appropriate lifting and access facilities, (the ability to achieve this optimum from a supply and regulatory perspective is unknown). This is an important consideration given the proportion of day centre clients requiring transport (and assistance) to participate in programs. It is of interest to note that many bus companies use a combination of bus and trailer to optimise passenger and luggage capacity and this might be something for HACC community transport providers to consider further.

Specific issues raised by contributors relating to the interface between the HACC community transport system and the commercial sector include:

- An increasing need for wheelchair access vehicles as in taxis;
- The need for affordable non HACC community transport options; and
- The need for a range of options in vehicle type, including accessible vehicles for those who need additional care.

The separation between the HACC community transport system and private providers is highlighted by the lack of integration between wheelchair accessible taxis (WATs) within the HACC community transport system. Within the metropolitan area the number of WATs has increased, however collaborative arrangements between the HACC system and private providers do not appear to have emerged as a means to optimise transport options. The development of (and use of existing) subsidy mechanisms and access to them by the HACC client group is of strategic importance if the mix of assistance options is to extend into the private sector as a means of meeting demand and increasing choice.

Volunteers

The HACC community transport system is highly dependent on volunteer drivers. Providers indicate mixed observations in relation to their ability to maintain the necessary volunteer pool; while some providers have a pool of 120 volunteers, 10 may operate on a daily basis and of the 120, only 30 may be frequently engaged.

Facilitating HACC client access to a transport interaction that achieves the necessary outcome has a level of complexity not found in the transaction that forms the basis of public transport. Contributors indicate that in some instances it is important to match the volunteer driver with the client characteristics and needs. This can relate to matters such as:

- The existence of clients with more complex needs and volunteer training to address and mitigate the associated risks;
- The potential health needs of a client on a return journey from medical treatments such as dialysis, and
- The volunteer's capacity to provide the necessary accompaniment support.

It is further identified by service providers that the match between vehicle characteristics and the client is critical; for example some clients are only able to use the front seat in particular vehicles.

The relationship between HACC community transport and the public transport regulatory system, including licensing, is an additional overlay to the attraction and retention of volunteer drivers. Discussions identify potential volunteer sensitivity to any need to gain licenses or certification; it was articulated by stakeholders in the consultation process that this could be a barrier to volunteering.

The following observations were made during the consultation process in relation to volunteer welfare:

- It is imperative to look after volunteers, issues such as the number of hours worked and long distances travelled were noted;
- The HACC volunteer workforce (like others) is ageing, consideration should be given to their physical capability and preparedness to support clients with higher levels of need;
- Circle of benefit (reciprocity) - there are benefits to both volunteers, the client and the organisation;
- Drivers are volunteers and not trained as carers, but expectations on the volunteers may be high;
- Volunteers require support and training; and
- Volunteer drivers may not be able to manage walking frames in and out of the vehicle, be able to safely store them (volunteers are often aged and there are Workplace Health and Safety issues to be considered), and as such a client's need for walking aids may form a barrier to community transport.

Workshops included key discussion around the optimum use of both volunteers and paid staff and identified issues such as:

- Potential differences between paid and volunteer staff in terms of work relationships (a matter of reality as opposed to formal relationships with respect to volunteers).
- The ability for a HACC service to request a suitable bus with the choice of supplying a paid or volunteer driver, who has local knowledge and is “a face” familiar to the clients.

HACC providers perceive a number of compliance factors potentially affecting volunteer recruitment and retention:

- The process for mini bus licencing is considered intimidating and costly;
- Limits on insurance for the >70 year olds was raised as discriminatory; and
- For the >55 age group, 15 hours volunteering per week negates the need for them to apply for 4 jobs per fortnight to retain benefit payment.

The degree to which these barriers and opportunities are limiting volunteering is untested, however, they are indicative of the complexity of the overlays that effect volunteering and the use of volunteers as a resource. The volunteer network is critical for the success and viability of the HACC community transport system. Contributors identify the need to apply the same principles to their interaction with volunteers as to the client base, respectful and needs based. Arguably this applies equally to expectations and safety; it is concluded that the HACC community transport system needs to carefully review and articulate its expectations of volunteers.

ACCESS & COORDINATION

A major component of this project was to test Recommendation 53 of the Banscott Review (2006),

“That the allocation and dispatch of community transport for the Tasmanian Cancer Council, the Red Cross, CTST and other HACC-funded non-government agencies be coordinated from the central Communications centre, and that a Community Transport Manager be appointed to the Communication centre to ensure an appropriate interface between the Centre, service providers, and DHHS.”

The central communications centre referred to in Recommendation 53 was that proposed in recommendation 41 to 52 of the report.

A number of providers in Tasmania and nationally are grappling with the topic of community transport for their client group. In Tasmania, the Council on the Ageing (COTA Tas) developed a position paper in 2013 “Addressing Transport Issues for Older People” which discusses the Banscott recommendation and concludes against this centralised coordination recommendation.

The value of local coordination was a strong theme raised by HACC providers throughout the consultation.

There is a mix of transport coordination currently occurring within the system; local as it relates to HACC service providers coordinating their fleet and on a subregional basis with CTST coordinating on a 5 day, limited availability basis from 9 locations (including the West coast). On a broader scale, TasCarepoint provides a centralised referral point for people seeking HACC services and HACC service providers. As recommended by Banscott to achieve service coordination improvements, Ambulance Tasmania coordinates transport from a centralised location; it is arguable that this patient transport is different to the large proportion of HACC community transport.

The quantitative and qualitative information contained in this report provides the context to the analysis of the Banscott recommendation relating to HACC community transport.

The “centralised” business model, while not explicitly identified as a rationale within the Banscott Review is a traditional business model approach designed to achieve capital and process efficiency through scale and standardised process. This approach is demonstrated in the growth of call centres as a sales and communication business model. They are particularly suited to standardised transactions in terms of both product and “script”.

It is important to determine the coordination factors within the HACC community transport system that warrant change from the current system and the “fit” to the Banscott Review recommendation.

The preceding review and analysis within this report identifies that a part-time coordination model, a situation driven by cost structures within a particular funding/business model, is unsatisfactory in terms of providing access to queries later in the day and in the event of an incident or change. Some

HACC service providers that include community transport as a component of their service profile provide out of hours back up contacts and response protocols in addition to full business hours service.

HACC community transport reflects a mix of long term regular transport provision such as weekly shopping and periodic medical appointments or day centre access with only marginal differences in demand from the two HACC age cohorts. Alongside this scheduled access is the necessity to accommodate “new” client needs and short notice requirements. The necessity to actively and promptly manage “problems” as they arise within the HACC community transport sector with a focus on achieving safe client outcomes is viewed by contributors to the discussions as a critical dimension of transport management and is argued by HACC service providers as an activity that should be localised.

The coordination issue was a core element addressed within the consultation process; contributions from stakeholders are summarised below:

- There may be cost benefits to centralised coordination but these may be associated with a decrease in client choice;
- HACC community transport is a multi-dimensional issue; it is not just about efficiency but critically about achieving necessary and defined client outcomes;
- It is easier to talk to clients within their region with local knowledge and rapport where the client knows who they are talking to;
- Last minute requests and crises are better handled locally;
- Centralisation does not reflect the needs or connections of clients;
- An example was outlined where a local volunteer was appointed as the ‘go to’ person for a remote area and the number of trips increased;
- The local ‘go to’ person can provide information; promote other services, support and coordination with local knowledge of options. This holistic approach is preferred;
- People prefer to deal locally, not centrally – as they often do not ask for help unless they are in crisis and the local contact is critical;
- In the United Kingdom, the Ministry of Transport investigated the optimal service model with the primary objective of moving people from A to B. A multiplicity of models were developed with solutions ranging from public transport to ‘dial a ride’ in the local village.

The responses to consultation indicate a focus on client outcomes as the predominant requirement of a HACC community transport system. The comment relating to the United Kingdom model is somewhat indicative of “the multiple options that are provided on the ground” in the current HACC transport environment.

This review has identified that to a significant degree HACC service providers (some of whom also provide community transport) tend to work in isolation from each other in terms of the transport

component; there is little evidence of collaboration in vehicle “sharing” to increase client access and utilisation.

This insularity results in providers not understanding the transport capacity of nearby providers and little sharing of vehicles. While some sharing on “trunk routes” was identified between local providers and CTST, this was also identified as an irregular occurrence. In addition to this pure logistics perspective, some providers indicated the importance of “care level”, the capacity of a provider to meet the needs of less able clients in a respectful and professional basis. This characteristic was seen as important in the selection of vehicle and driver; it was noted that there was a lack of understanding of the capacity of other services to meet client needs or concerns in relation to this.

During the review and discussions it became clear that the challenge from a stakeholder perspective is not so much about knowing where vehicles are at any point in time during the current trip, but about where they are scheduled to be in the future. This conclusion reflects the nature of the HACC community transport system as one where the majority of trips occur regularly; for example a same day/time pattern in the long term.

The key to improved coordination and utilisation is in developing an understanding of which vehicles are in the fleet, their capacity, their management and where they are scheduled to operate at a certain time. The ability to access this information in “real time” from a local request is a technically feasible response to enabling “inter provider” coordination in a manner that also reflects the benefits of local coordination, over centralised coordination identified during consultation. Local coordination matches both the highly dispersed characteristic of the HACC client group and the need for local knowledge to achieve an appropriate client service interaction. Consideration of the complexity of matching volunteer with client, while beyond the scope of this project is a further overlay to the success of HACC community transport.

There was provider support for this centralised information proposition when briefed at later forums and discussions. The system characteristics would enable:

- Providers to book their “own vehicles” on the system;
- Providers to identify whether other providers have excess capacity in vehicles already scheduled for a trip consistent with their client’s needs from the system;
- Service providers to discuss and where appropriate schedule a trip;
- Ongoing data collection and evaluation of HACC transport effectiveness; and
- Assessment of fleet characteristics and modelling of investment requirements from the information collected.

Such a central database could eventually be used for consumer directed bookings.

While vehicle sharing is an outcome which could optimise access and utilisation, in some instances it could be inappropriate to share the vehicle between clients with different needs and risk profiles, a key consideration managed by the HACC service seeking transport for a client.

These factors and challenges, as identified by contributors, present a coordination model that is perceived by contributors as one that needs to occur at a local level; however the use of a centralised information database as described above with inbuilt client data access levels and securities, provides the potential to both improve day to day outcomes and ensure that HACC vehicles start to become utilised as a statewide “fleet” along with the achievement of attendant efficiencies.

This centralised data option does not address the current limited hours of operation provided for coordination by some organisations or response to unplanned events identified throughout the review. It is considered critical that community transport service providers take responsibility for their hours of operations and management of unforeseen problems and incidents associated with that transport. They should have in place with each client organisation an agreed management protocol that is clear and understood by all staff and volunteers involved with the trip.

Coordination needs are not well met by part time coordination.

STRATEGIC FINDINGS AND CONCLUSIONS

Strategic Findings

The nature of HACC community transport is adapting to reflect the changing needs of the HACC client group. It is changing in terms of level and characteristics of demand, a greater proportion of clients need assistance to travel and the challenges in meeting the needs of the HACC target population. The penetration of HACC community transport into the target population who require assistance for daily living tasks is limited; as the number of people requiring assistance to live independently increases, transport needs will likely also increase. If these needs are to be met, the manner in which transport support is provided will need to become more efficient whilst primarily focused on providing the necessary level of service to meet client wellbeing outcomes. This will require a more efficient use of the existing fleet and strategic oversight of the model within which higher cost elements of the fleet, buses and modified vehicles, are provided and managed.

The HACC community transport profile has changed significantly since the 2006 evaluation. As a proportion of activity, group transport has increased markedly, southern Tasmanian based transport has increased as a proportion of statewide trips, large bus based transport has declined and day centre based trips have increased as has the proportion of their clients requiring assistance.

An increasing number of HACC community transport events are related to access to medical services, subsequently, the care of an individual within their community transport interaction is becoming increasingly challenging; drivers and carers need to respond to the consequences of “day surgery and treatments” on the return to home journey.

Access to HACC community transport to meet scheduled and reasonable needs is described by service providers as “*at times problematic*”. This includes after-hours access and access to a vehicle that enables the client to easily gain entry and travel in comfort for example, when returning from day surgery or treatment. The manner in which HACC service providers adapt their practices to respond to a shortfall in the ability to access, for example what they term appropriate buses, leads to inadvertent consequences such as staff diverted from other care programs to provide the required transport and other clients missing out on services because of the time spent on transport. This means that:

- Other HACC support programs may cross subsidise transport;
- Day Centres may not meet their nominated target numbers; and
- Other client outcomes may be prejudiced.

The above context highlights the difference between HACC community transport and public transport. In effect HACC community transport may be considered an interaction between the client and provider, one where the nature of the “trip” actively contributes to, and is focused on providing what is necessary for the social and physical wellbeing of the client, whereas public transport is

arguably a transaction that provides a seat to carry a person from “A” to “B”. Community transport, and in particular HACC community transport cannot be described as analogous to public transport or in most cases compared with it. Investment decisions within HACC community transport should be based on broad benefit/cost approaches that are inclusive of the consideration of client outcomes; this is different to public transport models where the decisions are made on a return on investment model. HACC community transport enterprise models need to reflect this difference and principles in their governance and relationships with clients and funding agencies.

The use of broad benefit/cost analysis techniques rather than enterprise focused return on investment models should be applied to the design of an appropriate fleet and other delivery options such as the optimisation between community and private providers as key transport options to respond to the strategic challenges faced within the sector.

Client and service provider access to “book” transport, to notify of alterations to existing bookings and in the event of emergency, are identified as inconsistent across the HACC community transport network. It is apparent that HACC community transport providers have made specific operational choices on which to base their business model and expenditure priorities. Some providers such as the Wattle Group are accessible from early morning to late afternoon and have a direct mobile number out of hours with an on call response to need out of hours. Conversely CTST has coordinator availability from morning until early afternoon; outside of this period there is no local contact mechanism for clients. This time period coincides with the period CTST identified as the organisation’s peak coordination demand period.

HACC community transport is provided in vehicles that are attached to specific service providers, the vehicles are generally not managed and used as a “pool” for the broader group outside that particular organisation’s ‘boundaries’. Even within a local area service providers did not indicate a significant level of awareness of vehicles operated by other providers or the support levels those services are able to provide to the client. This “containment” is further exacerbated in the instance where a vehicle has been provided by a local benefactor and although utilising HACC funds to operate the vehicle, it is only used for residents of the local area.

The traditional business model for the provision of HACC community transport is based on working from the client demand side; the key question in this decision making is whether the level of demand in a location justifies the capital investment and recurrent cost to ensure the broad benefit/cost of the investment. Where this benefit/cost relationship exists benefit will directly accrue to the client and indirectly to the taxpayer by ensuring the client is living within a lower cost environment as a consequence of HACC community transport. With access to medical services as a determinant for independence and HACC community transport need, an important complementary question relates to the cost of medical service provision, in particular the fixed costs for medical providers operating in multiple locations. In this instance the business case for the “medical service provider” to contribute

to the provision of transport as an option to the provision of more localised facilities, may result in a greater net benefit by providing a benefit to both the client and the medical service provider.

Vehicles operated by the “Cancer Council” are an example of an organisation connecting the client to a specific medical provider as response to a client with specific needs and while it is recognised that the rationale for this provision is different to that described above it is an example of a specific service/client linkage.

An extension of this approach into a more commercial or social enterprise joint venture between the medical service provider and the HACC community transport provider (at the medical provider’s cost) could prove efficient in the allocation of scarce resources. Proposals put forward by CTST to this review align with this approach; however it is understood that in this instance such vehicles would be provided by an independent party. Notwithstanding, there are arguably strong grounds for private sector providers to contribute to community transport links to their practices as part of ensuring the “system” includes many and varied transport options to meet client group needs.

The “trip” includes travel time, waiting time and activity time. It is important to note that the introduction of “transit lounges” for out-patients in specialist clinics and hospitals is an effective intervention and investment that reduces the need for “just in time” transport responses and increases the comfort and security for clients.

While the differences between HACC community and public transport have been identified previously, fleet efficiency, including both utilisation rates and the optimum vehicle for the interaction remains critical. The Banskott Review recommended the central coordination of community transport, specifically through Ambulance Tasmania (Recommendation 53). It is understood that this conclusion was based on the apparent scale efficiencies and coverage hours available. This recommendation is not supported by those consulted in this review or by our independent analysis of the context within which HACC community transport operates.

Discussion with service providers indicated the necessity for local coordination. This view is primarily based on the need to know and understand the circumstances of each client and the necessity at times to develop alternatives to reflect the priority of need; a capacity not considered achievable with centralised coordination. This conclusion is supported by the highly dispersed nature of transport delivery and the location of people needing assistance to live independently.

From a range of “technical” coordination options proposed, discussion with the sector indicates agreement with an “open access, real time” information system that shows the status of all HACC vehicles, enabling providers to coordinate their vehicles and to identify whether there is spare capacity in other provider fleets to suit their client transport needs. This would enable HACC service providers to “share” vehicles between destinations, an attribute that provides particular value to medical transport, particularly if that vehicle has specific configuration requirements and where trips

are often of longer duration. The model would equally support more efficient social transport needs. Within this embryonic “virtual fleet” system, HACC community transport providers would book their own service vehicles, while others wishing to use them could contact the provider to book. Later versions could potentially progress towards wider access to the booking process, including eligible client direct booking. As fleet utilisation is improved this could result in a vehicle or fleet replacement policy more reflective of the overall target population and regional need.

The data within this system would support more effective evaluation, planning and investment at a transport provider and a broad policy and program level. An important contribution of this system would be a tool which could be used to inform rigorous evaluation of, and improvement in the provision of HACC community transport to the client population.

From a technical perspective it is envisaged that the system would be ‘open access, real time’ consolidating fleet characteristics, logistics and management information in a central data base that is accessible through a secure web based browser that while hosted in a specific organisation is essentially self-managing in terms of data update.

Strategic Conclusions

The demands placed on community transport and HACC community transport in particular are many and varied. This demand will increase as HACC community transport is required to further penetrate places where eligible people are located. While medical transport is likely to continue to increase in demand and priority due to the time sensitive nature and the implications of lack of access to treatment, it is important that this priority does not overshadow the value of social and other support that HACC community transport also makes to promoting health and the contribution to the maintenance of client independence. Broad benefit cost or social return on investment models should replace enterprise based financial return on investment models as the dominant framework within which HACC community transport are made. It is critical that the cost of transport deficiencies are not transferred to the HACC client in the form of reduced access and wellbeing outcomes whilst also recognising that HACC community transport is a subsidy based system where all users contribute other than where a fee waiver is granted.

Given the complexity of HACC community transport and the relatively low proportion of the transport mix made up of the younger disabled cohort, it is considered unlikely that it would be viable to operate separate transport systems for the younger disabled and older HACC eligible client groups.

The current HACC community transport business approach is one of a number ensuring HACC client access to social, shopping and medical transport. Other volunteer based and “work around” transport models are in place. It is important that the business models operating within the HACC community transport system are flexible; enabling innovation in the way in which HACC community transport infrastructure is accessed, coordinated and funded; and importantly how the volunteer

effort on which it is largely based is sustained and developed. The integration of the HACC dominant model with transport options available from the private sector is a strategic challenge.

The first step is to improve the access and coordination of HACC community transport. While the efficiency of coordination is central, local coordination is identified as equally important in delivering appropriate client outcomes. Recommendation 53 of the Banskott (2008) review is not supported. However the underpinning centralised information base that would have been required to facilitate this recommendation is supported as a strategic initiative to improve the productivity of the HACC community transport system. It is critical that options for the provision of real time information to providers on fleet activity are considered as part of the HACC community transport system.

Given the role such consolidated transport data could play in ensuring the productivity of HACC community transport and in program evaluation, it is considered important that the system is hosted within an organisation that is separate from service delivery which is able to provide information to support the management of regional diversity and reflect differences in needs of the under 65 year age cohort from the 65 year and over age cohort.

It is recommended that Phase 3 of this project brief is implemented. This phase will determine the feasibility of a centralised information and fleet management system to enable flexible and efficient delivery of this critical client/community transport interaction. This would:

- Confirm the links and changes between the key transport challenges facing the HACC client groups and the changes in federal and state responsibilities and funding, and their impact on the proposed centralised information model;
- Design the parameters and functionality, cost and plan implementation of an “open access, real time” (cloud based) system that identifies the booking/allocation status of all HACC community transport vehicles, while maintaining client confidentiality;
- Design a system that enables providers to allocate their service vehicles and ensures continuous update;
- Design a system that enables providers to identify whether there is excess capacity in other provider vehicles that suits the client transport requirements and provides the necessary platform to achieve this productivity outcome;
- Design a system that enables the collection of critical information to support HACC community transport system decision making, in particular monitoring use patterns, evaluating fleet utilisation and effectiveness in meeting necessary client outcomes and planning changes to improve efficiency and contribution to HACC program objectives; and
- Identify the most appropriate “hosting and management” entity and design a sustainable business model.

The feasibility of this alternative must be comprehensively assessed prior to progression to development.

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