

PROXIMITY

Strengthening Aged Care Provider Governance

Report on Consultation Feedback

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Executive Summary

The Australian Government has accepted recommendations from the Royal Commission into Aged Care Quality and Safety relating to improving aged care provider governance arrangements, to place the care needs, preferences, and best interests of aged care consumers at the core of Australian aged care regulation.

The Government has introduced the *Aged Care and Other Legislation Amendment (Royal Commission Response No.2) Bill 2021* (the Bill). Subject to Parliament processes, the Bill will introduce new and stronger responsibilities for approved providers' governing bodies from 1 March 2022 in relation to:

- the membership of governing bodies, by requiring a majority of independent members
- the provider's constitution, ensuring it does not allow a director to act other than in the best interests of the approved provider
- the establishment of a Quality Care Advisory Body (QCAB) and Consumer Advisory Body (CAB) to give feedback to the governing body on the quality of care
- staff qualifications, skills and experience of the members of these bodies
- the suitability of key personnel in the provider's organisation
- providing an annual statement on the provider's operations.

In December 2021, aged care stakeholders were consulted on a range of matters through an Information and Consultation Paper and associated online questionnaire, as part of a program to implement the Royal Commission's recommendations and support the Bill in subordinate legislative change. Consultation occurred on:

- membership of the quality care advisory body and its report to the governing body
- what information ought to be reported in the approved providers annual statement on operations
- the records approved providers should keep on the proposed legislative requirements.

This report, prepared by Proximity, summarises the feedback from that consultation. The report is primarily focussed on the feedback relating directly to the matters being consulted on. Although consultation on the goals set out in the primary legislation (the Bill) was not sought many respondents did provide feedback on the Bill in this consultation process. This report also summarises some of this commentary on the Bill and other broader aged care matters related to the reforms consulted on. Proximity was not asked to provide recommendations based on the responses to the consultation.

The primary outcome from the consultations is a strong level of support across all elements of the proposed aged care governance requirements dealt with in the consultation. The responses indicated agreement for all items consulted on, and the total level of positive response was above 70% for all but three items.

- The proposed membership of the quality care advisory body is agreed to. However, the proposal to have a member of the governing body chair the QCAB was the least supported proposal of the questionnaire. A number of responses made suggestions for additional members of the QCAB, while some providers raised concerns about the difficulties in implementing the proposed membership.
- The proposals for the matters that the QCAB must report on in quality of care reporting to the governing body were strongly supported, including items such as concerns about quality of care and action taken to address those concerns by the governing body.
- Feedback also strongly supported the provider being required to give the members of the QCAB the information needed to write the report to the governing body.
- The suggested content of an annual statement on approved provider operations is strongly supported, including statements that the provider meets the Aged Care Quality Standards, and information on complaints.
- There is strong support for the record keeping requirements for approved providers, including details of:
 - governing bodies' independent non-executive members
 - the QCAB, its membership and meetings, written report content, and advice to and from the governing body
 - offers made to consumers and their representatives to form a CAB and if a CAB is formed, its meetings, and feedback and advice to and from the governing body respectively
 - how the governing body ensures staff have appropriate qualifications, skills and experience and are given opportunities to develop their capabilities
 - Information on key staff suitability.

Some respondents suggested that the key to assisting providers in managing these new requirements is to keep the reporting simple and not to duplicate other aged care or body corporate reporting requirements

The qualitative feedback from direct written submissions in response to the Information and Consultation Paper, and free text comments provided within the questionnaire, provides a constructive basis for refinement of the final proposals and for identifying potential implementation issues.

Most respondents suggested ways that support could be provided for implementation of the approved provider governance reforms. These largely fell under the following groupings:

- a document suite to assist providers to report under the new requirements
- template documents for the establishment of the new bodies
- IT support and funding for resources.

A number of matters raised in the consultation feedback warrant consideration to ensure that the proposed reforms are implemented in a way which will be most effective, as follows:

1. The least supported specific change was to have a member of the provider's governing body sit on and chair the QCAB. Respondents that disagreed with this change perceived it could create a conflict of interest; lead to a lack of objectivity in the body and interfered with the QCAB and governing body's independence.
2. While there was strong support for the consumer consultation proposals around QCAB membership and CAB record keeping, there was broader feedback around the cost of the CAB body, the difficulty of getting and sustaining consumer involvement, the inappropriateness of a one size fits all solution given the variety of provider models, and the fact that providers already have mechanisms in place to hear consumer voices.
3. While there was overall majority support for providers to keep records on these new governance arrangements, some respondents considered the key to assisting providers do this, is to keep the reporting simple and not duplicate other aged care or body corporate reporting requirements.
4. Respondents commented a feedback loop between the governing body and advisory bodies was needed to show continuous improvement, and ensure the values of transparency, accountability and responsibility are to be embedded in the sector.
5. Some respondents considered there is a need for these reforms to be flexible or modified to reflect the type of aged care being provided (residential, home care etc), and the nature and size of the provider.
6. Some respondents considered the confidentiality and privacy implications of the reforms need careful consideration and incorporation into the reform framework – for example when reporting key personnel names in the annual statement and when consumers are sitting on the QCAB or CAB and the possibility of disclosure of other consumer names and medical information arises.
7. Some respondents considered quality staffing is key to quality care reform programs, and while this can be improved with training, the serious shortage of skilled workers in aged care and their low wages, makes reform here very problematic.
8. Many respondents highlighted a need for additional funding and support for these reforms. Respondents proposed that Government funding be provided to facilitate transition and ongoing implementation of the new model, given the administrative compliance costs of the reforms to the sector.

Introduction

Strengthening aged care provider governance

The Australian Government has proposed a program of aged care reforms to increase high quality, safe care services and provide dignity and respect to senior Australians.ⁱ

This reform program follows the final report of the Royal Commission into Aged Care Quality and Safetyⁱⁱ which was tabled in Parliament on 1 March 2021.

The Royal Commission found

Good provider governance is essential for the delivery of high quality aged care.

and further that,

An aged care provider's most important objectives should be to enhance the wellbeing of older people by providing them with safe and high quality care, and to put the older person's wishes and needs first. Governance arrangements for aged care providers must be designed around these core objectives.

The Royal Commission made four recommendations in relation to strengthening provider governanceⁱⁱⁱ - legislative amendments to improve provider governance; requirements on governing bodies to monitor and increase staff leadership responsibilities and accountabilities; increasing the independence of governing bodies and introducing new advisory bodies to monitor quality of care; and assistance to providers to improve governance arrangements.

In line with the Australian Government Response to the Royal Commission^{iv}, the *Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021* has been introduced to Parliament. Amongst other things, this Bill includes amendments to the *Aged Care Act 1997* and the *Aged Care Quality and Safety Commission Act 2018* to give effect to Royal Commission recommendations in relation to strengthened provider governance.

Information and Consultation Paper

In December 2021 the Australian Government Department of Health (Department) circulated an Information and Consultation Paper^v outlining the proposed new provider governance requirements and seeking stakeholder views on the rules for applying these new requirements.

The Information and Consultation Paper sought responses on the following:

- membership of the quality care advisory body and its report on each service to the governing body and the need for the provider to give the quality care advisory body information to prepare its reports
- requirements for the approved provider annual statement on operations
- the records approved providers should keep on the proposed requirements in the legislation, including records of:

- the QCAB membership and meetings, written reports, and advice to and from the governing body
- offers made to consumers and their representatives to form a CAB, and if a CAB is formed, its meetings, and feedback and advice to and from the governing body respectively
- how the governing body ensures staff have appropriate qualifications, skills and experience and are given opportunities to develop their capabilities
- information on key staff suitability.

The consultation was open to:

- aged care consumers and their family members, carers or representatives
- aged care staff including care workers and health professionals
- aged care providers including governing bodies and administrators
- aged care peak organisations, and
- other interested respondents within the wider community.

Potential respondents were invited to respond either through direct written submissions in response to the Information and Consultation Paper, or through an accompanying questionnaire.

Questionnaire

The Information and Consultation Paper was accompanied by an online questionnaire.

The questionnaire was structured to seek responses to indicate respondents' level of agreement with 10 questions falling under the three areas above. These 10 questions, with 43 sub-questions, reflected elements of the proposed new governance requirements within the scope of the consultation.

The questionnaire asked respondents to respond to each element with one of the following responses: Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Not Sure.

The questionnaire sought free text comments where respondents indicated that they Disagreed or Strongly Disagreed with the question.

The questionnaire sought additional free text comments on the information, guidance or support providers and consumers will need to deliver the proposed new requirements and invited any other free text comments or suggestions. The questionnaire also sought responses on demographic information and consents.

About this report

This report has been prepared by Proximity to provide an independent summary of the consultation responses and feedback.

In preparing this report, Proximity has utilised data on scored questionnaire responses, and copies or extracts of written submissions and free text comment responses, provided by the Department.

Summary data has been provided on questionnaire responses. The direct written submissions in response to the Information and Consultation Paper, and the free text comments within the online questionnaire, provided qualitative feedback which is summarised in this report.

Given the number of responses received, Proximity has used best endeavours in this report to provide a summary which gives a fair and balanced representation of the consultation feedback, often quoting or paraphrasing from one response as indicative of others. In doing so, Proximity has taken into account where respondents indicated that they did not wish the content of responses to be published. Direct quotations are italicised and are attributed as appropriate based on the consents provided in the relevant response.

Although consultation on the reforms set out in the Bill was not sought, many respondents included feedback (positive and negative) on the Bill as part of this consultation process. The report has considered and incorporated some of these responses.

Proximity was not asked to provide recommendations based on the responses to the consultation.

Overview of responses

A total of 560 responses were received by the Department from 559 respondents.

Written submissions: The Department received 12 direct written submissions responding to the Information and Consultation Paper.

Questionnaire responses: The Department received 548 fully or partially completed online responses to the questionnaire.

As the demographic and substantive questions in the questionnaire were optional, it should be noted that questionnaire response totals given throughout this report do not total to 548.

Demographic information summarising the characteristics of the respondents to the online questionnaire is given in **Table 1** below. A summary of the ranked responses to the substantive questions and sub-questions included in the questionnaire is set out in **Table 2** below.

The qualitative feedback obtained through the direct written submissions and the free text comments within the online questionnaire is summarised in this report.

Clear positive support for proposed reforms

As **Table 2** shows, the ranked responses for all proposed aged care reform elements covered in the 43 sub-questions in the questionnaire were overwhelmingly positive. The responses indicated Agreement or Strong Agreement for all items, and the total level of positive response was above 70% for all but three items.

In general, the views expressed in the direct written submissions reinforce the positive questionnaire responses and does not change Proximity's view on this statement of clear positive support for all proposed reform elements covered in the questionnaire.

A primary outcome of consultations is a strong level of support across all elements of the proposed aged care governance requirements.

As one respondent put it:

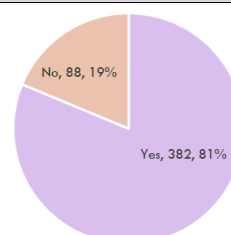
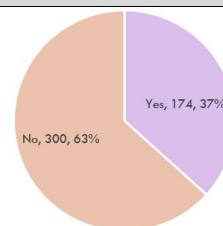
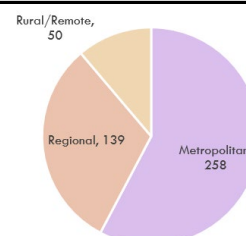
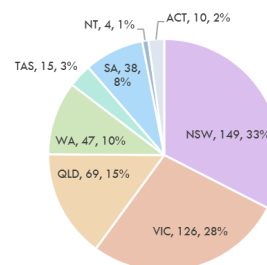
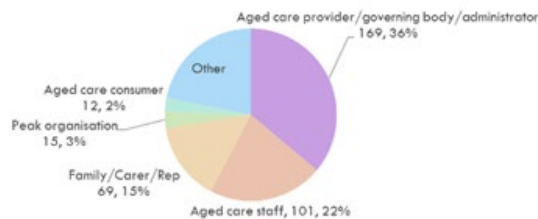
I think these are really important reforms and it is good to see the Royal Commission recommendations are being implemented (*Family member of an aged care worker*)

This strong level of overall support should be kept in mind when reading sections of this report summarising qualitative feedback from both direct written submissions and free text comments within the questionnaire.

The questionnaire prompted free text comments only where the respondent indicated disagreement to the item proposed. The qualitative feedback from free text commentary within the questionnaire, together with the written submissions, thus provides a constructive basis for refinement of the final proposals and for identifying potential implementation issues.

Table 1: Questionnaire respondents demographic characteristics

Respondent demographics	Number of respondents	% of respondents
Which of the following best describes your role?		
Aged care provider/governing body/administrator	171	36.1
Aged care staff	101	21.6
Family/Carer/Rep	69	14.7
Peak organisation	15	3.2
Aged care consumer	12	2.6
Other	102	21.8
Total*	470	100
In which state or territory do you currently live?		
NSW	149	32.3
VIC	126	27.3
QLD	69	14.9
WA	47	10.2
TAS	15	3.2
SA	38	8.2
NT	4	0.9
ACT	10	2.2
Other	4	0.87
Total*	462	100
Which of the following best describes your residential location?		
Metropolitan	258	57.7
Regional	139	31.1
Rural/Remote	50	11.2
Total*	447	100.0
Are you providing comments on behalf of an organisation?		
Yes	174	36.7
No	300	63.3
Total*	474	100
Do you consent for your submission to be published in whole or in part?		
Yes	382	81.3
No	88	18.7
Total*	470	100

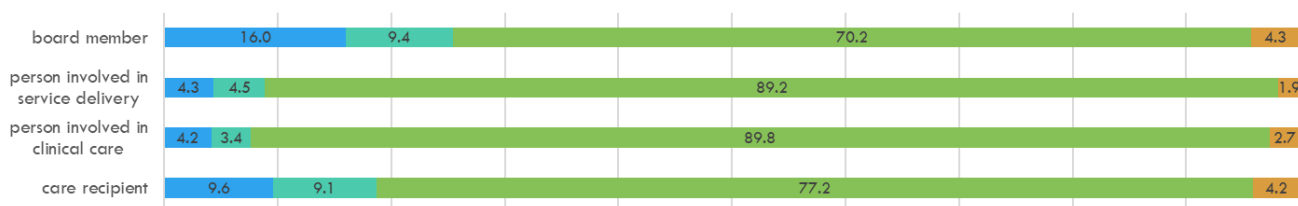


*Totals shown indicate total responses to each individual question.

Table 2: Summary of ranked responses to questionnaire questions, by level of agreement

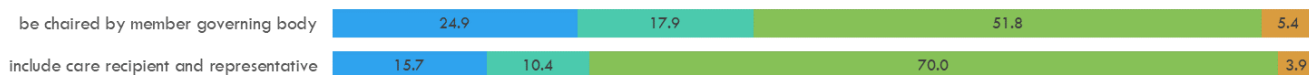
Respondents were asked to indicate their level of agreement with the following statements:	Nett Disagree	Neither agree nor disagree	Nett Agree	Not Sure	No. of responses
Q1. The quality care advisory body should include:					
a. board member of the organisation	16.0	9.4	70.2	4.3	531
b. person involved in the delivery of the provider's services	4.3	4.5	89.2	1.9	530
c. person involved in the delivery of the provider's clinical care services	4.2	3.4	89.8	2.7	527
d. person who receives care and services from the provider or their representative	9.6	9.1	77.2	4.2	530

The quality care advisory body should include:



Q2. The quality care advisory body should:					
a. be chaired by a member of the provider's governing body that does not hold another position in the organisation.	24.9	17.9	51.8	5.4	514
b. include both a person who receives care and services from the provider and a representative	15.7	10.4	70.0	3.9	517

The quality care advisory body should:



Q3. The quality care advisory body report should include an assessment of the quality of care provided by the service, taking into account:					
a. trends in quality of care (including quality indicators, incidents, consumer surveys, staff and consumer feedback and complaints)	1.8	1.6	94.7	1.8	493
b. progress made on the Plan for Continuous Improvement	3.8	4.3	90.5	1.4	494
c. concerns about the quality of care	2.6	1.2	94.9	1.2	495
d. action being taken against the service by the Aged Care Quality and Safety Commission or any other agencies	3.7	2.4	92.3	1.6	491
e. action being taken to address any concerns	2.6	1.2	94.9	1.2	492
f. matters/issues referred to the quality care advisory body by the governing body	3.1	3.1	91.6	2.2	491
g. signature of each person on the quality care advisory body to show they agree with the report	16.7	15.9	62.2	5.1	490

The quality care advisory body report should include an assessment of the quality of care provided by the service, taking into account:



Respondents were asked to indicate their level of agreement with the following statements:

	Nett Disagree	Neither agree nor disagree	Nett Agree	Not Sure	No. of responses
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Q4. Please indicate your level of agreement with the following statement:

a. Providers should be required to give the members of the quality care advisory body the information needed to write the report to the governing body.	5.5	3.0	89.5	2.0	494
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Please indicate your level of agreement with the following statement:



Q5. Aged care providers should be required to keep a record of:

a. the members of the quality care advisory body	2.5	2.1	94.0	1.4	486
b. evidence the quality care advisory body meets the membership requirements	3.1	3.7	91.8	1.4	487
c. written reports and feedback from the quality care advisory body to the governing body	2.1	1.8	94.9	1.2	487
d. written advice from the governing body to the quality care advisory body	2.9	3.3	91.8	2.1	487
e. meeting dates and minutes	3.1	1.2	94.7	1.0	488

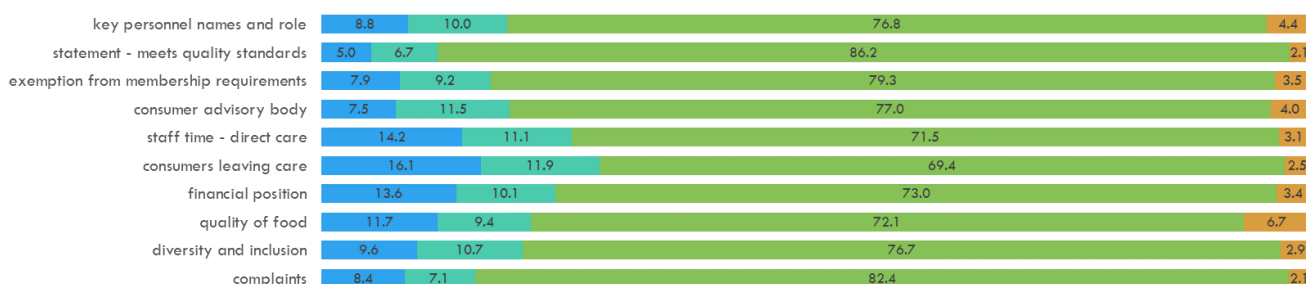
Aged care providers should be required to keep a record of:



Q6. The annual statement should include information about:

a. the approved provider's key personnel names and role	8.8	10.0	76.8	4.4	479
b. statement by the governing body that the provider meets the Aged Care Quality Standards	5.0	6.7	86.2	2.1	479
c. any exemption from the new governing body membership requirements (that is, the majority of members are independent non-executive members, and that at least one member has clinical experience)	7.9	9.2	79.3	3.5	479
d. if the provider has a consumer advisory body	7.5	11.5	77.0	4.0	478
e. time staff spent on delivering direct care	14.2	11.1	71.5	3.1	478
f. information about the number of consumers using/leaving the provider's service	16.1	11.9	69.4	2.5	477
g. the provider's financial position	13.6	10.1	73.0	3.4	477
h. the quality of food	11.7	9.4	72.1	6.7	477
i. how diversity and inclusion are addressed	9.6	10.7	76.7	2.9	477
j. complaints	8.4	7.1	82.4	2.1	477

The annual statement should include information about:



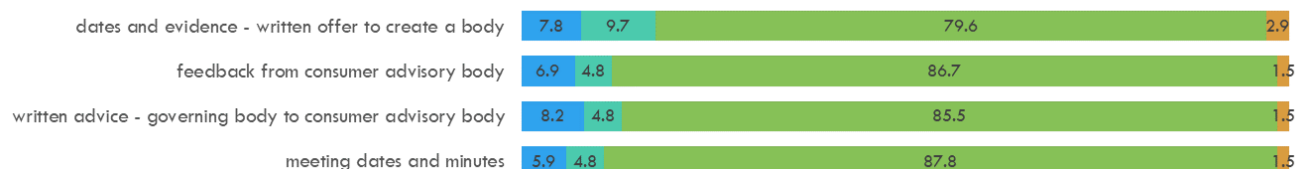
Respondents were asked to indicate their level of agreement with the following statements:	Nett Disagree	Neither agree nor disagree	Nett Agree	Not Sure	No. of responses
Q7. Aged care providers should be required to keep a record of the:					
a. independent non-executive members of its governing body	4.4	4.2	89.1	2.3	477
b. details of clinical experience held by the governing body members	6.3	7.3	84.1	2.3	478

Aged care providers should be required to keep a record of the:



Q8. Aged care providers should be required to keep a record of:					
a. dates and evidence of its written offer (to care recipients and their representatives) to create a body	7.8	9.7	79.6	2.9	476
b. feedback from the consumer advisory body to the governing body	6.9	4.8	86.7	1.5	475
c. written advice from the governing body to the consumer advisory body	8.2	4.8	85.5	1.5	476
d. meeting dates and minutes	5.9	4.8	87.8	1.5	476

Aged care providers should be required to keep a record of:



Q9. Aged care providers should be required to keep a record of how the governing body has ensured:					
a. staff have appropriate qualifications, skills or experience	4.4	2.5	91.8	1.3	476
b. staff have opportunities to develop their capability	4.0	5.5	89.5	1.1	476

Aged care providers should be required to keep a record of how the governing body has ensured:



Q10. Aged care providers should be required to keep a record of:					
a. the suitability of each member of their key personnel	4.7	3.6	90.5	1.3	472
b. all the evidence used to decide suitability (for example, qualifications, police checks)	4.2	3.0	91.5	1.3	472
c. date the provider considered the suitability of the key personnel	5.9	7.0	84.7	2.3	472

Aged care providers should be required to keep a record of:



Summary of qualitative responses

The Quality Care Advisory body

In its report the Royal Commission found the governing bodies of approved providers do not always pay sufficient attention to the quality of care being delivered to older people and recommended that every provider governing body has an advisory body with appropriate experience in providing care.

As a result, one of the proposed reforms is the requirement for providers to create and maintain a Quality Care Advisory Body (QCAB). The QCAB will provide feedback to the governing body and monitor and report (at least once every 6 months) to the governing body, on the quality of care delivered by the provider’s services to consumers.

Membership of the QCAB (Q1)

Respondents were asked to consider four suggestions for the membership of the QCAB.

Over 70% of respondents Agreed or Strongly Agreed that a board member of the provider organisation should be on the QCAB.

Over 89% Agreed or Strongly Agreed that a person involved in the delivery of the provider’s services (such as a person responsible for the delivery of care and services, a registered nurse, or a personal care worker) should be on the QCAB. The same level of agreement was given that a person involved in the delivery of the providers clinical care services, specifically, should be included. Some responses suggested that more than one member with these skills should be included, and others commented that the scope should be broader to include those in an allied health category. Some responses indicated the requirement a clinician to be part of the QCAB should only apply where the provider is delivering clinical care services.

One respondent advocated a diversity and balance of views in aged care governance:

The ever-decreasing number of registered nurses employed in the sector has meant that this expertise has not been available for organisational decision making, both operational and strategic, and has resulted in decision-making often resting in the hands of those without any healthcare experience or background. We would be horrified if clinicians were excluded from governance and decision making in the health sector and it is no different in aged care. What is needed is a diversity and balance of views including those with financial and business acumen as well as health experts. One form of expertise should not be privileged over other, which has been the failure in aged care. (Queensland Nurses and Midwives’ Union)

Over 77% of respondents Agreed or Strongly Agreed that a person who receives care and services from the provider, or their representative, should be on the QCAB. In some comments an advocate for aged care persons (such as a family member, relative, or carer) was suggested as a person who should be a member. One respondent said both should be required, as they are the ones who experience the end results of policies, processes and practices and the impacts these have.

Respondents were asked for suggestions for other types of people to be included on the QCAB. The most frequently suggested types of people (grouped in job category) were as follows:

Provider operational staff	Health Professionals
CEO	Registered nurse
Quality and risk management manager	Enrolled nurse
Compliance manager	General practitioner
Care coordinator or home care coordinator	Geriatrician, Dementia Specialist, Palliative Care Specialist
Business operations representative	Allied health experts – Physiotherapist, Occupational
Case manager	Therapist, Dietician, Speech Therapist
Clinical governance leader	Pharmacist

<p>Other service delivery Lifestyle representative Catering/food preparation services person</p>	<p>Independent Independent external advisor – such as from ACOSS, Red Cross, disability services Volunteer at the facility</p>
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Of the respondents who disagreed with these proposals, the following comments are representative and are grouped according to the main themes:

No need for a QCAB

As indicated above, the requirement to establish a QCAB was not part of this consultation. However, there were some respondents who commented on this point as outlined below:

- There is no need to have a QCAB. There are systems and processes already in place to deal with the quality of care issues. This increases the governance and red tape and reduces time spent on caring for consumers. It will be counterproductive for staff to be tied up in administrative duties.
- The responsibility for ensuring quality sits with the Board and it should be up to the Board to work out how it satisfies itself. This is a rigid, over-regulated, one size fits all approach that dictates means, not outcomes.
- Too prescriptive - it would be preferable for an approach that prescribes the functions and key outputs of the QCAB rather than hard rules on membership.
- Role confusion - there is confusion about whether the QCAB has powers and reports to the facility or is just advisory and reports to the governing body. It conflates the role of the Board and management. It is the Board's responsibility to provide strategic oversight and direction and management's responsible to execute this operationally. The body should remain the responsibility of management, with a formal reporting role to the Board, to help drive the accountability in the provision of high-quality care.
- It would be preferable that there is a requirement to adequately demonstrate consumer engagement in the design, development and improvement of services, and that minimum levels of consumer engagement and feedback are sought and acted upon.

Board members

- Should not be included in the QCAB, otherwise it becomes difficult to maintain Board independence, rather than conflating the role of the Board with the role of management and blurring management accountability.
- If staff are also on the QCAB they may be intimidated by the Board member.
- There would be conflicts of interest for the Board member when sitting on both bodies.
- Having to carry these dual roles would undermine the strategic authority of the Board.
- There would be increased difficulty recruiting Board members particularly if board members are not paid to sit on the advisory body.

Staff members

- An employee or contractor providing clinical care to the provider's consumers, may have conflicts of interest for personal reasons or due to loyalty to colleagues.
- An alternative is to have clinical care experts on advisory bodies that are independent of providers, who can become conduits for concerns from employees or contractors providing clinical care.

Care recipients

- A single care recipient is not representative of all consumers and is too inflexible, and not practical for a large national organisation.
- It is unrealistic to expect a care recipient would have required skills and knowledge.
- Many care recipients will have severe cognitive impairment (including dementia) and it may be more appropriate to use alternative methods including observation and informal personal discussions and linkages between the CAB and QCAB.
- It will be necessary to consider privacy perspectives when having individual consumers on the QCAB, when specific consumer details may be discussed.
- There would be a need to constantly replace consumers who transition through residential aged care facilities.
- Care recipients or their representatives should have the ability to provide feedback through the proposed CAB. A CAB can better capture and represent the broad concerns of a diverse range of consumers and their families.

Chairing the QCAB (Q2)

Respondents were asked whether the QCAB should be chaired by a member of the provider's governing body who does not hold another position in the organisation.

Out of all the questions asked, stakeholders gave the least positive response to this question with only 51.8% of respondents Agreeing or Strongly Agreeing that the QCAB should be chaired in this manner; 24.9% of respondents disagreed and 23.3% were not sure or neutral on the matter.

An example of a response expressing concern with this model is:

[Agree but] The chairperson of the advisory committee would conceivably have the power to set the agenda and choose who to induct into the advisory body. This seems too much power to give the governing body over the advisory committee, even if the member of the governing body doesn't have another role within the organisation this is unworkable and very difficult for small and not for profit businesses, particularly those with a small voluntary governing body. (Response on behalf of Occupational Therapy Australia)

Other responses representative of such concerns include:

- The chair should be independent from the governing body to enable all on the QCAB to have their say and to enable the QCAB to inform the governing body (rather than the governing body being a part of it).
- This may create a conflict of interest and a lack of objectivity.
- This blurs the lines of accountability and gives a perception of influence by the governing body.
- A small rural provider will not have the human resources and skills to have a person in the chair role who is independent from the provider.
- Not possible and unworkable to find a member of the governing body that does not have another position in the organisation. Many providers are people poor.
- Large, medium and small organisations often have administrative management that oversee multiple aspects in an effort to maximise efficiency. Limiting the body's chair to single position with no other positions in the organisation would be a detriment to both large and small providers.
- It is more appropriate to have someone directly involved in service delivery, consumer care, or quality being the chair.
- Someone with a detailed understanding of the Aged Care Act or policies regarding what constitutes excellent care needs to be the chair.
- The skills and attribute of the chair are more important than their position held in the organisation. The chair needs to prepare the meeting, open the meeting, facilitate discussion and keep the conversation focused and balanced. Their ability to do so, comes from their person skills and attributes and not a position or title they hold.
- To set who chairs an advisory body is too prescriptive and would limit opportunities to include and harness the best possible person in each organisation.
- The chair should be someone responsible for quality in the organisation or an independent person with knowledge in quality of care.
- Better for a board member to be an observer on the body.

Carers and a care representative on the QCAB (Q2)

Respondents were specifically asked whether the QCAB should include both a person who receives care and a representative (such as a family member or friend of a carer).

70% of respondents Agreed or Strongly Agreed that the QCAB should contain both these two members.

An example of commentary disagreeing with this is as follows:

As our Chairman has stated we see lots of difficulties in requiring a care recipient and/ or representative as a member of this body. What is required for effective governance is independent feedback from care recipients on a regular basis to the Board and senior executive leadership. This can be achieved in many different ways most of which are more effective than having one or two individuals sitting on a Committee/ board and attempting to speak for/represent possibly thousands (130,000 in Bolton Clarke's case) of clients across At Home Services and Residential Care with enormously diverse needs and personal and health situations. We would suggest that providers be required to demonstrate as part of Accreditation how they receive feedback from a wide cross section of their care recipients and what actions they have taken in

response including providing feedback to care recipients as to actions taken. (Response on behalf of the Bolton Clarke Board Clinical Governance and Care Committee)

Other commentary disagreeing with this is set out below:

- Consumer input to the QCAB would be better served by feedback through the CAB, which can better capture the broad concerns of a diverse range of consumers and their representatives.
- Feedback from consumers is better sourced through complaints, satisfaction surveys, incident reports, continuous improvement logs, quality indicators etc.
- Having two people is excessive and would make the body unwieldy.
- For small providers it will be very hard to find two people willing to volunteer their time.
- A one-sided, or non-strategic approach can result as the person/carer is oblivious to other factors in the decision process or to other consumer's experience of care at the service.
- In big organisations asking one consumer to provide feedback for the majority of consumers is futile.
- These proposed QCAB members may not be clinically trained and cannot share experiences beyond their own (due to their lack of knowledge and privacy issues).
- A lack of knowledge and background is likely to result in many requests for actions that are impossible or impractical.
- Consumers and their families often have unrealistic expectations and biased views centred around what they individually want. They do not represent the collective as a whole.
- Including a care recipient and representative may be resource intensive with turnover resulting from them transitioning through aged care, and it may be difficult to support continuity of knowledge for the QCAB.
- Being on such a body can place burden on the consumer – they would be daunted, out of their depth.
- A carer does not necessarily always represent the person's best interests.
- Family and friends are too removed from the business.

Reports by the QCAB (Q3)

Part of the proposed Bill reforms is to require the QCAB to produce a six-monthly report to the governing body of the provider. The governing body must consider this report when making decisions in relation to the quality of the aged care in the aged care service. In addition, to ensure there is a feedback loop, the governing body must inform the QCAB of how the governing body considered the report or feedback.

In relation to the subordinate legislation, respondents were asked what information the QCAB should take into account in producing the report, when assessing the quality of care provided. A large majority of respondents Agreed or Strongly Agreed with the information suggested in the consultation paper:

- Over 94% of respondents said trends in care (including quality indicators, incidents, consumer surveys, staff and consumer feedback and complaints) should be included.
- Over 90% said progress made on the Plan for Continuous Improvement should be included.
- Almost 95% said concerns about the quality of care should be included.
- Over 92% said action being taken against the service by the Aged Care Quality and Safety Commission (or other agencies) should be included.
- Almost 95% said action being taken to address any concerns should be included.
- Over 91% said matters/issues referred to the QCAB by the governing body should be included.
- Over 62% said the signature of each person on the QCAB showing they agree with the report should be included.

Disagreeing respondents' comments in relation to the report mostly focused on the requirement for all members to sign the report. In summary, respondents who disagreed felt this was 'overkill' as the chair of the QCAB could sign off the report. Further, the meeting minutes would reflect any consideration and disagreement and where different views arose. An alternative suggestion was to include a space for commentary from board members on the report but not require their signature.

One respondent commented that no individual member is going to sign up and be individually accountable. Another noted this mirrored prospectus due diligence requirements imposed on listed company directors and exceeded what is required to deliver the outcomes desired.

Some respondents suggested other areas that should be included in the QCAB report or expanded on suggestions included in the questionnaire. These included the issues listed below:

Compliance issues

- Incidents, concerns, abuse reports and complaints (from registered nurses, care staff, GPs, allied health professionals) – show the action taken, the time frame and person who took the action
- Complaints – both internal and to the Aged Care Quality and Safety Commission
- Compliance with Aged Care Standards
- Serious Incident Report Scheme (SIRS) incidents and trends.
- Work health and safety compliance

Consumers

- Profile of care recipients (including those with dementia) and trends.
- Customer experience, personal and independent responses – including how the QCAB has dealt with feedback provided through the CAB
- Incoming waitlists, response to service requests and management of unmet needs and service gaps

Staffing

- Staff ratios – indicators and an analysis and reporting of workforce, staffing and skill-mix. Rostering and allocations (such as registered or enrolled nursing hours in 24 hr period; how the staff/facility access clinical or palliative care throughout each week; unfilled shifts)
- Recruitment and retention, staff turnover
- Staff training and experience measures, and credentials
- The impact of staffing on the capacity of the provider to deliver high quality, safe care
- Volunteer numbers
- Call bell response data
- Police checks
- First language of staff and English is an Additional Language or Dialect skills

Improvements

- Innovations in care and services
- Positive feedback and contributions

Other

- Residential Medication Management Reviews completed and outcomes implemented
- Audits and performance monitoring
- Information about Restrictive Practices in place
- Information about Positive Behaviour Support Plans
- Money spent on care and money spent on services
- Quality of life information including Quality indicators for lifestyle programs
- Feedback loop from governing body to advisory body to show continuous improvement and cyclical accountability and ensure the values of transparency, accountability and responsibility are to be embedded in the sector.

Information required for QCAB reports (Q4)

Respondents were asked whether providers should be required to give the QCAB the information it needs to write its report. Over 89% Agreed or Strongly Agreed that providers should be required to do this.

Only 5.5% of respondents disagreed with this requirement. Those that did had concerns about the confidentiality of the information being given to all members of the QCAB, particularly if some of the information concerned individual consumers or was of a commercial in confidence nature.

Some respondents raised concerns about whether QCAB members would have the expertise to write reports to the governing body. One suggestion was that the reports be prepared by the provider's executive, management, or team members, following recommendations from the QCAB, which would then ratify the report.

One respondent commented that the organisation must have discretion in what can be given to the body. Another raised concern that the QCAB would be dependent on the provider to give it the information necessary to prepare its reports for the governing body, potentially compromising the QCAB's ability to assess the quality of care provided by the service.

QCAB records (Q5)

Respondents were asked what type of information on the QCAB should providers be required to keep in records. There were five suggestions provided and all were Agreed or Strongly Agreed to by most respondents.

94% of respondents agreed that records should be kept on the QCAB members.

Almost 92% agreed that records should be kept evidencing that the QCAB meets the membership requirements.

Almost 95% agreed that records should be kept on QCAB written reports and feedback to the provider's governing body. One respondent commented these reports and responses should also be made available to the staff and, in appropriate format, to consumers and carers of the service.

Almost 92% agreed that records should be kept of written advice from the governing body to the QCAB.

Almost 95% agreed that the QCAB meeting dates and minutes records should be kept. Some respondents commented that if minutes were kept then all the above requirements may be redundant or duplicated.

One respondent commented that in addition, records should be kept of how recommendations made by, or actions proposed by, the QCAB have been implemented/addressed; why a recommendation or action was not taken; and how the provider is ensuring the rights of older people receiving care and services are upheld, including access to education for staff and consumers.

Many respondents also noted providers are already required to keep a myriad of records:

- This is the board and senior executive's responsibility, and this documentation would be duplicating documentation already kept for the Aged Care Quality and Safety Commission.
- More compliance imposed on the provider. A paperwork exercise that directs time and skills away from care for residents.

Some respondents raised concerns about the QCAB reform generally in relation to the protection of Board confidentiality. For example, one respondent disagreed with the proposal that the Board is required to report back to the advisory body about how any reports or feedback were used, commenting that this should be at the discretion of the Board as some issues require confidentiality.

Records to be kept by approved providers

The Bill proposes to increase the proportion of independent members on a provider's governing body, so the majority of the members are independent. The rationale for this is that non-executive members bring independence and objectivity to a body and play a valuable role in challenging, monitoring and holding management to account. Consultation occurred on the records a provider should keep about this independence, which will form part of the subordinate legislation.

Records of the majority of members of governing body being independent (Q7)

Over 89% of respondents Agreed or Strongly Agreed that a provider should keep records of the independent non-executive membership of its governing body.

Positive comments welcomed the increase in provider governance standards through the increase in non-executive governing body members (as set out in the proposed primary legislation). A respondent noted that in the case of most charities, all directors are non-executive, and their details are listed in an annual report and submitted to the Australian Charities and Not-for-Profits Commission.

The comments from respondents who disagreed with the requirement to keep governing body records, did not discuss the issue of keeping records per se. Rather they disagreed that non-executive members should form the majority of governing body members, which was beyond the scope of the consultation process. Respondents identified that many small or private businesses do not have these types of members at all, and that it is difficult to obtain non-executive members. Others commented that the carve out provisions in the Bill were too narrow.

Examples of the comments here include:

[A]n independent governing body is not appropriate for privately owned business where the owners work day-to-day in the business. (Response on behalf of Ageis Aged Care Group Aged Care staff)

It is difficult not to conclude that the framing of the legislation in relation to the need for a majority of independent non-executive members of the provider governing body, has occurred absent an understanding of the corporate structures of many approved providers or the real-world consequences for many. (Response on behalf of the Aged Care Industry Association)

Other comments indicative of concerns in this area are:

- Some small businesses have no non-executive members. It is unworkable.
- There is not enough of these types of people. We can't get these types of people.
- An exemption from the Commission should not be timeframe limited.

Records of the requirement of a governing body member with clinical care experience (Q7)

To increase the focus on clinical care, a proposed Bill reform is to record the number of members with clinical care experience on the governing body. As part of the consultation, feedback was sought on requiring the provider to keep records of this.

Over 84% of respondents agreed a provider should keep details of the clinical experience held by members of the governing body.

Positive comments referred to the fact that clinical requirements are part of a balanced governance process to support aged care services and that the input of clinical care experts, including nurses and personal care assistants, is critical to ensuring quality care is understood at the executive level and translated into practice.

Others noted this information was already reported in annual reports of the organisation and in reports to Australian Securities and Investments Commission and Australian Charities and Not-for-Profits Commission.

Many comments from respondents who disagreed with this requirement, related to the underlying need for clinical expertise on the governing body, rather than the procedural aspect of recording the details of members with clinical expertise. For example:

- We are supporting disclosing details of clinical expertise of governing body members but do not support prescribing the skills necessary for board members.
- There is a need to ensure a focus on balance, as clinical experience can be gained in and on the job, not just through formal qualifications.
- Why do you need clinical experience to be a director? This may not be relevant to their usefulness on the governing body. A governing body needs a much broader scope of capabilities than just clinical experience. The focus should be on skills, experience and personal qualities of the members.
- Clinical experience is not required. At this level it is often outdated.

Other respondents noted that this requirement is not necessary for bodies that don't provide clinical services. When considering the requirements for governing body it is important to consider the type of care provided and where the service is located.

Records about the Consumer Advisory Body (Q8)

Another proposed reform in the Bill requires approved providers to offer care recipients and their representatives (consumers) the opportunity to create a Consumer Advisory Body (CAB). This CAB's purpose is to give the governing body consumer-based feedback about the quality of care delivered by the provider.

As part of the consultation, feedback was sought on requiring the provider to keep records of this offer, of feedback and advice between the CAB and the governing body and on the CAB's meeting dates and minutes.

Over 79% of respondents Agreed or Strongly Agreed that records should be kept of the dates and evidence of a provider's written offer to consumers to form a CAB.

Over 86% of respondents Agreed or Strongly Agreed that records should be kept of feedback from the CAB to the governing body.

Over 85% Agreed or Strongly Agreed that records should be kept of written advice from the governing body to the CAB.

Over 87% Agreed or Strongly Agreed that records of the meeting dates and minutes of the CAB should be kept, although there was one comment suggesting confidentiality for the minutes.

Other commentary provided by respondents on the CAB records included:

- A record should be kept of the profile of the CAB's members.
- Records should be kept of how recommendations or actions from the CAB were implemented or addressed.
- The record keeping is overly burdensome and costly.

A number of comments were made more generally about the QAB reforms addressed by the Bill. For example, positive respondent comments were received, such as:

We strongly agree with the need to ensure consumers are engaged in all aspects of service design, development and improvement that their representative needs are sought communicated and heard, and the governing body of the organisation is engaged in and understands the needs of the organisation's consumer base and can determine the organisation is acting upon consumer feedback. (Response on behalf of Resthaven Incorporated, aged care provider)

Others commented that the selection process is important:

...the selection process for members of these bodies be known to consumers and it should be a process of open and transparent selection. (Carers Australia)

...a risk that tokenistic offers will be made that either don't lead to the creation of a consumer advisory body or that sees a body implemented that doesn't represent the profile of all care recipients. More rigour is needed to ensure meaningful engagement and provision of appropriate support and tools, particularly for people living with dementia to be heard and actively involved. (Dementia Australia)

One respondent suggested that the CAB should report back regularly to consumers and carers on the outcomes from meetings and actions taken in response to its recommendations.

There was also some commentary provided around a potentially different framework for the CAB and its interaction with the QCAB. Comments included:

- For larger providers, one CAB bringing together representatives from across the facilities would suffice.
- One response indicated that alternate feedback and reporting mechanisms would be more suitable than what the consultation proposes. The respondent considered that responding and acting on the consumer advisory body's feedback is likely to have an operational focus which is the role of management, so it is more appropriate for the body to feedback to the QCAB. To enhance reporting and oversight to the Board, the QCAB should incorporate how it has dealt with CAB feedback when it reports to the Board. In receiving this report, the Board can determine whether consumer feedback has been appropriately considered and acted upon.
- Consumer engagement should be able to be multi-faceted in order to best suit the services being provided and the mix of the service involved.
- Consideration should be given to allowing care recipients to opt for the QCAB to also act as the CAB, one body with dual roles, given the synergies in the role. Membership should be voluntary, and positions not remunerated.
- The CAB and governing body should have a partnership model.
- It is important to publicise the terms of reference between the governing body and the consumer advisory body.

Although there was less than 8% disagreement from respondents to any of the suggestions posed around CAB record keeping, negative commentary centred around the cost of the body, the difficulty of getting and sustaining consumer involvement, and the fact providers already have mechanisms in place to hear consumer voices.

A sample of comments is below:

- A CAB is another layer of unnecessary bureaucracy. It is completely unnecessary and a logistical nightmare.
- This body makes no sense for a provider that operates 20 plus services as they may all be different, cater to different consumers and have different levels of performance.
- This is not appropriate for all organisations. There is no one size fits all approach to stakeholder engagement
- Consumers are often not interested, lack capacity and knowledge and feel intimidated.
- Many providers already use other tools such as surveys, consumer participation registers and resident meetings that are far more useful than a consumer advisory body.

Records about the governing body's responsibility for staff (Q9)

Another proposed Bill reform is to require the provider's governing body to ensure staff have appropriate qualifications and skills to provide care and services and have opportunities to develop their capabilities. As part of the consultation, feedback was sought on requiring the provider to keep records of this.

Almost 92% of responses Agreed or Strongly Agreed that providers should keep records showing how the governing body has ensured that staff have appropriate qualifications, skills and experience. For example:

the provider's governing body should also ensure that staff have appropriate qualifications, skills or experience and that key personnel are suitable for their roles [for example in continence care]. (Continence Foundation of Australia)

Over 89% of responses also Agreed or Strongly Agreed that providers needed to keep records showing staff have been given opportunities to develop their capability. There was a suggestion that the records also need to capture whether suitably qualified healthcare professionals are employed to deliver the specific services they have expertise in.

There was a suggestion that:

all members of the advisory and governing bodies receive information and also regular training relating to clinical governance and patient safety. Eg See <https://www.cec.health.nsw.gov.au/CEC-Academy/qi-for-boards>. (NSW Health)

Of the respondents who disagreed, many commented that providers already keep such records:

- There are already mandatory training requirements for which records must be kept. This is managed by Human Resources records on staff qualifications and performance and by standards 3 and 7 of the Aged Care Standards.
- Ideally, there should be a single framework and process to ensure compliance for worker screening across the country, with conflicting and overlapping obligations simplified wherever possible.

The Bill if passed will require the governing body to ensure the approved provider's staff members have appropriate qualifications, skills or experience to provide the care or other services to care recipients through an aged care service, and opportunities to develop their capability to provide that care or those other services.

Some disagreeing comments concerned the role of the governing body in staffing issues and related to the proposed change in the Bill:

- The governing body must be aware of these issues but it is not a strategic focus of the body and places an expectation that the governing body become involved in the operations aspects of the business. It is management's job not the governing body.
- There needs to be a balance between operational matters and governance responsibilities.
- Staff members can pursue their own continuing education just as other workers/professionals do.
- It is unclear how a governing body could 'ensure' that ALL staff have the appropriate qualifications, skills, or experience to provide the care or the services to care recipients.

Finally, there were comments about a shortage of qualified staff more broadly:

- Given the lack of staff in aged care how can a provider ensure this?
- Does it need to cover cleaning or gardening? Some recipients of home care complain of being made to wait a long time for very minor home care modifications, as a result of waiting for tradespeople who are expected to have specialised training to provide these.

Records about the suitability of Key Personnel (Q10)

Another Bill reform being considered is to require approved providers to be satisfied that their key personnel are suitable to be involved in providing aged care, at least once every 12 months.

As part of the consultation respondents were asked to consider what type of information providers should be required to keep in order to prove that this occurs. Most respondents Agreed or Strongly Agreed with the three categories suggested in the questionnaire.

Over 90% said that information on suitability of each member of the key personnel should be kept.

Over 91% said that all the evidence considered to decide suitability (such as qualifications, police checks) should be kept.

Over 84% said the date the provider considered the suitability of the key personnel should be recorded.

One respondent agreed on the definition of key personnel in the Aged Care Act that was set out in the questionnaire, in particular that the definition of key personnel should include any person who is responsible for the day-to-day operations of an aged care service, not only those providing nursing or other clinical services.

Many respondents who disagreed commented that such records were already kept. Others commented that this requirement will be burdensome, and others raised confidentiality concerns:

- These records are already required and implied. Another double up.
- This adds to an overly burdensome people function.
- Mandatory checks already require the individual to notify organisation of any change in circumstances.
- This is done when people are employed and annually at performance review, this seems like a waste of time if key competencies are not determined as part of an essential skill set required.
- Clarity to avoid duplication would be appreciated.
- That information should be kept confidential between the aged care provider and the individual employee, however consumers, their family and representatives should have reassurance that staff hold these prerequisites as a matter of employment with an aged care provider.
- A review each 12 months is inconsistent, for example, with a 3-yearly police check.

Annual Statement of Operations

The Royal Commission recommended that approved providers be required to submit an annual statement to the Department containing information about the provider's operations, and that this statement be made publicly available. An annual statement's purpose would be to encourage accountability and transparency, and to provide current and potential consumers, their families, and representatives with clear, timely and meaningful information about the quality of services and performance of providers. This statement will help care recipients and their families to understand key details of approved providers, including information about financial circumstances, staffing levels and complaints.

While most respondents Agreed or Strongly Agreed with proposals for what should be included in such an annual statement, some respondents did note it was necessary to provide clarity on the definitions used to avoid additional complexity or conflict with existing obligations. This included defining the terms *key personnel*, *complaint*, *quality of care* and *direct care hours*.

The Bill provides for an option for the provider to request to change the reporting period of this annual statement from 1 July – 30 June. One respondent commented that providers need to be able to align the reporting period of the annual statement with their financial year, and other statutory reporting requirements.

Records about information to include in the annual statement (Q6)

The questionnaire asked stakeholders about a list of information that could be included in the annual statement of operations.

Key Personnel names and role

Over 76% of respondents Agreed or Strongly Agreed that key personnel names and the role of key personnel should be included in the annual statement. Supporting commentary also suggested the qualifications and experience of these persons be kept. Some disagreeing respondents commented this may be a breach of the privacy of the individuals.

A statement the provider met the Aged Care Quality Standards

Over 86% of respondents Agreed or Strongly Agreed that the annual statement should include a statement that the provider has met the Aged Care Quality Standards. Further commentary noted:

- the information needs to be in-depth, relevant and evidence based.
- any non-compliance must be highlighted.
- any serious incidents and adverse outcomes reported.
- any information on sanctions, notices of improvement and failures in meeting standards included.
- any information on hospital admissions or deaths following preventable incidents (such as falls, medication errors) should be included.
- registration status of the service should be included.
- information about abuse cases should be included.
- clarity was needed around ensuring all understood what this attestation meant when saying the body meets Aged Care Quality Standards.

Whether there should be an exemption from the new governing body requirements

Over 79% of respondents Agreed or Strongly Agreed that the annual statement should include any exemption from the new governing body membership requirements that the governing body members should be independent and include at least one member with clinical experience.

Whether the provider has a consumer advisory body

77% of respondents Agreed or Strongly Agreed that the annual statement should state whether the provider has a consumer advisory body, with one commentator noting this could include the key achievements of the body.

Staff time spent on delivering direct care

Over 71% of respondents Agreed or Strongly Agreed that the annual statement should include staff time spent on delivering direct care. Further commentary suggested reporting on:

- An itemised breakdown of time spent by staff including allied health practitioners and the type of care they have provided
- Staff education and training
- The distinction between direct care and catering, cleaners, laundry staff and contract staff.

Consumers using and leaving the service

Over 69% of respondents Agreed or Strongly Agreed that the annual statement should include information on the number of consumers using and leaving a provider's service. Further commentary noted:

- This information will be of no importance unless reasons for leaving are also provided
- This information could include a profile of the provider's care recipients (such as age and diagnosis)
- For home care services, the people who started with and left the provider, and the reasons for leaving, can also be included.

Provider's financial position

73% of respondents Agreed or Strongly Agreed that the annual statement should include the provider's financial position. One commentator noted this should include the provider's profit and loss and balance sheets. Further commentary suggested reporting for that financial year:

- On whether the funding provided supported the staffing structure.
- On the budget spent on advertising and board members
- To include details of related party transactions.

Quality of food

Over 72% of respondents Agreed or Strongly Agreed that the annual statement should include information on the quality of the food provided to care recipients. Further commentary included:

- Information on food nutrition, and food enjoyment
- Food and weight loss
- Consumer engagement at food time
- Dietary restrictions.

Diversity and inclusion within the service

Over 76% Agreed or Strongly Agreed that the annual statement should include information on how diversity and inclusion issues are being addressed in the service. One respondent suggested this could include information on the percentage of aged care staff who are from priority focus groups.

Complaint information

Over 82% of respondents Agreed or Strongly Agreed that the annual statement should include information about complaints. Further commentary suggested this needed to cover:

- the responses/outcomes to those complaints
- a breakdown of the areas of complaint
- what actions have been taken to investigate, manage and address issues and complaints
- where the complaints come from
- whether the complaint is an internal complaint or a complaint to the Commission
- work health and safety compliance.

Other suggestions for annual statement

Respondents also suggested other information that could be included in the annual statement:

- Improvements made to the service.
- Positive feedback including from staff and consumer (and family) compliments, satisfaction surveys.
- Improvements in corporate and clinical governance and quality.
- Staff statistics including staff education/training and hours invested, staff turnover, staff qualifications, staff pay and conditions, staff to consumer ratio, staff ratios more broadly (actual not FTE), staff shortages.
- Support for consumers with dementia.

- Access to dental practitioners for consumers.
- Consumer wellbeing, such as access to activities arts, craft, outings, activities on and off site, and cultural activities offered.
- Consumer feedback and experience; how rights are being upheld and embedded.
- Equipment provided and used on palliative care.
- Access to allied health professionals and dentists.
- Professional interpreter use by facility.
- Compliance with COVID-19 requirements, including staff vaccinations.
- Outcome of Serious Incident Report Scheme and quality reviews.
- Reporting on services to persons with diverse needs.
- Name of chair of QCAB and members of the governing body.

Areas of disagreement with annual statement proposals

The top four items where respondents disagreed with the annual statement containing information were in relation to consumers leaving the service, time staff spent on delivering care, the financial position, and the quality of food. In addition, some thought information in the annual statement was overreporting and duplication. Some examples of such comments are:

- Reporting on the number of exits is effectively reporting the number of deaths which would lead to many unfounded interpretations.
- Departure from care can be a result of acuity and age of the consumers, not care. This data should exclude deceased consumers, so it is meaningful for consumers.
- There is no measure quantifying how we measure and report direct care time.
- Different models have different needs and comparison is pointless.
- The number of hours spent on care has no correlation to quality.
- Financial position should be limited to publicly available information (to prevent unnecessary administrative burden to providers).
- Financial position is already reported to the Department.
- Financial position has nothing to do with care.
- Some of the items such as quality of food and diversity are very subjective. Others can easily be fabricated (direct care time). Diversity and Inclusion is too nebulous to be of any use.
- The information sought is provided via other reporting channels and largely duplicates reporting obligations that already exist. This process will replicate what we already do. This is governance duplication.
- If you start making complaints public, you will encourage under reporting of complaints.
- Reporting should not be an accreditation process.
- What is the purpose of the annual reporting? Is it a declaration of service provision or a tool to gather statistical information about providers which can be used for benchmarking purposes?
- Specific metrics around complaints should not be disclosed as they are highly contextual and may disincentivise providers that have healthy, robust and comprehensive complaint reporting cultures.
- This report is straying from quality of care.

Implementation

Respondents were asked what further implementation information, guidance or support providers and consumers would need to deliver these changes. Over 300 comments were provided. The following sample provides an overview of what was suggested, sorted into categories:

Document suite to assist providers report against the new provisions

- Flowcharts, handbooks, terms of reference, templates of documentation, minutes and agendas, examples, checklists, standardised reporting templates.
- Guiding principles, operating framework outlining governance pathways and best practice principles, and outlining of agreed roles and responsibilities.
- Codes of conduct, rules, detailed information on governance and terms of reference for the advisory bodies and governing body.
- Frameworks for consumer survey design and consumer engagement.

IT support and funding for resources

- Funding appropriately to transition into the new model.
- Ongoing funding for additional staff and to pay new body members.
- IT systems to make the further burden easier for providers.
- Grants for electronic software programs in aged care to assist providers in implementation.

Government support and training

- Information campaign, education and support such as a government resources hub.
- Access to people with knowledge and skills, including a hotline.
- Training, mentoring and support to the new bodies to allow the members to actively contribute including training workshops, online training, roadshows and podcasts.

Other

- Brochure on the rights and responsibilities of the consumers and representatives. Involved in the new groups, and explaining how continuous quality improvement works.
- A governing body/unit separate from the Aged Care Quality and Safety Commission to manage the legislation, rules and governance.
- Reasonable time frames for implementation.
- Connecting QCABs and CABs into communities of practice to support each other and share best practice.
- What is provided needs to be easy to understand, accessible, available in different languages and different for the different aged care types of services.

Additional comments

Respondents were asked if they had any comments or suggestions (as free text commentary) additional to those raised in the consultation on the proposed aged care reforms. There were over 220 comments provided. The following sample provides an overview of the comments provided, sorted into categories (noting that some comments provided have been incorporated into the report above where the comment related to a specific question). Some comments address the aged care system and the approved provider governance reforms more generally, in addition to the matters consulted on during this consultation.

Proposals for modification to aged care legislation

- Where a corporate group operates multiple aged care entities, allow for the creation of only one Aged Care Governing Body, one QCAB and one CAB to cover all the entities.
- Employees and contractors sitting on either of the advisory bodies need whistle blower and employment protection assurance.
- There should be an equally strong emphasis on skills, qualifications and education of governing body members as staff.
- How is the Chair (of the governing body) supported by the Aged Care Quality and Safety Commission to facilitate broader change at the provider management level and what are the linkages here?
- A default, temporary exemption for the transitional period between a QCAB member leaving and their replacement being found, would enable providers the time to engage a suitable, sustainable candidate, rather than rushing such a decision to meet compliance.
- Providers be required to conduct an annual, independent survey of care recipient/representative views on quality of care and present this to the Board for consideration in decision making (rather than relying on having a QCAB).
- The changes should apply to all providers not just those with 40 beds or less than 5 board members. There needs to be clarification around the grounds for exemption from these general requirements and why these exemptions do not pose a risk to quality of care, from a governance perspective, especially to consumers with high care needs.

Additional funding

One recurring comment was that providers would need additional funding to meet the requirements, as they impose compliance costs, administrative burdens and take managers away from operational tasks:

- Funding needs to be directed at providing care, rather than creating statistics or policing.
- Who is going to fund this? Regardless additional staff are going to be needed to meet all these requirements as it is not possible to put this workload on existing staff.
- Providers are not funded for this level of administration.
- If this is not sufficiently funded, the quality of care may decline.

Different models need different regulation

- Give providers the responsibility to design and report as relevant to their service size and funding requirements.
- Need to consider the impact on small, remote and indigenous providers.
- Need to have proportionate expectations for the different care services.
- Suggest clarification about the methods in which those smaller providers may be able to meet a reasonable level of transparency of governance without administrative burden.
- Consideration needs to be given to the practicalities of the proposed reforms on ALL sectors of the aged care in-home support sector that the legislation impacts to ensure that compliance is possible. There is an increasing diversity and variation in models of business operation and governance across the sector.

Quality of care focus and staffing

- The focus of many of the reporting requirements in the consultation paper is very much at the operational rather than the strategic overview level.
- Where is the mandate for registered nurse input into aged care? The Royal Commission gave an opportunity to ensure there is a minimum standing qualification level for aged care and again will leave homes with fewer qualified staff relative to the high acuity clinical needs of the consumers.

- What is being developed is a rigid, formula-driven, compliance mindset approach to governance and regulation that will further distract boards and management from their task of delivering quality, safe, innovative services to consumers.
- I recall when the need for 24/7 registered nurses was removed from residential aged care. This was an enormous mistake and needs to be reinstated to ensure consumers receive quality care.
- Government needs to increase training of (and training places for) nurse practitioners, Registered Nurses and Enrolled Nurses and carers.
- Despite the Royal Commission noting the need for more face to face time with consumers, higher clinical standards and less onerous time spent on duplicated paperwork, these proposals seek to add yet more regulation and financial and administrative burdens on providers without any regard for the cost or the diversion of precious resources or any additional funding.
- Volunteering is important in contributing to the quality of care within aged care services.
- Put more focus on people being able to demonstrate continuous improvement and develop skills in this area.
- In order to ensure provision of quality care to consumers and those in the community, the quality and education of carers and support workers must improve, and their wages increase substantially. These workers must be sourced from appropriate education facilities and have at least Certificate 3 training in aged care as a priority.

Consumers

- The expertise of the membership of the new advisory bodies should be reflective of care needs and the profile of care recipients.
- Capture data on care recipients, including the number of people living with dementia.
- List dementia as a standing item on all meeting agendas, with discussion on workforce education and training, dementia-friendly physical environments and consumer engagement.
- Management and board members need to complete aged care and dementia care training courses.

Other

Link in with existing resources developed by Commonwealth and Jurisdictions..... Reduce duplication of requirements from differing bodies regarding Policies, accreditation, reporting, care standards etc – standardise these requirements – eg NDIS, Disability, Aged Care Commission, ACSQHC requirements and care standards, accreditation and reporting requirements. (NSW Health)

- Transparency and accountability needed – not simply reporting. ACQSC need to cross check accuracy of information through audit/unannounced site visit/independent consumer & representative & employee survey (including option for anonymity).
- Give providers an opportunity to adjust to the change and be flexible with reporting requirements.
- Improvement is now needed around public reporting requirements and visualisation of the information to inform improvement.
- Change in the organisation culture of aged care management.
- In a partly privatised service delivery model, this reporting and control system must be able to look at the conflict between profit and quality.
- The timing for introduction of the governance measures needs to be delayed to ensure providers can do the substantial implementation (including clinical governance committee and annual reporting requirements) required.

Endnotes

ⁱ www.health.gov.au/initiatives-and-programs/aged-care-reforms

ⁱⁱ Royal Commission into Aged Care Safety and Quality, Final Report: Care, Dignity and Respect, <https://agedcare.royalcommission.gov.au/publications/final-report>

ⁱⁱⁱ Recommendations 88 to 91.

^{iv} <https://www.health.gov.au/resources/publications/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety>

^v consultations.health.gov.au/aged-care-reform-compliance-division/strengthening-aged-care-provider-governance-consul/

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