Submission to Senate Community Affairs Legislation Committee Inquiry into the provisions of the Inspector-General of Aged Care Bill 2023 and the Inspector-General of Aged Care (Consequential and Transitional Provisions) Bill 2023

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This submission has been developed in consultation with AHPA's allied health association members.

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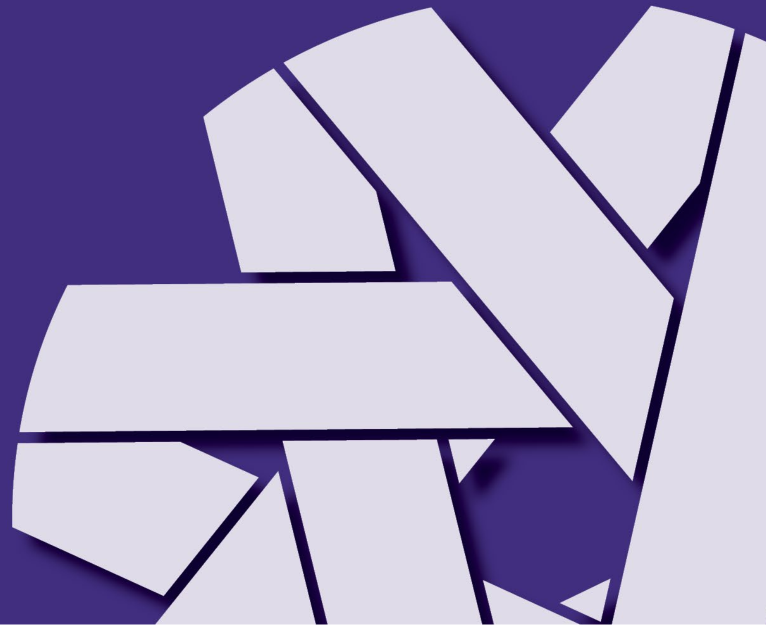

About Allied Health Professions Australia and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing Australia's allied health professions across all disciplines and settings. AHPA's membership collectively represents some 180,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners.

With over 200,000 allied health professionals, including 14,000 working in rural and remote areas, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, including providing diagnostic and first-contact services, and preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses.

Allied health practitioners also support pre- and post-surgical rehabilitation and enable participation and independence for people experiencing temporary or long-term functional limitations. Allied health therefore provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

Working with a wide range of working groups and experts across the individual allied health professions, AHPA advocates to and supports Australian governments in the development of policies and programs relevant to allied health.

Summary of our recommendations

AHPA strongly supports the Inspector-General of Aged Care Bill 2023 ('the Bill'). The changes to the Bill that we propose below are intended to enhance the role of the Inspector-General in ensuring accountability and transparency in Australia's aged care system.

Recommendation 1

The phrase 'facilitate positive change for older Australians' in the Objects of the Bill (Clause 3) should be replaced by wording along the lines of 'develop and maintain high standards of aged care quality and safety for older Australians and in accordance with human rights obligations'.

Recommendation 2

The roles of the Inspector-General and the Office should be legislatively embedded in a consultative structure that requires effective input from the aged care sector on systemic concerns, including annual work plans (Clause 15(3)), reviews on the Inspector-General's own initiative (Clauses 17–19), draft review reports (Clauses 21–22) and extra reports to Parliament (Clause 29). This input should be obtained via the Aged Care Advisory Council, the Council of Elders and a stakeholder consultative mechanism similar to those currently operating for the National Disability Insurance Scheme Quality and Safeguards Commission.

Recommendation 3

The Inspector-General must be statutorily empowered and resourced to monitor and/or review the implementation of responses to final review report recommendations, so that the relevant wording in Clause 24 of the Bill is similar to that in Clause 28 of the Bill (Reviews of implementation of Aged Care Royal Commission recommendations).

Recommendation 4

The Inspector-General should be mandated to report regularly on implementation of Royal Commission recommendations at least every six months.

Recommendation 5

The Inspector-General should be mandated to conduct independent evaluations of the effectiveness of selected measures and actions taken in response to the Royal Commission's recommendations, at least every two years. If Recommendation 4 is not accepted, these evaluations should include monitoring of progress on uncompleted implementation and should be conducted annually.

Introduction

AHPA appreciates the opportunity to make a submission on the Inspector-General of Aged Care Bill 2023 ('the Bill').

Our comments on the Bill emphasise the need for a strong and independent Inspector-General function that enhances the accountability of Australia's aged care system, via regular engagement with key stakeholders and public examination of pertinent systemic issues.

To provide context for this emphasis, our submission begins by outlining the current state of allied health services in the aged care system and existing approaches to monitoring of, and accountability for, the provision of allied health services.

Examining these issues and their relationship to the recommendations of the Royal Commission into Aged Care Quality and Safety ('Royal Commission') clearly reinforces the need for strong systemic oversight of the aged care system and of the associated implementation of reforms.

As consultation on the in-home aged care reforms is still in process, we focus on residential aged care.

Allied health in residential aged care

The provision of allied health services in residential aged care is in a parlous state, and the processes meant to provide system accountability are Kafkaesque. Insufficiently specific Aged Care Quality Standards combine with the current failure of the Aged Care Quality and Safety Commission to address systemic allied health issues, and a lack of Government commitment to any enforceable targets for allied health provision.

Royal Commission

The Royal Commission found that although allied health services are a fundamental component of aged care and are particularly critical in helping to maintain residents' wellbeing and facilitating restoration of function, allied health services are underused and undervalued across the aged care system.[1]

The Royal Commission concluded that this significant under-provision of allied health care produces morbidity, mortality and quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[2]

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[1] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83.
[2] See eg Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.

The Commissioners therefore called for 'a change in culture in the aged care sector, to view allied health services as valuable rather than a burden on funding',[3] and for allied health to become 'an intrinsic part of residential care'.[4]

The Royal Commission further recommended that the aged care system should focus on prevention, rehabilitation and restoration – or at least preserving older people's capacities as much as possible, such as after a fall. The Commissioners viewed the concept of older people's wellness as extending beyond physical health to a multidimensional view of wellbeing.[5]

Recommendation 38 focused on residential aged care and supported this more holistic approach, through requiring the provision of a level of allied health care appropriate to each person's needs.[6] The previous Government accepted this recommendation in-principle.

No benchmark or designated funding for allied health

Research undertaken for the Royal Commission by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong – the team which developed the Australian National Aged Care Classification (AN-ACC) – found that in 2019, aged care residents received, on average, only 8 minutes per person per day of allied health care.[7]

To meet the allied health needs of residents, the AHSRI recommended an average of 22 minutes' allied health care, and for funding for allied health service provision be built in to the AN-ACC model.[8]

This recommendation has not been implemented, and Australian allied health aged care still has no minimum required minutes. Identification of allied health needs and related necessary spending is instead left to the discretion of providers, without any designated funding allocation.

Although AHPA welcomed the recent care minutes reforms in nursing and personal care, we are extremely concerned about the lack of mechanisms to similarly ensure sufficient allied health services – as the third pillar of aged care – in residential aged care.

The most recent figures are even more concerning than the Royal Commission's 8 minutes. Total allied health per resident per day now ranges, depending on the source, from 2.85 to 6.36 – at best, around a quarter of the 22 minutes recommended.[9]

A recent scoping study commissioned by the Department of Health and Aged Care ('the Department') concludes that the level and breadth of allied health involvement in Australian

[3] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[4] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101.
[5] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021; 101; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 176 and Recommendations 35 and 36.
[6] Recommendation 36 proposes the same standard for in home care. This was accepted by the Coalition Government.
[7] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 2.
[8] Ibid, 33-35; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-10.
[9] 2.85 from Mirus for January 2023; 4.9 from University of Technology Sydney Ageing Research Collaborative for FY22; 5.07 from StewartBrown for FY22; 5.6 from Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022; 6.36 from StewartBrown for the three months ending 30 September 2022. These figures are averages, except for the Department's, which is a median.

residential aged care homes is 'limited'.[10] The Department does not provide a measure of what would be an acceptable average amount of allied health care.

A survey undertaken by AHPA's Aged Care Working Group, of allied health professionals working in residential aged care, shows that there are already serious impacts on both the workforce and residents. These trends include more than one in eight allied health professionals losing their jobs and another 30% planning to leave the sector, with professionals reporting particular distress about negative impacts on the quality of care they are able to provide.[11]

As the AN-ACC funding model did not commence until 1 October 2022, data reported by providers does not yet reflect its impact. However, without an allied health benchmark and targeted funding, the AN-ACC will not be sufficient to address the gross under-provision of care identified by the Royal Commission.[12]

No consistent definition of 'needs-based allied health'

The lack of a benchmark for allied health provision is linked to the fact that the actual amount and types of allied health that an older person should receive, as recommended by the Royal Commission, depends upon how the person's needs are assessed.

Yet despite recommendations from both the AN-ACC team and the Royal Commission,[13] the aged care reforms have not embedded automatic and nationally consistent allied health assessment, nor the use of nationally consistent care planning and delivery processes via multidisciplinary teams, in residential and home care.

Taking residential aged care as an example, an older person seeking a place in a residential facility first undergoes an Aged Care Assessment Team (ACAT) assessment, which also produces a support plan.

The ACAT assessors do not assess aged care residents for AN-ACC funding purposes. A separate AN-ACC assessment process assigns the older person to a particular AN-ACC class, which in turn determines the funding provided to the facility for that person.

As recommended by the AHSRI team that designed the AN-ACC, care planning – assessment of residents for delivery of appropriate care – is not conducted as part of the AN-ACC assessment and remains the responsibility of aged care providers.[14]

While, in theory, the support plan developed via the ACAT should identify allied health needs, in practice this is inconsistent. If it is then arranged that the person enters a particular residential facility, that facility is responsible for producing a care plan. However, there is no established process to ensure that the ACAT support plan is provided to the facility.

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[10] https://www.health.gov.au/resources/publications/scoping-study-on-multidisciplinary-models-of-care-in-residential-aged-care-homes-summary .
[11] https://ahpa.com.au/advocacy/3489-2/ .
[12] https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ .
[13] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 33; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-10; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ ; Royal Commission Recommendations 28, 31, 37 and 38.
[14] Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-11; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ ; 'What is AN-ACC and how will it work?' Department of Health and Aged Care, 2022.

It is then up to facility staff to identify any perceived allied health needs. Whether the resident ends up receiving allied health services therefore depends on existing staff skills and breadth of knowledge of different types of allied health, and so may only occur in response to an adverse event, and may vary by provider facility and even among individual staff.[15]

Aged Care Quality and Safety Commission

As outlined above, there is still no accountable standard for allied health service provision, and Government aged care policy has not defined, let alone quantified, allied health 'needs', nor established any consistent and reliable processes to identify them.

Equally concerning is a trend for aged care providers to substitute 'cheaper' workers from outside allied health, such as lifestyle coordinators, to provide services, when considerations of quality and safety require those services to be delivered by an allied health professional.

Similarly, allied health assistants (AHAs) are sometimes used to carry out essential allied health tasks. Although valuable contributors to the workforce, AHAs are less qualified than allied health professionals. AHAs therefore either require supervision, or are simply not suited to the task, which exposes residents to unacceptable risks.

Compromising allied health quality and safety in these various ways exacerbates Australia's already considerable health sector burden, via outcomes such as increased hospitalisations and surgeries.

When addressing allied health service provision and associated quality and safety issues, the Department places all responsibility squarely on the regulator. For example, the Department stated in Evidence to the Senate Community Affairs Legislation Committee Inquiry into the Aged Care Amendment (Implementing Care Reform) Bill 2022 that the Aged Care Quality and Safety Commission ('ACQSC') will identify any instances of insufficient allied health provision.[16]

The ACQSC regulates providers according to their obligations under the *Aged Care Act 1997*, and in particular as defined by the Aged Care Quality Standards in the *Quality of Care Principles 2014* ('Quality Principles').[17] Providers' legal responsibilities concerning the quality of the aged care that they provide include:

> to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;[18]
>
> to comply with the Aged Care Quality Standards;[19] and

[15] While there are some differences in home care, because an assessor determines the range of total service needs, including potential allied health services, for each person, the limitations are similar to those for residential care. It is up to the assessor to decide if the person should be referred on to an appropriate allied health professional for a detailed clinical assessment, which will then recommend the services they should receive. Whether the older person proceeds on this pathway again depends upon whether the assessor has the training and knowledge to decide on referral to an appropriate allied health professional.
[16] (Hansard Proof) Evidence to Senate Community Affairs Legislation Committee Inquiry into Aged Care Amendment (Implementing Care Reform) Bill 2022, Parliament of Australia, Canberra, 25 August 2022, 34-35 (Michael Lye and Mark Richardson, Department of Health and Aged Care). See also the Aged Care Quality and Safety Commissioner's response in the same transcript, and the Commission's Compliance and Enforcement Policy (14 July 2021), pp7-9.
[17] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5 and Schedules 1 and 2. See also the Regulatory Impact Statement for the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 which notes 'there is a risk that providers reduce allied care services within residential aged care when the requirement to provide certain treatments to access additional funding is removed. This risk is minimised by the Aged Care Quality Standards requiring the delivery of clinical care in accordance with the consumer's needs, goals and preferences to optimise health and well-being' (p198).
[18] *Aged Care Act 1997*, s 54-1(1)(b).
[19] *Aged Care Act 1997*, s 54-1(1)(d).

such other responsibilities as are specified in the Quality Principles.[20]

The ACQSC has not yet addressed systemic allied health issues, despite provision of needs-based allied health clearly being a quality and safety issue. The main ACQSC mechanisms for ensuring that providers meet their responsibilities under the Quality Standards are via accreditation assessments and performance assessments through site audits, review audits, quality audits and assessment contacts.

However, even monitoring allied health service provision via these processes requires translating the relevant Quality Standards into a measurable instrument – and as detailed above, such an instrument does not exist.[21]

In addition, the Royal Commission found that the ACQSC has not shown strong and effective regulation, with the regulatory framework not focused enough on outcomes, and the regulator being too ready to accept the assurances of providers and to manage every provider back to compliance.[22] This appears to have continued.[23]

Possible future development of an allied health-related quality indicator will also not provide the accountability urgently needed.[24]

Lack of public reporting of allied health service provision

An effective aged care system must be able to ascertain whether people are receiving allied health services according to assessment of their clinical needs, and if that care is being appropriately delivered and coordinated. Consumers can use the data to inform their choices about aged care services or facilities, and future improvements can then be based on evidence.

But there is no real accountability in the form of public reporting of allied health services in residential aged care. Some data on allied health costs and time spent is now included in the new Quarterly Financial Report for residential aged care (QFR).[25] However, although the next iteration of the QFR will reflect the AN-ACC changes, allied health care provided will not be publicly reported against each of the 13 AN-ACC classes. It will therefore not be possible to know whether, for example, older people with high needs received more allied health services on average than higher functioning residents.

While recent changes to the QFR mean that at least some residential facility allied health data by individual profession will now be reported, in-home care data will only include an aggregated allied health figure. It is important that data is collected for each specific type of allied health service across the aged care sector, not only to address older people's particular service needs, but also for workforce planning.[26]

Further, in the absence of any benchmarks or ringfenced funding, the purpose of even this level of reporting is unclear. The Department has simply stated:

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[20] *Aged Care Act 1997*, s 54-1(1)(h).
[21] See also https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ , especially pp 6-11.
[22] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 226-230.
[23] (Hansard Proof) Senate Community Affairs Legislation Committee Estimates, Parliament of Australia, Canberra, 10 November 2022, 111-118; https://ahpa.com.au/advocacy/submission-to-capability-review-of-the-aged-care-quality-and-safety-commission/ .
[24] For example, current Residential Aged Care Quality Indicators contribute a total of 15% weighting to Star Ratings, which then inform consumer choice rather than mandating quality.
[25] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022.
[26] For more detail see https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ , pp 8-9.

> 'This information is important because it will allow the Department to understand how allied health is delivered in residential aged care facilities. The reporting of allied health care minutes will help the Department to monitor the overall cost of care to aged care facilities.'[27]

Comments on the Bill

AHPA strongly supports the Bill, but we propose some amendments. Our suggested changes are all concerned with cementing the purpose and functions of the Inspector-General. The following themes should be directly addressed in either the Bill or in regulations, rather than risk being subject to the political whims of the day.

Role of the Inspector-General in the broader aged care system

AHPA agrees that the Inspector-General's roles and functions should not duplicate those of existing entities. Nevertheless, the Inspector-General and its supporting Office must play a key role in ensuring systemic transparency and accountability.

The phrase 'facilitate positive change for older Australians' in the Objects of the Bill (Clause 3) is neither clear nor strong enough in conveying the legislative intention that the Inspector-General take the lead in overall systemic oversight of the aged care system.

To remove any doubt, the Inspector-General should also be expressly required and empowered to address human rights aspects of Australia's aged care system, including through participation in relevant United Nations processes and entities.

Recommendation 1

The phrase 'facilitate positive change for older Australians' in the Objects of the Bill (Clause 3) should be replaced by wording along the lines of 'develop and maintain high standards of aged care quality and safety for older Australians and in accordance with human rights obligations'.

Breaking down siloes and embedding a consultative network

The Office of the Inspector-General should also play an important part in discouraging the current siloes in aged care, and instead facilitating communication and interaction among all relevant aged care system entities.

One of the ongoing difficulties AHPA experiences in advocating for allied health care to meet older people's needs is the way in which, since the Royal Commission findings, the rollout of different aspects of the aged care reform process tend to operate in a siloed manner, or at best sequentially.

Examples include the reforms to the Quality Standards and Quality Indicators, the separate Capability Review of the ACQSC, establishment of the star ratings system, and amendments to QFR and other reporting requirements.

Similarly, the place and implications of proposed human rights-based amendments in the proposed new Act are unclear given that these changes are yet to take place, despite many reforms having already been implemented or at least finalised in proposal form.[28]

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[27] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers . See also https://www.health.gov.au/resources/publications/questions-and-answers-from-australian-national-aged-care-funding-reforms-webinar-17-november-2022?language=en .
[28] Royal Commission Recommendations 1–3.

These different consultations, policy development and practices are often interconnected 'pieces of the same puzzle' and would therefore be better addressed as a whole in collaboration with sector stakeholders.

To ensure allied health service quality, it is essential that all relevant entities – the ACQSC, the Independent Health and Aged Care Pricing Authority, the different teams in the Department engaging with issues of quality, service provision, regulatory and legislative reform (including human rights), and key aged care stakeholders – are able to communicate and interact. A powerful and well-networked Office of the Inspector-General of Aged Care should play a lynchpin role in this process.

While the independence of the Inspector-General and the Office must be guaranteed, it is also critical that these roles are legislatively embedded in a consultative structure that requires and facilitates effective input from the aged care sector on systemic concerns. It is important that consultation and input from the aged care sector is consistent and representative of all key stakeholders: consumers and their advocates, care professionals (including healthcare), industry and unions, and providers. Otherwise there is a risk, as sometimes occurs in other sectors, that consultation is informal, selective and ad hoc.

Accordingly, the Aged Care Advisory Council and the Council of Elders should be resourced to regularly engage with the Inspector-General. In addition, AHPA proposes the establishment of a stakeholder consultative mechanism similar to those currently operating for the National Disability Insurance Scheme Quality and Safeguards Commission.

It should be an expectation that via such mechanisms, key aged care sector stakeholders such as providers, aged care workers, health professionals (including allied health) and consumers are regularly given the opportunity to comment on annual work plans, reviews on the Inspector-General's own initiative and draft review reports.

Recommendation 2

The roles of the Inspector-General and the Office should be legislatively embedded in a consultative structure that requires effective input from the aged care sector on systemic concerns, including annual work plans (Clause 15(3)), reviews on the Inspector-General's own initiative (Clauses 17–19), draft review reports (Clauses 21–22) and extra reports to Parliament (Clause 29). This input should be obtained via the Aged Care Advisory Council, the Council of Elders and a stakeholder consultative mechanism similar to those currently operating for the National Disability Insurance Scheme Quality and Safeguards Commission.

Responses to Inspector-General's final review report recommendations (Clause 24)

AHPA is pleased that the Bill sets a time limit for responses to recommendations and mandates publication of those responses. However, it is also important that the Inspector-General is statutorily empowered and resourced to monitor and/or review the implementation of responses, similar to the power and function pertaining to Royal Commission recommendations proposed in Clause 28.

Recommendation 3

The Inspector-General must be statutorily empowered and resourced to monitor and/or review the implementation of responses to final review report recommendations, so that the relevant wording in Clause 24 of the Bill is similar to that in Clause 28 of the Bill (Reviews of implementation of Aged Care Royal Commission recommendations).

Reviews of implementation of Royal Commission recommendations (Clause 28)

AHPA welcomes the proposal to legislate reviews of the Commonwealth's implementation of its responses to the Royal Commission recommendations, including of how Commonwealth measures and actions taken correspond to the recommendations, and an analysis of their effectiveness.

As outlined above, this process has been lacking for most Royal Commission recommendations concerning allied health. We strongly endorse the Royal Commission's finding that:

> 'Government must account fully for its response to our recommendations and must explain to the Australian people why it decides, if it does decide, not to accept a recommendation or to accept it only "in part" or only "in principle". The Government should also specifically and clearly explain why and how it is confident that high quality aged care will be available to those who need it where it has decided not to implement our recommendations.'[29]

Clause 28(2) of the Bill requires a review under Cl 28(1) to consider, in relation to each recommendation of the Royal Commission, the measures and actions taken by the Commonwealth in response to the recommendation, and the effectiveness of those measures and actions in implementing the recommendation.

To remove any doubt, that subsection should include or refer to a note to the effect that 'measures and actions' include the absence of measures and actions.

We note that the Consultation Paper on the Exposure Draft of the Bill (p 6) referred to the Inspector-General producing annual reports on implementation of the Royal Commission recommendations. This was in addition to the 5- and 10- year reports on an evaluation of the effectiveness of Royal Commission reform measures, to be undertaken in 2026 and 2031. Although the latter provision is in the Bill (Clause 28), the former is not.

Despite requests to the Department, AHPA continues to have considerable difficulty in accessing updates on implementation, and it is too important to be left to possible actions under Clause 29 or to the content of regulations under Clause 71(1)(c). AHPA therefore proposes that the Inspector-General report on implementation at least every six months, which is also consistent with Royal Commission findings.[30]

AHPA is also concerned that the proposed dates for evaluations of Commonwealth implementation of the Royal Commission recommendations are 2026 and 2031. This would make the first evaluation due five years after the Royal Commission Final Report, with another five years before the second evaluation. We note that although these timeframes were recommended by the Royal Commission, they were to be in tandem with its recommended 6-monthly monitoring of implementation.[31]

AHPA submits that it would be more aligned with the number and scope of Royal Commission recommendations and the practicalities of implementation to regularly monitor implementation, interspersed with more of a rolling series of 'mini-evaluations' of completed implementation of specific recommendations.

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[29] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B The new system*, 2021, p 930.
[30] Royal Commission into Aged Care Quality and Safety, Recommendation 148; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B The new system*, 2021, pp 929-949.
[31] Royal Commission into Aged Care Quality and Safety, Recommendation 148; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B The new system*, 2021, pp 929-949.

Recommendation 4

The Inspector-General should be mandated to report regularly on implementation of Royal Commission recommendations at least every six months.

Recommendation 5

The Inspector-General should be mandated to conduct independent evaluations of the effectiveness of selected measures and actions taken in response to the Royal Commission's recommendations, at least every two years. If Recommendation 4 is not accepted, these evaluations should include monitoring of progress on uncompleted implementation and should be conducted annually.

Finally, although we acknowledge that ensuring this outcome may be outside the scope of the Bill, the Office of the Inspector-General must be sufficiently resourced to be able to effectively perform its role.