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Roundtable

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JOINT COMMITTEE OF PUBLIC ACCOUNTS AND AUDIT

Monday, 18 August 2003

Members: Mr Charles *(Chair)*, Senators Colbeck, Crowley, Hogg, Moore, Murray, Scullion and Watson and Mr Ciobo, Mr Cobb, Mr Georgiou, Ms Grierson, Mr Griffin, Ms Catherine King, Mr Peter King, Ms Plibersek and Mr Somlyay

Senators and members in attendance: Mr Charles, Ms Catherine King, Ms Plibersek and Mr Somlyay

Terms of reference for the inquiry:

Review of Auditor-General’s report, fourth quarter 2002-03.

WITNESSES

BAILEY, Ms Jane Olivia, Assistant Secretary, Quality Outcomes Branch, Department of Health and Ageing 1

BRANDON, Mr Mark William, Chief Executive Officer, Aged Care Standards and Accreditation Agency Ltd 1

BUSHROD, Mr Ross John, General Manager, Accreditation, Aged Care Standards and Accreditation Agency Ltd 1

GRAY, Mr Richard Nelson Worsley, Director Aged Care Services, Catholic Health Australia 1

JACKSON, Ms Deborah, Senior Director, Performance Audit Services Group, Australian National Audit Office 1

MEERT, Mr John Emil, Group Executive Director, Performance Audit Services Group, Australian National Audit Office 1

MERSIADES, Mr Nick, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing 1

MUNDY, Mr Gregory Philip, Chief Executive Officer, Aged and Community Services Australia 1

NICOLL, Dr Paul, Executive Director, Performance Audit Services Group, Australian National Audit Office 1

SPARROW, Mrs Patricia Lee, Policy Manager, Aged and Community Services Australia 1

YOUNG, Mr Rod, Chief Executive Officer, Australian Nursing Homes and Extended Care Association 1

Committee met at 10.50 a.m.

MUNDY, Mr Gregory Philip, Chief Executive Officer, Aged and Community Services Australia

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MERSIADES, Mr Nick, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing

CHAIRMAN—I declare open today's public hearing, which is the fourth in a series of hearings to examine reports tabled by the Auditor-General in the financial year 2002-03. This morning we will be taking evidence on Audit report No. 42 2002-03: *Managing residential aged care accreditation*. We will run today's session in a roundtable format. I ask participants to observe strictly a number of procedural rules. Firstly, only members of the committee may put questions to witnesses if this hearing is to constitute formal proceedings of the parliament and attract parliamentary privilege. If other participants wish to raise issues for discussion, I ask them to direct their comments to me, and the committee will decide if it wishes to pursue the matter. It will not be possible for participants directly to respond to each other. Secondly, given the length of the program, statements and comments by witnesses should be relevant and succinct, and I emphasise the last word.

Thirdly, I remind witnesses that the hearings today are legal proceedings of the parliament and warrant the same respect as proceedings of the house itself. The giving of false or misleading

evidence is a serious matter and may be regarded as a contempt of parliament. Evidence given today will be recorded by *Hansard* and will attract parliamentary privilege. Finally, I refer any members of the press who are present to a committee statement about the broadcasting of proceedings. In particular, I draw the media's attention to the need to report fairly and accurately the proceedings of the committee. Copies of this committee statement are available from secretariat staff. I welcome representatives from the Department of Health and Ageing, the Aged Care Standards and Accreditation Agency, the Australian Nursing Homes and Extended Care Association, Aged and Community Services Australia, Catholic Health Australia and the Australian National Audit Office to today's hearings. I apologise for Baptist Community Services; their witness is ill.

Do representatives of any the organisations present wish to make a brief opening statement before we proceed to questions? Does ANAO have a brief opening statement?

Dr Nicoll—No, Chairman.

CHAIRMAN—The first question I would like to ask is: why the Australian Nursing Homes and Extended Care Association Ltd and Aged and Community Services Australia gave their submissions late Friday afternoon and how on earth do you expect us to have done anything with that?

Mr Young—Our apologies, certainly from my organisation, for the lateness. However, the information and the invitation to attend were also fairly late in coming. It was fairly difficult for us to respond in the time frame that we had to address a submission at all, but we welcome the opportunity to be here.

CHAIRMAN—One of the consistent things that I saw throughout the report related to the rush of effort that was required initially. Of course, the legislation came in and everyone needed to be accredited. It creates some real difficulties for the Aged Care Standards and Accreditation Agency I understand because of the extremely variable nature of workload since you are required to have all sorts of accreditation people out once every three years and the rest of the time you are running on idle. Do any of the participants have a view on whether that is a policy issue that should be addressed? Has anyone suggested to either the department or the agency that that is something we ought to think about?

Mr Mundy—That certainly is an issue from the industry's point of view. We can see that there is a very uneven workload that applies to the agency and that is not an ideal arrangement in terms of ensuring consistency because they are naturally forced to take on extra staff to cope with the peak workload. It is one of the reasons why we would be inclined towards a more open model of accreditation whereby the accrediting agency would cover a broader range of industries and then could have a more regular, smooth workflow and not have a peak in one year and then a trough for the next two years. We do see that as a problem and one that, if we do not change anything else, we are probably stuck with as the cycle runs over a considerable period of time.

Mr Gray—The ANAO report did identify that the agency was established in October 1997, but the first general manager of the agency did not start until March 1998. Of course, the agency really had to start from scratch and it was not until September 1999 that the principles were gazetted, which then enabled the agency to commence audits. Certainly in terms of the first

round of accreditation, the agency was in a very difficult time pressure situation, which was not of its own making. Of course, the point that Mr Mundy has made is very relevant for the ongoing operations of the agency.

CHAIRMAN—I think all of us here appreciate that this audit is now old news. That is not why we are here. We are here to see whether the industry has moved on and whether the recommendations made by ANAO—because they were accepted—have been picked up and implemented and whether that is working well or whether there are things that we ought to recommend either to the department, the agency or indeed to government.

Ms Bailey—In relation to the historical perspective, although I was not there, from my reading of the files there was significant consultation with the sector on the development of the first set of accreditation grant principles. There was an interim set before the 1999 set and that was all part of the preparation for a major change that was going to happen to the industry. From a policy viewpoint, we believe that accreditation audits are just one part of the cycle and with continuous improvement models there is a job of work the agency is doing continually in the sector as well as just the three-year accreditation cycle.

Mr Brandon—It is true that there is an uneven cycle to the work, because we grant a maximum period of three years accreditation, but it is more of a logistical issue than anything else. To try to smooth it out artificially would be to destroy the integrity of the whole process, I suspect. My thinking is that it is logistical. The concerns that were raised earlier about, I suppose indirectly, the quality of assessment that goes on can be addressed, and are being addressed, by better selection of assessors and better training of assessors. One of the things that happens during that peak period is that we get the benefit—and I stress 'the benefit'—of a number of assessors who actually work in aged care. There is a trade between having the benefit of the people who actually work in the sector and the teams that are made up of people who are full-time assessors, and we try to put together teams that have a mix of those skill sets. So the logistics of it are corrected by constituting good team mixes and also by ensuring that we have our assessors adequately trained. That was one of the issues picked up in the audit report, and we are well down the path to revising their selection and their training.

CHAIRMAN—On page 74 of the audit report, table 6.1 'Compliance with the accreditation standards—ratings given by assessors, state by state, as at 30 June 2001' talks about an extremely variable outcome. It makes me wonder whether it is because of different standards set by different states or whether it is the fact that different individuals will assess a particular item on the accreditation standards list differently. It is well known that, if you get a person to ring up with a complex question of the Taxation Office and you talk to five different people on five different days, it is possible—and I am not saying you will—to get five different answers, and that is part of life. So what is the problem?

Mr Mundy—Mr Chair, I would like to comment on that from an industry point of view. Certainly, in the first round of accreditation the consistency of assessments was a major issue for the industry. We all had access to the statistics, and peers talking to peers could not believe there was a real difference in the quality of services of this order of magnitude, so we think it did come down to variability between individual assessors. In the process that the previous minister for aged care set in train at the end of 2001, there was a series of focus groups around Australia. I remember vividly that one manager who had 13 facilities had 12 of them accredited by one team

and the 13th one, which she regarded as the last pea in the pod, by a different team, and she received a radically different answer. We certainly do put the variability down to different judgments being applied by different people, and in that round of accreditation—and Mr Brandon might want to comment on the changes since then—there was no robust mechanism for establishing inter-rater reliability between the different teams; whereas in some other types of agencies there is a routine of assessors sitting down and asking, 'What would you give this?' and deciding to give it an A. Perhaps because of the workload pressure there was no such process so robustly in place at the first round.

CHAIRMAN—Before we move on to ask the question that you have just raised, does anyone else have a comment about the variability in outcomes?

Mr Gray—One of the things we found when we surveyed all our members in August 2000 and in talking to many of them, particularly in Victoria, was that a number of them identified what they called a 'sea change' in the way the agency performed its audit function at the time of the publicity around the kerosene bath affair in the Riverside Nursing Home in Melbourne. In our report on accreditation, which went to the then minister—and a copy was provided to the ANAO—we did identify that that appeared to be a significant point of change and therefore we believed there was a degree of lack of fairness between the way facilities visited pre February 2000 and facilities visited post February 2000 were assessed, particularly in Victoria; we believed there was an issue of lack of consistency.

Mr SOMLYAY—On the question of lack of consistency, if you had two teams—as Mr Mundy said—surely there would have been a wide range of things they would have agreed on and perhaps a small range of things on which there were differences. On what types of things were there differences?

Mr Mundy—A typical example might be a particular regime of managing medications, where you may get differences in the professional judgments of two different nurses about what is a safe system of doing that and about what is an adequate level of documentation. You are reflecting a difference in professional opinion between two nurses. They may have been trained differently. One or both of them has the power to write the report, but they could quite easily make a different judgment about what is a safe practice regarding medication. There have been some examples. The report makes it clear that there have been relatively few appeals to the Administrative Appeals Tribunal, possibly because it is a very difficult and expensive process, but some of those have turned on that issue of a difference in professional judgment about the medication management regime.

Mr SOMLYAY—That is the judgment of the teams?

Mr Mundy—Yes. In the ones that went to appeal, there was a difference of opinion between the provider and the agency, but there could just as easily be a difference of opinion between two teams who had a different opinion about how those things were properly done.

Mr Brandon—I will make a comment firstly about ratings. That table has four ratings: commendable, satisfactory, unacceptable and critical. If you draw a line between satisfactory and unacceptable—that is, basically, between those that pass and those that fail—then, whilst on the face of it the differences are significant, the range between states of those who were found

compliant, to have passed, is 96.5 per cent to 98.9 per cent. So the difference is on the margin between satisfactory and commendable. The figures are correct. They are an accurate reflection of the findings, but for a nursing home both satisfactory and commendable are good outcomes. Collectively, the figures are up around the range of about 3.6 per cent—from doing the numbers fairly quickly. That gives us some context.

Having said that, post round 1 there was a review and there was work done with the industry. The agency and industry came to an agreement, I understand, that there would be two ratings—compliant and non-compliant. That is the round we are currently in. We do not have the figures for those at the moment, but other things we did to address the inconsistencies were that we introduced a new level of training so assessors could not get involved in the second round without having done additional training and we introduced an assessor handbook, a results and processes handbook. So we did a lot of work to address these issues. Whilst I think the numbers say what they say, there is a level of perception about just breaking into compliant and non-compliant ratings. In the new regime, those are the two measures we have.

Ms PLIBERSEK—One of the underlying issues the audit report alludes to is that we are spending all this money on accreditation and putting a lot of time and energy into it, but at the end of the day we do not know whether over time aged care in Australia is improving. We are not measuring ourselves over time; we are not measuring ourselves against aged care in other countries. Can you tell me how we could design a system that was not just a list of boxes to tick but that actually gave some indication of whether over time we are providing better care to older Australians? It does not have to be the agency that answers. If someone else wants to make some comments on that, I would appreciate it as well.

Mr Mundy—There are a number of things we could do that would get us on the path to doing proper benchmarking over time and between countries, for example. If we were able to develop some standardised data collections for the aged care industry, we could measure some of the things you can count over time.

Ms PLIBERSEK—Can I just interrupt for a minute. Maybe that data is available and you do not have the time or the resources to analyse it because you are so busy accrediting nursing homes? Do you think that this data already exists somewhere but that we are not looking at it in a way that is useful for making policy decisions?

Mr Mundy—I do not think it does exist in a readily accessible form. The sort of data that I would have in mind I do not think is routinely collected.

Ms PLIBERSEK—What sort of data would you collect?

Mr Mundy—You would need to do it on a resident-mix-adjusted basis, but you could look at the incidence of quality failures. For example, you could look at the incidence of ulcers from pressure sores and so on. You would need to do that on a casemix-adjusted basis because some people are very prone to them and some are not, but if you did collect a minimum data set for residential aged care you would be able, over time, to build up a picture of whether you were improving or getting worse. There are some quantitative measures you could probably put together from existing data, but they are not collected for that purpose; it would be a major effort to do that. One of the reasons why we tend to favour a more generic quality industry approach to

accreditation is that it would open the system up to benchmarking practices that are used in other industries. We see that as a potential advantage.

Ms PLIBERSEK—So you would have one quality assurance agency that looked at nursing homes, child care and what other industries?

Mr Mundy—We would favour having a number of accreditation service providers, operating under the JASANZ framework which licenses each of them as being competent, so that you could, in principle, have an accreditation service that was able to compare the standard of accommodation that is provided in aged care with that provided in hotels—not that you would expect them to be the same, but you would have another point of reference that would enable you—

Ms PLIBERSEK—Why wouldn't people just go for the agency that is most likely to give them a good result?

Mr Mundy—If they all had to pass a test in order to be competent to do the assessment, that would be the protection against that.

Ms PLIBERSEK—It is like doctors and lawyers. If you are going to court, you can go to a psychiatrist who you know is more likely to write you a report saying that you will never be able to work again or to a psychiatrist that says 'You should just pull your socks up and get on with it.' People have developed reputations for lying at one end of the spectrum or the other.

Mr Mundy—It is true to say that the robustness of such a system depends on the quality of the accreditation that is provided from the quality management industry, but we have just been talking about the variability that applies within the current system. You need to make a careful objective judgment about it—you cannot assume that it is 100 per cent objective now, compared to zero.

Ms PLIBERSEK—But we are trying to get rid of that disparity and what you are introducing is the potential for greater disparity.

Mr Mundy—It introduces two sets of variables. One is more agencies but the other is a framework that would routinely be applied to the methodology of every one of those agencies. The principal reason why we would favour a more open approach is that the majority of our members do more than one thing. They are faced with a situation where there is one unique agency that has to accredit the residential care services and necessarily they have to go to different people for the variety of other programs that they provide. Given that the sector is moving very slowly towards more comprehensive provision of services to older people, as long as we have a monopoly in one area it condemns people to having to go through a variety of different accreditation processes for every separate program that they provide. That is not a problem for every player in the industry; there still are some services that only do one thing, but an increasing number, particularly in our sector—that is, the not-for-profit sector—will have half a dozen major strands of activity and currently they have half a dozen different accreditation systems to go through.

Ms PLIBERSEK—I think Mr Young wanted to add something there.

Mr Young—When you were talking about benchmarks a minute ago I was going to mention that there are now quite a lot of facilities—in my estimation, well in excess of 600 facilities out of nearly 3,000 nationally—who participate in some sort of voluntary benchmarking exercise for their clinical services. The sorts of things that Mr Mundy just mentioned—like the occurrence of infection rates, bed sore rates, medication errors and those sorts of things—are being recorded, in fact they form an integral part of those facilities' quality improvement systems for accreditation purposes. I am very much aware that when agency assessors visit facilities which have those sorts of systems in place, they use them quite extensively to demonstrate the quality improvement framework. What we do not have—

Ms PLIBERSEK—You would have to guess though, wouldn't you, that it would be the better places that would engage in a voluntary data collection system like that; it would not be the places that really needed the upgrading that would participate voluntarily?

Mr Young—One would assume that that would be a natural human reaction, yes. We do not have this as a consistent benchmarking exercise across the whole sector. We are certainly growing it over time and as people see that it assists their accreditation process quite specifically and demonstrably, that assistance and take-up rate will grow. But it is not an obligatory activity for providers at the moment.

Mr Brandon—I would like to respond to the commentary about the number of services that have multiple services and multiple accreditation. Unfortunately, no-one can give us a figure so we do not know what we are dealing with. To go back to your question about AMI, the AMI system does record the compliant and non-compliant by the 44 expected outcomes and by service. We are building that information as round 2 goes on and we will certainly make that available to the sector. Of course, it is available to each approved provider, anyway. In today's environment the accreditation finding of compliant and non-compliant is a crude proxy for quality. There can be a long debate about the quality of assessment but I think we are addressing that quite substantially with the revised training and the selection processes. Once we get that squared away we have a crude measure. The other measure that we are thinking about is in terms of quality. A lot of the discussion so far has been about things which are clinical or quasi clinical and they do not actually focus on the overall quality of life for residents. I think the main game is the overall quality of life for residents.

Ms PLIBERSEK—Are you measuring that? Can you measure that?

Mr Brandon—In today's environment, in the absence of other information—and I agree with Mr Mundy and Mr Young that there is an absence—the finding of compliant or non-compliant for each of the 44 expected outcomes is a crude proxy for quality.

Ms PLIBERSEK—So how should we be measuring quality?

Mr Brandon—I think there is a strong argument for looking at other areas. In my limited time in the agency I have not been able to find something that you can pick up and say, 'Yes, this relates exclusively to aged care,' because aged care is unique in the sense that it is a mix of other things.

CHAIRMAN—Have you thought about such outcomes as longevity? Is that unreasonable? What are we trying to do here?

Ms KING—I do not want to be hooked up to a machine.

CHAIRMAN—Following some work done in New Zealand back in the eighties, a lot of local councils have hired private sector firms to survey the residents and determine what they think about the care they are getting. Everybody laughs at me for asking about how long you live, but I thought longevity would be pretty—

Ms PLIBERSEK—It would be a top priority for some.

CHAIRMAN—Do you want to answer that?

Mr Brandon—I think I will leave the question of longevity alone. One of the things we do as part of the accreditation process is to talk to residents and their relatives because when push comes to shove you can have all the measures, statistics and figures that you like, but if the residents do not think they have a good quality of life, they do not. It is not a scientific issue. You cannot say, 'Aren't you lucky because you did not fall out of bed and these other people did.' You have to look at residents and say, 'Do you feel you have a good quality of life?' That is the true measure.

CHAIRMAN—Do you do that?

Mr Brandon—We do not ask them that specific question. As part of the accreditation process we interview at least 10 per cent of the residents in each nursing home.

Ms PLIBERSEK—In private?

Mr Bushrod—In private, yes.

Ms Bailey—I would like to raise a couple of issues in relation to consistency and the need to evaluate. The 44 outcomes that are specified represent a mind shift. There was a move from an input measuring model to an outcome model, and I think that has been important. One of the consistency arguments will always centre around the fact that our industry is very diverse. There are small homes that might have five retired members of a religious order and homes that might have 200 residents on site. So any system we have has to be applicable across the whole range. Therefore it will always have to be a balance of subjectivity and objectivity. I think that absolute consistency is important but the industry is very diverse so we have to have a system that can apply across the whole industry.

One of the recommendations in some work we are doing for the minister on the paperwork review is that we develop a minimum data set for the aged care sector. I see that as being fundamental to the future way we measure improvements. No doubt duration of stay in aged care is important to us. The length of stay at the higher categories of care is, I think, quite an important indicator. It is not possible to say one thing or another but that is something you should look at. Mr Brandon mentioned quality of life indicators. In the American system, they are based largely on falls, restraint use and infection control. I think you also have to balance it

with what would be some useful quality of life indicators. I know the Queensland University of Technology is currently undertaking a research project to identify what might be some quality of life indicators you could use in the aged care sector.

CHAIRMAN—I would question one of the things that you said about length of stay. Judging by my memory of aged care going back into the eighties, the whole sector has changed dramatically. People who used to go into hostels are now staying home and if they need some assistance they are getting it either through HACC or through community care packages. Nursing homes for high care level patients have become an institute of last resort. In fact, most of the people that are today in high care would years ago have been in hospital.

Ms Bailey—Yes. You cannot use it as an absolute measure.

CHAIRMAN—So how on earth do you use longevity or length of stay as a measure?

Ms Bailey—There are many factors in the equation there; you cannot draw a line. But certainly we are looking for indicators that the care is good quality and therefore people are living the optimum life they can, pain free, with privacy and dignity and all those things respected. It might be an indicator. I am just saying that might be one issue that you could look at. It is not a definitive one but it is certainly something we look to.

Mr Mundy—I have a couple of comments. When looking at the situation with the length of stay of people in residential care, you really need to divide residents into two groups. There is a group who have quite short lengths of stay—of less than six months duration—but there is also a group who stay in high care for a very long period of time. We now have some who have been there over five years. One of the variables that appears to explain that difference is that people with dementia have very long survival rates, if you like, and they tend to be the longer staying residents. When you aggregate the data into a single average length of stay it obscures the fact that there are at least two quite different groups in the high care population.

Going back to the quality of life indicators question, which is really what I wanted to comment on, I think that is probably the most important thing for the residents of aged care facilities. I believe intuitively that they are more interested in quality of life issues than they are even in some of the technical aspects of whether their medication arrives on time and so on. I think that would be right. The Queensland University of Technology and Blue Care, which is a Uniting Care service in Queensland, have been working for about two and a bit years on developing a set of quality of life indicators and they have just published the first report on the project in the *Australasian Journal on Ageing* that came out just last week. I have seen it in the table of contents but I am yet to study it.

The American minimum data set, as Ms Bailey indicated, is very heavily concentrated on the technical quality of care. But it does have a set of variables around things that they refer to as social engagement—the question of whether a person is linking with the other people in their environment and with the people that visit them and so on. I think those are the sorts of measures that we should be developing here—asking whether people are alive, talking to people, talking to visitors and engaging with staff. Those are the sorts of things that you can assess behaviourally, that you can record and that can help you come up with a sort of cumulative record of whether people are getting a better or worse quality of life over time.

It is our perception that that quality of life area is one that has been under the most pressure in residential aged care over the last four or five years. Because it is not measured that objectively or quantitatively, when people have been forced to make economies—which they certainly have been—it is one area that we believe has been reduced over the last five or six years. One of the benchmarking studies that Mr Young referred to is one that is done by a commercial operation called Bentley's. Their survey shows that the amount of time per resident per day has declined consistently over the last five years. So the amount of time that staff can spend talking to residents has been reduced. There are methodological issues with that survey but it is probably the best evidence that we have available.

Ms KING—Is there any evidence of what has contributed to that reduction in time?

Mr Mundy—It is our view that there has been a reduction in the effective price paid for residential care in the Commonwealth subsidies over a five-year period.

Ms KING—So it is price, not process, that has been involved in that?

Mr Mundy—It is our view that people have been forced to economise because the effective value of the subsidy has objectively declined over a five- or six-year period, that it is measurable and that that is the area that people have trimmed back first. If they cut back on the things that are technically regulated, they will get into trouble. If they reduce the amount of time that staff have to make residents a cup of tea or to sew on a button that has come off, no-one will penalise them for that but the residents' quality of life has probably been diminished. The only objective measure we have of that to date is the amount of time per resident per day, and that is actually not a bad measure of the ability for an institution to support its clients.

Ms PLIBERSEK—Can I ask a couple of questions directly of the agency. One of the ANAO report findings was that you are not using data to systematically identify state and national training needs and that you have minimal human resource data on internal and contract assessors. I am hoping that you are going to tell us that you have put measures in place to address that since the report was completed. Is that the case?

Mr Bushrod—Since the audit was carried out, the agency has been progressing with a change to its structure and the level of support that the national office can provide to the states. In the key area of personnel, there is now a personnel manager. In addition to that, the agency has worked on the review of competency standards and better defined the competency standards required for quality assessors, the people who carry out the audits. It has continued with the audit methodology training and made that basically compulsory for all the people who undertake audits for round 2. That audit methodology training has involved a standardised assessment for all quality assessors undertaking audits in round 2. Further work has been done on reviewing ongoing training for quality assessors, and that will be implemented as that work is concluded. We are also collecting data to help us to understand the extent to which there can be differences between assessors and whether or not there are differences between assessors and the way in which they carry out audits. The information we have at this stage is not available to us in a form which tells us that there are specific things that we need to be pursuing by way of compliance outcomes.

So we have engaged in a range of activities to improve assessors' skills, to further identify the competencies that they need to continue to develop in, to develop further training and to provide them with some tools. Mark Brandon mentioned earlier that we had issued a results and processes document which is an outline of the expected outcomes of the accreditation standards and how assessors would approach an audit in relation to these outcomes, and an assessors' handbook which has been provided to all quality assessors to guide them in relation to the way in which audits should be carried out. The idea is that those documents basically set out the standard for all assessors to follow.

Ms PLIBERSEK—If a new nursing home opened up and got accreditation that ran out three years from when they got accreditation, not at the same time as everyone else's, would this bunching of people that you have to re-evaluate every three years dissipate over time?

Mr Bushrod—A commencing service, under the legislation, can only be accredited for one year. The legislation makes it clear that a new service that is just starting up is entitled to accreditation for one year only. The numbers involved there would not rapidly lead to a smoothing of the pattern of accreditation and reaccreditation over time because they are not very big numbers.

Mr Brandon—To go back to an earlier answer I gave in relation to the smoothing, I have to say I do not see that it is an imperative that we smooth the workload or the accreditation just for our convenience.

Ms PLIBERSEK—It just does not seem sensible to have all this pressure on you at one time of the year in one year, and income coming in, and then for two years you are in deficit and do not have the workload.

Mr Brandon—My rough guess is that the cycle covers around 18 months. Therefore we certainly show an operating loss for a couple of years, and an operating profit. I think so long as we have a solid sense of the future and the funding arrangements, then knowing that you are losing money one year because you are going to make it up next year and so long as we remain solvent, which we will—our current funding for 2003-04 has been negotiated with the department, which will give us a year-end equity of about $1.3 million and we are currently negotiating new funding—the major point is to introduce a certainty of funding rather than any particular number. That is what I want them to do.

Ms Bailey—I want to add, particularly to what I said before, that the accreditation visit is just one part of the whole cycle of monitoring of homes. In the other years the agency, as Mr Brandon mentioned, has a very big job to do outside the accreditation visits. I think it is an issue about workload. While the income might be slightly peaky the workload is pretty well distributed, albeit with a necessary decision-making load in one year—but I think the workload for visits is high across the whole time.

CHAIRMAN—To follow up on that, one of the things that bothered me in reading the audit report was the fact that the agency had an extremely suspect—if even recognisable—costing system to cost services. I would like to know what you have done about that. This committee has a strong interest in costing and has been critical over time of a number of government departments and agencies over costing methodology which is far less than that apparent and used

every day in private sector industry, so the committee would be interested in knowing where you are.

Mr Brandon—Prior to the delivery of the audit report we commenced a review of our costing methodology. Whilst the audit report is more about the attribution of cost—we knew where the money was being spent and from which accounts it was coming; there was no issue about that—it was more to say, ‘If you are doing certain things, how much does each of them cost?’ So we have now developed a cost model which has two elements. One is the budgetary side, which says, ‘If we know where we need to go, how much will it cost to do a site audit or support contact?’ and in fact we have developed the costs for doing each of those transactions at each nursing home. We know, if we are going to send an audit team to Moree to do a site audit, how much that will cost us. We have done that; we have built that. We have costed in—

CHAIRMAN—Do you keep time sheets?

Mr Brandon—No, we do not keep time sheets; that is the budgetary side of it. We have costed how much it costs us to deliver those services for the purpose of preparing a budget. Then the next stage in that—

CHAIRMAN—So it is an estimate; it is not a costing system? You are distributing costs based on a standard cost model?

Mr Brandon—A specific cost model.

CHAIRMAN—Do you then pick up variances?

Mr Brandon—We will by the end of the year. We are moving into the system of actually expensing it. The process starting point is that we asked, ‘How much money do we need to deliver our services?’ and we have done the budget based on the number of site audits that we know we needed to do plus estimates of support contacts by site. The next stage in that, which is also in place, is that we have broken that back into whether it is an education function, an accreditation function, a support contact or whatever. The third stage, which we are now actually developing—and I think this goes to what you are talking about—is: if we go to Moree, how do we cost that back so we know what it actually costs, so we are able to do some validation of our budgetary figures?

CHAIRMAN—Is it too honest to keep time sheets?

Mr Brandon—No. In fact, that is what we will end up doing.

Ms KING—You have now gone through the second round of accreditation. Can I ask all witnesses, other than ANAO, how has that gone compared to this round?

Mr Gray—The feedback that I have had from our services that have been through the second round of accreditation has all been very favourable. The reports on the professionalism of the assessors, the approach taken by the agency on the compliant/non-compliant issue and the need for a triangulation of evidence to support non-compliance, so that the decision maker has evidence to base the decision on with respect to both the rating and the accreditation decision,

have all indicated that the professionalism of the assessors in this round has far exceeded the first round.

Mr Young—I support Mr Gray's comments that that is the general feedback from the industry that is occurring. We can also report that where there are some potential anomalies thrown up from the sector the agency has been far more amenable to looking at whether there is a problem and addressing it fairly rapidly.

Mr Mundy—I would support that too. The general feedback from our members is that the round 2 process is much better than the round 1. There have still been some issues with individual assessors, but I endorse what Mr Young has said. Generally speaking, the response and follow-up from the agency has been a qualified improvement on the first round.

CHAIRMAN—Does QOB have a view?

Ms Bailey—It appears to us, as the funders, that it has progressed fairly smoothly. We have a watching brief to determine whether any homes do not achieve accreditation. But it appears to have progressed pretty smoothly, from the feedback we have had from the industries.

CHAIRMAN—Does ANAO have any statement about that? I realise you have not measured it but I assume that you would be happy to hear the words that you have just heard?

Mr Meert—Yes. It is very good. As I said, the agency was very positive about the audit and putting in place systems to fix it.

Ms KING—The Australian Nursing Homes Extended Care Association and Aged and Community Services Australia, in their submissions to us, are pushing for the JASANZ system. Do ANAO, the agency and the health department have a view on JASANZ?

Dr Nicoll—We see that issue for government; it is a question of policy. The government has established a regulatory arrangement and we do not comment on government policy. We audited the execution or the implementation of the current approach to regulation.

Ms KING—To follow on from some of the questions that Tanya was asking—I always have to deal with things in a simple way—if I was to ask all the witnesses, perhaps not the ANAO, can you tell if the quality of life for residents in aged care facilities in Australia improving and how do you know?

Ms Bailey—What we would say is that since the introduction of accreditation every home that the Commonwealth funds has now been seen by the agency and measured against a set of outcomes. That has given us some view of what is happening and more importantly it has given the industry a focus on how it should be going about its business and how it can improve and what procedures and processes it needs to have in place across the entire sector. The view I have is that that has been quite a steep learning curve. There were many terrific homes but across the whole industry for everyone to have put in place standard processes and procedures and achieved an understanding of resident input and people centre care and work with families has been a very significant achievement. This can be gleaned from a couple of things: the outcomes of accreditation and, probably, the complaints, which is the other side of what we deal with.

The issues there have been fairly stable or reducing over the last couple of years. While you cannot make it an absolute finding—I believe that people are still having issues about things—basically people feel now there is a framework to understand what aged care is offering them. Their relatives can get a feel for what the home might be offering. There is more information on which to make a decision and a judgment and there is more capacity for families to understand where they can complain if they are not happy. That is the take I have on it at the moment.

Mr Mersiades—I cannot give you definitive figures to support it but the underlying principle of accreditation is continuous improvement which means that all the providers have to sign up to that sort of process or exit the industry. It is interesting that the combined effect of certification and accreditation a couple of years ago saw a number of players exit the industry. Those who are left are signing up to a process of continuous improvement using the sorts of statistics that Mr Young was referring to in terms of tracking how they are performing against things like bedsores, falls and medication processes. Overall, the system is more conducive to delivering a better outcome. There was an article that came out recently that talked at length about different tools for measuring quality of life and whether the emphasis is on health or on some of the lifestyle issues. At this point, there is a lot of conjecture around what is an appropriate tool. I noted in the ANAO report, the emphasis on the need for us to be doing evaluation of how the accreditation process is going. We are in the process of doing a scoping study in conjunction with the agency. I do not think it will ever be 100 per cent because there are so many factors which impact on the quality of care. It is not just the accreditation system alone. But we do need to be able to make a better fist of being able to demonstrate that the accreditation system is having a positive effect. There is work under way to try to improve what we can say around that subject.

Mr Gray—The fact that facilities for the first round of accreditation had to go through a self-assessment process and focus on what they say they do, what they actually do and what are the demonstrated improvements out of that process did immediately force facilities to start thinking about having proper processes in place for measuring those outcomes. Now that facilities who have had to also focus on—because there is a legislated requirement for continuous improvement—ensuring that the systems they put in place are maintained and have now gone through a second round of accreditation are now starting to achieve some degree of maturity. Prior to the first round of accreditation, there was no real requirement for that approach although there were certainly outcome standards and there was a departmental way of checking whether facilities complied with those outcome standards through standards monitoring teams. The accreditation process is a far more robust and independent process than previously and therefore that has certainly made facilities conscious of the legislated requirement and the focus on what accreditation and quality systems are about. Just in the fact that the facilities now have good systems in place, whereas previously they may not have, is a significant sign that there is a focus on improvement of quality.

Mr Mundy—I note that one of the recommendations of the ANAO was that a comprehensive assessment of the overall impact of recommendation 5 should be undertaken. There probably is a case for doing that in terms of planning how we move on from what have been, I agree with Richard, real gains to the state. The additional point that I would make is that if we are going to do that we should have a proper process that includes the genuine stakeholders in the sector not only us as providers but also consumer representatives and ideally an independent chair of such

a process who can say, 'This is all the evidence; this is what we think the next generation of quality systems in aged care should be.'

I think Richard is right: I think the accreditation processes, as a set, are much better than the ones that went before. Clearly, we have identified areas where we think they could be further improved, but we do not really have definitive information outcomes. You can have better processes and not get better outcomes if other things have been going on in the meantime, and certainly there is currently a real strain on the industry to do better with less. When you have two variables operating on the same terrain at the one time, the net impact of those is quite difficult to assess.

Mr Young—I would like to enhance Mr Gray's comment. What we are now seeing is that the whole system of quality improvement is becoming embedded. So, by the time we find ourselves at round 3 in three years time, it will simply be imbued within most organisations as just part of their ongoing management processes. At round 1, I think many were looking at it as just a once-off—many had moved it into their philosophical framework but many had not—but I think it is now becoming systemic throughout the whole organisation. I will not pretend for a moment that we cannot do things better, but at the same time it is becoming imbued within organisations that this is part of their systems and ongoing quality improvement mechanisms.

Ms KING—By way of comment, it bothers me enormously that, despite all the effort and despite all the resources and intellect that have gone into developing an accreditation system, we do not know whether things have improved.

Mr SOMLYAY—From the point of view of delivering quality care, what sort of impact does the availability or shortage of qualified nursing staff have on the accreditation process? Is sufficient emphasis given to aged care training in the process of the academic requirements to be accredited as a nurse?

Mr Mundy—One of the things that we have discovered this year, in conjunction with the Department of Health and Ageing, is that there is considerable variability in what goes into nursing training throughout Australian universities—both in how much time and content they get on aged care and in how much time they spend on what are, effectively, management processes such as accreditation. Our conclusion would be that it is quite variable. It is a specific set of skills and techniques that needs to be taught, and I would not necessarily assume that any nurse has a trained professional background in how you assess quality. They could say what they like and what they do not like and how they would do it, but there is a real rigour about applying a quality management framework to those sorts of judgments, which I have alluded to before. That is one of the reasons why we do favour a system that is rooted in the quality industry rather than in aged care. I think you would say that there is still room to improve in that area. There is still a lot of scope for what you could call subjective judgment, but let us call it professional judgment—that is more generous and perhaps more accurate—to be genuinely different.

Mr Young—Certainly, our ability to be able to attract the appropriate skilled staff, which in the main are registered nurses, is under significant difficulties, just like the rest of the health system. The fact that we are under even greater stress to be able to pay comparable wage rates et cetera puts us under even greater stress. At the same time as we change our focus of care in coming years, there is a need for us to be able to re-look at how we actually structure our nursing

staff and what skills they need and also at what our care staff's skills and needs are going to be. Two obvious things happening at the moment are the expansion of the clinical capabilities of registered nurses, through nurse practitioners, while enhancing the role of enrolled nurses at the other end to be able to administer more medications.

Mr SOMLYAY—How does that impact on the quality that we are all trying to define but cannot?

Mr Young—Obviously, if they are your main drivers—because we are very much a human resource dependent sector—you cannot ignore your capability of delivering quality care if you have deficiencies in either the flexibility as to how you can use your staff or the actual capability of recruiting a suitable number of staff, particularly at the registered nurses end.

Mr Mundy—There is also scope to look at the work systems we use in aged care. When the shortage of nurses is a reality that has been with us for some time it is hard to see that it will change qualitatively, certainly not in a short period of time, and I think we do need to do some work around the systems we use to deliver care, to make sure that they do provide safe, quality care with the resources we actually have, rather than the ones that we might wish we have but are unlikely to get, considering the shortage of nurses. I think that is an area for future work.

CHAIRMAN—On page 26 of the audit report, figure 1.3 'Operational residential places by provider type, at 30 June 2002' shows not-for-profit, private and state government. We have not figured out exactly where local council owned facilities fit into that. Does anyone have any comment about whether or not this audit process or the continuing work that you have done since the audit shows any demonstrable difference between the sectors in terms of outcomes?

Mr Young—There is nothing that I have seen in the report or anecdotally, from the industry, that necessarily indicates particular differences between ownership. There are some differences, as we discussed earlier on, that occurred in round 1 between states.

CHAIRMAN—Yes, we did discuss that.

Mr Young—Part of the anecdotal comment is really going to be the aggregated data that the agency can develop, once they have completed round 2, as to whether there is variability regarding size or location of facility in the outcome results, but we really do not have that detail as yet. We would certainly like to have it and are hoping that that database, when it is available for the industry to use, will be able to give us that sort of detail.

CHAIRMAN—I can understand the size issue well. What I am not clear about is whether there is any variability between the sectors—that is, private, state or not-for-profit—that anybody could discern?

Mr Mundy—I am unaware of any data that would demonstrate systematic differences.

CHAIRMAN—Mr Brandon?

Mr Brandon—No, we do not have any data.

CHAIRMAN—Mr Mundy, regarding this proposal to have numerous accreditors, I wonder firstly who would accredit the accreditors and secondly who would accredit the accreditors accrediting the accreditors?

Mr Mundy—The framework that was established by JASANZ—

CHAIRMAN—Sorry?

Mr Mundy—The JASANZ committee is the committee appointed by the Australian and New Zealand governments which has been in place since about 1991. They have developed a whole set of criteria under which they accredit accreditors, so that is the first answer to your question. That is the body that grants that accreditation. It may be of some relevance to note that the disability employment services are to be accredited under that system. That was announced about this time last year. They themselves do, I think, subscribe to various forms of international membership of organisations like the International Standards Organisation, but I could not give a definitive account of the detail of how that operates. I do know that they operate in an international framework.

CHAIRMAN—I thank all the respondents to our questions and everyone who came along today: thank you for participating. Thank you to my colleagues and the secretariat staff and, as always, God bless *Hansard*.

Resolved (on motion by **Ms King**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 11.54 a.m.