Department of Health

Response to Notice to Produce Documents and Give Information NTG-0736

24 March 2020

1 This is a response to the Notice to Give Information No NTG-0736 dated 12 March 2020, which has been issued by the Royal Commission into Aged Care Quality and Safety (**Royal Commission**) to the Department of Health (the **Department**).

2 This information is produced to the Royal Commission on the basis that it will be tendered and received in evidence by the Royal Commission pursuant to Notice No NTG-0736 and on the basis the information be treated as evidence pursuant to section 6DD of the *Royal Commissions Act 1902* (Cth).

HOME CARE

Question 3

On 2 April 2019 in the 2019 – 20 Federal Budget, the Australian Government announced a $282 million investment over five years from 2018-2019 to support Australians who wish to stay at home for longer by providing an additional 10,000 home care packages across all levels. Based upon the forward estimate model for the appropriate aged care appropriations as agreed between the Departments of Health and Finance, and in relation to this announcement:

a. how many home care packages, broken down by level of package and residential aged care places were projected to be in existence on 30 June 2020, 30 June 2021, 30 June 2022, 30 June 2023 and 30 June 2024 by reference to:
   i. the forward estimate model that formed the basis of the costing of the estimates as published in the 2017-18 MYEFO.
   ii. the forward estimate model that formed the basis of the forward estimates at the time of the 2018-19 Budget,
   iii. the forward estimate model that formed the basis of the costing of the estimates as published in the 2018-19 MYEFO.
   iv. the forward estimate model that formed the basis of the forward estimates at the time of the 2019-20 Budget,
   v. the forward estimate model that formed the basis of the costing of the estimates as published in the 2019-20 MYEFO

b. having regard to the number of home care packages that would have been released pursuant to the models referred to in a(i) and (ii), how many additional home care packages were released pursuant to this announcement between 2 April 2019 and 31 January 2020, than would have been released if the measure had not been implemented? Provide a breakdown by package level.

c. what are the timeframes for the release of any home care packages that are to be released pursuant to this announcement that would not have been released if the measure had not been implemented or that would have been released pursuant to the models referred to in a(i) and (ii), broken down by package level?

Question 4

In December 2019 the Australian Government released the Mid-Year Economic and Fiscal Outlook (**MYEFO**) 2019-20. The Australian Government announced a $496.3 million investment over four years for the release of an additional 10,000 home care packages. In relation to this announcement:

a. how many home care packages, broken down by level of package, and residential aged care places were projected to be in existence on 30 June 2020, 30 June 2021, 30 June 2022, 30 June 2023 and 30 June 2024 by reference to:
   i. the forward estimate model that formed the basis of the costing of the estimates as published in the 2017-18 MYEFO.
   ii. the forward estimate model that formed the basis of the forward estimates at the time of the 2018-19 Budget,
   iii. the forward estimate model that formed the basis of the costing of the estimates as published in the 2018-19 MYEFO.
   iv. the forward estimate model that formed the basis of the forward estimates at the time of the 2019-20 Budget,
   v. the forward estimate model that formed the basis of the costing of the estimates as published in the 2019-20 MYEFO

3 Tables 1 to 5 below show the number of mainstream home care packages (**HCPs**),[1] broken down by level of package, and residential aged care places that were projected to be in existence on 30 June 2020 to 2024 by reference to the forward estimate model (**FEM**) for the appropriate aged care appropriations, as agreed between the Department and the Department of Finance that formed the basis of the:

(a) costing of the estimates as published in the 2017-18 to 2019-20 Mid-Year Economic and Fiscal Outlooks (**MYEFOs**); or

(b) forward estimates at the time of the 2017-18 to 2019-20 Budgets.

[1] The figures in Tables 1 to 5 do not include flexible home care and residential aged care places provided under the Multi-Purpose Service (**MPS**) Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care (**NATSIFAC**) Program.

4 Table 1 sets out the number of mainstream HCPs and residential aged care places projected before the $282 million Budget announcement on 2 April 2019 (**2 April 2019 Budget announcement**), and corresponds with the 2017-18 MYEFO FEM.

Table 1: HCPs and residential aged care places as at the 2017-18 MYEFO, by reference to the 2017-18 MYEFO FEM

Level	2020	2021	2022	2023	2024
Level 1	8,740	10,427	13,438	13,953	14,469
Level 2	64,545	66,106	67,046	69,574	72,067
Level 3	20,745	24,471	26,489	27,364	28,267
Level 4	29,293	32,421	33,528	34,691	35,850
Total home care[2]	**123,322**	**133,424**	**140,501**	**145,582**	**150,653**
Residential care[3]	226,066	234,557	242,829	250,891	258,914

[2] The total number of home care places (flexible and mainstream) expected to be operational in the future is calculated by applying the national planning target to projections of the population aged 70 years and over. The national planning target is currently in the process of increasing from 27 places per 1,000 people aged 70 years and over in 2013, to 45 places per 1,000 people aged 70 years and over by 2022. The population projections are supplied by Treasury. The total number of mainstream packages available under the HCPs Program is equal to the total calculated under the method outlined above, less the expected operational flexible home care places (provided under the MPS program, the NATSIFAC Program and the Innovative Care Programme), plus any additional packages that are provided for as a result of recent policy changes to redirect unused residential aged care to home care and to bring forward future HCPs to be made operational early.

[3] The total number of residential care places (flexible and mainstream) expected to be operational in the future is based on the number of existing places, the number of provisionally allocated places (i.e. those released to providers to build) and the estimated number of places expected to be released to providers under the Aged Care Approval Round (**ACAR**), with provisional places and expected ACAR releases having assumed rates of operationalisation. The estimated number of places to be released under the ACAR is based on approaching the current national planning target (78 places per 1,000 people aged 70 years and over from 2022). The total number of mainstream residential care places is equal to the total calculated above, less the expected number of operational residential places provided by the flexible programs, less the reduction in future place releases that resulted from the combined flexible residential and home care appropriation in 2018-19 which redirected funding from residential to home care where the demand was more acute.

5 Table 2 sets out the number of mainstream HCPs and residential aged care places projected before the 2 April 2019 Budget announcement, and corresponds with the 2018-19 Budget FEM.

Table 2: HCPs and residential aged care places as at the 2018-19 Budget, by reference to the 2018-19 Budget FEM

Level	2020	2021	2022	2023	2024
Level 1	8,240	9,927	12,938	13,453	13,969
Level 2	62,105	63,666	64,606	67,134	69,627
Level 3	27,796	31,559	33,578	35,243	36,936
Level 4	36,284	39,501	40,607	41,297	41,983
Total home care	**134,425**	**144,652**	**151,730**	**157,126**	**162,514**
Residential care	216,984	225,074	233,882	241,930	249,952

6 Table 3 sets out the number of HCPs and residential aged care places projected before the 2 April 2019 Budget announcement, and corresponds with the 2018-19 MYEFO FEM.

Table 3: HCPs and residential aged care places as at the 2018-19 MYEFO, by reference to the 2018-19 MYEFO FEM

Level	2020	2021	2022	2023	2024
Level 1	8,240	9,927	12,938	13,453	13,969
Level 2	62,105	63,666	64,606	67,134	69,627
Level 3	28,189	31,559	33,578	35,243	36,936
Level 4	36,353	39,501	40,607	41,297	41,983
Total home care	**134,887**	**144,652**	**151,730**	**157,126**	**162,514**
Residential care	217,119	225,209	234,017	242,245	250,267

7 Table 4 sets out the number of mainstream HCPs and residential aged care places projected after the 2 April 2019 Budget announcement, and before the $496.3 million MYEFO announcement in December 2019 (**December 2019 MYEFO announcement**), and corresponds with the 2019-20 Budget FEM.

Table 4: HCPs and residential aged care places as at the 2019-20 Budget, by reference to the 2019-20 Budget FEM

Level	2020	2021	2022	2023	2024
Level 1	11,240	11,915	13,119	13,453	13,969
Level 2	64,605	65,166	66,106	67,134	69,627
Level 3	30,689	31,559	33,578	35,243	36,936
Level 4	38,353	39,501	40,607	41,297	41,983
Total home care	**144,887**	**148,140**	**153,411**	**157,126**	**162,514**
Residential care	219,135	226,753	234,600	242,792	250,166

8 Table 5 sets out the number of mainstream HCPs and residential aged care places projected after the December 2019 MYEFO announcement, and corresponds with the 2019-20 MYEFO FEM.

Table 5: HCPs and residential aged care places as at the 2019-20 MYEFO, by reference to the 2019-20 MYEFO FEM

Level	2020	2021	2022	2023	2024
Level 1	11,240	11,915	13,119	13,453	13,969
Level 2	64,974	67,536	67,536	67,536	69,999
Level 3	33,689	35,689	35,689	35,689	36,936
Level 4	40,853	41,353	41,352	41,352	41,983
Total home care	**150,756**	**156,492**	**157,697**	**158,030**	**162,887**
Residential care	217,460	223,951	229,754	235,458	243,839

2019-20 Budget and MYEFO

9 The impact of the 2 April 2019 Budget announcement is reflected in the difference between the projections contained in Tables 3 and 4 above.

10 The impact of the December 2019 MYEFO announcement is reflected in the difference between the projections contained in Tables 4 and 5 above.

Changes between Budget and MYEFO periods

11 The announced policy changes are not the only factors that can affect the numbers of HCPs and residential aged care places between Budget and MYEFO periods. The expected profile of HCPs and residential aged care places can change between Budget and MYEFO periods due to a range of factors, including:

(a) **the latest stocktake of residential places**: this is conducted for 30 June each year with results available around September and can lead to changes in expected future operational, provisional and offline residential aged care places. This is because the current stock of places may be different to the original estimate, which will have flow-on effects to future years in terms of re-basing the profile and revised building rates;

(b) **planning for a new release of residential aged care places through the ACAR process**: this is based on the latest expectations of when an ACAR might take place and any other considerations that might affect the total release amount. The resulting update may flow through to the agreed FEM in a subsequent update; and

(c) **the latest projection of flexible home care and residential aged care places**: this is because these affect the availability of mainstream HCPs and residential aged care places as described in footnotes 2 and 3 above. This input is based on the advice of the relevant policy area responsible for conducting expansion rounds in the key flexible programs, being the Multi-Purpose Services Program and National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Additional HCPs released between 2 April 2019 and 31 January 2020

12 No additional HCPs would have been released in relation to the models the subject of Question 3(a)(i) and (ii) absent the 2 April 2019 Budget announcement.

13 Table 6 shows the number of the 10,000 additional packages released between 12 February 2019 and 2 April 2019, and the number released between 2 April 2019 and 31 January 2020. Column 4 also shows how many of the additional packages were released prior to 31 January 2020, that is, the cumulative total of columns 2 and 3.

Table 6: Additional HCPs released between 12 February 2019 and 2 April 2019, and 2 April 2019 and 31 January 2020

Level	Released between 12 February and 2 April 2019	Released between 2 April 2019 and 31 January 2020	Released between 12 February 2019 and 31 January 2020
Level 1	579	1,774	**2,353**
Level 2	405	1,475	**1,880**
Level 3	0	1,458	**1,458**
Level 4	0	1,167	**1,167**
Total	**984**	**5,874**	**6,858**

Release of HCPs pursuant to the 2 April 2019 Budget announcement

14 As indicated above at paragraph 12, no additional HCPs would have been released in relation to the models the subject of Question 3(a)(i) and (ii) absent the 2 April 2019 Budget announcement.

15 Of the 10,000 additional HCPs announced in the 2019-20 Budget, 3,142 were still to be released as of 1 February 2020. These packages are currently being released evenly across the remainder of 2019-20. The following table provides a breakdown of the 3,142 packages by level.

Level	Packages released / to be released between 1 February 2020 and 30 June 2020
Level 1	647
Level 2	620
Level 3	1,042
Level 4	833
Total	**3,142**

Question 5

On 22 March 2019, Fiona Buffinton of the Department of Health (**the Department**) gave evidence that it would take approximately $2-2.5 billion per annum to provide access to all people on the home care waiting list to the level of care they need:[4]

a. explain whether the Department considers the announced additional home care packages, referred to in questions 3 and 4 above, sufficiently address the home care package waitlist
b. if not, explain whether the Government has any plans to announce further home care packages.

16 It is clear that under the current program arrangements, demand for HCPs continues to be greater than supply. Although, for a number of reasons, and as outlined below, it is unclear at this time how far demand falls short of supply, and therefore what level of additional funding would sufficiently address the home care waitlist.

17 Significant investment by the Government in home care has resulted in a large increase in the number of people receiving a HCP since the announcements of additional HCPs. Despite this, there were still approximately 104,500 people in the Home Care National Prioritisation System (**NPS**) as at 31 December 2019 who had not yet received a package at their approved level.[5] The Department notes that the NPS is not an accurate reflection of actual demand or unmet need for a HCP for a number of reasons, including package take up rates and an increase in funds available to care recipients that remain unspent.

18 The Department notes that approximately 50 per cent of HCPs released to people who are not already in a package, are not actually taken up. Together with informal feedback from HCP recipients, this suggests that there are many people who are in the NPS who are unlikely to be actively seeking to take up a package offered to them at that time. This may be because they already have appropriate care in place and maintain their approvals as a safety net should their situation change.

19 In addition, many people have approvals for both home and residential aged care (**dual approval**), and some will take up a residential care place instead of a HCP. At 31 December 2019, around 67 per cent (69,737) of people in the NPS had dual approvals,[6] having been approved for a permanent place in a residential aged care facility (**RACF**).

20 Future plans to announce further home care packages is a matter for Government.

[4] Transcript, Adelaide Hearing 2, Fiona Buffinton, 22 March 2019 at T.1057-1058.
[5] To be published in the next Home Care Data Report for the period 1 October 2019 to 31 December 2019.
[6] To be published in the next Home Care Data Report for the period 1 October 2019 to 31 December 2019.

Question 6

Describe any work undertaken by the Department to assess whether or to ensure that services will be available to meet the need arising from the increased number of home care packages.

21 The Department's primary method of ensuring that services are able to meet the need arising from the increased number of HCPs is to plan the release of new HCPs to provide for a steady increase in the number of people in care. This helps ensure that the market will be equipped to respond to demand and grow sustainably.

22 To assist the market in understanding the likely needs arising in respect of HCPs, the Department publishes a Home Care Data Report on a quarterly basis that provides transparency as to the number of people being approved for a HCP or waiting for a package in the NPS (the **Quarterly Data Reports**). This information is provided at an Aged Care Planning Region level to allow providers to gain an understanding of the pipeline of potential care recipients in the regions they service or are looking to service.

23 To date, the Quarterly Data Reports have shown an increase in the number of people receiving a HCP and a consistent volume of packages released. This provides confidence to the sector that the HCP program is growing sustainably.

24 Further, to date, no clear indication has been provided by the sector that would suggest difficulties in meeting the increased demand that has arisen from the increased volume of packages entering the system. The incremental nature of the announcements of additional packages, made over a number of budgetary updates has facilitated this, with the sector growing at a steady and sustainable rate.

25 In respect of current work being undertaken by the Department, the Department has engaged Ernst & Young (**EY**) to develop a model to forecast the demand and distribution of aged care services in Australia over the next 30 years (the **Demand Model**). The Demand Model will incorporate 'aged care need' arising from all causes, including frail ageing, chronic disease, disability and injury. The Demand Model will enable the Department to examine a range of future demand scenarios based on a variety of different policy settings and assumptions, providing a more rigorous basis for assumptions to help plan out services for the future. For example, the Demand Model will assist in making an assessment of how many HCP or HCP-like services are needed against forecast supply.

26 EY will deliver the Demand Model (which is based on a microsimulation approach) in two stages:

(a) stage one – development of the demand component of the Demand Model, which will include a population and household module, an income and assets module, a support needs module and a behavioural (interactions) module. A prototype of the Demand Model is anticipated to be complete by end-April 2020, with stage one to be complete by 30 June 2020; and

(b) stage two – development of the supply component of the Demand Model, which will include an industry and services module, a labour market module, and a key services and policy settings module. Although stage two is yet to be formally contracted, the development of parts of stage two will commence during stage one of the project. It is anticipated that both stages will be complete by 30 September 2020, at which time the Demand Model will be fully functioning.

27 The Demand Model will become an enduring asset that sits within the Department and will be adaptable for future policy changes.

Question 7

On 19 November 2019 the Department of Health released a statement seeking participation from home care providers in a national survey about the types, volume and cost of care and services delivered as part of home care packages.[7] In relation to the survey, provide:

a. any analysis that has been conducted on the survey responses

b. the unit record data.

28 The Department has undertaken a survey called the Home Care Provider Survey (**HCP Survey**) and data collection activity to provide a national picture as to the types, volume and cost of care and services being delivered under the HCP program. The HCP Survey and data collection will help address the lack of information on the types, and volumes of services that are delivered under HCP. This will support improved policy analysis and decision making for the current program as well as future options for care in the home.

29 The HCP Survey was open to home care providers from 25 November 2019 to 31 December 2019, with an extension granted until 14 January 2020. Home care providers participated in the HCP Survey on a voluntary basis and provided information for services delivered over the 2018-19 financial year and the September 2019 quarter. Over 50 per cent of home care providers responded to the HCP Survey, which represents over half (57 per cent) of people receiving a HCP. The results of the initial analysis are pending.

30 Deeper analysis and data collection activities were undertaken with providers who volunteered to participate between 15 January 2020 and 14 February 2020. This allowed analysis of several issues that required more detailed, and resource intensive, data collection that could not realistically be undertaken through the broader HCP Survey. This covered a range of topics such as:

(a) the differences in service provision across different locations;

(b) the percentage of services that were subcontracted;

(c) the most common capital purchases;

(d) the most common consumables;

[7] https://www.health.gov.au/news/home-care-provider-survey.

(e) provider travel expense policies; and

(f) more detailed information on living arrangements and unspent funds.

31 The data collected through the HCP Survey is being reviewed by StewartBrown, which was engaged by the Department to deliver a final report on the HCP Survey. The final report, and underlying unit record data, is expected to be provided by StewartBrown to the Department by late March 2020.

Question 8

In relation to the letter from Gilbert + Tobin dated 24 December 2019 and the Home Care Compliance Action Plan:

b. describe the requirements if any imposed under the Aged Care Act and subordinate instruments in relation to the handling of unspent home care package amounts in the hands of approved providers of home care.

c. describe any action taken to establish enhanced date sharing arrangements with other agencies regarding providers who pose financial or fraud risks to consumers and Government.

Requirements for handling of unspent HCP amounts

32 Division 3A of the *User Rights Principles 2014* (Cth) (**User Rights Principles**),[8] sets out the requirements and responsibilities of approved providers of home care in relation to the handling of unspent home care amounts and exit amounts.

33 A care recipient's unspent HCP amount is the total amount of unspent funds left in their HCP on the day on which they cease to receive care from their approved provider (the **date of cessation**), which may occur if the person changes home care provider, leaves home care, or passes away.[9] In the context of unspent funds which are, for example, not spent by a care recipient in the allocated year, the unspent HCP amount comprises unspent amounts from the care recipient's contribution (the **care recipient's unspent HCP contribution**) and the Commonwealth's contribution made through home care subsidies (the **Commonwealth's unspent HCP contribution**). The Department does not have oversight of care recipient contributions, which are recorded in individualised monthly statements issued by approved providers to care recipients. In 2017-18, care recipients contributed around six per cent of overall home care provider revenue. In 2018-19, care recipients contributed around four per cent of overall home care provider revenue.

[8] The User Rights Principles are made under s 96-1 of the *Aged Care Act 1997* (Cth) (**Aged Care Act**).

[9] User Rights Principles s 21C; see also <https://www.health.gov.au/initiatives-and-programs/home-care-packages-program/managing-home-care-packages/unspent-home-care-amounts>.

34 The key responsibilities of approved providers in respect of unspent HCP amounts include:

(a) **Calculating the unspent HCP amount of care recipients.** The unspent HCP amount is calculated for the period beginning on 1 July 2015 or the day the approved provider begins to provide home care to the care recipient, whichever is later, and ends on the date of cessation.[10] The User Rights Principles provides a detailed step-by-step process for determining the unspent HCP amount;[11]

(b) **Returning the Commonwealth's unspent HCP contribution.** If the care recipient does not transfer to a new provider and the unspent HCP amount is more than nil, the Commonwealth's unspent HCP contribution is due and payable by the approved provider to the Commonwealth at the end of 70 days after the date of cessation.[12] The approved provider is required to provide notice to the Secretary of the Department within 70 days of the date of cessation, setting out when the Commonwealth's unspent HCP contribution will become due and payable, or if the Commonwealth's unspent HCP contribution is nil; and

(c) **Returning the care recipient's unspent HCP contribution.** The approved provider must return the care recipient's unspent HCP contribution to the care recipient or their authorised person within 70 days after the cessation day. Where the care recipient has passed away, the care recipient's unspent HCP contribution must be paid within 14 days after the approved provider is shown the probate of the will or letters of administration.[13]

35 A portion of a care recipient's unspent HCP amount may be deducted from other amounts payable to the approved provider, such as amounts to cover the provision of services delivered and any relevant exit fee.[14]

36 Failure by an approved provider to comply with its obligations in relation to unspent HCP amounts under the User Rights Principles may lead to sanctions under the *Aged Care Quality and Safety Commission Act 2018* (Cth) (**ACQSC Act**).[15]

[10] User Rights Principles s 21C(a)-(b).
[11] Ibid.
[12] User Rights Principles s 21F(3).
[13] User Rights Principles s 21F(2).
[14] Aged Care Act s 95-3.
[15] Part 7B.

37 In the 2019-20 Budget, as part of the *More Choices for Longer Life – Improving the Quality, Safety and Accessibility of Aged Care Services* budget measure (the **More Choices Budget Measure**), the Government announced that payment administration arrangements for HCPs would be improved to address stakeholder concerns regarding unspent funds and align home care arrangements with other Government programs, such as the National Disability Insurance Scheme (**NDIS**). Once these new arrangements are fully implemented:

(a) the Commonwealth will pay home care subsidies and supplements in arrears (instead of the current advance payment) and on invoice for the services delivered in the month; and

(b) the Commonwealth's unspent HCP contributions will no longer accumulate with the provider and will instead be managed by the Commonwealth.

38 To this end, in September 2019, the Government approved a two phased approach to amend the way HCP subsidies are paid to providers.

39 Phase 1, which is planned to commence on 1 June 2020 (subject to the commencement of amending legislation), involves the payment of home care subsidies and supplements, meaning home care providers will receive the last payment in advance for May 2020. The payment will be for the full subsidy amount on claims made by providers and providers will continue to hold a liability for unspent funds.

40 Phase 2, which is anticipated to be implemented in April 2021, will involve the payment in arrears to providers for services actually provided on claims made by providers. It will also include an increased level of support and monitoring for the sector and consumers until August 2021.

41 The Government is currently considering the detail and timing of the changes under Phase 2.

Enhanced data sharing arrangements regarding providers who pose financial or fraud risks

42 The Department is currently consulting with the Aged Care Quality and Safety Commission (**ACQSC**) on initiatives to enhance data sharing arrangements regarding providers who pose financial or fraud risk to consumers and the Government.

43 The current transitional Memorandum of Understanding (**MoU**) between the Department and ACQSC dated 18 December 2019 sets out the parameters for enhanced data sharing under the auspices of both the Aged Care Act and the ACQSC Act. The Aged Care Quality and Safety Commissioner (the **Commissioner**) and the Secretary of the Department are each required to give the other information required for the purposes of their respective functions or powers.[16] The transitional MoU also establishes the data sharing protocols allowing the Department and the ACQSC to continue to share data as required to satisfy the ongoing functions of the Commonwealth in respect of their respective aged care functions and powers.

[16] The Commissioner is required to give the Secretary of the Department information in accordance with section 56 of the ACQSC Act. The Secretary of the Department is required to give the Commissioner information in accordance with section 57 of the ACQSC Act.

44 A new MoU between the Department and the ACQSC is currently under development and is anticipated to be in place by 1 July 2020. In particular, the new MoU will have a greater focus on data governance. While the new MoU is being developed, interim data governance arrangements are being progressed in parallel by the Department and the ACQSC with the involvement of the Data Sharing Working Group (**DSWG**) (which has members from both the Department and the ACQSC) as an oversight body to track the development of IT sharing capability. After the signing of the new MoU, the DSWG will be recast into a higher level oversight body to facilitate ongoing data sharing arrangements between the Department and the ACQSC.

45 The Department is also developing the Home Care Data Strategy (the **Data Strategy**) in consultation with the ACQSC. The Data Strategy is currently in an advanced draft state and is anticipated to commence in May or June 2020. The key objective of the Data Strategy is to enable the Department to better target providers who may pose a financial or fraud risk through aligning data understandings between differing data sources. This will be done through aligning the Department's definition and capture of home care data sets across both the Department and ACQSC.

46 The Data Strategy involves development of a common set of entity definitions for the management of home services to enable data matching across systems, so that equivalent comparisons can be made between data sets. Implementing these entity definitions will support information sharing and risk profiling activities between the Department and the ACQSC.

47 The Data Strategy will support the Home Care Risk Profiling Project due to be rolled out by 30 December 2022. The Home Care Risk Profiling Project will address, among other things, financial and fraud risks to consumers and Government.

48 The Department has also progressed, and is continuing to progress, a three-stage Fraud Action Plan. The Fraud Action Plan, which is part of the Home Care Compliance Action Plan described in response to Questions 8(a), 9 and 10 below, includes activities relating to data sharing arrangements regarding home care providers who pose financial or fraud risks. Under Stage 1 of the Fraud Action Plan, which was completed in December 2019, the Department undertook a project to match cross-agency data to identify high risk providers.

49 Stage 2 of the Fraud Action Plan is currently underway, to better manage fraud risk and capability mapping.

50 Stage 3 of the Fraud Action Plan, which is also underway, is a project to improve intelligence and data sharing capabilities, and to develop fraud identification and investigation approaches. This project involves:

(a) data sharing pilots across the Commonwealth in collaboration with the Commonwealth Fraud Prevention Centre;

(b) baselining the Department's capability to identify and manage HCP fraud; and

(c) improving internal data holdings to enable the development of a risk profiling model to better target integrity activities.

51 As part of its work on Stage 3 of the Fraud Action Plan, the Department conducted a number of discrete data sharing exercises with the Australian Taxation Office and the Department of Education in 2019 to investigate identified aged care program risks. The outcomes of these exercises provided insight into specific risks in the aged care portfolio and have led to the Department pursuing opportunities to build further risk identification capabilities through further data sharing pilots with other agencies. These will be further scoped in the 2020-21 financial year.

52 As part of another stream of work under Stage 3 of the Fraud Action Plan, the Department has also engaged with the Commonwealth Fraud Prevention Centre, the Department of Education, the Australian Taxation Office and the National Disability Insurance Agency, to build new relationships between agencies and identify potential financial or fraud risks that are common across Commonwealth programs. These engagements are ongoing and include discussions and coordinated activities, such as data matching and program assessments aimed towards identifying fraud and financial vulnerabilities in the aged care sector.

53 In addition, the Department has expanded its access to intelligence on financial and fraud risks through ongoing participation in Commonwealth inter-agency working groups that share information and insights about fraud and financial matters relating to Commonwealth programs.

Question 8

In relation to the letter from Gilbert + Tobin dated 24 December 2019 and the Home Care Compliance Action Plan:

a. explain the progress that has been made against this action plan. In your response, address the timeframes for implementation of the action plan.

Question 9

On 2 April 2019 in the 2019-20 Federal Budget, the Australian Government announced $7.7 million over two years from 2018-19 to develop an end-to-end compliance framework for the Home Care program, including increased auditing and monitoring of home care providers. Insofar as the funds were allocated to the Department of Health:

a. explain the progress that has been made against this announcement

b. provide an itemised budget for the expenditure of the announced $7.7 million

c. identify for each of the items in the budget for the expenditure of the announced $7.7 million how much of each item was spent before 31 January 2020

d. describe the 'end-to-end compliance framework' including timeframes for its development and implementation.

Question 10

On 2 April 2019 in the 2019-20 Federal Budget, the Australian Government announced $5.6 million in 2019-20 to commence the implementation of an enhanced home care compliance framework to improve the quality and safety of home care services and enhance the integrity of the home care system. Insofar as the funds were allocated to the Department of Health:

a. explain the progress that has been made against this announcement

b. provide an itemised budget for the expenditure of the announced $5.6 million

c. identify for each of the items in the budget for the expenditure of the announced $5.6 million how much of each item was spent before 31 January 2020

d. describe the 'enhanced home care compliance framework' including timeframes for its development and implementation. In your answer, explain the difference between this measure, and the measure set out in question 9, above.

Overview of the home care compliance framework

54 In the 2019-20 Federal Budget, the Australian Government announced allocation of funding under the More Choices Budget measure for the development and implementation of the home care compliance framework, as follows:

(a) $7.7 million was allocated for the development of an end-to-end home care compliance framework, which included the formulation of an action plan entitled the 'Home Care Compliance Action Plan' (**Action Plan**) and preliminary work in accordance with it. This initiative funded the design and costing of an end-to-end compliance framework. Of the $7.7 million allocated, $3.504 million was allocated to the Department, and $4.175 million was allocated to the ACQSC over a two-year period. A copy of the relevant Budget announcement is at **Exhibit NTG-0736-1** [**CTH.1000.0004.0508**]; and

(b) $5.6 million was allocated for the implementation of an enhanced home care compliance framework that lays the groundwork for risk-based assessment of home care providers and for additional audits in home care. Of this, $3.148 million was allocated to the Department in the 2019-20 financial year and the remaining $2.419 million was allocated to the ACQSC in the 2019-20 financial year. A copy of the relevant Budget announcement is at **Exhibit NTG-0736-2** [**CTH. 1000.0004.0507**].

Expenditure against these measures by the Department is detailed at paragraph 62 below.

55 An 'end-to-end' compliance framework takes a system view of regulatory environment, from when a provider enters the system, to their exit (if relevant). It seeks to embed best practice, including making better use of the full range of regulatory tools and making it easier for care recipients and the wider community to understand what can happen if a service is found to be non-compliant. For providers, it facilitates greater appreciation of the end-to-end regulatory process: the imperative and opportunities to demonstrate compliance or return to compliance, the escalation points, and the consequences of serious risk decisions and failure to return to, or maintain, compliance. It also bolsters the regulator's intelligence gathering capabilities which will, in turn, assist the ACQSC to understand relative risk.

Home Care Compliance Action Plan

56 In consultation with the ACQSC, the Department developed the Action Plan as an end-to-end compliance framework to mitigate the quality, safety and fraud risk flowing from the expansion of the HCP program from February 2017 in response to the introduction of a NPS under the *Increasing Choice in Home Care* Budget measure. The Department commenced development of the Action Plan in February 2019 and provided the completed Action Plan to Government in October 2019.

57 The Action Plan is designed to address short to medium-term risks for home care regulation as well as invest in regulatory capability and capacity to embed adjustments and provide an ongoing platform for effective regulation. The Action Plan makes observations on current approaches across components of the regulatory system, distils key problems, lists identified solutions and articulates the objectives being sought. As a compliance framework, it is aimed at driving short to medium term improvements in the quality, compliance and integrity of home care services. A copy of the Action Plan is at **Exhibit NTG-0736-3** [**CTH.1000.0004.0501**].

58 The Action Plan is currently being implemented by both the Department and the ACQSC. As at 1 January 2020, the Department has been involved in the following completed and ongoing activities in support of the Action Plan:

Completed activities

(a) the introduction of legislative changes to empower the ACQSC to conduct unannounced visits to home care providers and visit care recipients in their homes from January 2019;

(b) the introduction in July 2019 of the Aged Care Quality Standards set out in *Quality of Care Principles 2014* (Cth) and the Charter of Aged Care Rights set out in the User Rights Principles;

(c) implementing pricing transparency measures for home care providers on 1 July 2019 to improve consumer engagement, which include requirements for providers to publish all of their prices on the My Aged Care website and provide a pricing schedule to all clients;

(d) improvements to the My Aged Care website in July 2019, which included updating consumer communications materials in support of the pricing transparency measures;

(e) undertaking quantitative and qualitative analysis of HCP complaint information held by the ACQSC's complaints function in August 2019;

(f) research directed at improving the Department's understanding of the experiences of people who receive and deliver HCPs, to support a stronger evidence-based, person-centred approach, including through using behavioural insights to drive change in the aged care sector in August 2019;

(g) the development and consideration of options to strengthen the provider approval process, including the introduction of revised approved provider application forms to account for the new Aged Care Quality Standards and introduce more structured data requirements;

(h) the introduction in November 2019 of standard operating procedures for approved provider applications that support consistent decision making in line with legislative intent;

(i) transferring approved provider and compliance functions to the ACQSC to create a single agency responsible for approvals, complaints, quality, safety and compliance in aged care; and

(j) delivering Stage 1 of the Fraud Action Plan in December 2019 (referred to at paragraph 48 above), which included:

(i) auditing a sample of HCP providers;

(ii) conducting cross agency data matching to identify high risk providers; and

(iii) establishing the Home Care Compliance and Investigations team to monitor compliance and investigate home care providers in respect of their responsibilities under aged care legislation;[17]

Ongoing activities

(k) the commencement of Stage 2 of the Fraud Action Plan in July 2019, being a project to improve fraud risk and capability mapping as discussed in response to Question 8(c) above. Stage 2 is expected to be completed in June 2020;

(l) implementing four programs of trials (information hubs, community hubs, specialist support workers and financial information services officers) under the Aged Care System Navigator measure (the **Navigator Measure**) that are testing different system navigator models to support people and build their capacity to understand and engage with the aged care system. The aged care financial information service officer trials commenced in October 2018 and concluded in October 2019. The remaining trials commenced from January 2019 and will be subject to a short-term extension beyond 30 June 2020;[18]

(m) developing a scoping exercise to consider approaches to program assurance over care delivered, fees and consumer outcomes based on the outcomes of the HCP Survey. This is expected to be completed in March 2020;

(n) the commencement of a data-based home care program risk profiling system and information sharing platform in July 2019. KPMG were engaged to build a risk profile model, which included an assessment of the feasibility of the information available to build the risk profile. This project is discussed in more detail from paragraph 59 below;

(o) commissioning EY to conduct a research project into elements of provider approval processes utilised by other government agencies and how these elements can be incorporated into a revised process for aged care. EY commenced this work in January 2020 and the project is expected to be completed in May 2020;

[17] The Home Care Compliance and Investigations team was previously part of the Department's Aged Care Compliance Branch. On 1 January 2020 the team was transferred to the ACQSC.

[18] More information about the Navigator Measure is provided in the Statement of Jaye Alexander Smith dated 10 May 2019 at paragraphs 170 to 182 [**WIT.0128.0001.0001**], the Statement of Jaye Alexander Smith dated 4 October 2019 at paragraphs 105 to 112 [**WIT.0427.0001.0001**], and the letter from Gilbert + Tobin to the Royal Commission dated 5 March 2020 regarding NTG-0427 and NTG-0486.

(p) the delivery of an activity-based resource model (development of which commenced in January 2019) to cost existing and potential aged care regulation approaches to inform future, evidence-based policy and align regulatory resourcing to growth in aged care. This is due to be delivered in April 2020.

Implementation of an enhanced home care compliance framework

59 The Action Plan also contemplates the introduction of a data-based home care program risk profiling system and information sharing platform to better target compliance action. This item in the Action Plan is supported by the $5.6 million funding described above at paragraph 54(b). Using its allocation of the $3.141 million, the Department has taken steps to develop a data-based home care program risk profiling system and information sharing platform to better target compliance action. This has involved:

(a) the engagement of a project manager to lead this work and design analysts to capture all known home care program data sources and undertake a gap analysis;

(b) conducting a feasibility study to inform the future development of a home care program risk profiling system, the outcome of which was that the development of such a system is not presently feasible due to a lack of reliable data. To address these issues, the Department and the ACQSC are proceeding with an implementation roadmap to improve the data environment and ensure consistent intelligence for effective regulation of the HCP Program; and

(c) the implementation of a roadmap to improve the data in respect of home care risk and compliance. The roadmap identifies necessary enhancements to the data environment in order to produce a robust risk model for home care. The estimated completion date for these enhancements is currently 30 June 2022.

Timeframes for development and implementation

60 The end-to-end compliance framework for the home care program is anticipated to be fully developed and implemented by June 2022, however the exact date will be subject to a decision of Government.

61 The Department is continuing to implement the Action Plan by undertaking the following activities in the timeframes indicated:

(a) by end of March 2020:

(i) release new HCP consumer manuals to support consumer understanding and decision making;[19]

[19] This has been completed and is available at: https://www.myagedcare.gov.au/sites/default/files/2020-03/Home%20Care%20Packages%20Program%20Operational%20Manual%20for%20Home%20Care%20Package%20Consumers_0.PDF.

(ii) release new HCP provider manuals to support providers in maintaining compliance and decision-making;[20] and

(iii) conduct a survey of HCP service usage to gain a better understanding of the types, volume and cost of care and services delivered under the HCP program. The final data from this survey was collected in February 2020 with a final report due to be completed in late March 2020;

(b) by end of April 2020:

(i) deliver an activity-based resource model to cost existing and potential aged care regulation approaches to inform future, evidence-based policy and align regulatory resourcing to growth in aged care. The user acceptance testing of the final model has been completed and governance arrangements are anticipated to be settled with the ACQSC in late March/early April 2020;

(c) by end of May 2020:

(i) conduct a research project into elements of provider approval processes utilised by other organisations and how these elements could be incorporated into a revised process for aged care as discussed at paragraph 58(o) above;

(d) by end of June 2020:

(i) develop a project to design and test the different monthly HCP financial statement templates, used by providers to give consumers clear and consistent information on the services they are being charged for. The funding for this project has been secured with procurement commencing shortly; and

(ii) develop Stage 2 of the Fraud Action Plan, which involves drafting a Home Care Package Fraud and Integrity Strategy to improve HCP fraud risk and capability mapping. Stage 2 will be focused on developing long term strategies to address fraud risk and completing comprehensive fraud risk assessments;

(e) by end of June 2021:

(i) conclude the four trial programs under the Navigator Measure described above at paragraph 58(l);

(f) by end of August 2021:

(i) improve payment administration arrangements for HCPs, to address stakeholder concerns regarding unspent funds and align home care arrangements with other Government programs, such as the NDIS, as discussed at paragraph 38 above;

[20] This has been completed and is available at: https://www.health.gov.au/sites/default/files/documents/2020/03/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.pdf.

(g) by end of June 2022:

(i) develop Stage 3 of the Fraud Action Plan to improve intelligence and data sharing capabilities and to develop fraud identification and investigation approaches, as described further at paragraphs 50 to 51 above; and

(ii) develop a data-based HCP risk profiling system to enable quicker identification and responses to HCP risks.

Expenditure

62 The following table details the itemised budget for the expenditure of the proportion of the announced $7.7 million and $5.6 million allocated to the Department.[21]

Item	Budget	Amount spent	Amount spent prior to 31 January 2020
Home Care – Further Enhancing Safety, Quality and Integrity in Aged Care (terminates 30 June 2020) $3.504 million of $7.679 million was allocated to the Department			
Design and development of the Action Plan (2018-19)	$1,376,000	$624,126.26	$624,126.26
Engaging additional staff (Approved providers and compliance functions - 7.75 ASL-equivalents in 2018-19 and 6.00 ASL-equivalents in 2019-20)	$2,128,000	$2,128,000	$2,128,000
Home Care Compliance Framework – Phase One Implementation (terminates 30 June 2020) $3.148 million of $5.567 million was allocated to the Department			
Engaging 3 x APS 6, 2 x EL1 staff (ASL-equivalent) for six months (July to December 2019)	$381,000	$381,000	$381,000
Design and development of the risk profiling system (2019-20)	$1,087,000	$581,168.66 expenditure as at 29 February 2020	$550,417.12
IT systems to support risk profiling system database (2019-20)	$1,680,000	Nil as at 29 February 2020	Nil

[21] The Department notes that these figures may differ from amounts published. This is due to the differences in rounding of figures.

TRANSPARENCY OF PROVIDER INFORMATION (STAR RATING SYSTEM)

Question 11

Describe the 'differentiated performance rating model' that will be introduced in July 2020, as described in the letter from Gilbert + Tobin dated 24 December 2019, including:

a. what information will be publicly available with respect to individual providers, and how that information will be presented

b. where the ratings will be publicly accessible

c. whether the model will allow for comparison of the performance of aged care services in an area, and if so how

d. how often the ratings will be updated, and whether this will be done on a routine and/or ad hoc basis

e. which domains of information will form part of performance rating (for example, results from accreditation audits and consumer experience feedback), and any weighting given to individual domains in determining the rating

f. any plans to expand the domains of information that form part of performance rating after the introduction of the model in July 2020.

63 The differentiated performance rating model (the **Model**) is an online resource that brings together a range of data elements into a single repository of easy-to-understand information on the quality of residential aged care services to support consumers to make informed decisions about their care.

Information which will be publicly available with respect to individual providers and how that information will be presented

64 From 1 July 2020, the Model will provide information to the public on four aspects of individual providers, namely:

(a) compliance ratings;

(b) performance metrics;

(c) audit reports and outcomes of consumer satisfaction interviews; and

(d) compliance history data.

65 An overall Government compliance rating for each provider will be displayed as a range between 1 and 4 in the form of dots on each providers' My Aged Care profile (**Compliance Ratings**). The Compliance Ratings will reflect the following levels of compliance:

(a) Rating 1 (one dot) – major issues with the RACF having a sanction issued against it;

(b) Rating 2 (two dots) – significant improvement needed with the RACF having been issued a Notice of Non-Compliance against it;

(c) Rating 3 (three dots) – minor improvements needed with the RACF having not met Aged Care Quality Standard requirements; and

(d) Rating 4 (four dots) – compliant with no active compliance actions or not met requirements against the RACF.

66 Performance metrics of providers against each of the Aged Care Quality Standards will also be provided to the public. The performance metrics are displayed at a layer below the Compliance Ratings and will be available by clicking on the Quality tab on a provider's My Aged Care profile. The Quality tabs will lead the consumer to the quality page where two layers of detail on quality can be inspected, namely:

(a) Quality Layer 1 – rating against each of the Aged Care Quality Standards; and

(b) Quality Layer 2 – snapshot of performance against each specific requirement of the relevant standard.

67 Audit reports and outcomes of consumer satisfaction interviews will be available on the Quality tab on a provider's My Aged Care profile. Consumer experience survey results will be displayed in two formats: first, in a carousel feature where consumers can scroll left or right to see the most recent consumer experience results from that service and second, via a downloadable consumer experience report that contains the same data as the carousel feature but in a printable version.

68 Consumers will be able to access compliance history data including current and past performance of a provider as a graph based on their Compliance Rating over the last three years, and past performance in a chronological list based on their Compliance Rating over the last three years.

Where the ratings will be publicly accessible

69 The Compliance Ratings will be publicly accessible on the My Aged Care website, with some components also residing on the ACQSC website. There will also be a link to the My Aged Care website from the ACQSC website. The data will be accessible in such a way to allow others to access and extract the data in line with the Australian Government's Open Data approach.

Whether the Model will allow for comparison of the performance of aged care services in an area

70 The Model allows for regional comparison by suburb or postcode in list view or map view. The 'Find an aged care home provider portal' will include a 'select a location' box, as well as allowing the selection of 'including surrounding suburbs'. This process also provides a comparison function to allow users to compare current compliance ratings and the performance metrics of approved providers.

How often the ratings will be updated, and whether this will be done on a routine and/or ad hoc basis

71 The Compliance Ratings are based on data from the ACQSC and Department's IT systems and therefore the times to update vary. Ratings that are derived from applying or lifting Sanctions and Notices of Non-Compliance against a service will update within one hour from the time the change is approved in the source system. Ratings that are derived from new records of performance against each specific component of the relevant standard will update within 24 hours from the time the change is approved in the source system.

Which domains of information will form part of performance rating and any weighting given to individual domains in determining the rating

72 The performance ratings are derived from compliance findings as part of the quality assessment and compliance activities conducted by the ACQSC.

73 There are no weightings specific to the Model. Any non-compliance finding by the ACQSC will, at a minimum, result in an identified area for improvement (Rating 3), and, where triggered by findings, multiple or serious instances of non-compliance will result in either a Notice of Non-Compliance (Rating 2) or a Sanction (Rating 1).

Any plans to expand the domains of information that form part of performance rating after the introduction of the Model in July 2020

74 The Department is exploring options for potential future enhancements to this project. For example, the Review of National Aged Care Quality Regulatory Process report by Kate Carnell AO and Professor Ron Paterson ONZM (**Carnell Paterson Review**) recommended that once quality indicators have been validated, they could be incorporated into the performance rating reporting structure.[22]

75 Other potential future directions that the Department is considering include expanding performance differentiation to include home care services and developing an additional rating within the current solution to show aged care services that are performing at a particularly high level. An 'excellent' rating level may allow consumers to make more informed decisions about their care and may also provide a strong incentive for providers to improve the quality of their services.

76 Whether or not the domains of information that form part of performance rating after the introduction of the Model in July 2020 will be expanded will be a decision for Government.

[22] Exhibit 1-24 [**RCD.9999.0011.1833**], page 104.

Question 12

In relation to the letter from Gilbert + Tobin dated 24 December 2019, describe the 'extensive stakeholder consultation across aged care sector representative organisations (providers and consumers)' on the differentiated performance rating model.

77 The Department has engaged with external advisors across the aged care sector representative organisations on the differentiated performance rating model through several forums, namely:

(a) a meeting of the Quality Reform Program Risk Advisory Group[23] on 5 December 2018, focused on performance differentiation;

(b) three dedicated stakeholder forums in March, June and October 2019 with attendees including consumer representative peak bodies and aged care providers. A fourth (and likely final) stakeholder forum is planned for April 2020 to demonstrate the product;

(c) a presentation of the prototype of the performance ratings website to the National Aged Care Alliance in February 2020; and

(d) most recently, presentations at the Aged and Community Services Australia Financial Symposiums (which are ongoing across the country) in February and March 2020.

78 The Department has undertaken dedicated consultations with consumers on the look and feel of the differentiated performance ratings system on My Aged Care through one on one user testing conducted by Liquid Interactive, the third-party operator of the My Aged Care website, to monitor data relating to user experience.[24] These consultations have entailed five rounds of user testings of the design starting from March 2019 and ending in November 2019. The user testings included a total of 41 participants. The testing methodology used was consistent with the approach recommended by the Digital Transformation Agency's Digital Service Standard Criteria.

79 Testing participants were drawn from groups that are expected to use the performance differentiation website, including those looking for, or recently moved to, an aged care home (including persons assisting a loved one). Users from diverse geographic and demographic backgrounds were also included in testing.

80 The demographics of the 41 participants engaged in all five rounds of user testings are outlined below (participants may simultaneously identify as being a member of a number of different groups):

(a) Gender:

(i) 27 female; and

(ii) 14 male.

[23] The Risk Advisory Group comprises members from the Department, the ACQSC, the Australian Institute of Health and Welfare, the Australian Commission on Safety and Quality in Health Care, the Department of Social Services, State and Territory health departments, industry groups and both provider and consumer representatives.

[24] The My Aged Care website was built by Liquid Interactive, which is responsible for website operations. The website is owned by the Department.

(b) Location:

(i) 23 from New South Wales;

(ii) 7 from Victoria;

(iii) 6 from Queensland;

(iv) 3 from Western Australia; and

(v) 2 from South Australia.

(c) Background:

(i) 14 from culturally or linguistically diverse backgrounds;

(ii) 29 identified as having a disability; and

(iii) 4 identified as Aboriginal or Torres Strait Islander.

(d) Employment:

(i) 13 employed full-time;

(ii) 12 retired;

(iii) 8 employed part-time;

(iv) 3 self-employed;

(v) 3 carers or on home-related duties; and

(vi) 2 employed on a casual basis.

(e) Metro/Regional Area:

(i) 30 from metro areas; and

(ii) 11 from regional areas.

SERIOUS INCIDENT RESPONSE SCHEME

Question 13

In relation to the 2019-20 Budget announcement of $1.5 million in 2019-20 to undertake preparatory work for the introduction of a new Serious Incident Response Scheme from July 2022, provide:

a. a summary of the responses to the consultation on the Serious Incident Response Scheme for Commonwealth funded residential aged care – Finer details of operation

b. the timeframes for undertaking the additional preparatory work under this Budget measure, including any plans for further consultations on the design elements of the serious incident response scheme

c. a copy of the KPMG report on the prevalence of aggression between residents.

Summary of responses

81 In January 2020, the Australian Government released the *Report on the Outcome of Public Consultation for Serious Incident Response Scheme for Commonwealth Funded Residential Aged Care* dated November 2019 (**SIRS Consultation Outcomes Report**). The SIRS Consultation Outcomes Report sets out the responses to the public consultation on the Department's previous consultation paper, titled *Serious Incident Response Scheme for Commonwealth funded residential aged care: Finer details of operation – consultation paper* (the **SIRS Consultation Paper**). The SIRS Consultation Outcomes Report also outlined the feedback received in the consultation process that has been used to refine the Serious Incident Response Scheme (**SIRS**) design. A copy of the SIRS Consultation Outcomes Report is at **Exhibit NTG-0736-4** [**CTH.1000.0004.0006**].

82 In summary, 45 submissions were received on the SIRS Consultation Paper. A number of key themes emerged from these submissions, which are outlined at pages 8 and 9 of the SIRS Consultation Outcomes Report.

Timeframes for undertaking preparatory work and further design work

83 The Department has undertaken a number of streams of work aimed at progressing the introduction of the SIRS in residential aged care.

84 One of the streams of work has involved undertaking a consultation on the details of the SIRS. This has involved the following:

(a) Between June and August 2019, the Department developed the SIRS Consultation Paper. An initial version of the SIRS Consultation Paper was circulated to a key stakeholder group and discussed at a facilitated teleconference on 17 July 2019 with:

(i) the Older Persons Advocacy Network;

(ii) the Council on the Ageing Australian (**COTA Australia**);

(iii) Leading Age Services Australia;

(iv) HammondCare;

(v) the Australian Nursing & Midwifery Federation;

(vi) United Voice;

(vii) the ACQSC;

(viii) the NDIS Quality and Safeguards Commission;

(ix) the New South Wales Ombudsman;

(x) Aged Care Services Australia;

(xi) Wintringham;

(xii) Dementia Australia; and

(xiii) the Aged Care Guild.

Feedback from these key stakeholders was used to refine the SIRS Consultation Paper ahead of broader, public consultation.[25]

(b) The final SIRS Consultation Paper was publicly released from 30 August 2019 to 11 October 2019 on the Department's Consultation Hub. Face-to-face consultation workshops were subsequently undertaken on 3 and 4 September 2019 with aged care consumer representatives, aged care provider representatives and Government agencies that operate comparable incident schemes. Targeted consultations were also undertaken with the National Aged Care Alliance on 15 August 2019 and the Aged Care Sector Committee on 13 September 2019. A copy of the final SIRS Consultation Paper released on 30 August 2019 is at **Exhibit NTG-0736-5** [**CTH.0001.1001.3263**].

(c) The Department reconvened the SIRS key stakeholder group again on 31 October 2019 for a teleconference. The purpose of the meeting was to provide feedback on the key themes that emerged from the consultations and to outline how the Department proposed to refine the SIRS model in response to the feedback. During the meeting, stakeholders discussed:

(i) further refinement of the definitions including scope and examples;

(ii) setting thresholds and exemptions; and

(iii) public reporting of SIRS data.

Some stakeholders provided written feedback following the teleconference.

85 The Department continued to refine the proposed SIRS design, in partnership with the ACQSC who will administer SIRS, taking into consideration the implementation and operation of the scheme.

[25] For further information see Exhibit 8-31 [**WIT.0279.0001.0001**], paragraph 49(b).

86 In respect of an operating model to support the administration of the SIRS once commenced, the Department and the ACQSC executed an MoU on 19 September 2019 for the provision of $240,000 in 2019-20 to the ACQSC to develop and cost the operating model. This work is substantially modelling the new activities and resource efforts required by the ACQSC to administer the requirements and obligations that the SIRS will place on approved providers, including all of the downstream regulatory responses by the ACQSC. The Department has regular ongoing engagement with the ACQSC on the operating model, which is informing advice to Government on the resourcing implications of the SIRS.

87 On 31 July 2019, the Department contracted KPMG to conduct a study into the prevalence and type of resident on resident incidents that are exempt from reporting under the current compulsory reporting arrangements. The Department commissioned this study to obtain more reliable estimates and information regarding the frequency and type of resident on resident incidents that are currently exempt from reporting and inform advice to Government.[26] Between 16 September 2019 to 4 October 2019, a total of 196 residential aged care services participated in the study, of which 17 were subsequently excluded due to matters such as duplicate registrations or incomplete data submissions. The study concluded in November 2019, with the data from 179 participants analysed and the findings extrapolated to prepare national modelling detailing estimates of the number and type of resident on resident incidents that are currently exempt from reporting across all States and Territories.

88 The outcomes of the preparatory work is being used to provide advice to Government on the implementation of the SIRS model in residential aged care.

89 As part of an ancillary stream of work of the 2019-20 Budget announcement of $1.5 million, $147,000 in funding was allocated to undertake a scoping exercise to define the objectives and requirement of an aged care worker register. Further details regarding the scoping exercise is set out in the Department's response to question 15 below.

KPMG Report

90 A copy of the KPMG Final Report titled *Prevalence Study for a Serious Incident Response Scheme (SIRS)* dated November 2019 is at **Exhibit NTG-0736-6** [**CTH.1000.0004.0045**].

[26] For further information see Exhibit 8-31 [**WIT.0279.0001.0001**], paragraph 58.

Question 14

In relation to the statement of Glenys Beauchamp dated 20 September 2019, in particular paragraph 92 of that statement, explain:

a. whether the Department has provided advice to the Secretary on the structure and operation of the serious incident response scheme, legislative requirements and resourcing implications of such a scheme, and timeframes for implementation

b. if so, provide a copy of that advice

c. if not, provide information about when the Department expects to be in a position to provide such advice.

91 The Department has not provided advice to the Secretary on these specific matters. No such advice is planned, as advice is normally provided to the Minister and Government through the Deputy Secretary of the Ageing and Aged Care Group.

Question 15

In relation to the statement of Charles Wann dated 20 September 2019, and in particular Part G of that statement:

a. provide an update on the scoping exercise to define the needs and requirements of an aged care workforce register

b. explain whether the Department has provided advice to the Minister on the structure and operation of an aged care workforce register, legislative and regulatory requirements and resourcing implications of such a register, and timeframes for implementation

c. if so, provide a copy of that advice

d. if not, provide information about when the Department expects to be in a position to provide such advice.

Update on the scoping exercise

92 The Department has engaged the service of MPConsulting to conduct a scoping study to explore options for aged care worker regulation (the **Scoping Study**).[27] The Scoping Study is the first step in exploring options for a regulatory framework which mandates recruitment and employment screening to ensure public safety and to provide surety that only those who are fit and suitable are providing services to older people. The Scoping Study will require consideration of current frameworks being used in other sectors, including the health and disability sectors.

[27] This is further discussed in the Commonwealth Submissions, *The future of the aged care workforce*, 13 March 2020 at paragraph 44.

93 The contract for the Scoping Study was executed on 12 February 2020, with a completion date of 30 June 2020. MPConsulting has commenced initial consultation with stakeholders and a public consultation paper is expected to be released in early April 2020. Stakeholders will also have the opportunity to respond to an online survey once the public consultation is released. The consultation process will also involve two face-to-face forums with a variety of stakeholders, including key provider peak bodies, government stakeholders, consumer peak bodies, personal care work representatives and unions.

Advice to the Minister

94 The Department has not provided advice to the Minister on the matters specified.

95 Subject to the options that emerge in the Scoping Study, the Department expects to be in a position to provide such advice following the completion of the Scoping Study at the end of June 2020.

ENHANCED COMPLAINTS HANDLING BY THE AGED CARE QUALITY AND SAFETY COMMISSION

Question 16

Explain the progress that has been made to implement recommendation 10(i) of the Carnell Paterson Review, that the Aged Care Quality and Safety Commissioner be given a power to publicly name a provider who is not sufficiently responsive to, or will not comply with, a direction issued by the Commissioner in respect of a complaint.

96 Recommendation 10(i) of the Carnell Paterson Review was intended to increase the powers of the Commissioner to address providers who are unresponsive to complaints and/or interventions.[28]

97 The Commissioner has a number of functions, including resolving complaints made to the ACQSC in accordance with rules made under the ACQSC Act. The ACQSC Act and the ACQSC Rules provide a range of mechanisms for the resolution of complaints, including investigation powers, or working with the relevant provider to examine and resolve issues raised in a complaint and report back to the ACQSC.

98 If, in undertaking a resolution process, the ACQSC is concerned that a provider is not complying with their responsibilities, it will formally notify the provider of the ACQSC's concerns, through a Notice of Intention to Give Directions, and provide them with an opportunity to respond to those concerns.[29]

99 If a provider does not respond or does not satisfy the ACQSC that they are compliant with their responsibilities, the Commissioner may issue the provider with directions. Directions outline the actions the provider is required to undertake (including necessary timeframes) in order to meet its responsibilities.

[28] Exhibit 1-24 [**RCD.9999.0011.1833**], page 152.
[29] *Aged Care Quality and Safety Rules 2018* (**ACQSC Rules**) r 19-20.

100 Under the ACQSC Rules, providers are required to comply with a direction. If a provider fails to comply with a direction, they have also failed to comply with a responsibility under the Aged Care Act.[30]

101 Under section 59(1)(h) of the ACQSC Act, the ACQSC has the power to make public certain information, including information about the provider's performance in relation to its responsibilities under the ACQSC Act or the Aged Care Act.[31] Section 59(1)(h) was introduced on 1 January 2019 when the ACQSC Act first commenced.

102 In addition, failure by a provider to comply with directions may then result in the Commissioner initiating compliance action under Part 7B of the ACQSC Act, in accordance with the processes set out in that Part.

Question 17

With respect to the Department of Health's statement in or around February 2019 (CTH.0001.1000.4510) that the Aged Care Quality and Safety Commissioner will have the power to name residential aged care providers who obstruct the resolution of legitimate complaints, and that this will be progressed as part of the reforms to the Commission from 1 January 2020, explain:

a. whether, in the Department's opinion, this power was included in the legislation amending the functions of the Aged Care Quality and Safety Commissioner that came into effect on 1 January 2020 (and if so, identify the relevant provision or provisions)

b. if not, when the Department expects this matter will be progressed

c. any advice provided by the Department to the Minister after February 2019 about whether this matter should be progressed.

103 The power of the ACQSC to name residential aged care providers who obstruct the resolution of legitimate complaints is captured by section 59(1)(h) of the ACQSC Act. As noted at paragraph 101 above, the ACQSC has had this power since the commencement of the ACQSC Act on 1 January 2019. The exercise of the power is a matter for the ACQSC.

104 The Department did not provide any advice to the Minister after February 2019 about this matter.

[30] ACQSC Rules r 19; Aged Care Act s 56-4(1)(e).

[31] The Commissioner also has the power to make publicly available information about a provider's performance in relation to the provider's responsibilities under the funding agreement that relates to the service (ACQSC Act s 59A(1)(g)).

RUCS TRIAL

Question 18

On 2 April 2019 in the 2019 – 20 Federal Budget, the Australian Government announced a $4.6 million investment from 2018-19 to 2019-20 to trial a new residential aged care funding tool to replace the longstanding Aged Care Funding Instrument (ACFI). It was announced that the new tool is intended to provide long term funding certainty and greater equity in how funding is distributed, and that two hundred facilities are involved in the trial, which will start in the second quarter of 2019 and end in the first quarter of 2020. In relation to this announcement:

a. an overview of the trial since its commencement on 25 November 2019, including the methodology of recruitment and management of teams by HealthCare Australia, Access Care Network Australia, Care Tasmania and Aspire 4 Life, and the methodology of the Australian National Aged Care Classification (AN-ACC) tool

b. a summary of any initial results of the trial.

105 The Department is trialling a new assessment framework for residential aged care funding, the Australian National Aged Care Classification (the **AN-ACC**),[32] which is a casemix classification model.[33] The AN-ACC tool is being used to assess over 10,000 aged care residents as part of the trial. The trial will test the external assessment workforce operation, design and supporting systems necessary to implement the AN-ACC.

106 To date, the trial has involved:

(a) inviting approved providers to take part in the trial through an expression of interest in July 2019;

(b) seeking assessment partners through an open request for tender; and

(c) engaging four assessment organisations which commenced assessments on 25 November 2019.

107 The trial will provide information on the application of the AN-ACC tool outside of a controlled research environment including:

(a) the application of the AN-ACC clinical assessor tool by an independent assessment workforce (registered nurse, physiotherapists and occupational therapists), which was developed through the Resource Utilisation and Classification Study (**RUCS**);[34]

[32] For further information on the AN-ACC, see letter to the Royal Commission dated 15 November 2019 [**RCD.0012.0037.0001**] and Submissions by the Commonwealth on Melbourne Hearing 3: Aged Care Workforce dated 15 November 2019 [**RCD.0012.0033.0002**].

[33] A 'casemix classification' allocates service recipients into classes. Care recipients within a class will have similar clinical attributes and their care will involve similar levels of resource consumption: Exhibit 7-1, General Tender Bundle, Tab 60 [**RCD.9999.0145.0001**].

[34] Further information on RUCS is available at < https://www.health.gov.au/resources/publications/resource-utilisation-and-classification-study-rucs-reports>.

(b) IT and assessment data collection systems that will support assessors;

(c) the adequacy and validity of training materials, workshops and peer support provided to assessors;

(d) the average length of time taken to complete assessments;

(e) whether the tool can be used to assess all types of residents in care, and whether additional training is needed, or a refinement of assessment skills sets is indicated; and

(f) the profile and distribution of the AN-ACC casemix classes across a broader range of residents and facilities than was obtained through the RUCS.

108 The Department has contracted four organisations (HealthCare Australia, Access Care Network Australia, Care Tasmania and Aspire4Life) through an open tender process to undertake assessment for the trial. An open tender process allows the Department to engage the most suitable suppliers to deliver the required services. The four organisations were chosen as they meet the Department's assessment criteria, representing value for money and capability to deliver. Each of the four assessment organisations have been responsible for managing their own assessment teams, which consist of registered nurses, physiotherapists and occupational therapists. The assessment organisations filled the positions of trial AN-ACC assessors using a combination of existing staff and staff recruited specifically for the purposes of the trial.

109 The Department's approach to the trial has followed action research principles,[35] involving constant learning and adjustment throughout the process. For example, the training manual for assessors has been regularly updated as a result of feedback obtained during regular clinical communities of practice meetings with the four assessment organisations and their assessors. The training manual has also been modified to take into account the broad clinical background of the assessment workforce. In addition, the training provided to assessors has been amended from two to three days, to provide assessors a more interactive training approach. A 'tips and tricks' newsletter is also provided to the four organisations on an ad-hoc basis to provide clarification on a range of matters to continually improve the process of conducting the assessment during the trial.

110 The Department is testing a prototype of the AN-ACC tool through an Apple Inc. iPad app. All external assessors have been issued with iPads and paper tools to conduct the assessments. The app will support the external assessor to upload the outcome of the assessment and the classification outcome will not be visible to the assessor on the app. Assessors will use the tools to undertake the assessment.

111 Participating approved providers will receive a profile of the collective AN-ACC classification scores for their facility. Due to ethics considerations this data will be de-identified. The Department has received ethics approval for the trial through the Australian Institute of Health and Welfare (**AIHW**).

[35] An 'action research principle' is a type of research principle which involves the researchers learning from and adapting the project as it progresses. In the context of the AN-ACC trial, it means that regular feedback sessions from the organisations conducting the assessments will be used to alter the assessment process and any training provided to assessors as the project progresses.

None of the Department, external assessor or approved providers will be able to access AN-ACC classification scores identifiable against an individual resident.

112 Since the commencement of the trial on 25 November 2019, the Department and the University of Wollongong have trained 60 assessors to assess consumers in 170 RACFs and 5,365 assessments have been completed in metropolitan, regional, rural and remote regions.

113 A copy of the summary of the results of the trial up to 29 February 2020 is at **Exhibit NTG-0736-7** [**CTH.1000.0004.0040**].

MY AGED CARE

Question 19

In the 2018-19 Budget, the Australian Government committed to investing $61.7 million over two years to make the My Aged Care website easier for consumers to use. On 24 June 2019, the Australian Government launched an updated My Aged Care website. In December 2019 the Australian Government released the Mid-Year Economic and Fiscal Outlook (**MYEFO**) 2019-20. The Australian Government announced a $21.9 million investment to support the operating costs of the My Aged Care System. In relation to these announcements:

a. detail the improvements that have been implemented on the updated My Aged Care website since the updated website was launched on 24 June 2019

b. how does the Department evaluate or propose to evaluate these improvements? Provide any evaluation conducted to assess any improvements in efficacy and functionality of the My Aged Care website since 24 June 2019

c. provide an overview and any initial evaluation of the electronic referral process introduced in November 2019 for GPs to refer their patients directly to My Aged Care for assessment.

114 Under the 2018-19 *My Aged Care Extension* Budget measure, $61.7 million was provided from the *More Choices for a Longer Life* package over two years from 2018-19 to improve users' experience accessing Government-funded aged care services.[36] As part of this Budget measure, the Department delivered the following key projects over an 18-month period:

(a) a new and improved My Aged Care website and 'Find a Provider' tool (which is described at paragraph 117(b) below);

(b) a self-service online registration and screening system (described at paragraph 119(a) below);

(c) improvements to the client portal, which is accessible via myGov (the **Client Dashboard**) (described at paragraph 131 below); and

(d) the electronic referral capability for general practitioners (**GPs**) (**e-Referral system**) (discussed at paragraph 135 below).

[36] Budget Measures Budget Paper No. 2 2018-19, page 117.

115 The Department has commenced post-implementation reviews of each of these projects. The reviews will focus on customer satisfaction, customer engagement, operational budget status, contract management and incident and defect management. Details of evaluation activities specific to each project are discussed below.

116 In the 2019-20 MYEFO, the Government also announced a $21.9 million investment to support the operating costs of the My Aged Care system.[37] This funding will ensure My Aged Care can maintain existing service levels in line with the growing demand while the Government considers the ongoing operations of the system and potential future enhancements.

My Aged Care website enhancements

117 The updated My Aged Care website was released on 24 June 2019 (the **updated website**), with key changes informed by user testing and included:

(a) a clearer, simplified and supportive user experience that guides consumers through the steps to access aged care services and how to navigate the aged care system;

(b) updates to the 'Find a Provider' tool, which consumers can use to search by location for providers of residential care, home care, home support or short-term care. The updates included improved search capability and more filter and comparison options;

(c) improved design, including use of more white space to improve readability (especially for people with vision impairments or cognitive impairments); and

(d) updated style and tone to ensure the content is in plain English.

118 Consumers and stakeholders have responded positively since the release, including:

(a) the Federation of Ethnic Communities Councils of Australia Inc., which provided positive feedback about the ability to search by language in the 'Find a Provider' tool for all programs;

(b) Dementia Australia, which responded positively to the new design of the updated website, noting that it makes it easier to use for people with cognitive decline; and

(c) Vision Australia, which provided feedback that accessibility to the My Aged Care website and its pages had significantly improved.

119 Since the updated website went live, the Department has sought consumer and stakeholder feedback to identify opportunities for further improvement (more detail is set out in paragraph 124 below). A significant program of monthly improvements is underway. Since the release, the Department has made enhancements including:

(a) a new self-service registration and screening system released on 19 January 2020, which enables older Australians and their carers to check eligibility for aged care and apply for an assessment. This is described in more detail in paragraphs 126 to 130 below;

[37] MYEFO 2019-20, page 229.

(b) a system solution preventing duplicate HCP entries from appearing in the 'Find a Provider' tool;

(c) more printer friendly website content including provider comparison results;

(d) improvements to site search logic to enable better access to content across the website;

(e) introduction of drop down menus to improve navigation to lower level content; and

(f) continued improvements to the website's accessibility including screen reader optimisations for those with vision impairments.

Evaluation of improvements to the My Aged Care website

120 The impact of changes to the My Aged Care website is evaluated by the Department through collecting and analysing data from a variety of sources.

121 The Department's ongoing work in evaluating changes to the updated website since 24 June 2019 includes:

(a) monitoring benefits to the various audience and users of My Aged Care;

(b) working with Liquid Interactive;[38] and

(c) collecting and analysing consumer and stakeholder feedback.

Each of these activities is described in further detail below.

122 The Department monitors specific key performance indicators (**KPIs**) to assess the updated website, including the rate of customer satisfaction, which is the primary KPI. Respondents are able to rate their experience on a 5-point scale of very dissatisfied to very satisfied in response to an on-site survey. This KPI is measured by adding together respondents who are satisfied or very satisfied.

123 The Department works closely with Liquid Interactive, to monitor and report on the user experience of the updated website. Liquid Interactive provides monthly feedback regarding performance against key objectives, investigating and tracking critical issues, assessing the impact of recent changes, and opportunities for improvement. The reports provided by Liquid Interactive to date indicate that overall, customer satisfaction has improved since the updated website was launched. By way of example of the types of reports provided by Liquid Interactive to the Department, a copy of the February 2020 performance report from Liquid Interactive is at **Exhibit NTG-0736-8** [**CTH.1000.0004.0649**].

124 The Department also engages in an ongoing and active process of seeking and addressing feedback from consumers and stakeholders on the efficacy and functionality of all of the activities developed through the My Aged Care Extension Budget measure, including through:

(a) feedback sent to the My Aged Care contact centre online, by telephone, by fax, or by post;

(b) on-site surveys to capture immediate feedback;

[38] The Department has engaged Liquid Interactive, who provide design, development and support for the My Aged Care website.

(c) telephone and online surveys to capture feedback on general perceptions of the site;

(d) carrying out significant user testing when testing possible enhancements to ensure new functionality meets the needs of users conducted by an independent market research agency; and

(e) regularly capturing feedback from both internal stakeholders (such as policy / program areas and the Department's Health State Network) and external stakeholders (such as COTA Australia, Dementia Australia, Vision Australia, Carers Australia, and assessor and provider organisations), including through formal stakeholder consultations.

125 All feedback received by the Department is monitored and prioritised according to the impact on users and may inform the Department's ongoing program of iterative improvement.

Self-service online registration and screening system

126 The new registration and screening form allows clients or their carers to submit an application for an aged care assessment via the My Aged Care website quickly and easily, at a time that best suits them, including when the My Aged Care contact centre is not open.

127 The functionality bypasses the contact centre as the request goes straight to a relevant assessment organisation. The assessment organisation is responsible for confirming that the client has provided consent for the assessment to go ahead, a record to be created in the system, and for representatives to be set up in the system.

128 The Department recognises that not all clients or their family members may wish to use this way of applying for an assessment. Alternative existing channels will continue to be available including being referred by a GP or health professional, or calling the contact centre.

129 User testing indicated that there would be high demand for this service and this has been evident since the release of the form. Between 19 January and 13 March 2020, 5,557, consumers have submitted the form.

130 Feedback has been very positive with an approximately 90 per cent satisfaction rating via an on-site survey in the first two months. Feedback is sought via the same mechanism as for the website, described in paragraph 124 and enhancements will be made to the form as required.

Client dashboard (enhancements to the consumer portal)

131 The My Aged Care client portal is a personalised record of client information and can be accessed by clients and their representatives via myGov.

132 The portal was updated in 2019 to provide a dashboard or 'summary page' with a journey tracker and automatic email notifications at key stages in the client's journey to access care. This allows clients and their representatives to see key information such as steps completed, next steps, assessment outcomes, assessment and provider organisation details and care types being received.

133 Similar enhancements have also been made to the contact centre, assessors and provider views of the client portal to enable those supporting clients to access key information quickly.

134 Feedback is sought via the same mechanism as described for the website, described in paragraph 124, and has been broadly positive. Work is currently underway to identify further enhancements to the portals through user research, prototype development and testing.

e-Referral system

135 The Department has developed a new e-Referral system which allows GP practices, to send referrals to My Aged Care directly from their practice management systems to request an aged care assessment, making the referral process easier and faster.

136 The e-Referral system is a form that is integrated into the existing Best Practice, MedicalDirector and Genie practice management systems. The system securely links, extracts, prepopulates and transmits patient data to My Aged Care, placing the focus on patient screening and streamlining the referral process. After sending an e-Referral, GPs receive an acknowledgement in real time with a reference number to use to follow up on referrals.

137 Previously, GPs and practice staff could only make referrals to My Aged Care by telephoning the My Aged Care contact centre, sending a fax, or using an external web form. These options are not integrated into practice management systems, require manual data entry which creates risk of error, and impose administrative burden on both GP practices and the contact centre.

138 The e-Referral system was trialled in July 2019 through an initial three month pilot, which allowed the Department to make improvements based on feedback from the participating practices. The Department launched the e-Referral system nationally in late October 2019.

139 The Department is currently engaging in a 12-month evaluation period involving monitoring take-up and feedback. At 13 March 2020, there have been over 3,200 e-Referrals from 750 GP practices.

140 The Department's ongoing activities to continue its evaluation of the e-Referral system include:

(a) reviewing daily reports from HealthLink (the third-party delivery partner for the system), which set out trends relating to the number of referrals;

(b) reviewing a range of surveys and monthly data extracts. The information in these includes data on assessor satisfaction with the quality of information provided, the total number of e-Referrals, submitting practice sites and the tracking of the number of referrals made through other channels to measure the uptake of the e-Referral system;

(c) collecting feedback on the e-Referral system by email and engagement with GPs through the vendor. To date, the Department has generally received positive anecdotal feedback from health professionals and peak bodies (including the Australian Medical Association and the Royal Australian College of General Practitioners (**RACGP**)) regarding the system;

(d) carrying out market research to understand how to improve the system for GPs; and

(e) collecting further usage data to determine whether the e-Referral system has resulted in a significant shift away from legacy referral channels referred to at paragraph 137 above.

141 Informed by the results of its evaluation of the e-Referral system to date, the Department is currently undertaking work to refine the system with enhancements such as utilising more help text and resolving technical issues.

Question 20

The Australian Government announced the Aged Care System Navigator in the 2018-19 Budget to test different models to assist people to understand and engage with the aged care system. In relation to this announcement:

a. the COTA-led trial is funded until 30 June 2020. Provide the timeframes for reporting of the outcome of the trial to the Australian Government

b. provide an overview of any initial evaluation on the efficacy of the Aged Care System Navigator.

Timeframes for reporting on the outcomes of the trials

142 The Department had originally anticipated receiving the final evaluation report on the System Navigator measure on 15 June 2020.

143 A short-term extension of the System Navigator measure beyond 30 June 2020 has been agreed by the Minister. This will enable consideration of a more comprehensive data set in respect of trials under the System Navigator measure, together with any recommendations made by the Royal Commission on potential future aged care consumer contact models.

Overview of any initial evaluation findings on the efficacy of the trials

144 Preliminary findings from the evaluation will be presented in an interim evaluation report. The Department anticipates receiving a draft interim evaluation report from Australian Healthcare Associates on the System Navigator measure in late April 2020. The evaluation includes an assessment of the implementation, appropriateness, effectiveness and cost-effectiveness of trials implemented under the System Navigator measure.

GP ACCESS IN RAC

Question 21

In the 2019-20 MYEFO, the Australian Government announced $98 million over four years from 2018-19 to increase the Medicare Benefits Schedule (**MBS**) fees for General Practitioners (**GPs**) attending a residential aged care facility to help ensure that GPs have appropriate incentives to provide care in aged care facilities.

There was a minor increase in the number of Residential Aged Care Facility (**RACF**) attendances billed following the March 2019 changes. However, the growth in RACF attendances matched the growth in total MBS services over this general time period. In addition, the average number of services billed per person remained relatively stable.[39]

In his statement to the Royal Commission, Dr Troye Wallett said that the new MBS call out fee provides 'very little difference in the end as the value of each MBS item for the service component of the consultation was also reduced at the same time'.[40] Dr Anthony Bartone said, 'Based on the results of the 2017 AMA Aged Care Survey, MBS rebates needed to increase by at least 50 per cent to adequately compensate for the additional time and complexity involved in comparison to a GP attendance in their own consulting rooms. The $98 million increase announced at MYEFO 2018 falls a long way short of this 50 per cent mark. Further, the new structure leaves GPs who visit a large number of patients in one RACF visit financially worse off than before.'[41]

Explain whether the Department agrees with this analysis, and:

a. explain why the rebate for the new item number 90001 ('GP call out') was set at $55

b. explain why the announced increase to the MBS will sufficiently address the issue of low GP attendance at residential aged care facilities

c. under NTG-494, the Commonwealth Department of Health produced relevant MBS data for the six months from 1 March 2019 to 31 August 2019. Provide updated MBS data month by month for the period 1 March 2019 to 31 January 2020. In addition to NTG-494, provide the benefits paid against the relevant MBS billed services.

d. provide updated data for RACF-specific attendance items billed per month for the period 1 March 2018 to 28 February 2019 on the old MBS items, including benefits paid.

[39] Royal Commission into Aged Care Quality and Safety 'Medicare Benefits Schedule – New Arrangements for General Practitioner Services in Residential Care' 6 December 2019, RCD.9999.0280.0050.

[40] Exhibit 14-6, Canberra Hearing, Statement of Troye Stuart Wallett, WIT.0617.0001.0001 at .0010 [59].

[41] Australian Medical Association submission to the Royal Commission into Aged Care Quality and Safety, September 2019 AMA.9999.0001.0001 at .0005.

Increase in MBS fees for GPS attending a RACF

145 The Department does not agree with the analysis provided by Dr Wallett and Dr Bartone. While the Australian Medical Association has noted that the updated payment model for non-referred attendances at RACFs leaves some GPs, who see a high volume of RACF patients, disadvantaged, this statement does not hold for the vast majority of scenarios where GPs visit RACFs to provide services. A scenario which results in comparatively lower revenue requires more than 20 patient services per flag-fall, as this is the cross-over point where the previous derived fee approach results in higher net cumulative rebates. Data previously provided to the Royal Commission shows the average number of services per RACF flag-fall is approximately 5.[42] Unpublished MBS data indicates that fewer than 5 per cent of RACF visits result in enough services to yield reduced total cumulative MBS rebates.[43]

146 With respect to Dr Bartone's assertions that MBS fees need to be increased at least 50 per cent to compensate for the additional time and complexity involved in comparison to a GP attendance in their own consulting rooms, the Department notes that level B RACF consultations (item 90035) are the dominant service claimed for RACF services. This is despite level C consultations, for attendances between 20 minutes and 40 minutes (item 90043), having a rebate that is almost double that of level B consultations. Additionally, proportionately more short (level A) consultations (item 90020) and fewer long (level C) consultations appear to be provided by GPs to residents of RACFs. This could be due to a variety of reasons, including the patient's clinical complexity, whether the services are bulk-billed or the value of the fees to the GP for their time and effort.

Why the rebate for the new item number 90001 ('GP call out') was set at $55

147 The rebate for the standard schedule fee for Group A35 items provided by vocationally registered GPs was set to $55.00 as a result of a decision of Government. This amount was intended to recognise the costs to GPs of spending time outside their consulting rooms and travelling to RACFs.

Why the announced increase to the MBS will sufficiently address the issue of low GP attendance at RACFs

148 The Department does not agree with the premise of this question for two important reasons. First, information already produced to the Royal Commission by the Department shows that, for the 2018-19 financial year, patients living in a RACF receive more primary care services annually than similarly aged patients in the community, with the vast majority of these services provided by a GP.[44] Second, the Department understands 'sufficient' in the context of demand for GP RACF attendances to be undefined, with the potential for both significant variability in relation to individual patients' needs, and access to care being affected by factors unrelated to MBS policy such as workforce distribution.

[42] See Response to Notice No. NTG-0494 produced to the Royal Commission on 24 October 2019 (**NTG-0494**).
[43] This data covers a period of 1 March 2019 to 31 December 2019.
[44] Exhibit 14-31 [**WIT.0573.0002.0001**], paragraph 57.

149 The question may also misinterpret the objectives of the changes to MBS RACF items. While this measure is providing real investment in GP RACF services, the changes, as initially proposed in draft recommendations of the MBS Review Taskforce, are not intended to result in significant increases in service volumes. Rather, stakeholder advice was that GP RACF service levels were likely to diminish without investment, and the previous derived fee model unnecessarily complicated GPs' calculations of their MBS revenue in relation to their RACF services. The intention of the changes to the MBS RACF items was to both maintain GP RACF service levels and provide a simpler method of calculating MBS revenue for approved providers.

Provide updated MBS data month by month for the period 1 March 2019 to 31 January 2020, the benefits paid against the relevant MBS billed services and updated data for RACF-specific attendance items billed per month for the period 1 March 2018 to 28 February 2019 on the old MBS items, including benefits paid.

150 The data is provided at **Exhibit NTG-0736-9** [**CTH.1000.0004.0648**].

PALLIATIVE CARE

Question 22

The Department produced a draft Implementation Plan for the National Palliative Care Strategy 2018 to the Royal Commission, current as at 16 January 2020:

a. advise when the Implementation Plan is expected to be finalised

b. the Implementation Plan was intended to be completed one year after the National Palliative Care Strategy in 2018. Explain the delay in finalising the Implementation Plan.

151 The Implementation Plan for the National Palliative Care Strategy 2018 (**Implementation Plan**) was drafted following extensive consultation throughout 2019 with all States and Territories and the Commonwealth and submitted for initial endorsement by the Health Services Principal Committee (**HSPC**) of the Australian Health Ministers' Advisory Council (**AHMAC**) in January 2020. The Implementation Plan was endorsed by the AHMAC on 7 February 2020.

152 Due to a need to focus on urgent priorities at the COAG Health Council (**CHC**) meeting on 28 February 2020, the Implementation Plan is being progressed out of session to CHC for endorsement.

153 In addition to the consultation process outlined above, the timing for finalisation has been dependent upon timeframes and processes required for endorsement through the HSPC, then AHMAC, and lastly the CHC. An out of session agenda paper, seeking endorsement of the Implementation Plan will be sent from the Secretariat of the CHC to State and Territory Health Ministers, who will have one month to respond. The Department anticipates the agenda plan being circulated shortly. Once endorsed by the CHC, the Implementation Plan will be finalised.

ACATS AND RAS TO BE STREAMLINED

Question 23

On 10 December 2019, the Department of Health opened consultation on a single streamlined model of consumer assessment for all aged care services, which would be selected through a national tender process in 2020.

The discussion paper released as part of the consultation stated: "Decisions have not been made about specific implementation or tender arrangements for a new national assessment workforce. This discussion paper does not make assumptions about who the providers of assessment services will be into the future with regard to their status as existing or new providers, or as public, private or non-government organisations":

a. provide an update on the consultation for a streamlined model of consumer assessment, including timeframes for the consultation

b. provide an overview of any advice the Department has provided to the Secretary or Minister regarding whether the new streamlined model of consumer assessment for all aged care services should be delivered by public and/or private providers.

Update on the consultation for a streamlined model of consumer assessment

154 In the 2018-19 Budget, the Government announced that it will design and implement a new framework for streamlined consumer assessments for all aged care services, to be delivered by a new national single assessment workforce from 2020.[45]

155 Public consultation commenced from December 2018,[46] on a proposed consumer assessment model commenced from December 2018, which included:

(a) the release of the public Discussion Paper for the period from 10 December 2018 to 11 February 2019; and

(b) targeted consultation sessions with all existing assessment organisations and aged care peak bodies in January and February 2019.

156 On 19 June 2019, the Department released a summary report of consultation feedback on the streamlined assessment webpage.[47]

[45] Department of Health, My Aged Care, 'Streamlined Consumer Assessment for Aged Care Discussion Paper' (**Discussion Paper**), page 2: https://consultations.health.gov.au/in-home-aged-care-division/streamlined-consumer-assessments-for-aged-care-ser/supporting_documents/Discussion%20Paper%20%20Streamlined%20Consumer%20Assessment%20for%20Aged%20Care.pdf.

[46] The Department released the Discussion Paper on 10 December 2018 and two consultation papers on 26 September 2019 and 20 December 2019, respectively, discussed at paragraph 157.

[47] https://www.health.gov.au/resources/publications/streamlined-consumer-assessment-for-aged-care-consultation-summary-report-of-key-insights.

157 On 26 September 2019, the Department provided a consultation paper to States and Territories seeking feedback on streamlined and transitional aged care assessment arrangements in hospital settings and remote locations (**Consultation Paper**). A copy of the Consultation Paper dated August 2019 is at **Exhibit NTG-0736-10** [**CTH.1000.0004.0563**]. Following this, the Department undertook to progress development of the streamlined assessment model:

(a) From 2 to 8 October 2019, the Department arranged teleconferences with officials from each State and Territory government to discuss the issues raised in the Consultation Paper.

(b) On 14 October 2019, the Department met with all States and Territories through the Aged and Community Care Officials. The purpose of this meeting was for all States and Territories to consider feedback from all jurisdictions in response to the Consultation Paper. Most jurisdictions did not support the separation of the assessment workforce between hospital and community settings, as it did not meet the objective of streamlined assessment. This feedback was considered in the final design of the arrangements presented to Government.

(c) Visits to Aged Care Assessment Teams (**ACATs**) to discuss and observe the hospital assessment processes were conducted in November 2019 and December 2019 specifically, South Australia (25 November 2019), New South Wales (26 November 2019), Australian Capital Territory (3 December 2019) and Victoria (9 December 2019).

(d) On 20 December 2019, the Department released a further consultation paper to jurisdictions seeking feedback on implementation considerations for hospital assessment arrangements (**Second Consultation Paper**).

(e) From 16 to 31 January 2020, the Department conducted individual consultation sessions with all States and Territories to discuss feedback in response to the questions posed in the Second Consultation Paper.

(f) On 28 February 2020, the Department met with all States and Territories through ACCO. The purpose of this meeting was for all States and Territories to consider feedback from all jurisdictions in response to the Second Consultation Paper.

Release of information on tender arrangements

158 In December 2019, the Department initiated arrangements to notify the market of the intention to undertake a tender for a single assessment workforce:

(a) On 6 December 2019, the Department released information on its website confirming that a single assessment workforce would be engaged through a tender process in 2020.

(b) On 11 December 2019, the Department presented a webinar on the changes to aged care assessment arrangements. This included detailed information on the tender process and timeline and was open to any interested member of the public. A recording of this webinar was made available on the Department's website.[48]

[48] The webinar recording was removed on 6 March 2020.

Overview of any advice the Department has provided to the Minister on tender process

159 At the CHC meeting on 28 February 2020, the Government agreed to work with States and Territories to have a consistent, uniform, efficient and integrated aged care assessment process. The Commonwealth confirmed at this meeting it is not proceeding with the current tender process. Over the longer term, the Commonwealth will consider advice from States and Territories and from the Royal Commission about what the exact delivery mix should be.[49]

160 The Department had provided briefings and advice to the Minister regarding the proposed model for streamlined consumer assessment. Advice was also provided in relation to a tender process for a national aged care assessment workforce, as part of the model for streamlined consumer assessments, including whether this tender process should include those assessments currently performed by the States and Territories in hospitals and remote areas.

161 An overview of advice provided to the Minister on the streamlining project is as follows:

(a) As part of the 2018-19 Budget process, the then Minister for Health and Minister for Aged Care was briefed on design and implementation of a streamlined aged care assessment arrangement.

(b) In November 2018, the then Minister for Health and Minister for Aged Care was briefed on the public discussion paper released in December 2018 and, at this time, the Department noted that there may be some sensitivities asking States and Territories to participate in a contestable tender for all aged care assessments.

(c) In November 2018, the Minister for Health and Minister for Aged Care was briefed on the potential for a competitive tender to be conducted in June 2019.

(d) In April 2019 the Department provided the then Minister for Health and Minister for Aged Care with a verbal overview of the proposed model, and met with him to outline the proposed arrangements including the proposal to retain the States and Territories to deliver assessments in public hospitals, tender arrangements for community assessments, and an implementation timeline proposing a tender to be released in July 2019.

(e) In June 2019, the Department provided an overview of the streamlined assessment framework to the incoming Minister for Aged Care and Senior Australians.

(f) In July 2019, the Department sought the Minister's agreement to proceed with the implementation of streamlined assessment and to commence discussions with jurisdictions on assessment arrangements in hospitals and remote locations. The proposed model at this time still had assessments in hospitals and remote locations being excluded from the tender and retained by the States and Territories.

[49] CHC meeting Communique (28 February 2020) https://www.coaghealthcouncil.gov.au/Portals/0/Final%20CHC%20Communique_28%20February%202020.pdf.

(g) In September 2019, the Department sought the Minister's approval to commence discussions with States and Territories on workforce options in hospitals and remote areas including whether the States and Territories retain this function or alternatively have been included in a tender.

(h) Up to November 2019, the Minister was briefed on the outcomes of consultations with the States and Territories and the proposed tender arrangements to engage a new assessment workforce covering all aged-care assessments (including in a hospital setting) which would be open to all potential providers (including States and Territories), with a revised date for the commencement of the tender (April 2020).

(i) On 28 January 2020, the Department briefed the Minister on public comments relating to the tender process, specifically noting that there had been recent public criticism on the decision to engage a new assessment workforce through an open tender process. The Department noted the option that State and Territory governments retain hospital-based assessments on an interim basis or these be removed from the tender process and offered to State and Territory governments.

(j) On 18 February 2020, the Minister was briefed on potential timeframe options for release of a tender process.

(k) On 27 February 2020, the Department briefed the Minister on deferring the tender process.

Overview of advice to the Secretary

162 The Secretary was briefed regularly on the development and implementation of streamlined aged care assessment arrangements. Briefings were provided in the context of Federal Budget processes, engaging in response to the Royal Commission and engagement with aged care stakeholders.

163 Specific written briefings were provided to the Secretary on a streamlined assessment as set out below.

164 On 31 May 2019, the Secretary attended the AHMAC meeting. Input to the Secretary's brief for the AHMAC meeting highlighted key issues raised by jurisdictions in the early 2019 consultation process. This included concerns regarding:

(a) the potential displacement of the ACAT workforce if the States and Territories were not successful in the tender;

(b) the impact on existing hospital arrangements including discharge planning; and

(c) the loss of integration between the aged care system and the health system.

165 Input to the Secretary's brief for the AHMAC meeting held on 13 September 2019 reiterated these concerns and noted that consultation feedback was being considered by Government.

166 The Secretary received a brief on streamlined assessment for the 6 December 2019 AHMAC meeting. This brief noted a number of jurisdictions' preference to be the single assessment provider across all settings and all levels of assessment, including New South Wales, South Australia and Western Australia.

167 On 7 February 2020, New South Wales and Western Australia presented a paper to AHMAC seeking a review of the decision to proceed with the tender. The Secretary's brief identified this was not supported by the Commonwealth.

168 At the COAG Health Council meeting on 28 February 2020, the Commonwealth confirmed it was not proceeding with the tender. The brief for this meeting highlighted that aged care assessments are not being privatised.

MANDATORY NATIONAL QUALITY INDICATORS PROGRAM

Question 24

With respect to the letter to the Royal Commission dated 24 December 2019 from Gilbert + Tobin on Department of Health Update on Key Reform Areas:

a. describe the consultation that concluded on 17 December 2019 on the development of the two new quality indicators and on the existing quality indicator measures
b. provide a summary of the feedback provided in that consultation, including any feedback on the existing quality indicator measures. Provide a copy of any advice the Department has produced to the Secretary on the outcome of that consultation.
c. explain why the pilot for the two new Quality Indicators of medication management and falls and fractures is not commencing until 1 July 2021
d. describe the pilot, including how many residential aged care facilities will participate, and how long the pilot will run
e. describe the current proposal for the two new quality indicators (medication management and falls and fractures).

17 December 2019 consultation

169 A consortium of PricewaterhouseCoopers (**PwC**), the Centre for Health Services Research at the University of Queensland (**UQ**) and the RACGP was engaged by the Department to develop quality indicator measures for residential aged care services as part of the National Aged Care Mandatory Quality Indicator Program (**QI Program**). The consortium was engaged to develop new quality indicators relating to falls and fractures and medication management, as well as review the three existing quality indicators (pressure injuries, use of physical restraint and unplanned weight loss).

170 The process to develop the new quality indicators and to review the current quality indicators, which concluded on 17 December 2019, has, to date, involved the following stages and associated consultation:

(a) Stage One: an evidence-based literature review, which identified and comprehensively assessed potential quality indicators across the five (new and existing) domains (discussed at paragraph 179 below) and included consultation with the following groups:

(i) the RACGP Standards and Quality of Care Committees;

(ii) the Australian Commission on Safety and Quality in Health Care (**ACSQHC**);

(iii) the Department of Health and Human Services Victoria;

(iv) AIHW;

(v) Brown University (USA);

(vi) the University of Waterloo (Canada); and

(vii) the United Kingdom's National Health Service falls and fragility expert.

The literature review resulted in the development of the "*Development of Residential Aged Care Quality Indicators – technical findings from review of evidence*" report dated 18 November 2019 (**QI Technical Report**). A copy of the QI Technical Report is at **Exhibit NTG-0736-11** [**CTH.1000.0004.0303**].

(b) Stage Two: national face-to-face (125 participants) and public written consultations (317 responses), on the "*Development of Residential Aged Care Quality Indicators – Consultation Paper*" dated 18 November 2019 (**QI Consultation Paper**). The QI Consultation Paper was used as a basis to obtain sector feedback, from peak bodies, aged care service providers, consumer representatives and advocates, health professionals and other key stakeholders, in relation to quality indicators (across the five domains) that have been established nationally and internationally. A copy of the QI Consultation Paper is at **Exhibit NTG-0736-12** [**CTH.1000.0004.0224**] and additional details relating to consultation dates and participants are provided at **Exhibit NTG-0736-13** [**CTH.1000.0004.0001**].

(c) Stage Three: expert consultation on 17 December 2019 to obtain technical advice on the development of the quality indicators, considering the QI Technical Report, QI Consultation Paper and sector consultation findings summarised in the Department's Clinical Expert Group Briefing Paper. The Clinical Expert Group included individual expert medical and health professionals, as well as those representing the following organisations: the Department, the ACQSC, the Pharmaceutical Society of Australia, the Australian Medical Association, the Australian College of Rural and Remote Medicine, the ACSQHC, the RACGP, UQ, the Dietitians Association of Australia, Wounds Australia Limited, the Pan Pacific Pressure Injury Alliance, and the Australian Physiotherapy Association of Australia. A copy of the Clinical Expert Group Briefing Paper dated 11 December 2019 is at **Exhibit NTG-0736-14** [**CTH.1000.0004.0139**].

Summary of the feedback provided in that consultation

171 A summary of the feedback provided in the aged care sector consultations, including feedback relating to the existing quality indicators, is contained in the QI Consultation Paper at **Exhibit NTG-0736-12** [**CTH.1000.0004.0224**]. The feedback obtained from the Clinical Expert Group meeting, referred to in paragraph 170(c) above, was summarised by PwC in a presentation provided to the Department on 16 January 2020. A copy of the presentation titled "*Development of residential aged care quality indicators*" is at **Exhibit NTG-0736-15** [**CTH.1000.0004.0153**].

172 The Department has not provided any advice or briefing to the Secretary of the Department on the outcome of the quality indicator consultations. No advice is planned as advice of this nature is normally provided to the Minister and Government through the Deputy Secretary of the Ageing and Aged Care Group.

Pilot for potential quality indicators

173 As provided for in the 2019-20 Budget measure *More Choices for a Longer Life – Mandatory National Quality Indicators* and *Reducing misuse of medicines in aged care settings*, the QI Program will be expanded to include new quality indicators relating to falls and fractures and medication management. These quality indicators will be implemented from 1 July 2021.

174 Two sequential six-week pilots will test the potential quality indicator measures. These pilots commence on 2 March 2020 and 13 April 2020, with the final pilot concluding on 22 May 2020. The quality indicator pilot findings will be used to further consider any necessary changes to the existing three quality indicators, as well as to inform the decision about which new quality indicators relating to falls and fractures and medication management will be implemented as part of the QI Program.

175 In the lead up to 1 July 2021, a number of activities to support the implementation of the new quality indicators will be undertaken by the Department. These include, but are not limited to:

(a) obtaining Government agreement to the new quality indicators to be included in the QI Program;

(b) development of IT infrastructure within the My Aged Care Provider Portal;

(c) changes to the *Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019* and the *National Aged Care Mandatory Quality Indicator Program Manual 1.0*; and

(d) development of guidance materials and communications to support the sector to implement and understand changes to the QI Program.

Description of the pilot

176 The quality indicator pilot process will trial the collection and reporting of the potential quality indicators across two condensed (six-week) data collection cycles, by a national sample of 191 residential care services (as at 11 March 2020).

177 The quality indicator pilot objectives are to examine:

(a) the relevance, appropriateness and useability of the piloted quality indicator measures for the purposes of the national QI Program;

(b) the nature of data capture and data collection processes including implications for residential aged care service providers;

(c) the accessibility, clarity and usefulness of the specifically developed QI Program support materials;

(d) considerations of potential formats for reports summarising and comparing service provider results; and

(e) enablers for implementation and the learnings for consideration in the further development of the QI Program.

178 Service provider feedback relating to the objectives will be sought through post pilot cycle evaluation surveys. Further details on the quality indicator pilot is provided for in the National Aged Care Quality Indicator Pilot Handbook dated 3 March 2020 (**Pilot Handbook**). A copy of the Pilot Handbook is at **Exhibit NTG-0736-16** [**CTH.1000.0004.0567**].

179 The domains and quality indicators selected for the pilot are:

(a) pressure injuries – percentage of care recipients with pressure injuries, reported against six pressure injury stages;

(b) use of physical restraint – percentage of care recipients who were physically restrained;

(c) unplanned weight loss – percentage of care recipients who experienced significant unplanned weight loss (5 per cent or more) and percentage of care recipients who experience consecutive unplanned weight loss;

(d) falls and fractures – percentage of care recipients who experienced one or more falls and percentage of care recipients who experienced one or more falls resulting in major injury; and

(e) medications management – percentage of care recipients who were prescribed nine or more medications and percentage of care recipients who received antipsychotic medications.

Current proposal for the new quality indicators

180 As discussed at paragraph 174 above, the quality indicators relating to medication management and falls and fractures are included in the pilot.

181 The pilot findings and further Clinical Expert Group consultation findings will be provided to Government to help inform the decision as to which measures will be included as part of the falls and fractures and medication management quality indicators to be implemented as part of the QI Program from 1 July 2021. These findings will also inform the decision as to whether further developments are required to the existing quality indicators as part of the QI Program.

CHEMICAL RESTRAINTS

Question 25

With respect to the letters sent by the Chief Medical Officer as described in the letter from Gilbert + Tobin dated 24 December 2019:

a. what constitutes a 'high' prescriber, and how many prescribers fall within this category?

b. will the Department monitor the prescribing patterns of high prescribers following the late February/early March 2020 letter, and is the Department planning to take any further action with respect to high prescribers?

c. explain how repeat prescriptions for the antipsychotic Risperidone will be restricted from 1 January 2020, including who will provide the additional approval for the prescription of Risperidone beyond an initial 12 weeks.

d. provide an explanation for the initial 12 week timeframe allowed for the prescription of Risperidone, and for the exclusion other non-Risperidone psychotropic medications in this regulation.

What constitutes a 'high' prescriber and how many prescribers fall within this category

182 The Department has no set definition at this point as to what constitutes a 'high' prescriber. In determining what will constitute a 'high' prescriber, the Department and the Aged Care Clinical Advisory Committee (the **Committee**) are currently working to define the scope of a letter to be sent to prescribers of antipsychotics and benzodiazepines to residents in residential aged care. This letter will reflect the Committee's view on what constitutes 'high' prescribing.

183 Best practice guidelines indicate that prescribers should attempt to reduce and cease antipsychotics after a period of 12 weeks. Any set definition will accommodate for gradual introduction and reduction of the medication directly before and after the 12 week period.

184 It is expected that the letters will be sent to prescribers in mid-2020. The intention of the letter is to ask prescribers to reflect on and give further consideration to their prescribing of antipsychotics and benzodiazepines to patients in residential aged care.

185 It is unclear at this stage how many prescribers fall within this category. Final assessment of the number of prescribers to be sent the 'high prescribing' letter will be determined following agreement on the selection criteria by the Department and the Committee in April/May 2020.

Will the Department monitor the prescribing patterns of high prescribers and what further action is being taken with respect to high prescribers

186 The Department will continue to monitor the prescribing of antipsychotics and benzodiazepines to patients in residential aged care using periodic matching of data. Further action will be considered as appropriate with an initial evaluation of the impact of the letters to occur 12 months after they are sent.

Restriction of repeat prescriptions for Risperidone and explanation for the initial 12-week timeframe for the prescription of Risperidone

187 Treatment for the first 12 weeks of Pharmaceutical Benefits Scheme (**PBS**) subsidised therapy for behavioural disturbances associated with dementia of the Alzheimer's type in a year, is available through an 'initial' Authority Required (Streamlined) listing. From 1 January 2020, PBS-subsidised prescriptions for Risperidone for the treatment of behavioural disturbances associated with Alzheimer's type dementia beyond an initial 12 weeks are restricted through the addition of a new 'continuing' PBS listing that is Authority Required from Services Australia (i.e. electronic or telephone procedures).[50] Patients must have responded to an 'initial' course of treatment with Risperidone for this condition to access PBS subsidised 'continuing' treatment. This 'continuing' listing allows prescribers to treat these behavioural symptoms with Risperidone, beyond 12 weeks of 'initial' therapy, when clinically appropriate and provides prescribers with the opportunity to trial dose reduction or cessation in their patients, before extended PBS-subsidised treatment with Risperidone.

188 Risperidone was listed on the PBS for behavioural disturbances associated with dementia of the Alzheimer's type and for 12 weeks duration of treatment. The duration of treatment was recommended by the Pharmaceutical Benefits Advisory Committee (**PBAC**) on the basis of their review of available evidence. The PBAC noted that there is minimal evidence of efficacy of treatment beyond 12 weeks.

189 Risperidone is the only antipsychotic listed on the PBS for behavioural disturbances associated with dementia and consequently can be targeted with this revised listing. It is the most prescribed antipsychotic in residential aged care. Appropriate prescription of antipsychotics and benzodiazepines (psychotropic medications) in aged care is being addressed through a range of other measures including an educational letter from the Chief Medical Officer sent to prescribers in December 2019 and a targeted letter planned for mid- 2020 to high prescribers of these medications as noted in paragraph 182 above.

190 The Drug Utilisation Sub-Committee (**DUSC**) of the PBAC regularly examines the utilisation of PBS items when there is at least 24 months of prescription data available and where the DUSC or the PBAC has highlighted items of interest. The PBAC recommendation in August 2019 to review Risperidone will be considered as part of this process. This will include the consideration of the utilisation of other antipsychotics and benzodiazepines that may occur as a result of the restriction changes for Risperidone.

[50] Further information on Authority Required procedures see Exhibit 3-2, General Tender Bundle, Tab 115 [**CTH.0001.1000.5911**] and Exhibit 3-55 [**WIT.0129.0001.0001**].

Question 26

In relation to the announcement made by the Hon Greg Hunt on 1 November 2019 regarding the commission of a national baseline report on Quality Use of Medicines and Medicines Safety:

a. provide an update on the national baseline report being prepared by relevant agencies including the Australian Commission on Safety and Quality in Health Care and the Australian Digital Health Agency.

191 The ACSQHC is undertaking scoping work for the national baseline report on Quality Use of Medicines and Medicines Safety and preparing a project plan which will include what is achievable in the first 12 months following the announcement. On 28 February 2020, the Department met with the ACSQHC to discuss the progression of the national baseline report.

WORLD HEALTH ORGANISATION DECADE OF HEALTHY AGEING

Question 27

The World Health Organisation (**WHO**) has launched the Decade of Healthy Ageing (2020-2030) as an opportunity to bring together groups including governments for ten years of concerted, catalytic and collaborative action to improve the lives of older people, their families, and the communities in which they live:

a. provide an overview of the Australian Government's proposed involvement in this initiative

b. to the extent not addressed in paragraph 27(a) above, provide an overview of the Government's proposed plan (including time frames) to meet the objectives of the Decade of Health Ageing (2020-2030). In your response, identify the relevant Department with responsibility for overseeing the implementation of the plan.

Overview of the Australian Government's proposed involvement in this initiative

192 The *Decade of Healthy Ageing 2020-2030* (the **Decade**) proposes international collaboration by governments, international organisations, professionals, academia, the media, the private sector and civil society, led by the WHO, to improve the lives of older people, their families and the communities they live in. The Decade has been developed through a broad multi-stakeholder consultative process, with submissions from 89 Member States of the WHO, 19 United Nations entities and over 300 non-state actors.

193 Australia has expressed its support for the Decade and has provided both written and verbal comments to the WHO, beginning with the first draft of the proposal for the Decade in February 2019. The last consultation was in September 2019.

194 In formulating Australia's response, the Department consulted across portfolios, including with the Department of Foreign Affairs and Trade, the Department of Prime Minister and Cabinet, the Department of Social Services, the Department of Home Affairs, the Attorney-General's Department and the Department of Education, Skills and Employment.

195 Australia is a member of the WHO Executive Board (the **Board**), which endorsed the draft proposal for the Decade at its 146th session (3 to 8 February 2020) for adoption by the 73rd World Health Assembly (the **Assembly**) in May 2020. The decision to be adopted by the Assembly transmits the Decade to the United Nations Secretary General for consideration by the General Assembly. Consideration by the General Assembly will generate engagement across the broader United Nations system to facilitate multi-sectoral action for a life-course approach to ageing, as envisaged by the Decade.

Australian Government's proposed plan to meet the objectives of the Decade

196 Once the Decade is launched in October 2020, the Department will work collaboratively within and across Australian governments to coordinate Australia's response. Implementation of actions in Australia will require significant collaboration across sectors and all levels of government. The Department will have the lead role in co-ordinating and overseeing Australia's plan to meet the objectives of the Decade.

197 The Decade prioritises the roles of national and sub-national leadership and their ownership of results. Priority is also focused on building strong capacity, including to monitor and evaluate national policies and strategies on ageing. During the Decade, the Department will monitor progress with the Decade's objectives by using indicators specific to ageing including those established by the WHO Global Strategy and Action Plan on Ageing and Health and the Sustainable Development Goals.[51]

198 The framework for tracking progress throughout the Decade include:

(a) taking stock of the vision and action areas;

(b) building on the indicators of progress agreed on for the global strategy;

(c) extending other WHO and United Nations global policy instruments to include older people; and

(d) linking to the four enablers – voice and engagement, leadership, capacity-building and research and innovation.

[51] World Health Organisation, *'Global strategy and action plan on ageing and health'* (2017) <https://www.who.int/ageing/WHO-GSAP-2017.pdf?ua=1>.

199 WHO and United Nations partners will produce status reports at baseline in 2020, then in 2023, 2026 and in 2029 before the end of the Decade. Progress reports will draw on previous WHO reports, the reporting mechanism for the Madrid International Plan of Action on Ageing and national reviews in achieving the Sustainable Development Goals. Apart from these three review dates, no further timeframes have been identified in the Decade proposal. Once endorsed at the UN General Assembly, the Department will engage with relevant stakeholders to identify steps to meet reporting requirements for the review periods identified above and to implement the objectives of the Decade.

EMBEDDING PHARMACISTS IN AGED CARE

Question 28

In the 2019-20 Budget, the Australian Government announced "a Canberra trial to embed a part-time pharmacist in all 27 residential care facilities to ensure the quality use of medicines".[52] This was also referred to by Professor Brendan Murphy in his evidence to the Royal Commission on 14 May 2019.[53] The Royal Commission understands that this measure was based upon an earlier smaller trial in several facilities in the ACT:[54]

a. outline any evidence of the results of the smaller trial that informed the decision to extend the trial

b. explain how pharmacists taking part in the trial will be remunerated

c. provide details of any costings or estimates that may have been prepared of the impact of the trial on pharmaceutical utilisation and any other measures of health status.

200 The initiative to embed a part-time pharmacist in all 27 residential care facilities in the Australian Capital Territory (**ACT**) is funded under the Community Health and Hospitals Program announced in the 2019-20 Budget.[55]

201 The Department sought expressions of interest from State and Territory governments and Primary Health Networks (**PHNs**) for funding for a range of objectives under the $1.25 billion program.

202 The ACT PHN submitted an expression of interest through this process, and was ultimately successful in being granted funding to progress the trial. A copy of the ACT PHN expression of interest is at **Exhibit NTG-0736-17** [**CTH.1000.0004.0504**].

[52] https://www.health.gov.au/sites/default/files/more-choices-for-a-longer-life-reducing-the-misuse-of-medicines-in-residential-aged-care_0.pdf.

[53] Transcript, Canberra Hearing, Professor Brendan Murphy, 14 May 2019 at T.1648-49.

[54] The Royal Commission's understanding is that there was an initial trial in 2017 (written up in) <https://researchprofiles.canberra.edu.au/en/publications/the-effect-of-a-residential-care-pharmacist-on-medication-adminis> and <https://www.australianpharmacist.com.au/aged-care-pharmacist-pilot-a-winner/>. Goodwin then decided in late 2018 to institute the model in three services <https://www.australianageingagenda.com.au/2018/12/13/on-site-pharmacist-a-first-for-aged-care/>.

[55] Fact sheet: Investing in the health of Australians <https://budget.gov.au/2019-20/content/factsheets/health.htm>.

203 The ACT PHN developed an Activity Work Plan which provides for the activities that are proposed to be undertaken for the periods 2019-20, 2020-21 and 2021-22 in respect of core funding, GP support funding and its community health and hospital program. A copy of the Activity Work Plan is at **Exhibit NTG-0736-18** [**CTH.1000.0004.0544**].

Evidence of the results of the smaller trial that informed the decision to extend the trial

204 The Department did not specifically consider the results of the smaller trial in the process of the ACT PHN submitting an expression of interest for a grant of funding. However, as set out in the ACT PHN expression of interest submission, the proposed model of interdisciplinary care has been successfully examined by the University of Canberra in a proof-of-concept study conducted in 2017. This formed the basis of the PHN proposal that was supported by the Commonwealth.

205 The ACT PHN set out in their expression of interest for funding:

In 2017-18 the University of Canberra conducted a pilot study in which an on-site pharmacist was integrated with nursing to form a multidisciplinary team in RACFs to improve medication use and prevent medication-related hospitalisation and harm. The proof-of-concept study reported of positive outcomes…

206 The preliminary findings from the smaller trial suggested that the model resulted in:

(a) the prevention of adverse drug events and potential hospital avoidance;

(b) improved influenza vaccination rates in RACFs for staff and residents;

(c) improved medication administration and clinical documentation in RACFs;

(d) improved efficiencies for RACF industries resulting in cost savings for RACFs; and

(e) the provision of education for nursing and carer staff to improve the quality use of medicines and reduce medication / medication administration errors.

207 The ACT PHN will partner with the University of Canberra to deliver the trial.

208 The ACT PHN's expression of interest states that the primary outcome of the trial is to "reduce the rate of hospital admissions (all cause and medication-related)". Secondary outcomes are listed as:

(a) reduced frequency of presentations to an emergency department;

(b) increased rate of vaccination (compared to baseline and national standards);

(c) reduced rate of influenza and influenza-related hospitalisation;

(d) reduced rates of medication adverse events;

(e) stakeholders' (residents, general practitioners, nursing staff and pharmacists) satisfaction-mixed methods;

(f) reduced rate of falls and associated hospital admission;

(g) developing a viable economical model and feasibility assessment for a widespread dissemination; and

(h) The impact on deprescribing of resident medications.

How pharmacists taking part in the trial will be remunerated

209 The ACT PHN expression of interest sets out that:

The University of Canberra will provide funds, through a Service Level Agreement, to all consenting RACFs in the ACT to employ a non-dispensing pharmacist to provide pharmacy services.

Additionally, in the Budget of the ACT PHN's EOI, it sets out the following expenditure assessment for salaries of pharmacists:

Expenditure	***2018-19***	***2019-20***	***2020-21***
Salaries Pharmacist 0.4FTE in 27 RACFs	*$463,320*	*$1,111,968*	*$648,648*

Details of costings or estimates that may have been prepared of the impact of the trial on pharmaceutical utilisation and any other measures of health status.

210 The Department is not currently aware of any costings or estimates that may have been or will be prepared on the impact of the trial on pharmaceutical utilisation and any other measures of health status.

PSYCHOLOGICAL TREATMENT SERVICES FOR PEOPLE WITH MENTAL ILLNESS IN RACFS

Question 29

In the 2018-19 Budget the Australian Government committed $82.5 million over four years for the Psychological Treatment Services for People with Mental Illness in Residential Aged Care Facilities measure. The purpose of the measure was to support Primary Health Networks "to commission psychological treatment services targeting the mental health needs of people living in residential aged care facilities. These services are intended to enable residents of these facilities with mental illness to access mental health services similar to those available in the community through the Better Access to Psychologists, Psychiatrists and General Practice through the MBS Initiative (Better Access)":[56]

a. explain the progress that has been made against this announcement

b. provide details of and an itemised budget for expenditure of the announced $82.5 million over four years

c. provide a table showing, by year and by PHN, the number of people who:

   i. have already received services under this measure

   ii. are estimated to receive services under this measure.

[56] https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/11PHN%20Guidance%20-%20Psychological%20treatment%20services%20in%20Residential%20Aged%20Care.pdf.

d. provide a table showing, by year and by PHN, the number of psychological treatment services:

   i. already provided under this measure

   ii. estimated to be provided under this measure.

e. If (c) or (d) is not possible, explain why not, and provide the best information available on numbers of people and services.

The progress that has been made against this announcement

211 Each PHN is at a different stage of implementation in respect of the *Psychological Treatment Services for People with Mental Illness in RACFs* Budget measure. Some PHNs have extended existing in-reach psychological treatment services to RACFs, some have completed trial programs and are moving towards implementing or expanding programs, and some are in the process of conducting trial programs. All PHNs have taken steps to deliver in-reach psychological treatment services.

212 In support of the measure, the Department has funded the Australian Psychological Society to develop and deliver a series of interactive online training modules to upskill the mental health workforce commissioned by PHNs. Approximately 1,600 clinicians and 600 support workers will benefit from these programs. This training is expected to be available in mid-2020.

Details of and an itemised budget for expenditure of the announced $82.5 million over four years

213 The announced $82.5 million provides for:

(a) $79.8 million for PHNs to provide in-reach psychological services to residents in RACFs; and

(b) $2.7 million to support the development and implementation of these services through PHNs.

A breakdown of this expenditure is set out in further detail at **Exhibit NTG-0736-19** [**CTH.1000.0004.0647**].[57]

Service delivery under this measure

214 As at 31 December 2019:

(a) approximately 2,480 people had already received services under this measure; and

(b) over 12,000 psychological treatment service contacts had occurred.[58]

[57] It is apparent from Exhibit NTG-0736-20 that the Department expects a $1.68 million underspend of the $2.7 million mentioned in paragraph 213 across the 2018-19 to 2021-22 financial years. The current spending of the $2.7 million is reflected in rows 34 to 36 of Exhibit NTG-0736-20. This will be available for reallocation into other elements of this measure, such as an evaluation.

[58] Primary Mental Health Care Minimum Data Set. This data is current at 3 March 2020, and only contains data where the client has given consent for their data to be provided to the Department (approximately 85 per cent of all clients). Numbers may change due to delay in data uploads. Data is only available for 2019.

A breakdown of these numbers is set out in further detail at **Exhibit NTG-0736-20** [**CTH.1000.0004.0645**].

215 As at 30 June 2019, 223 RACFs have been involved in the implementation of the measure.[59]

216 The Department does not hold current estimates of the numbers of recipients anticipated to receive services or the number of psychological treatment services to be provided year by year and by PHNs under this measure. The psychological treatment services are a new measure which is being rolled out incrementally by PHNs leading up to full implementation by 2021-22.[60]

217 As indicated in the witness statement of Glenys Beauchamp dated 15 November 2019 and signed 9 December 2019, under this measure, PHNs are encouraged to be innovative in the commissioning of their services.[61] This means that there will be variation between PHNs as to how many people will receive psychological treatment services and how many psychological treatment services are provided under the measure. PHNs provide the Department with regular reports that support implementation of the measure, including data on client numbers who receive services through the Primary Mental Health Care Minimum Dataset.

BUSINESS IMPROVEMENT FUND

Question 30

In relation to the 31 January 2020 Australian Government announcement of $50 million to establish a targeted aged care Business Improvement Fund (**BIF**), explain

a. whether the Department has provided advice to the Secretary on the structure and operation of the BIF, legislative requirements and resourcing implications of such a scheme, and timeframes for implementation

b. if so, provide a copy of that advice

c. if not, provide information about when the Department expects to be in a position to provide such advice.

218 The Department has not provided written advice to the Secretary on these specific matters and no specific written advice to the Secretary is planned at this time. However, the Secretary was verbally informed about matters relating to the program. Advice is normally provided to the Minister and Government through the Deputy Secretary of the Ageing and Aged Care Group in relation to this program.

[59] Results from Department survey of PHNs conducted in October 2019.
[60] Exhibit 14-31 [**WIT.0573.0002.0001**], at [287].
[61] Exhibit 14-31 [**WIT.0573.0002.0001**], at [288].