Aged Care
Standards and Accreditation Agency Ltd

21 March 2011

The Chairman
Productivity Commission
GPO Box 1428
CANBERRA CITY ACT 2601

Dear Sir

Draft Report – Caring for Older Australians

I have attached Aged Care Standards and Accreditation Agency Ltd response to the Commission's draft report.

In framing our response we have taken the view that readers including the international audience will regard the background information in the final report as factual. While we accept that the draft report reflects what the Commission may have been told in some submissions, there are areas where the information may mislead the reader. Consequently, as well as responding to the relevant recommendations, we have provided additional information to provide context based on the available evidence, our knowledge of other quality promotion and quality assurance frameworks in health and long term care and our experience as the accreditation body over the past twelve years. The context is particularly relevant where a statement leads the reader to conclude something is (say) widespread or (say) rare when in fact that is not the case or misrepresents a process or policy.

In responding we have confined our comments to the areas in which we have particular experience or knowledge. That is largely Chapter 12.

We are quite prepared to provide any further information or reports that might help you in your deliberations.

Yours faithfully

Jim Harrowell AM
Chairman

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AGED CARE STANDARDS AND ACCREDITATION AGENCY LTD

Response to the Productivity Commission Draft Report

Caring for Older Australians

March 2011

Background: The roles and functions of the accreditation body appointed under the Aged Care Act (Aged Care Standards and Accreditation Agency Ltd)

The Accreditation Grant Principles 1999 set out the role of the accreditation body. Under the legislation the body corporate appointed as the accreditation body is required to

- Manage the accreditation process using the Accreditation Standards
- Promote high quality care and help industry to improve service quality by identifying best practice, providing information, and supplying education and training services
- Assess and strategically manage services working towards accreditation
- Liaise with Department of Health and Ageing (DoHA) about services that do not comply with the Accreditation Standards.

The Aged Care Standards and Accreditation Agency Ltd is the body corporate that has been appointed as the accreditation body. The appointment is not on going and each agreement has a term.

In the Federal parliament Dr Nelson (2nd reading speech on 30 November 1998) said 'The core functions of the agency are threefold: the first is the *management* of the residential care accreditation process itself; the second is the *provision of assistance to proprietors to continually improve service quality* through education and training, the dissemination of information and the identification of best practice *to promote and encourage better quality aged care*; and the third is to assess and strategically manage services not yet ready for accreditation.'

The Accreditation Agency, the accreditation program and the standards exist for the benefit of residents. They must serve the dual (and inseparable) purposes of promoting high quality care and protecting the health and well- being of residents. To achieve this, the accreditation body must work closely with a range of stakeholders. Our experience is that these stakeholders have a variety of expectations and understanding of the accreditation arrangements and its objectives.

The education activities, assessment visits (announced and unannounced) and reporting of performance to the approved provider and DoHA contribute to the dual purposes. The identification of a home that has failed to meet the standards and the reporting of that failure to the regulator (DoHA) is a critical part of the multifaceted quality and regulatory framework that exists in residential aged care. However, merely identifying and reporting the failure does not fully serve the interests of residents. Their interests are only truly served when the home meets the standards and is continuously improving the care and services to residents.

Managing the Accreditation Process (Accreditation Grant Principles)
The work of the Accreditation Agency include:

- Assessing performance against the accreditation standards and strategically managing services working towards accreditation
- Informing DoHA about services that do not comply with the Accreditation Standards

Promote high quality care and assist industry to improve service quality identifying best practice, providing information, education and training (Accreditation Grant Principles)
This involves a collaborative approach with homes which is undertaken in concert with the accreditation management process. The Accreditation Agency offers:

- Educational and training support for quality assurance, continuous improvement and for identified issues (often targeted through the data analysis of assessment data)
- QUEST seminars which are short education sessions delivered to front-line staff in residential care homes
- Better practice awards for homes performing well beyond the Accreditation Standards
- Better Practices conferences are annual conferences held in each state capital at which better practice in aged care is showcased over two days
- Better Practice in Aged Care awards that recognise innovation in aged care.

The Accreditation Agency must work with stakeholders including approved providers to achieve better results for residents. It is vital that there is a clear understanding of the roles and functions of the Accreditation Agency and that the language used to describe the roles and functions does not misrepresent the purpose and actions.

Standards and the Delivery of High Quality Care

Reference page 409
Accreditation standards

Standards and quality care

The Productivity Commission (PC) Report provides discussion on the role and effectiveness of the setting of standards and their relationship to the quality of care. It is reported that Weiner et al (2007) questioned whether standards alone provide enough incentives for providers to improve quality above the lowest common denominator or the minimum requirement. The Accreditation Agency agrees that standards alone do not provide incentives for providers to improve quality above the minimum. There is a range of variables which influence care outcomes for residents that are not directly related to specific performance on the standards. The most obvious is day to day and strategic business decisions made by aged care managers and a number of other issues identified by the Productivity Commission in the draft report such as workforce and revenue streams.

Weiner is one of many researchers who have commented on standards and standard setting around the world. The assessment of performance of an organisation against standards is only one form of quality measurement. There are many audiences for these assessments and often there is no shared view among the audiences about what represents quality (Raleigh and Foot 2010).

Quality in healthcare is seen from many different perspectives – service users and professional groups (staff and management), informal carers and other interested groups but also from the organisational and systems level. Assessing performance against standards therefore provides an assessment (with varying degrees of objectivity) against a range of expectations concerning the quality of service outcomes. The important aspect is an understanding that assessed standards will drive performance and therefore the standards must be 'fit for purpose' for the individual and organisations. In the case of residential care that means 180,000 individual residents in 2850 homes. The Accreditation Agency maintains that the current Accreditation Grant Principles reflect a positive approach to ensuring facilities participate and continue to evolve their services to achieve better outcomes for residents.

General nature of standards

The PC Report commented that Weiner (2007) indicated that the general nature of the accreditation standards leaves too much flexibility for providers and assessors "with the latter subject to 'regulatory capture' by the former". This argument is speculative and not supported in Weiner's research paper which does not explain or reference 'regulatory capture'. In practice this argument is not applicable in Australia because the accreditation body is not a regulator (which is further discussed in this response).

Weiner did however report in his paper that "Nonetheless, the consensus opinion in Australia is that these broad standards are better than more specific standards because they allow inspectors (sic) and providers to focus on the broad issues rather than to get bogged down in less important details." Braithwaite also argued that the Australian standards were more reliable precisely because they were broad, subjective, and undefined in regard to protocols (Braithwaite, 1998)

The PC report further suggests that "it might be possible to develop a middle ground between broad standards and specific standards which allow the development of more systematic, quantifiable measures of the quality of care that could be used over time to compare facilities or to benchmark the whole system to track changes over time". The Accreditation Agency suggests that the development of measures is more relevant to performance indicators which are an input to the assessment of performance. Measurement of quality in residential aged care is not linear because of the necessity to balance best practice, duty of care and resident choice and decision making and resident views of what constitutes 'good quality'.

The development of standards which are overly specific and prescriptive combined with a strong focus on a compliance and enforcement regime would certainly make for easier and a less complex assessment process. However, it would stifle innovation in service delivery, would discourage improvement in the quality of care, place an emphasis on the minima and not serve the needs of residents.

Is the accreditation body a regulator? - No

Accreditation body purpose and functions
The legislation and the speeches by government at the commencement of the accreditation arrangements under the *Aged Care Act* made it clear that the Accreditation Agency is not a regulator.

Hansard 30 November 1998 reports Minister Moylan as saying;
"In place of a rigid policing style system, we will have a system that will work to assist residential aged care facilities to improve service delivery and, indeed, the social and physical environment by the process of continuous education. That becomes a very important feature of the whole accreditation process. It is not one driven by waving the four by two around and having a very policeman style of monitoring, but this is an accreditation system that seeks to assist, aid and educate facilities so that they can continue to provide the best possible services available."

The accreditation body has multiple responsibilities. The Accreditation Agency meets these responsibilities through a number of activities involving not only visits to homes to assess performance against the Standards and it is also required to work with the homes to achieve a higher quality of care (*Accreditation Grant Principles 1999*). The aim of the accreditation management process is not policing, but rather supporting the quality assurance approaches of facilities to assist them successfully attain accreditation and improve outcomes for residents. The importance of promoting quality care is well established in the legislation.

The number of homes meeting all expected outcomes reflect that pathway and a successful accreditation management process. It is important that the activities undertaken in that pathway (site audit visits, support visits, education and training support etc) are understood for what they are i.e. accreditation actions that focus on achieving high quality care through a collaborative approach.

The Accreditation Agency should, and does, report the outcomes of its quality of care assessments following accreditation and monitoring activity to the regulator (DoHA). It is the DoHA that has the complete picture of the home (i.e. quality of care and services, building, prudential position and key personnel) and is best placed to determine the appropriate regulatory response.

The Accreditation Agency's responsibility is to support and encourage a quality improvement environment that supports quality care and improvement in aged care while indentifying where homes have failed to meet the Standards. This approach is in the interests of the residents who are usually frail, vulnerable and elderly. To do this role adequately requires a strongly collaborative approach with the stakeholders. This does not align with an inspectorial/policing approach.

As argued in Campbell (2005), there has been much discussion about the inherent contradiction of combining the support of quality improvement in an open and transparent environment (e.g. the accreditation objectives) with compliance objectives that can result in penalties and may not reward open disclosure. "Accreditation is intended to perform a different function from government regulatory systems" (Campbell 2005 p105).

A change to an enforcement and compliance monitoring arrangement as suggested in the PC Report (refer Figure 1) seems to be underpinned by a belief that enforcement will promote continuous improvement. It would be a return to the practices of the late 1990's. This is a retrograde step that is contrary to international trends and would undo what the current arrangements have achieved. The Campbell Report was clear concerning the positive role of the current arrangements in improving quality from the low percentage of homes meeting all expected outcomes in 2000 to the 90% plus in 2009.

The Government created an 'accreditation agency' and defined its role along the lines of an accreditation body (Mrs Moylan Hansard 30 November 1998) not an inspectorate or a regulator. The Accreditation Agency manages the process that supports facilities to achieve the regulated standards and expectations, including the attainment of accreditation against the Standards. The general use of the word 'regulator' as a primary or even secondary role of ACSAA is not correct and it misrepresents the Accreditation Agency's mandated roles.

Reference page 388
No powers of enforcement
Accreditor v regulator

The Accreditation Agency remains strongly of the view that, on the evidence, it is not a regulator. Revoking or determining a period of accreditation is not an enforcement power.

In 1997 the Parliament decided that a body corporate would be appointed as the accreditation body. The language in Section 80-1 is quite clear. It did not expect the accreditation body to act as a regulator nor did establish it as one. The language of the enabling legislation separates the responsibilities of the accreditation body from that of the regulating Department and the responsibilities are those of an accrediting body.

- The accreditation body has no powers. (PC draft report page 388)
- The Aged Care Standards and Accreditation Agency Ltd does not appear anywhere in the legislation
- Assessors are appointed as independent team members separate from the accreditation body for site audits and teams are then disbanded
- Assessors are representatives of the accreditation body compared with the authorised officers of the Department
- Approved providers may nominate assessors for accreditation audits
- There is no right of entry compared with the Department
- There is no power to compel the provision of documents or information
- Time tables for improvement are agreed between the accreditation body and the approved provider compared with the Notice of Required Action of the Department
- The opportunity to create the Accreditation Agency as a regulatory body existed and was not taken up
- Any body corporate may be appointed as the accreditation body under the Act
- The accreditation body is obligated to help accredited providers improve service quality to their (the approved providers) clients (*Accreditation Grant Principles 1999*).

It is an important distinction that the Accreditation Agency is obliged to help providers improve service quality by much more than indentifying non compliance. Unlike a regulator such as APRA or ASIC or the ATO, the accreditation body does not nor can it force an accredited provider to do anything. The accreditation body assesses what the provider has achieved for the benefit of residents and is required to help in the conduct of their business.

Reference page 392
Comparisons with regulators

The role of the regulator is more aligned to ensure the regulated community does ‘something’ for the regulator and in a way the regulator expects. It is hard to conceive that ASIC will consider how a company’s business processes deliver quality outcomes for the company’s clients. A regulator approach to driving quality service above the minimum and continuous improvement in the health or aged care sector will not succeed. It is essential that the accrediting body can pursue its functions of promoting quality care and not be nor perceived to be the ‘industry policeman.’ Australian (Australian Commission on Safety and Quality in Healthcare) and international practice has moved strongly to separate standard setters, funders, regulators and accreditation bodies as much as is practical.

Reference page 386
Decisions

The outcome of compliance with the accreditation standards as determined by the Accreditation Agency is not equivalent to the outcome of compliance as determined by the regulator. The Accreditation Agency believes some aged care managers are confused because of the use of the term compliance in different contexts. The decision concerning compliance with the accreditation standards is that of the Chief Executive Officer of the accreditation body (Clause 1.5 Accreditation Grant Principles). The other references tend to mean a failure to comply with the responsibilities as an approved provider (of which being accredited is only one). It is the Department (DoHA) that determines failure to comply with the responsibilities as an approved provider.

The Accreditation Agency is currently contemplating reporting performance in relation to expected outcomes as met or not met (rather than compliant or not compliant). This is consistent with international practice in other 3rd party evaluation schemes.

Reference page 393
Assessment and education

It is stated in a submission (sub 433) reported in the draft PC Report that 'regulation and education' are the two main roles of the ACSAA. This is not correct as set out under the Act. For accuracy it needs to be restated that the two main roles of the Accreditation Agency are;

- Management of the accreditation process
- Promotion of high quality care and help industry to improve service quality, by identifying best practices and providing information, education and training to industry.

Please refer to Figure 2 for more details.

Governance

Reference page 392
Governance arrangements

The question of the governance structure of Aged Care Standards and Accreditation Agency Ltd was considered following the Uhrig Review. It is important to separate the role of the accreditation body from the governance structure of the company currently appointed as the accreditation body.

The view that the company should be subject to the FMA Act is built on the misunderstanding of the accreditation body's role as set out in the Act. The Accreditation Agency argument concerning why the accreditation body does not have a regulatory function has been made previously in this submission.

The Accreditation Agency believes that the governance arrangements for the company are a matter for government. It also believes that placing the organisation responsible for the accreditation program within a regulatory commission and under the banner of 'Compliance and Enforcement' will not deliver positive outcomes for residents.

Reference page 383
Delegation of responsibility

Contrary to the assertion at page 383, the responsibility for accreditation and promotion of high quality care is not delegated to the accreditation body. The Act provides that the Secretary of the Department will enter into a written agreement with a body corporate and pay the body corporate a grant called the accreditation grant. That grant currently represents approximately 62% of the Accreditation Agency revenues. Aged Care Standards and Accreditation Agency Ltd is currently appointed as the accreditation body. While the Secretary has a contractual power to cease the contract, the role of the accreditation body cannot be performed by the Department.

Process and Outcomes

Reference page 120
Approaches to assessment

Should the accreditation assessment process focus on processes used at the home rather than outcomes as suggested in some submissions? It needs to do both. The assessment process needs to ascertain whether outcomes are being achieved and form a view concerning whether those outcomes are likely to continue. The assessment model whereby the outcomes, documentation and processes are assessed optimises the outcomes for residents. Put another way, the question is "does the home have staff, systems and processes in place and will those staff and processes continue to deliver outcomes for residents?" To ignore the processes and documentation is to not see the 'accident waiting to happen'.

Reference page 409
Standards structure

The current mix of process and outcome standards is a result of theoretical and practical necessity. The accreditation standards are a mix of process and outcome standards. That mix is necessary because of the practical complexity of measuring outcomes in some activities but ones that nonetheless contribute to the objectives of the Standards. In some areas it is virtually impossible to measure outcomes. However there is strong evidentiary base to support a process standard eg medication management.

The standards are broad in context and not all elements are easily measured with objective outcomes, therefore it is necessary to measure the processes that underpin the outcome (Ranasinghe & Miller, 2006). Weiner stated that 'Nonetheless, the consensus opinion in Australia is that these broad standards are better than more specific standards because they allow inspectors and providers to focus on the broad issues rather than to get bogged down in less important details.'

Braithwaite has also said that the Australian standards were more reliable precisely because they were broad, subjective, and undefined in regard to protocols (Braithwaite, 1998).

It is possible that the submitters who commented about standards and performance measures had some level of confusion. Performance measures are complex when one is considering outcomes for a cohort of individuals living in a nursing home. The numeric measures are inputs to determining whether an outcome has been achieved. The indicator is merely that, indicative.

It should also be noted that quality cannot always be defined by standardised outcomes, and in particular is often more complex in health focussed outcomes. For example, residents may have quite diverse views about what constitutes quality of life.

The current Department of Health and Ageing review of the Standards will strengthen the standards in regard to outcomes; however the theoretical underpinnings of quality improvement in healthcare require adequate measurement and monitoring of all aspects -structure, process and outcomes. It is not logical to separate out the elements of quality assurance and focus on only one aspect. Without understanding processes there would be no understanding of why outcomes have changed. Accreditation is currently best served by a mixture of process and outcome standards as is the practice in other countries (e.g. Care Quality Commission of England states that although they focus on outcomes, they look at systems and processes to determine what actions are required).

The Accreditation Agency's preference is a focus on outcome standards then if they are not available revert to process standards when there is evidence the process will deliver a positive outcome.

The Accreditation process and the role of the visit program

Reference page 124
Processes

Non compliance with the Standards (failure to meet an expected outcome) is identified throughout the accreditation management process, not just at one single point. There are various types of visits undertaken in the process; site audit visits (all announced), review audits (announced and unannounced) and support contacts (announced and unannounced) that may be part of the annual target (of one per home) or following the completion of a timetable for improvement and review audit visits.

In regard to the PC discussion concerning the number of visits in 2008/09; there were 2,846 Australian government subsidised Residential Aged Care homes in Australia (AIHW 2009, Residential aged care in Australia 2007–08: A statistical overview). The number of visits in 2008/09 was atypical because it is the peak year in the accreditation cycle. Well over 50% of homes (1,622) underwent an accreditation site audit in that year. In that year there were 303 homes identified as having failed to meet at least one expected outcome. Thirty one percent (30.7%) of these homes were identified from site audit visits, 51.5% from Support Contacts and 17.8% from Review audit visits. Unannounced support contacts identified 110 of these 303 homes.

It can be seen that a significant percentage of issues are identified from support contacts, in particular from unannounced visits. This highlights the importance of the full range of visits used in promoting and maintaining the quality of care for older Australians and protecting residents' health and well being.

The success of the accreditation and performance management process is indicated by the fact that over 90% of the 303 homes that had failed to meet an expected outcome had the problem corrected within 3 months. Following the identification of failure to meet an expected outcome the Accreditation Agency works with the home to varying degrees in order for the problem to be corrected. This is called a timetable for improvement. The question should be asked, what level of compliance with the standards and importantly what level of quality of care would be achieved without these processes of identification and support.

By the very nature of support contacts, they follow a case management approach in that the local case management committee determines the date of the visit and the aspects of the homes operations that will be reviewed taking into account the history of the home.

Unannounced support contacts are a risk mitigation strategy and rarely exceed a day on site in aged care services. Naturally more time is devoted to those homes fail to meet the standards or have occurrences that have been identified a creators of significant risk. We note the International trends to the adoption of unannounced visits as part of the monitoring program by accreditation bodies.

Reference page 124
Unannounced visits

The Minister determined that each facility will receive at least one unannounced visit by the Accreditation Agency annually. This requirement is set out in the Accreditation Agency's written agreement with the Commonwealth.

While the PC Report indicates that there were some providers who felt the Accreditation Agency visits were disruptive on occasions, the results from the feedback surveys as reported in the ACSAA Annual Report (2009/10) and other feedback from aged care managers does not support the idea that such views are universally held. The survey results (sample of 2,700 responses in 2009/10) indicated that the large majority of homes (89%) reported that the Accreditation Agency were 'Excellent or Very Good' in allowing care staff to continue with their duties during visits. Most of the respondents are anonymous.

It is also important to note that while some inconvenience may be experienced by some homes, the benefit of these visits for residents has been clearly demonstrated. There was also some discussion concerning the value of unannounced visits. Failure to meet expected outcomes is routinely identified during unannounced visits (Howe sub 355). The identification of failure to meet an expected outcome is important for resident care and it provides the opportunity for homes to improve their systems and practices.

Documentation

Reference page 120
Documentation by aged care staff

The perspective of documentation overload as expressed in the PC Report is now considered. The question of documentation load may also be as a result of other demands or the processes being used by the homes. There is no doubt that the nature of aged care and health care requires substantial record keeping. The question is how much? Is any for the purpose of meeting the needs of the accreditation body rather than to support the delivery of care and services?

What documentation is required?
The accreditation system does not dictate the amount or type of evidence to be provided for accreditation purposes and the Act allows for a flexible approach to fit in with organisational approaches. In this light, it was not intended to be an extra documentation burden.

The Campbell Report (2005) reported that aged care managers and staff reported that accreditation had been the major driver of quality improvement in the sector. That is, that the underlying assessment methodology of monitoring and measuring process and outcomes against the standards is seen as a worthwhile investment of resources. This includes the review of documents and records.

It is important to sort out the sources of the frustration regarding the amount of documentation. The Accreditation Agency agrees with the proposition that too much emphasis on process and documentation adds to costs without commensurate value. The challenge in regard to this is to understand what the actual level of documentation is and why aged care workers undertake the level of documentation they do. To date, the evidence does not support the proposition that such documentation is required by the accreditation process exclusively for the purpose of assessment of the performance of the home.

Arguably some documentation is undertaken as a protective strategy by aged care workers. The Accreditation Agency supports the use of electronic records and IT to support the delivery of care and services. The Accreditation Agency has promoted the use of IT through its conference program. Our discussions with industry however suggest that some aged care managers see the investment in IT as a cost and do not yet fully see the possible benefit.
The evidence to support the propositions concerning a focus on the creation of documentation actually required for accreditation made by commentators is limited. It is also not clear how services delivering high quality care are disadvantaged. (Sub 253)

On 28 February 2011 the Accreditation Agency announced a project directed at ascertaining what, if any documents people create exclusively for the purpose of accreditation and developing a strategy to stop the practice.

Regulatory Burden and Duplication

The Accreditation Agency agrees that the question and extent of duplication needs to be investigated and the facts established.

There were various comments from submissions in the PC Report about regulatory burden. Those that relate to the Accreditation Agency's role are discussed below. The unannounced visits which are also relevant have been discussed previously.

The Department of Health and Ageing (DoHA) and the Accreditation Agency

Reference page 125
Accreditation and CIS

The examination of a complaint and the assessment of performance against standards are markedly different activities. The Accreditation Agency accepts that there is some confusion about these roles by some in the sector. An analysis of the data reveals that the Accreditation Agency received 2138 referrals from the Department of Health and Ageing in 2009/10. Generally speaking a very low percent lead to an additional visit. The local case management committee might schedule an additional visit because the information and the Accreditation Agency records suggested there may be an issue related to performance against the standards and a visit was not scheduled in the near future. Also a visit that does take place in relation to such information will often displace a visit planned for later.

The inference that when there is a visit by investigators from the Complaints Investigation Scheme a visit by Accreditation Agency assessors soon follows, is not supported by the facts. However, there is the possibility of a visit for unrelated purposes within the next couple of months because in any 2 month period 1/6th of homes will receive an (annual) unannounced visit on average.

The roles of the Complaints Investigation Scheme (CIS) and accreditation do not produce a duplication of outcomes. The distinction to be made here is that the CIS investigates complaints and the accreditation body assesses the homes performance against the standards.

CIS refers information to the Accreditation Agency which inputs that information to its local case management. As stated above, little of the Departments referral of information to the Accreditation Agency actually leads directly to visits. Generally it informs the Accreditation Agency's understanding of the home. It seems entirely appropriate for the accreditation body to receive information when the CIS believes the issue they are investigating may reflect a broader systematic issue as contrasted with a complaint about a specific incident.

Reference page 390
Investigations?

The Accreditation Agency does not 'investigate non compliance' with standards. The role of the accreditation body is to assess performance against the standards. In doing so the Accreditation Agency seeks to understand why homes fail to meet standards and reports the findings publically. It is the role of the DoHA is to consider that assessment in the broader context. While the Accreditation Agency reports failure to meet standards, it does not enforce compliance. It is the Department that enacts enforcement such as penalties and sanctions.

The risk of duplication between the Complaints Investigation Scheme and Accreditation Agency is managed by the legislation quite simply. One manages an accreditation scheme and the other investigates complaints.

Reference page 413
Gathering information

The 'inconsistencies' mentioned in the gathering of information for accreditation reviews and for CIS investigations are more correctly characterised as 'differences'. That is because there is a considerable difference in both the objectives and approach of investigating a complaint and assessing performance against standards (accreditation). As the PC reported earlier in the draft report, ACSAA has no enforcement powers. The promotion of quality and helping industry to improve service quality is explicitly set out in the legislation. The Complaints Investigation Scheme has no parallel responsibility.

We note the submission (sub 341) concerning homes becoming non compliant 'very shortly' after a visit. The reason the submitters know the home has become non compliant shortly after a previous visit is because the Accreditation Agency has conducted a follow up visit. Follow up visits are usually conducted because the assessors on the first visit have reported concerns about sustainability of the

homes systems or we have information concerning an occurrence that is on the list of significant risk creators eg loss of key personnel.

There are few cases where a home has a downward turn in the number of expected outcomes that have previously and recently been assessed as compliant. The reviews in these cases have revealed that in almost all cases the change has been the direct result of an occurrence at the home. These risk creators have been published and reported to industry by the Accreditation Agency.

All enforcement decisions are made by the Department of Health and Ageing. Consequently any perceived inconsistency in enforcement outcomes is within the Department's responsibility.

Other bodies and the Accreditation Agency

Reference page 425
Duplicate regulations

Residential Aged Care Standards and standards from other bodies (e.g. infectious disease outbreaks, food safety etc) have different purposes and the content of standards have a different objective or focus. Few seem to have the individual resident and continuous improvement at the centre.
The Accreditation Agency believes that the question and possible extent of duplication generally across other bodies and the residential aged care standards needs to be investigated and the facts established.

Other issues

Reference page 391
Audit reports

Audit reports

Assessment team reports are written for decision makers (Accreditation Grant Principles). The report received for comment by the accredited provider does not contain the decision. That is because the provider is being asked to comment on the report before a decision is made. The inclusion of the assessors recommendations which are made based on their visit is included in the final report. This is because the assessors are required to make a recommendation and it is transparent to not seek to disguise that fact when the final decision (which will consider information from the provider in response to the visit report) is made.

Assessment team reports may be similar. That is not surprising when, one considers they are reporting against the same standards and there is similarity in the way services are delivered to residents, particularly if the approved provider operates a number of homes. Why being similar is 'inappropriate' is not made clear by the submission (sub 369). The Accreditation Agency aims for accurate reports.

The Accreditation Agency does recognise the consumer 'demand' for informative reports and is considering how to develop a 'consumer friendly' report.

The Productivity Commission Proposed Model

The following brief description is based on the information provided in the PC Report under the heading of *Regulating the quality of community aged care (pages 393-394).*

The PC argues that "... a single organisation should undertake the regulation of quality, and investigations of non-compliance, across all aged care regulations for which the Australian Government has responsibility."

"With the proposed move to a single independent regulator (the AACRC) and the proposed operation of ACSAA as a statutory office of that body, the Commission envisages that these two processes would be streamlined.

In particular the Commission proposes that AACRC have responsibility for approving both community and residential aged care providers for Government subsidised services and the right to limit, suspend or terminate such approvals where there is non-compliance. "
The proposed PC Model can be found in Figure 1.

Issues with the proposed model

The proposed model of the PC Report would effectively place two functions that are inherently contradictory into one organisation:

- regulatory function
- accreditation function

This would not assist (and would actively work against) the current legislated role the Accreditation Agency plays in promoting high quality care and assisting industry to improve services and care. As has been argued earlier in this submission, there is no evidence that combining these functions improves the quality of care and in fact it goes against the learning's from;

> (i) the Campbell Report (2005) "Accreditation is intended to perform a different function from government regulatory systems", and
> (ii) the Accreditation Agency that it is more effective for the agency to keep a clear and distinct distance from the regulatory functions. Otherwise the facilities cannot trust the very organisation that is trying to work alongside them in a collaborative manner.

Accreditation is intended to perform a very different function from a regulatory system. Some regulatory systems recognise and respond to this perspective by separating accreditation systems (the primary objective of which is quality improvement) from compliance systems (the primary objective of which is assuring stakeholders of compliance with minimum standards).

The Productivity Commission is not proposing an accreditation program?

What is being proposed is not an accreditation program. Accreditation addresses organisational capability and performance and focuses on continuous improvement strategies and the achievement of optimal quality rather than adherence to minimum standards.

While each may provide information to the other, the actual function of promoting high quality care and services and the functions of a regulator are inconsistent. The monitoring of performance against standards is part of the quality promotion activity (that involves working with facilities). Many approved providers would see a conflict in the organisation examining complaints about it and the same organisation assessing its performance against standards. Whilst the decision makers may be statutory office holders appointed by the government there will be the corporate culture.

The Accreditation Agency assesses processes and outcomes, monitors for any unmet compliance, and then assists (e.g. helps) the facilities to meet their requirements. The accreditation body role cannot be effectively combined with a policing role.

A single commission may provide greater independence from the funder, but the functions of the body directed to promote quality improvement and help industry (as set out in the Accreditation Grant Principles and contemporary practice directed at promoting achievement above the minima) should not sit within a regulatory commission.

Focus on minimum standards will not improve the quality of care

As reported in the Campbell Report (2005) a focus on minimum standards will not encourage excellence. A focus on assessing performance for the purpose of promoting high quality care is more likely to lead to quality improvement. This approach is not inconsistent with the protection of residents.

There is a community expectation that the monitoring aspect should be performed. The Accreditation Agency believes the protection of residents is the paramount issue. However residents are not protected over the long term with a return to the compliance and enforcement approaches that preceded accreditation.

Accreditation can be and currently is for the dual purpose of protection of residents through quality assurance directed toward promoting high quality care. A culture of high quality care that continues

to emerge in the aged care sector is more likely to benefit residents than a model of regulatory compliance.

Regulatory Groups and Accreditation

Reference page 392
APRA, ASIC etc.

The relationship of regulatory groups such as Australian Securities and Investments Commission (ASIC), Australian Prudential Regulation Authority (APRA), Australian Fisheries Management Authority (AFMA) with their clients is qualitatively different to that of an accreditation body with its clients. None of these are accreditation bodies. None assess performance against standards and none enforce a regulation that is so specific it exists directly for the benefit of the specific clients of the regulated community. It is doubtful that ASIC is required to be involved in the promotion of quality in the companies it does regulate.

The notion of compliance in the examples provided in the draft PC report is more akin to a business to business relationship where the regulator requires a very specific action and within a specific time frame from the regulated and if the regulated does not comply enforcement action can occur. This is somewhat similar to the role of the DoHA who manages a regulation that requires a provider to be accredited in order to receive government subsidies.

Working with approved providers in the way the accreditation body is required to do in order to "promote high quality care and help industry to improve service quality, by identifying best practices and providing information, education and training to industry" does not occur with regulators.

The notion of 'regulating for quality' is not widespread in the safety and quality sector. The focus on promoting quality and helping providers means that the Accreditation Agency must have a very different relationship with the range of stakeholders vis a vis the regulators.

The Accreditation Agency reports to all stakeholders and considers the impact of the service on the consumer (e.g. resident and their family). The Department (DoHA) are one client of the Accreditation Agency; the Agency also focuses on all stakeholders while supporting the sector and promoting the quality of care delivered to the consumer. Accreditation in the healthcare industry is unique in this way, in that it not only monitors a quality process; it is also focussed on the outcomes of quality for the users of services.

The function of assessing the performance of a health or human services and accrediting that organisation for the purpose of that organisation accessing Australian government funding is not uncommon in Australia. However, in no other system is the accreditation body regarded as a regulator. Other Australian government auspiced examples (which are not seen as regulators) include general practice, disability services, childcare, diagnostic imaging and pathology. The Accreditation Agency has more similarities with these organisations than it does with the regulatory bodies.

Preferred Accreditation Agency model

The Accreditation Agency welcomes the opportunity that the PC inquiry into 'Caring For Older Australians' offers to move forward in the area of protecting residents and promoting quality improvement.

The Accreditation Agency believes the way forward for this important part of the framework is not achieved by creating a single entity. The Accreditation Agency has strongly argued in this submission that it does not currently have a regulators role, and that linking accreditation, complaints and compliance and enforcement under the one banner is inconsistent with the promotion of high quality care nor does it offer the level of resident protection some might envisage because we need to build systems and processes in homes that are sustainable and not focussed on meeting minimum standards in order to escape regulatory censure.

The accreditation arrangements for the future should reflect the informed expectations of the community concerning quality and protection and the evolution of the aged care sector since 1998.

The Accreditation Agency is recommending that the accreditation body should remain a separate organisation, independent from any regulatory functions or role.
By way of comparison, the model of accreditation under the Australian Health Care Standards approved by the Australian Health Ministers has mandatory standards, accreditation by accreditation bodies and 'enforcement' undertaken by 'jurisdictions' (regulators). There is no enforcement role for the accreditation bodies (Aust Commission on Safety and Quality in Healthcare). The role is one of assessment and reporting performance to the regulators.

The Accreditation body should continue to be independent but related to government, not be a regulator and therefore should not be part of the organisations that will make up the single commission whose stated function is 'Industry Regulation'. Accreditation does not operate in the same manner as the inspectorial functions within the proposed AACRC.

The role of the accreditation body as stated previously in this submission cannot operate successfully if the accreditation body is as acting in a regulatory or policing role. This would risk the accreditation body becoming an inspectorate, which is the most common form of assuring minimum standards (Neis 2010). The difference between approaches of 'pure' inspection and a quality management approach is that the former is aimed at triggering a bureaucratic control mechanism and the latter at triggering a continuous improvement response aligned with expectations of accreditation e.g. high quality care.

It is also important to consider the evolution in the sector over the past 10 years, which indicates that the accreditation approach has been successful and that the industry is becoming more sophisticated in their understanding and application of quality.

The literature, the accreditation data and our experience with the sector all support that the industry has continued to improve their quality assurance processes and outcomes. The Campbell Report (2005) indicated that the aged care managers and staff believed accreditation was the major driver of quality improvement in the sector. In 2000 63.5% of homes were assessed as meeting all outcomes at their last site audit. By December 2009 that had grown to over 90%.

This performance does not warrant a return to the more punitive approach that preceded accreditation; rather it supports the trend down Runciman's regulatory pyramid from a command and control approach towards voluntary self regulation (ACSQHC). It should be noted here that the Accreditation Agency does not recommend self regulation at this stage in the sectors development.

The purpose of an independent Accreditation body (e.g. why the organisation exists) would be to:
- Promote high quality care
- Provide sector quality assurance

It should have the following functions (high level activities):
- Manage the accreditation process of homes
- Monitoring (in-between accreditation) the performance of homes against the standards
- Industry education
- Reporting on performance by homes to community and regulator

And the following key activities:
- Assessing performance of homes through accreditation audits and support contacts
- Supporting the sector and high quality care by developing and delivering training programs, conferences, courses etc concerning service delivery by homes
- Identifying best practice through the assessment processes
- Publication of assessment findings concerning individual homes to inform the regulator
- Publication of information concerning individual homes to inform the community
- Production of sector performance to inform government and the community

A diagrammatic representation of the preferred model is illustrated in Figure 2. Figure 1 is the PC recommended approach.

Figure 1: PC Model (Fig 12.2)

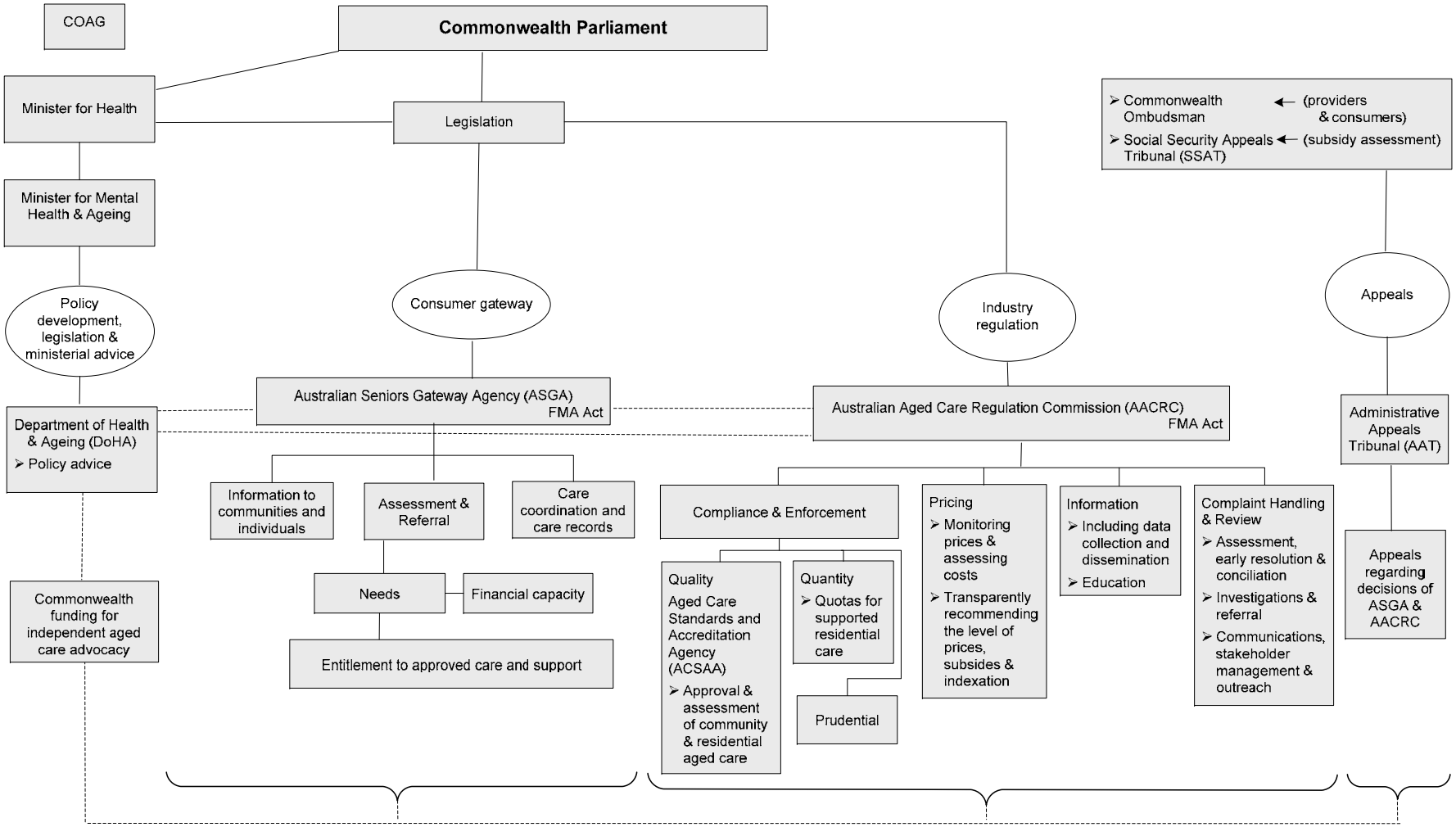

Figure 2: ACSAA Recommendations to Model