The Auditor-General
Audit Report No.10 2012–13
Performance Audit

Managing Aged Care Complaints

Department of Health and Ageing

Australian National Audit Office

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Australian National Audit Office

Canberra ACT
13 November 2012

Dear Mr President
Dear Madam Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Managing Aged Care Complaints.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

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Abbreviations

ACCB	Aged Care Complaints Branch
Agency	Aged Care Standards and Accreditation Agency Ltd
ASL	Average Staffing Level
CALD	Culturally and Linguistically Diverse
CIS	Complaints Investigation Scheme
Commissioner	Aged Care Commissioner
CRS	Complaints Resolution Scheme
DoHA	Department of Health and Ageing
FMA Act	*Financial Management and Accountability Act 1997*
HACC	Home and Community Care
IMS	Investigation Management System
KPI	Key Performance Indicator
NCCIMS	National Complaints and Compliance Information Management System
OACQC	Office of Aged Care Quality and Compliance
Operations Committee	National Aged Care Regulatory Operations Committee
PBS	Portfolio Budget Statements
RARP	Risk Assessment and Resolution Plan
ROACA	Report on the Operation of the *Aged Care Act 1997*
The Scheme	Aged Care Complaints Scheme

SMART	Criteria for KPIs: Specific, Measurable, Achievable, Relevant and Timed
Strategy and Policy Committee	National Aged Care Regulatory Strategy and Policy Committee
STO	State and Territory Office (DoHA)
The Act	The *Aged Care Act 1997*

Glossary

Accreditation Standards	Standards against which residential aged care facilities are assessed in order to be eligible for Australian Government funding. The standards cover: management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems.
Aged Care Commissioner	The Commissioner a statutory appointment, reviews decisions of the Aged Care Standards and Accreditation Agency Ltd and the Aged Care Complaints Scheme
Complaint	An expression of dissatisfaction with any aspect of a service provider's responsibilities that requires the Scheme to facilitate the resolution of the complaint.
Complainant	A person who contacts the Office of Aged Care Quality and Compliance and provides information or raises a concern about the care and/or service being provided to a care recipient of Australian Government subsidised aged care services.
Walton Review	The review of the Aged Care Complaints Investigation (CIS) conducted by Associate Professor Merrilyn Walton in response to industry and community concerns about the operation of the CIS. The review examined: natural justice; communication; training of CIS staff; access to clinical and investigative expertise; risk assessment of complaints; adequacy of information collected in investigations; relationships between the CIS and the Aged Care Commissioner, and the Aged Care Standards and Accreditation Agency Ltd and other relevant bodies; and processes, practices and timeliness of responses. The review report was released in October 2009.

Summary and Recommendations

Summary

Introduction

1. The Australian Government subsidises residential aged care places to assist with the cost of care and accommodation services for eligible older Australians. As at 30 June 2010, there were approximately 183 000 government funded residential places, provided at a cost of $7.3 billion, or approximately $40 000 per recipient.[1] Almost one in four persons aged 85 years and over is in a residential care facility.[2] The importance of residential aged care is increasing rapidly, with the number of persons aged 85 years and over estimated to increase by 120 per cent over the 20 years to 2030.[3]

2. The *Aged Care Act 1997* (the Act) and related legislative instruments (Aged Care Principles) establish the framework for financial support for residential aged care places and regulate the conditions of that support. The Act also specifies a number of objects that relate to the quality, type and level of care to be provided in aged care facilities, and provides for a complaints scheme.

3. The complaints scheme was introduced as a means to help ensure that providers meet their responsibilities to provide high standards of care to aged care recipients, who can be among the most vulnerable members of society. As with other complaints schemes, effective handling of aged care complaints assists in resolving problems before they become worse, providing a remedy to clients who have suffered disadvantage, and nurturing good relationships between service providers, government agencies and the public. Complaints also provide useful information about potential program weaknesses and service delivery faults.

4. The complaints scheme is one component of a broad framework established by the Act to promote quality in residential aged care. This framework includes: accreditation and monitoring of providers against the

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1 Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2009–10: a statistical overview*. Aged Care Statistics Series Number 35, p. vii, and Australian Institute of Health and Welfare, *Australia's Welfare 2011*, p. 186.

2 Productivity Commission, *Caring for Older Australians, 2011,* p. 42.

3 ibid., p. 39.

accreditation standards; monitoring by the Department of Health and Ageing (DoHA) of service providers' compliance with their responsibilities under the Act; the provision of internal complaints mechanisms by service providers; government funded advocacy services to support care recipients in exercising their rights; and the Aged Care Commissioner who reviews DoHA's complaints decisions and processes, and the conduct of the accreditation processes.

5. There have been three distinct complaints schemes for aged care since the commencement of the Act:

- the Aged Care Complaints Resolution Scheme (CRS) commenced in 1997 and aimed to improve the quality of Commonwealth-subsidised aged care services. The focus of the CRS was on the resolution of complaints;
- the Aged Care Complaints Investigation Scheme (CIS) replaced the CRS on 1 May 2007, giving departmental officers greater investigatory powers to determine whether the provider had breached its responsibilities under the Act. A Senate committee report published in 2009 identified providers' concerns with the administrative burden arising from the CIS, and the Australian Government subsequently commissioned an external review, known as the Walton Review, to identify areas for improvement[4]; and
- the current Aged Care Complaints Scheme (the Scheme) came into operation from 1 September 2011 in response to the Walton Review, with the Australian Government committing $50.6 million from 2010–11 to 2013–14 to reform the management of aged care complaints.[5]

6. Key measures adopted to improve the management of aged care complaints through the Scheme include: providing a wider range of options for resolving complaints; focusing on the resolution of complainant concerns rather than on whether the provider had complied with accreditation standards; streamlining complex management structures; providing extra

[4] Walton, Associate Professor Merrilyn, *Review of the Aged Care Complaints Investigation Scheme,* 2009. See <http://www.health.gov.au/Internet/main/publishing.nsf/Content/6E29D85E65EF32FACA257703000 36CB1/$File/ReviewCIS21009.pdf> [accessed 26 June 2012].

[5] Australian Government, *A National Health and Hospitals Network for Australia's Future: delivering better health and better hospitals,* 2010, pp. 122, 127. See <http://www.health.gov.au/Internet/yourhealth/publishing.nsf/Content/report-redbook/$File/HRT_report3.pdf> [accessed 27 June 2012].

resources and enhanced staff training to improve the responsiveness, fairness and consistency of complaint resolution; and improving monitoring, reporting and feedback mechanisms. Reflecting the scale of the reforms, implementation has been planned over four phases and four years, as set out in Table 1.

Table 1

Annual schedule for implementing the Scheme

Phase and year	Key focus and deliverables
Phase 1 (2010–11)	Getting the basics right and preparing for change, including developing and deploying a training program for staff and revising procedures and templates.
Phase 2 (2011–12)	Implementing the complaints management reforms and communicating these reforms to industry. Ensuring that DoHA staff, consumers and industry understand the new complaints framework.
Phase 3 (2012–13)	Communicating outcomes and influencing industry by using information and trends analysis of the complaints scheme to provide feedback to the industry, consumers, and to policy and other aged care regulatory areas.
Phase 4 (2013–14)	Leading good practice in complaints management through further development of information and trends analysis to inform the industry of trends in residential aged care complaints and related systemic improvements.

Source: Department of Health and Ageing, *Strategic Plan 2010–14: Aged Care Complaints Scheme.*

7. From the commencement of the Scheme on 1 September 2011 to 30 June 2012, DoHA's systems recorded receiving 3195 complaints. Complaints can relate to any aspect of a service provider's responsibilities that requires the Scheme to facilitate resolution.[6] The main categories of complaints have concerned: health and personal care; interactions with staff; consultation and communication; and the physical environment. Within these categories common topics have included: infection control; the quality of meals and cleanliness of laundry; staff skills; provision of information; and occupational health and safety. While many complaints involve relatively routine lifestyle and personal care issues, there is a spectrum through to serious health issues such as errors in administering medication. The effective resolution of complaints is of particular importance for aged care recipients, many of whom are among the most frail and vulnerable in the community.

[6] Complaints can be made by any person or organisation, including: care recipients and their family or friends; staff members or volunteers/carers; advocacy services; other areas of DoHA; and external organisations.

8. The Scheme is managed by DoHA's Office of Aged Care Quality and Compliance which is based at DoHA's Canberra headquarters, and has staff working from offices in each other capital city to manage complaints received in the respective state or territory. Management and operational committees are also in place to facilitate communication and consistency between locations. DoHA's budget estimate for administering the Scheme in 2011–12 was $26 million, with 237 staff employed in the Scheme in that year.

Audit objective, criteria and scope

9. The audit objective was to assess DoHA's implementation and ongoing management of the Aged Care Complaints Scheme and the effectiveness of DoHA's complaints management systems in supporting service delivery and regulatory outcomes.

10. The audit focused on DoHA's management of complaints from residential aged care recipients and their representatives[7], and examined whether DoHA has:

- effectively progressed the current reform program in line with the Australian Government's response to the Walton Review;
- effectively promoted the complaints management arrangements and ensured accessibility for complainants;
- implemented fair and responsive processes and practices to resolve complainants' concerns; and
- established appropriate monitoring and reporting arrangements, and analysed aged care complaints to support systemic improvement in residential aged care, regulatory outcomes and the transparency and accountability of the Scheme.

Overall conclusion

11. The Aged Care Complaints Scheme (the Scheme) is a key element of the Australian Government's framework for promoting high standards of care for

[7] The work undertaken by the Aged Care Commissioner, the Aged Care Standards and Accreditation Agency, and advocacy services in relation to the Scheme was not covered in the audit; however these stakeholder organisations were consulted during the course of the audit.

the large and potentially vulnerable cohort of aged care recipients.[8] As at 30 June 2010, there were approximately 183 000 government-funded residential places, provided at a cost of $7.3 billion. The Scheme was introduced in response to the Walton Review[9], an external review of the then Aged Care Complaints Investigation Scheme conducted in 2009, with the Government providing $50.6 million from 2010–11 to 2013–14 to fundamentally reform the management of aged care complaints. Implementation of the Scheme was planned over four years and four phases, with Phases 1 and 2 scheduled for completion by July 2012, and Phases 3 and 4 scheduled for completion by the end of June 2013 and June 2014 respectively.[10]

12. DoHA has made good progress to July 2012 in the implementation and ongoing management of the Scheme, with Phases 1 and 2 completed largely in line with the deliverables and timing agreed by the Australian Government in response to the Walton Review. At the commencement of the Scheme on 1 September 2011, the new complaints resolution options were available[11] to complaints officers and potential complainants, and around 3200 complaints were finalised through the Scheme between its commencement and 1 July 2012.

13. Drawing on a program of consultation with industry stakeholders and a mostly well-managed project planning approach, DoHA has changed the focus of complaints management away from a concentration on the investigation of non-compliance with accreditation standards to a focus on the resolution of complainants' concerns, as proposed by the Walton review. To address the review's concerns about a lack of natural justice, responsiveness and fairness, the department has developed initiatives to improve national

[8] Other elements of the framework include an Aged Care Commissioner, the Aged Care Standards and Accreditation Agency, and aged care advocacy services.

[9] Walton, Associate Professor Merrilyn, *Review of the Aged Care Complaints Investigation Scheme*, 2009. See <http://www.health.gov.au/Internet/main/publishing.nsf/Content/6E29D85E65EF32FACA257703000 36CB1/$File/ReviewCIS21009.pdf> [accessed 26 June 2012].

[10] According to DoHA's *Strategic Plan 2010–14: Aged Care Complaints Scheme*, Phase 1 involved 'getting the basics right and preparing for change', while Phase 2 focused on 'implementing and communicating change'. Phase 3 is 'communicating outcomes and influencing industry', while Phase 4 is to 'lead good practice in complaints management'.

[11] In addition to investigation, complaint resolution methods now include service provider resolution, conciliation and mediation. The additional methods are intended to offer greater flexibility to resolve complaints and improved responsiveness for all parties. Methods can be selected with the agreement of all parties to allow the quickest resolution of complaints, and the protection of the relationship between the provider and the care recipient. Early resolution occurs during the Intake Phase and precludes cases from entering a formal resolution process.

consistency in the administration of complaints processes. In particular, DoHA has delivered an extensive, nationally-coordinated training program to complaints staff since the approval of the Scheme, and has promulgated detailed guidance to assist them to consistently apply complaint processes. The department has also introduced new governance arrangements to improve national oversight and liaison between offices in different jurisdictions.

14. Stakeholders, representing both industry and consumers, have provided generally positive feedback about the implementation and administration of the Scheme to date, including the renewed focus on the care recipient and the more responsive resolution of complaints. A further indication of the improved responsiveness of the Scheme has been the reduction in the time taken to resolve complaints, as a result of the additional complaint resolution methods.[12] However, DoHA could not confirm the advice of many stakeholders that complaints were being resolved more appropriately and the Scheme's processes, practices and outcomes were fairer, as it had not compiled relevant data or performance measures.

15. At the time of audit fieldwork to July 2012, the Scheme was in the early stages of establishment, and there was scope for DoHA to improve aspects of its administration as processes and practices evolve over time. While the department had generally promoted the Scheme effectively, it should consider options to improve access, particularly for isolated care recipients who generally do not have someone available to represent them in a complaint. To further improve monitoring and reporting of Scheme performance, there is scope for DoHA to increase the coverage and response rates for the satisfaction survey sent to the relevant parties after the finalisation of each complaint.[13]

16. To implement Phases 3 and 4 of the Scheme, DoHA has undertaken planning and commenced activities to communicate Scheme outcomes and lead good practice in complaints management. Key deliverables planned for 2012–13 include a report on the operation of the Scheme to communicate outcomes around Scheme learnings, and the further development and

[12] The average time taken to resolve or finalise complaints from the commencement of the Scheme on 1 September 2011 to 30 June 2012 was 48 days, with investigations averaging 90 days to resolve. While DoHA could not provide reliable timeliness data for complaints received under the previous Complaints Investigation Scheme, it advised that investigations, which were the focus of that scheme, had a similar duration to resolve of around 90 days.

[13] More than half of the Scheme performance measures are based on the survey, which had a response rate of only 34 per cent in 2011–12 and excludes complaints referred to early resolution and mediation.

dissemination of a complaints handling toolkit to support better practice in handling complaints at the provider level.[14] Notwithstanding these projects, it will be challenging for DoHA to successfully conduct the systemic analysis of aged care complaints that is required to complete Phase 3 of the Scheme by 30 June 2013. Despite managing various aged care complaints schemes since 1997, the department has limited experience in using complaints data to identify and address systemic issues.[15] Further, there are acknowledged problems with the integrity of data held on the electronic complaints management system and the system's capacity to support analysis. Consequently, DoHA has established a small project team to complete these tasks, relying on largely manual processes. Given the extent of these challenges, it is important that DoHA monitors the strategies and activities proposed to fully implement the Scheme on schedule, in order to support service delivery and regulatory outcomes for the benefit of aged care residents.

17. The ANAO has made two recommendations relating to the implementation and ongoing administration of the Scheme. The first is aimed at improving access to the Scheme for isolated care recipients and the second is aimed at increasing the level of confidence in feedback obtained from complaints satisfaction surveys.

Key findings by chapter

Progress in Implementing the Scheme (Chapter 2)

18. As previously discussed, DoHA has made good progress to July 2012 in the implementation and ongoing management of the Scheme, having completed Phases 1 and 2 largely on schedule and in line with the funding received.

19. A key factor in the implementation of the Scheme has been the consultative process employed by the department. DoHA adopted a sound approach to communicating with key stakeholders via ongoing engagement throughout the reforms, providing consistent messages, tailoring information to suit the audience, and improving web-based communication.

[14] DoHA, *2012–13 Operational Plan, Aged Care Complaints Branch,* p. 9.

[15] The main recent examples of the department identifying and addressing systemic issues are through the publication of a *What can we learn* report and *Industry alerts*. To date, the *What can we learn* report covered *Residents who go missing*, and *Industry alerts* have covered processes in relation to smoking and bed poles (both coronial findings) and call bells.

Implementation was further supported by the development of a detailed project implementation plan, which included a list of actions to be addressed that were tracked in the first two project phases.

20. The Walton Review reported that the 'lack of a clear management structure for the national complaint scheme and the overly complex reporting and accountability requirements has led to different complaints management arrangements developing across the state and territory offices.'[16] While operational structures have not been altered[17], the department has established four committees, comprising management from state and territory offices and central office, and revised the structure of the Aged Care Complaints Branch, to improve national oversight and liaison between offices in different jurisdictions.

21. The Walton Review also concluded that there was a need to change the focus of complaints management away from investigation and towards complaint resolution focusing on the care recipient. Accordingly, DoHA has encouraged the consistent application of the principles of procedural fairness, responsiveness and proportionality when conducting extensive training and recruitment, and through the release of new guidelines.

22. To further support the change in focus towards the care recipient in resolving complaints, government funding was provided to increase the number of complaints officers, in order to reduce the average case load per officer. Despite an increase in total Scheme staffing across Central Office and state and territory offices in 2010–11, the number of staff decreased by 30 nationally in 2011–12 when the funding allowed for an increase of 15 staff over this period. As the number of complaints is likely to increase following the transfer of the administration of the Commonwealth HACC Program from most state and territory governments to DoHA from 1 July 2012[18], there would be merit in the department reviewing the allocation of resources for managing aged care complaints in light of other departmental and program priorities.

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16 Walton, op. cit., p. 28.

17 The Scheme continues to be administered locally from offices across all states and the Northern Territory. The seven state and territory managers continue to report to four different Deputy Secretaries in DoHA, with only two reporting to the Deputy Secretary with overall responsibility for the Scheme.

18 From 1 July 2012 the Australian Government assumed full funding, policy and operational responsibility for Home and Community Care services, covering over 450 000 clients in all states and territories (except Victoria and Western Australia).

Operation of the Scheme (Chapter 3)

23. An important aspect of complaints management is to facilitate clients' access to complaints schemes through promotion and service arrangements. DoHA's approach to promoting the Scheme has been generally effective. The department has widely distributed information on the Scheme and is adjusting its promotion activities to take into account feedback on stakeholder preferences for receiving information.

24. As most complaints are made by telephone, private access to telephones for care recipients facilitates their access to the Scheme. Alerting service providers to the benefits of enabling private access for all care recipients is particularly important in regional and remote areas where access to Internet services may be limited and care recipients have fewer options to relocate if they fear adverse treatment after making a complaint. To improve access to the Scheme for isolated care recipients who generally do not have someone available to represent them in a complaint, DoHA should consider options to support this group, including making use of existing programs that target isolated care recipients.

25. DoHA receives complaints and determines options for their management through detailed intake and assessment processes. However, unlike many call-based operations, DoHA does not monitor the quality of intake call interactions to gauge the extent to which the intake officer is satisfying the relevant service requirements. Monitoring a sample of complainant calls would help strengthen the Scheme's client communication practices, with the results potentially being used to provide performance feedback to staff, and more broadly to guide training and refinement of the Scheme Guidelines.

26. During intake and initial assessment, complaints officers apply a risk assessment and resolution planning process that guides them in identifying the level of risk and determining the most appropriate method to resolve the complaint. This approach supports officers to identify cases that represent serious risks to the health, safety and wellbeing of a care recipient, and prioritise these cases for resolution.[19] The risk assessment and resolution

[19] The highest risk cases are generally referred for investigation, and, depending on circumstances, reported to the: Aged Care Standards and Accreditation Agency for monitoring and investigation at a facility level if required; or DoHA's aged care compliance area if the provider may not be meeting its legislated responsibilities.

planning process focuses on determining approaches to resolving the particular complaint but does not explicitly take into account the likelihood of the complaint issue occurring—either again for the respective care recipient or for other aged care residents. Including the likelihood of a similar incident occurring, together with its consequence, in the risk assessment and resolution planning matrix would support complaints officers to consider systemic issues when assessing complaint risk and determining the resolution method.

27. As discussed earlier, DoHA has implemented the resolution methods recommended by the Walton Review and agreed by government, namely: conciliation; service provider resolution; investigation; and mediation. Stakeholders generally advised that these options have provided a fairer, less adversarial process, with complaints being resolved more promptly, appropriately and proportionately.[20] While appreciating these positive qualitative views, the department could not confirm the effectiveness of the various resolution methods, as it had not compiled relevant data or performance measures—such as the number and proportion of cases resolved, referred or not resolved through each resolution method.

Continuing to Full Implementation of the Scheme (Chapter 4)

28. As already noted, DoHA has conducted planning and commenced activities to implement Phases 3 and 4 of the Scheme. In 2012–13, the strategies focus on communicating outcomes of the Scheme and influencing industry to improve the quality of residential aged care. If delivered effectively, the strategies and priority activities have the potential to support the successful implementation of the Scheme.

29. As discussed earlier, it is important that the department monitors the progress of strategies to implement these latter phases, particularly to address challenges associated with conducting systemic analysis of complaints, and to consider emerging issues such as broader sectoral reforms affecting the administration of aged care complaints.[21]

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[20] Conversely, a small number of individual complainants reported delays and poor outcomes under the Scheme, a lack of ongoing communication and little improvement following its implementation.

[21] The Aged Care Complaints Branch faces uncertainty about the future volume and nature of complaints following the transfer of responsibilities for the Commonwealth's HACC Program (as discussed in paragraph 22) and the possible integration of complaints relating to a number of other aged care programs (such as the National Respite for Carers Program).

30. DoHA's capacity to readily conduct systemic analysis of complaints has been affected by the limitations of the existing electronic complaints management system[22], and delays in introducing the new National Complaints and Compliance Information Management System (NCCIMS). When fully operational, DoHA expects that NCCIMS functionality will enable: the collection of substantially more business information; regular and ongoing analysis of complaint trends at a national, state and territory and agency level; and the ready production of reports. NCCIMS was initially planned to be operational at the commencement of the Scheme in September 2011, but is now expected to 'go live' in December 2013, which is over five months after Phase 3 is due for completion.[23]

31. Delays in implementing NCCIMS have also postponed the development of reports drawing on Scheme data to identify trends in complaints about residential aged care services. While internal business reports have provided data on a number of areas, they do not fully align with the processes used in the Scheme and could be better used to identify, analyse and address provider performance issues.

32. DoHA uses a customer satisfaction survey at the finalisation of each complaint to assess and report on the Scheme's performance. Survey results for 2011–12 showed high levels of satisfaction, including 82 per cent satisfaction with the overall operation of the Scheme. However, there has been a moderate response to these surveys, with 34 per cent of aged care complaints satisfaction surveys being returned in 2011–12. Taking actions that increase the response rate would provide DoHA and other stakeholders with greater confidence in the results of the finalised complaint surveys.

DoHA's response to the audit

33. The Department of Health and Ageing notes the audit report and agrees with the recommendations.

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[22] Limitations of the existing electronic complaints management system extend to data integrity, functionality and analysis tools.

[23] In implementing NCCIMS, DoHA was required to pay for licences for staff to use the system. Despite internal advice to the contrary, the NCCIMS contract included the payment of initial licence fees and annual fees over three years before 30 June 2012 without any discount for prepayment, which imposed a cost on the Commonwealth. The amount paid by DoHA on signing the contract limits the options available to DoHA, such as holding back payments to manage the contract risks associated with delivery of required outcomes.

Recommendations

Set out below are the ANAO's recommendations and the Department of Health and Ageing's responses.

Recommendation No. 1

Para 3.18

The ANAO recommends that the Department of Health and Ageing considers options to provide isolated care recipients with appropriate access to the Scheme, recognising that they generally do not have someone available to represent them in a complaint.

DoHA response: Agreed.

Recommendation No. 2

Para 4.46

To increase the level of confidence in feedback obtained from surveys of customer satisfaction with aged care complaints processes, the ANAO recommends that the Department of Health and Ageing considers opportunities to increase survey responses.

DoHA response: Agreed.

Audit Findings

1. Introduction

This chapter provides background information on the Aged Care Complaints Scheme administered by the Department of Health and Ageing. It also outlines the audit approach and the structure of the report.

Residential aged care in Australia

1.1 The Australian Government subsidises residential aged care places to assist with the cost of care and accommodation services for eligible older Australians. As at 30 June 2010, there were approximately 183 000 government funded residential places, provided at a cost of $7.3 billion, or around $40 000 per recipient.[24] Almost one in four persons aged 85 years and over is in a residential care facility.[25] The importance of residential aged care is increasing rapidly, with the number of persons aged 85 years and over estimated to increase by 120 per cent over the 20 years to 2030.[26] In addition to a growing population requiring residential aged care, the diversity of the older population is also expanding. By way of illustration, there is an expected 43 per cent increase in the number of older people from culturally and linguistically diverse backgrounds[27] over the 15 years to 2026.

Legislative framework to ensure quality of residential aged care

1.2 The *Aged Care Act 1997* (the Act) and associated legislative instruments (Aged Care Principles) made by the Minister for Mental Health and Ageing provide for financial support for residential aged care places and regulate the conditions of that support. The Act specifies a number of objects that relate to the quality, type and level of care to be provided in aged care facilities, as shown in Table 1.1.

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[24] Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2009–10: a statistical overview*. Aged Care Statistics Series Number 35, p. vii, and Australian Institute of Health and Welfare, *Australia's Welfare 2011*, p. 186.

[25] Productivity Commission, *Caring for Older Australians,* 2011, p. 42. This publication cites 2006 data from the Australian Institute of Health and Welfare, which show that 235 persons per 1000 aged 85 years and over are in permanent residential care.

[26] ibid., p. 39.

[27] ibid., p. 47. Older people were defined as those aged 65 years and over.

Table 1.1

Objects of the Act relating to the quality, type and level of care

Key objects
Promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals.
Protect the health and well-being of recipients of aged care services.
Ensure that aged care services are targeted towards the people with the greatest need for those services.
Facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location.
Promote ageing in place through the linking of care and support services to the places where older people prefer to live.

Source: *Aged Care Act 1997*, section 2–1.

1.3 To promote the quality of residential care, the Act (s 56-1) specifies that approved residential care providers (providers) are responsible, among other aspects, for:

- providing care and services consistent with the rights of care recipients and provider responsibilities that relate to financial arrangements, security of tenure, and complaints arrangements; and
- complying with the accreditation standards.

1.4 The accreditation standards are set out in the Quality of Care Principles.[28] They relate to:

- the health and personal care of care recipients;
- the lifestyle of care recipients;
- safe practices and the physical environment in which residential care is provided; and
- management systems, staffing and organisational development relating to the provision of residential care. One of the standards requires that the provider gives residents, their representative and other interested parties access to internal and external complaints mechanisms.

[28] *Quality of Care Principles 1997,* Schedule 2, Part 1 (made under the Act).

1.5 The Act also establishes a regulatory framework applying to providers as a means of promoting quality of care. The key features of the framework are:

- accreditation and monitoring of providers against accreditation standards administered by an independent accreditation body[29];
- monitoring providers' compliance with all aspects of their responsibilities under the Act by the Department of Health and Ageing (DoHA).[30] If providers do not comply with their responsibilities, including failure to implement improvements required by the accreditation body or the department, DoHA can apply remedial actions including formal sanctions under the Act[31];
- access to internal and external (through DoHA) complaints schemes for the management and resolution of complaints about the services delivered by providers. The *Complaints Principles 2011*, a legislative instrument under the Act, provide the basis for the design and operation of the external scheme;
- grant payments for the provision of advocacy services to assist in enabling care recipients and their representatives to exercise their rights[32]; and
- the Aged Care Commissioner, a statutory position appointed by the Minister for Mental Health and Ageing under the Act and independent from the department, who has statutory authority to review:
  - DoHA's decisions arising from its resolution of complaints;
  - DoHA's processes in handling complaints; and

[29] The Act provides for the Secretary of the Department of Health and Ageing to delegate this responsibility to an external agency (sections 42-4 and 96-2 (6), and as detailed in the *Accreditation Grant Principles 2011*). Since 1998, the Aged Care Standards and Accreditation Agency Ltd has been the accreditation body. The agency, independent from the department, is a Commonwealth company limited by guarantee, with the Minister for Mental Health and Ageing its sole member. The quality framework was examined in ANAO Audit Report No. 48, 2010–11, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*.

[30] The Act provides that departmental officers are able to obtain information and documents and enter premises without the owners' consent in exercising their monitoring powers (sections 90–94).

[31] Sections 64–68 of the Act.

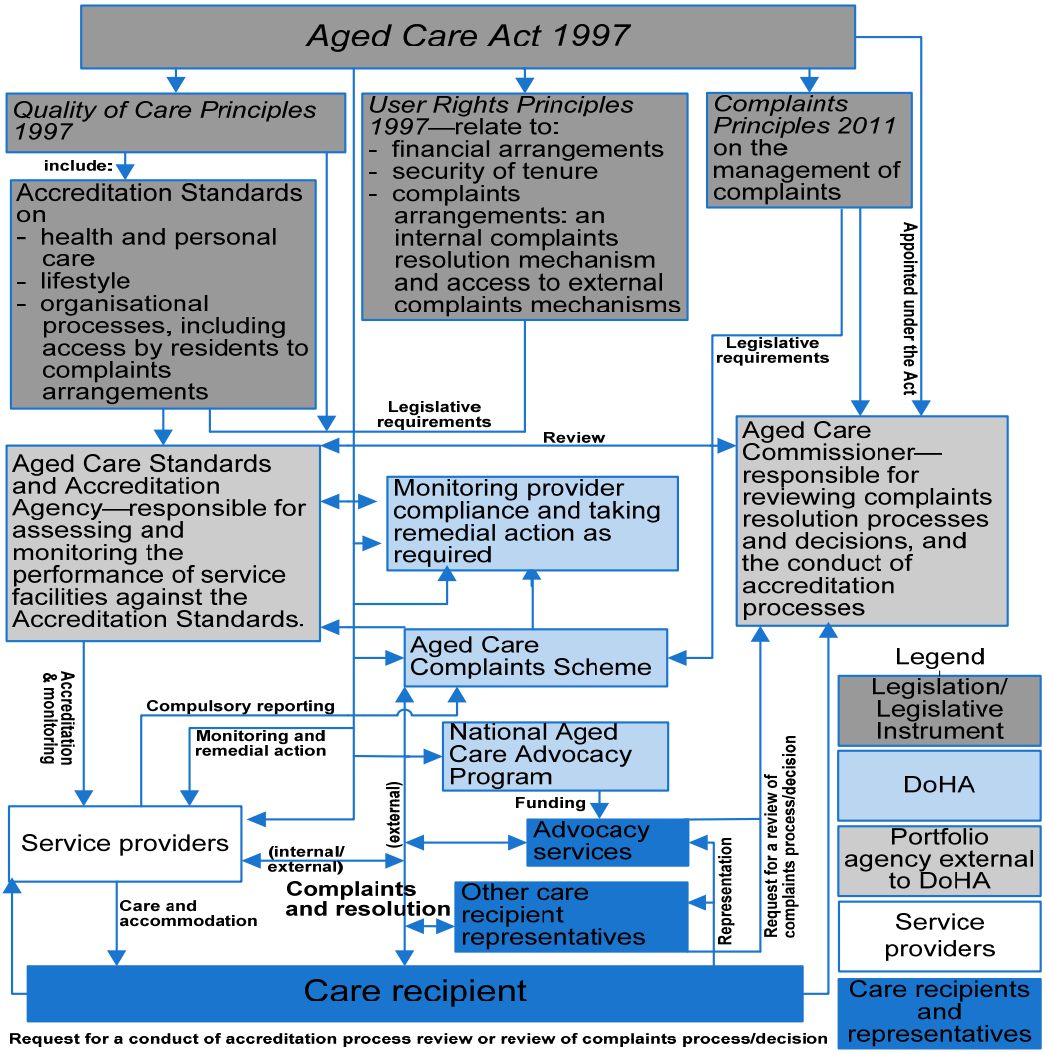
[32] Section 81 of the Act. Grant payments are currently provided to not-for-profit service providers in each state and territory through the National Aged Care Advocacy Program.

– the conduct of accreditation processes undertaken by, or on behalf of, the accreditation body in relation to its responsibilities under the *Accreditation Grants Principles 2011*.

1.6 Figure 1.1 provides an overview of the framework for regulating and promoting quality residential aged care.

Figure 1.1

Framework for regulating and promoting quality residential aged care



Source: ANAO analysis of the *Aged Care Act 1997* and associated legislative instruments.

The Aged Care Complaints Scheme

1.7 As shown in Figure 1.1, the Aged Care Complaints Scheme is just one component of a complex framework for helping to ensure that providers meet their responsibilities to provide high standards of care to aged care recipients. As with other complaints schemes, effective handling of aged care complaints helps to resolve problems before they become worse, provide a remedy to clients who have suffered disadvantage, and nurture good relationships between service providers, government agencies and the public. Complaints also provide information about potential program weaknesses and service delivery faults.

1.8 In the residential aged care context, complaints can relate to any aspect of a service provider's responsibilities that requires the Scheme to facilitate resolution.[33] While many complaints involve relatively routine lifestyle and personal care issues, there is a spectrum through to serious health issues, such as errors in administering medication.[34] The effective resolution of complaints, therefore, is of particular importance for aged care recipients, many of whom are among the most frail and vulnerable in the community.

Overview of aged care complaints schemes

1.9 There have been three distinct complaints schemes for aged care since the commencement of the Act, as discussed below.

Complaints Resolution Scheme

1.10 On commencement of the Act in 1997, the department implemented the Aged Care Complaints Resolution Scheme (CRS) as part of the measures at that time designed to improve the quality of Commonwealth-subsidised aged care services. The focus of the CRS was on the resolution of the complaint for the complainant. There were two initial options for achieving this—bilateral negotiations between the provider and the complainant, which did not require the complainant to have dealings with the provider, and mediated negotiations where some face-to-face discussions between parties to the complaint were held. A third option, a determination by a Complaints Resolution Committee

[33] Complaints can be made by any person or organisation, including: care recipients and their family or friends; staff members or volunteers/carers; advocacy services; other areas of DoHA; and external organisations.

[34] Paragraph 1.16 and Table 1.3 describe the main categories of complaints.

was available if negotiations failed to achieve agreement.[35] From September 2000, the legislation made provision for an independent Commissioner for Complaints, responsible for overseeing the effectiveness of the CRS and dealing with complaints about its operation.

Complaints Investigation Scheme

1.11 The Aged Care Complaints Investigation Scheme (CIS) replaced the CRS on 1 May 2007. The CIS moved away from the dispute resolution approach. The CIS gave departmental officers greater investigatory powers, allowing the department to determine the validity of a complaint and, if warranted, investigate the complaint to determine whether the provider had breached its responsibilities under the Act.[36] The Act also provided for the appointment of an Aged Care Commissioner[37], whose duties included reviewing departmental processes in complaints handling and complaints decisions. The amendments to the Act which resulted in the creation of the CIS also included requirements for compulsory reporting to the department of alleged or suspected assaults. A subsequent amendment was made in 2008, which expanded compulsory reporting to require providers to advise the department if there was an unexplained absence by a care recipient from a residential aged care service.[38]

1.12 A Senate committee report published in 2009 identified providers' concerns with the administrative burden arising from the CIS.[39] Later that year, a media report called into question the effectiveness of the CIS in fully investigating the basis for complaints.[40] Subsequently, the Australian Government commissioned an external review to identify areas for improvement to ensure the CIS achieved best practice management of aged care complaints. The review, known as the Walton Review, was based on:

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[35] Department of Health and Aged Care, *Report on the operation of the Aged Care Act 1997: 1 October 1997–30 June 1999*, pp. 50–52. Available from <http://www.health.gov.au/Internet/main/publishing.nsf/Content/44AC5B9CB3577BD0CA256F19001013FE/$File/rep.pdf> [accessed 15 June 2012].

[36] ibid., pp. 63–65.

[37] The Aged Care Commissioner replaced the Commissioner for Complaints.

[38] The *Accountability Principles 1998*, a legislative instrument under the Act, identifies the compulsory reporting requirements.

[39] Senate Standing Committee on Finance and Public Administration, *Residential and Community Aged Care in Australia,* 2009, pp. 40–43.

[40] 'End of the line', *Four Corners*, Australian Broadcasting Corporation, 1 June 2009. See <http://www.abc.net.au/4corners/content/2009/s2584582.htm> [accessed 25 June 2012].

public submissions; documentation from DoHA and the Aged Care Commissioner; legal advice on the adequacy of the CIS in providing natural justice to all parties; and better practice comparisons. The associated report[41] made a number of recommendations to government primarily relating to: incorporating a broader range of resolution processes, in addition to investigation, to support the resolution of complaints in a timely and effective manner; using a risk assessment framework to assess and prioritise complaints; and improving training for staff and communications with stakeholders. The report also explored options for the organisational location of the CIS, recommending the placement of the function in a newly established Aged Care Complaints Commission, a statutory body separate from DoHA.

Aged Care Complaints Scheme

1.13 The Australian Government responded to the Walton Review in April 2010, committing $50.6 million from 2010–11 to 2013–14 to reform the CIS, as part of the National Health and Hospitals Network process.[42] The response included increased funding to: improve timeliness and procedures for managing cases; and provide greater options for complaint resolution, including giving care recipients and their families access to mediation and conciliation as a means of addressing their concerns. Subsequent changes were made to the Act and associated principles, including replacement of the *Investigations Principles 2007* (that had provided the legislative direction for the CIS) with the *Complaints Principles 2011*. Table 1.2 highlights the key measures being adopted to improve the management of aged care complaints, in order to implement the recommendations of the Walton Review agreed by government.

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41 Walton, Associate Professor Merrilyn, *Review of the Aged Care Complaints Investigation Scheme*, 2009. See <http://www.health.gov.au/Internet/main/publishing.nsf/Content/6E29D85E65EF32FACA257703000 36CB1/$File/ReviewCIS21009.pdf> [accessed 26 June 2012].

42 Australian Government, *A National Health and Hospitals Network for Australia's Future: delivering better health and better hospitals,* 2010, pp. 122, 127. See <http://www.health.gov.au/Internet/yourhealth/publishing.nsf/Content/report-redbook/$File/HRT_report3.pdf> [accessed 27 June 2012].

Table 1.2

Major changes to the management of aged care complaints in response to the Walton Review

Issue raised in Walton Review	Complaints Investigation Scheme	Aged Care Complaints Scheme
Limited range of options and processes for resolving complaints.	Sole focus on investigations.	Wider range of options for resolving complaints, comprising service provider resolution, conciliation, investigation and mediation.
Focus of complaint outcome.	Result of investigation was either a 'breach' or 'no breach' of standards.	Focus on the resolution of complainant concerns, particularly with respect to the care recipient.
Length of time taken to resolve complaints.	Lengthy and delayed finalisation of investigations.	Additional resolution options provide opportunities for more rapid finalisation of complaints.
Limited communication with stakeholders.	*Investigation Principles 2007* provided for communication only at discrete stages of the investigation.	Ongoing communication is advised in order to be transparent and responsive, and to support a positive ongoing relationship between the complainant and the provider.
High case load per officer.	2008–09: average of 84 cases per officer per annum (which is high as most were investigations).	Increased staffing levels are expected to decrease caseloads to 60 per officer per annum.
Insufficient provision of natural justice within the complaints process.	Provider not given an opportunity to respond to a complaint before decision made that a breach had occurred or issue of a Notice of Required Action.	Natural justice is afforded to the provider and complainant during resolution processes, through: involvement of both parties throughout the process; increased accessibility of review mechanisms; and provision for providers to address the Scheme's concerns prior to formal action being taken, through a notice of intention to issue directions.
Inconsistent practices across DoHA's state and territory offices (STOs).	A wide variation of practices for handling complaints across STOs.	New governance structures provide central office coordination of training, performance measures and guidelines for more consistent complaints management across STOs.
Lack of risk assessment and risk management of complaints.	No formal risk assessment or risk management of complaints. A risk averse culture that did not prioritise cases, resulting in a high rate of investigations.	Formal risk assessment process at intake and during assessment, to prioritise complaints and inform escalation decisions and complaints management.

Source: ANAO analysis of Walton Review and DoHA information.

1.14 The new scheme, known as the Aged Care Complaints Scheme (the Scheme), came into operation from 1 September 2011.[43] DoHA's internal budget estimate for administering the Scheme in 2011–12 was $26 million.

1.15 DoHA records indicated that it managed 8177 in-scope cases from the commencement of the Scheme to 30 June 2012. In-scope cases include complaints and notifications, including compulsory reporting—which are explained in Figure 1.2 and paragraph 1.17 respectively.

Figure 1.2

Aged care complaints

Complaints can be made by any person or organisation, including: care recipients and their family or friends; staff members or volunteers/carers; advocacy services; other areas of DoHA; and external organisations.

Complaints can relate to any aspect of a service provider's responsibilities that requires the Scheme to facilitate resolution. This includes: the quality of care provided to the care recipient; user rights; accountability for the care that is provided; and the suitability of key personnel.

Source: Department of Health and Ageing, *Guidelines for the Aged Care Complaints Scheme*, Chapter 4.

1.16 As shown in Table 1.3 the main categories of complaints have concerned: health and personal care; interactions with staff; consultation and communication; and the physical environment. Within these categories common topics have included: infection control; quality and timing of meals and cleanliness of laundry; staff skills; provision of information; and occupational health and safety.

[43] In April 2010, the Government requested that the Productivity Commission develop detailed options for redesigning Australia's aged care system to ensure it can meet the challenges of an older and increasingly diverse population in coming decades. The Productivity Commission report, *Caring for Older Australians, June 2011,* included a recommendation similar to that in the Walton Review, for the establishment of an Australian Aged Care Commission that included a Commissioner for Complaints and Reviews to determine and refer complaints and handle reviews. In its response to the Productivity Commission report in April 2012, *Living Longer, Living Better: Aged Care Reform Package*, the government rejected this recommendation, arguing that the current reforms to the complaints scheme were likely to yield higher returns to older Australians and the broader community.

Table 1.3

Categories of complaint issues from September 2011 to June 2012

Category and sub-category	Number	Percentage
Health and personal care:	**2956**	**47.6**
Health and personal care	1536	24.7
Medication management	425	6.8
Food and catering	378	6.1
Specified care and services (such as physiotherapy)	298	4.8
Falls and fall prevention	177	2.8
Personal property	142	2.3
Interactions with staff:	**1155**	**18.6**
Personnel	740	11.9
Choice and dignity	415	6.7
Consultation and communication:	**1042**	**16.8**
Consultation and communication	832	13.4
Financial	210	3.4
Physical environment:	**796**	**12.8**
Physical environment	651	10.5
Security of tenure	145	2.3
Abuse:	**261**	**4.2**
Abuse	221	3.6
Restraint	40	0.6
Other	1	0.0
Total	**6211**	**100.0**

Note: Numbers are based on issues within complaints, and one complaint can include multiple issues.

Source: ANAO analysis of DoHA data.

1.17 Notifications, which are not viewed as complaints, generally relate to the compulsory reporting by service providers of an alleged or suspected assault or an unexplained absence of a care recipient. These reports are received by the Scheme to assist DoHA in monitoring the safety of aged care residents. Responsibility for determining whether or not an assault has occurred and any subsequent action rests with the police. Other notifications by service providers include providing DoHA with notice of an infectious disease outbreak, a natural disaster, an emergency event or any other related

matter. All notifications are reported to the area of DoHA responsible for managing aged care complaints.

Scope and governance arrangements for the Scheme

1.18 The Scheme is administered by DoHA, and aims to:

- protect the safety, health and wellbeing of recipients of the following government-subsidised aged care services:
  - Residential Aged Care Services;
  - Community Aged Care Packages;
  - Extended Aged Care at Home;
  - Extended Aged Care at Home Dementia; and
  - from 1 July 2012, the Commonwealth HACC Program except for Victoria and Western Australia[44];
- resolve complaints in a timely and proportionate manner to provide positive outcomes for care recipients;
- educate complainants so they are empowered to make informed decisions; and
- assist service providers to understand their responsibilities and identify opportunities for continuous improvement.[45]

1.19 The Scheme is managed by DoHA's Office of Aged Care Quality and Compliance, which is based at DoHA's Canberra headquarters, and has staff working from offices in the capital city of each state and the Northern Territory.[46] An average of 237 full-time equivalent staff were employed on the Scheme in 2011–12.[47] The office communicates regularly with both: the Aged

[44] Under national health reforms, the Commonwealth assumed full policy and funding responsibility for aged care services. Except in Western Australia and Victoria, this included Health and Community Care services, previously administered through the states and territories, with the Commonwealth taking full policy and funding responsibility for the Health and Community Care Program from 1 July 2011 and full operational responsibility from 1 July 2012.

[45] Department of Health and Ageing, *Guidelines for the Aged Care Complaints Scheme,* 1 September 2011, p. 1.2.

[46] In May 2011 the ACT office was combined with NSW State Office in Sydney.

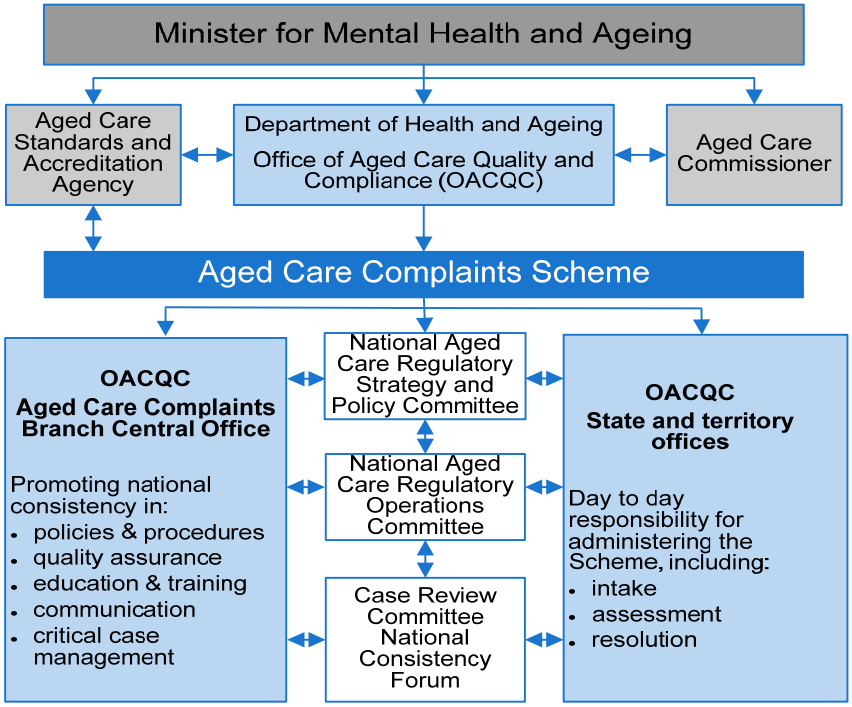
[47] The geographical distribution of full time equivalent staff working on the Scheme in 2011–12 was: 47 in Central Office, 56 in NSW/ACT, 53 in Victoria, 38 in Queensland, 16 in South Australia, 16 in Western Australia, 8 in Tasmania and 3 in the Northern Territory. Staffing levels are discussed in Chapter 2.

Care Standards and Accreditation Agency, referring matters that may impact on the accreditation status of a service; and the Aged Care Commissioner, regarding requests to the Commissioner for the review of a decision or process arising from the management of a complaint.

1.20 The Scheme operates nationally, with complaints generally received and managed within the state or territory where the care is being delivered. Management and operational committees are in place to assist communication and consistency between locations. Figure 1.3 outlines the governance arrangements for the Scheme, which are examined further in Chapter 2.

Figure 1.3

Aged Care Complaints Scheme: governance arrangements



Source: Adapted from DoHA, *Strategic Plan 2010–14: Aged Care Complaints Scheme*, 2011, p. 6.

Previous ANAO audits

1.21 In 2010–11 the ANAO conducted a performance audit of the effectiveness of monitoring arrangements by the Accreditation Agency and compliance activities DoHA put in place to achieve residential aged care facilities' compliance with the accreditation standards and their other related responsibilities under the Act and its associated instruments.

1.22 The ANAO found that the framework and the majority of strategies adopted by DoHA (and the Accreditation Agency) were focused on promoting quality in individual accredited homes, with less focus on sector-wide risks to quality (and compliance).

1.23 Other ANAO audits examining complaints management were in Centrelink in 2005 and 2009 and in the Department of Veterans' Affairs and the Child Support Program in 2011–12.[48]

Audit approach

Audit objective and criteria

1.24 The audit objective was to assess DoHA's implementation and ongoing management of the new Aged Care Complaints Scheme and the effectiveness of DoHA's complaints management systems in supporting service delivery and regulatory outcomes.

1.25 The audit criteria were that DoHA has:

- effectively progressed the current reform program in line with the government's response to the Walton Review;
- effectively promoted the complaints management arrangements and ensured accessibility for complainants;
- implemented fair and responsive processes and practices to resolve complainants' concerns; and
- established appropriate monitoring and reporting arrangements, and analysed aged care complaints to support systemic improvement in residential aged care services and regulatory outcomes and the transparency and accountability of the Scheme.

1.26 The ANAO drew on better practice guidance on complaints management from Australian and international standards[49], and the Commonwealth Ombudsman's *Better Practice Guide to Complaint Handling,*

[48] The three most recent ANAO audits examining complaints management were: ANAO Audit Report No 37 2011–12, *The Child Support Program's Management of Feedback;* ANAO Audit Report No 32 2011–12, *Management of Complaints and Other Feedback by the Department of Veterans' Affairs;* and ANAO Audit Report No 22 2008–09, *Centrelink's Complaints Handling System.*

[49] SAI Global, *Customer Satisfaction—Guidelines for complaints handling in organisations* (ISO 10002–2006).

2009, in analysing relevant aspects of DoHA's management of aged care complaints.

Audit scope and methodology

1.27 The audit focused on DoHA's management of complaints from residential aged care recipients and their representatives. The work undertaken by the Aged Care Commissioner, the Aged Care Standards and Accreditation Agency, and advocacy services in relation to the Scheme was not covered in the audit. However, these stakeholder organisations were consulted during the course of the audit.

1.28 Compulsory reporting (of missing residents and allegations of abuse) and other notifications (of public health and emergency events) by providers are made to the Scheme.[50] While the audit did not focus on these aspects, coverage is provided where relevant—for instance in the discussions on public reporting and resourcing.

1.29 To form an opinion against the audit objective, the ANAO:

- interviewed managers and staff from the national and state offices of DoHA's Office of Aged Care Quality and Compliance;
- examined DoHA's documentation relating to the Scheme;
- substantively tested a selection of complaint cases;
- observed live complaint management processes, including intake calls with complainants;
- examined DoHA's information technology (IT) database of complaints and related case management system, and tender documents for the proposed new IT complaints management system; and
- consulted stakeholders, including consumers and providers, and their representative bodies.

1.30 The audit was conducted in accordance with ANAO's auditing standards, at a cost of approximately $300 000.

[50] Compulsory reporting and other notifications are not classified as complaints (Scheme Guidelines, p. 4.11). However, DoHA is responsible for responding to them during the intake of contacts for the Scheme and recording all relevant information in the Scheme database. (Scheme Guidelines, Chapter 9).

Report structure

1.31 The audit findings are reported in three chapters, as outlined in Table 1.4.

Table 1.4

Structure of the report

Chapter 2 Progress in Implementing the Scheme	Assesses DoHA's progress to July 2012 in implementing the Scheme.
Chapter 3 Operation of the Scheme	Examines the effectiveness of DoHA's administration of the Scheme from its inception in September 2011 until July 2012, including the application of fair and responsive processes that are focused on the care recipient.
Chapter 4 Continuing to Full Implementation of the Scheme	Examines DoHA's preparation and planning for the full and timely implementation of the Scheme, including through planning for Phases 3 and 4, the development of a new electronic complaints management system, and enhancements to performance monitoring and reporting arrangements.

Source: ANAO.

2. Progress in Implementing the Scheme

This chapter assesses DoHA's progress to July 2012 in implementing the Aged Care Complaints Scheme.

Introduction

2.1 The Walton Review recommendations accepted by the government affect key elements of the aged care complaints scheme, with a view to: streamlining complex management structures; reforming processes for managing complaints to support a greater range of resolution options; improving the effectiveness of complaints officers by increasing resourcing levels and providing adequate training; and improving monitoring, reporting and feedback mechanisms.

2.2 These changes aim to:

build a responsive and customer focused aged care complaints system that:

- affords natural justice to all parties;
- focuses on clear and timely communication; and
- seeks to help consumers and service providers understand their rights and responsibilities, the Scheme and options to resolve concerns.[51]

2.3 Reflecting the scale of the reforms, implementation has been planned over four phases and four years, as set out in Table 2.1.

[51] DoHA Website: '*About the reforms*', available from <www.agedcarecomplaints.govspace.gov.au/about-us/about-the-reforms/> [Accessed 22 August 2012].

Table 2.1

Annual schedule for implementing the Scheme

Phase and year	Key focus and deliverables
Phase 1 (2010–11)	Getting the basics right and preparing for change, including developing and deploying a training program for staff and revising procedures and templates.
Phase 2 (2011–12)	Implementing the complaints management reforms and communicating these reforms to industry. Ensuring that DoHA staff, consumers and industry understand the new complaints framework.
Phase 3 (2012–13)	Communicating outcomes and influencing industry by using information and trends analysis of the complaints scheme to provide feedback to the industry and consumers, and to policy and other aged care regulatory areas.
Phase 4 (2013–14)	Leading good practice in complaints management through further development of information and trends analysis to inform the industry of trends in residential aged care complaints and related systemic improvements.

Source: DoHA, *Strategic Plan 2010–14: Aged Care Complaints Scheme,* 2011.

2.4 At the time of audit fieldwork in July 2012, DoHA was scheduled to have completed implementation of Phases 1 and 2 and be preparing for the implementation of the final two phases by the end of June 2013 and June 2014 respectively. To determine the effectiveness of DoHA's progress in implementing the Scheme, the ANAO examined the:

- overall progress against the key requirements of Phases 1 and 2, and the level of preparedness for Phases 3 and 4 as at July 2012; and
- effectiveness of key elements of the administration underpinning the implementation of Phases 1 and 2, particularly:
  - project planning and governance of the implementation effort;
  - changes to the management of aged care complaints;
  - engagement and communication with key stakeholders;
  - resourcing, with a focus on staffing levels and skilling[52]; and

[52] Planning and its governance, stakeholder management and communications; and resource management are key building blocks to better practice implementations of program and policy initiatives: Department of the Prime Minister and Cabinet and ANAO, *Implementation of Programme and Policy Initiatives, Making implementation matter*, October 2006, p. 3.

– the development of policies and guidance consistent with government expectations and the agreed recommendations from the Walton review.

Summary of overall progress

2.5 DoHA has made good progress, to July 2012, in its implementation of the complaints management reforms in line with the deliverables and timing agreed by the Australian Government.

2.6 Key milestones of the implementation process to date have been:

- establishing the consultative process for the development and implementation of the new scheme;
- implementing a new governance structure, comprising four committees to represent management from central office and the state and territory offices, covering the strategic level through to operational management. The new committee structure is intended to promote national consistency;
- conducting extensive training and recruitment; increasing access to clinical advice; and releasing new guidelines which incorporate timeliness, responsiveness, proportionality and natural justice. These initiatives are intended to promote a cultural shift from investigation to complaint resolution; and
- completing Phases 1 and 2 largely on schedule and in line with the funding received.

2.7 Notwithstanding the progress made to date, there has been some slippage which has affected the completion of Phase 2, and which will have implications for the subsequent phases. This slippage has mainly involved the implementation of the National Complaints and Compliance Information Management System (NCCIMS), which is the electronic complaints management system replacing the Investigation Management System.[53] The implementation of NCCIMS is discussed in detail in Chapter 4.

[53] NCCIMS was originally planned to be operational in September 2011, however this had been rescheduled to December 2013.

Project planning and governance of the implementation process

2.8 The breadth of changes to the aged care complaints arrangements (as outlined in Table 1.2) underlines the importance of effective planning to achieve the required delivery. Better practice to effectively implement time-critical and expensive changes includes the development of implementation plans which:

> ... provide a map of how an initiative will be implemented. The map should deal with matters such as:
>
> - roles and responsibilities of all those involved in implementation;
> - resources (including funding and human resources);
> - timeframes, including the different phases for implementation;
> - risk management, including how any potential barriers to implementation will be dealt with; and
> - monitoring and reporting requirements.[54]

2.9 Early in 2010–11, DoHA developed a detailed project implementation plan for Phase 1, supported by a list of actions to be addressed, as summarised in Table 2.2.

[54] Department of the Prime Minister and Cabinet and ANAO, *Implementation of Programme and Policy Initiatives: Making implementation matter*, 2006, p. 26.

Table 2.2

Project plan for implementing the Scheme

Key element	Detail of planning
Project governance and ongoing Scheme management	Project governance: the Strategy and Policy Committee was the project sponsor and steering committee, supported by the Operations Committee and a project team comprising the branch and section heads of the then CIS Operations Branch (now the Aged Care Complaints Branch). Management arrangements: The Aged Care Complaints Branch was divided into four sections, incorporating Walton's recommendation to include a division of communications and stakeholder relations, the other sections being: policy and performance; procedures and training; and complaints assistance and case review, as shown in Figure 2.1.
Stakeholder engagement	The Scheme's *Communication and Engagement Strategy 2010–2014* outlines a four-year approach to Scheme communication and details the various internal and external communication activities as well as stakeholder engagement strategies to be implemented across the reform period.
Resourcing requirements	Funding of $50.6 million over four years (2010–11 to 2013–14). Skills and expertise from within the Scheme to be utilised where possible and appropriate to achieve the project objectives of the Scheme. External expertise to be sourced when required.
Project scheduling: Phases 1 and 2	The *Aged Care Complaints Scheme Reform Implementation Tracker* included a list of 81 actions, associated deliverables, timelines and the responsible manager.
Risk management: Phases 1 and 2	Identified risk consequences, current and target risk ratings, and the controls/mitigation approaches (as part of the implementation tracker).
Monitoring and reporting	Updates on the progress of reforms to be provided to the Strategy and Policy Committee as a standing item using the implementation tracker.

Source: ANAO analysis of DoHA *Draft Scheme Reform Project Plan v1.4.*

2.11 A revised implementation tracker was developed in September 2011 for Phase 2 of the implementation. At the time of the audit, comparable planning had not been completed for Phases 3 and 4.

Project governance

2.12 As the key management committees guiding the implementation of the Scheme, the Strategy and Policy and Operations Committees met regularly throughout the implementation of Phases 1 and 2. A standing agenda item for the Strategy and Policy Committee included an update on the progress of reform implementation, including an update on risks to implementation. In addition, up until September 2011, a project implementation tracker report was

included as part of this agenda item. This report identified the current status for each action item as one of the following:

- completed;
- on track—the action is on track for delivery;
- problematic—one or more elements of the action requires substantial attention; or
- highly problematic—requires urgent and decisive action. Significant elements of the action have failed or are likely to fail.

2.13 In order to achieve implementation of the reforms, the project plan and associated tracking report were updated (until September 2011 in the case of the tracking report when NCCIMS was the only outstanding item) to reflect further deliverables as their importance emerged.

2.14 In November 2010, the Strategy and Policy Committee delegated the ongoing management of implementation risks to the Operations Committee. Subsequently, updates to the risk register, including controls and mitigation strategies, were considered at each meeting of the Operations Committee and endorsed, as relevant, through the Strategy and Policy Committee.

2.15 Overall, these governance arrangements have been effective in oversighting and facilitating the implementation of the project plans for Phases 1 and 2. However, the implementation of NCCIMS could have been more actively oversighted by the Strategy and Policy Committee and the Operations Committee to mitigate the impact of delays on the completion of Phases 3 and 4.

Changes to the management of aged care complaints

2.16 The Walton Review reported that the 'lack of a clear management structure for the national complaint scheme and the overly complex reporting and accountability requirements has led to different complaints management arrangements developing across the State and Territory Offices (STOs).'[55] One aspect of management the review referred to was the reporting by STO managers to four Deputy Secretaries in DoHA, with the Deputy Secretary

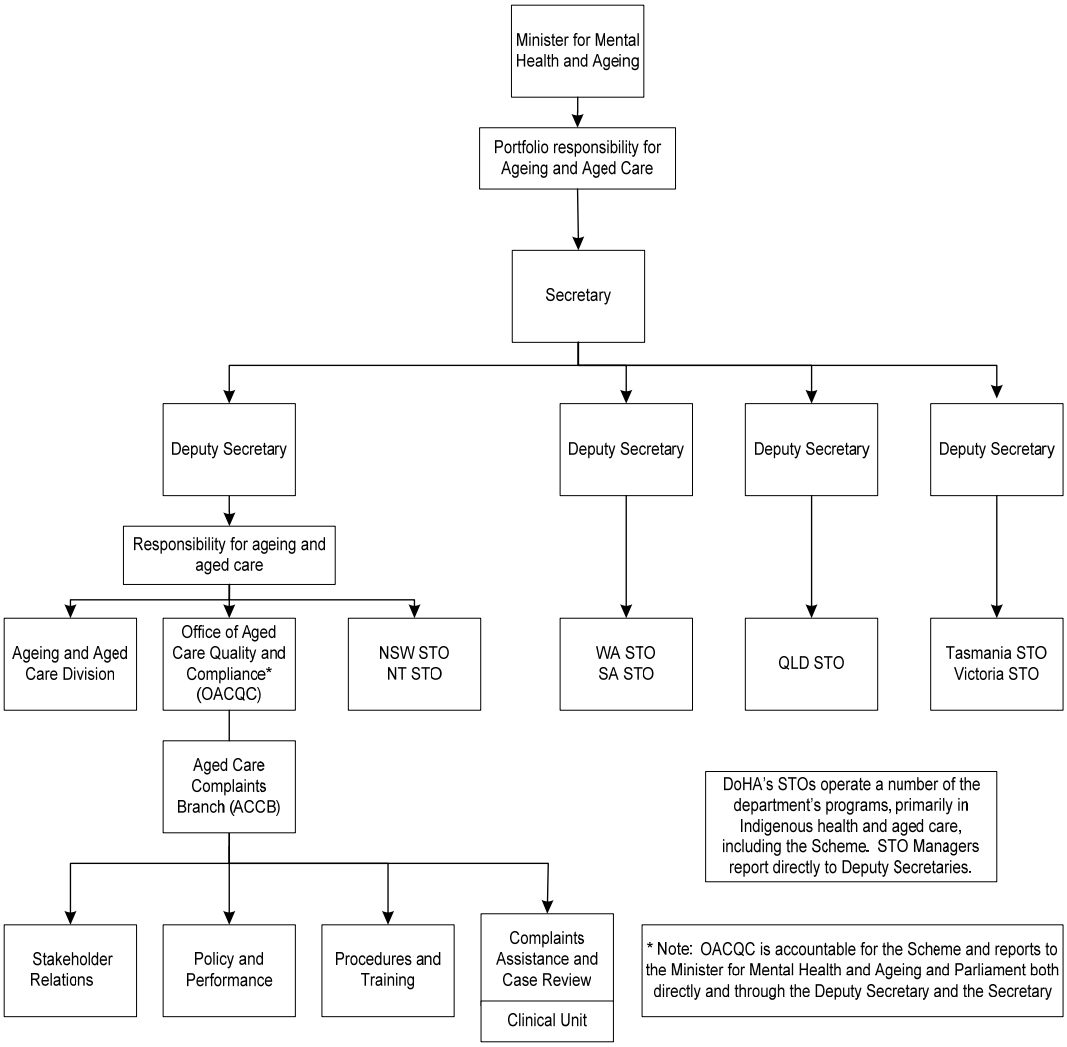
[55] Walton, op. cit., p. 28.

responsible for New South Wales and the Northern Territory also being responsible for the Office of Aged Care Quality and Compliance (OACQC).

2.17 Other than the creation of a specific Aged Care Complaints Branch as part of OACQC in Central Office focused on the operations and policies of the Scheme, the management reporting arrangements for STOs have not been revised, and are shown in Figure 2.1.

Figure 2.1

Scheme organisational structure



Source: DoHA.

2.18 While maintaining the department's organisational arrangements for managing aged care complaints, to assist in delivering nationally consistent administration, improvements have been made to the coordination of complaints processes across Central Office and the STOs through the following committee structure:

- National Aged Care Regulatory Strategy and Policy Committee[56] (Regulatory Strategy and Policy Committee) chaired by the First Assistant Secretary of OACQC, with membership comprising the STO managers and the Assistant Secretaries for the Aged Care Complaints Branch (ACCB), Quality and Monitoring Branch, Prudential and Approved Provider Regulation Branch, and the Senior Nurse Adviser;
- National Aged Care Regulatory Operations Committee[57] (Regulatory Operations Committee) chaired by the Assistant Secretary, ACCB with membership comprising section heads of the STO aged care complaints operations and relevant national program section heads within OACQC. This committee considers operational and procedural matters as well as taking direction from and providing advice to the Regulatory Strategy and Policy Committee;
- Complaints Case Review Committee chaired by the Director of the Complaints Assistance and Review Section, Central Office and comprising team leaders undertaking the day-to-day management of complaints in the STOs, a legal advisor and a clinical advisor. This committee focuses on facilitating learnings that arise out of retrospective case analysis and takes direction from and reports to the Regulatory Operations Committee; and
- National Consistency Forum chaired by the Performance Improvement Manager, Policy and Performance Section, ACCB, and a STO representative elected by forum members. This forum comprises representatives from STOs that have a variety of intake/assessment and resolution teams and Central Office representatives from the Policy and Performance Section and Stakeholder Relations Section. This forum

[56] The Strategy and Policy Committee added to its name to reflect an increase in its responsibilities since the Scheme commenced, eventually becoming the National Aged Care Regulatory Strategy and Policy Committee in early 2012.

[57] The National Aged Care Regulatory Operations Committee also added to its name to reflect responsibilities in early 2012.

focuses on improving Scheme quality and consistency with consideration of Scheme business improvement and reports to the Regulatory Operations Committee.[58]

2.19 These approaches to improve national consistency are intended to improve the quality of complaints resolution and to facilitate a cultural change from the investigation of complaints to their resolution.[59] STO staff and managers interviewed by the ANAO were generally satisfied with their level of involvement in the changes associated with the reforms, with staff from all levels of the office having opportunities to provide feedback. Those consulted also reported that they were well prepared for the changes to come into effect in September 2011 because of this involvement, as well as the training that accompanied the reforms (discussed in paragraph 2.38). Staff generally reported that they felt able to provide feedback if they encounter issues with Scheme processes at any time and that they would be listened to by management.

2.20 The new governance arrangements have provided STO staff with an accessible means through which to propose changes to, and provide feedback on, the Scheme. Policy and operational decisions are communicated to all staff through the new committees and forum. These arrangements, or alternative communication mechanisms, did not exist under the Complaints Investigation Scheme (CIS).

Engagement and communication with key stakeholders

2.21 The Walton Review identified the importance of engaging with key stakeholders to guide industry improvements and deliver quality outcomes for aged care recipients, as well as the need to communicate clearly with aged care consumers about the Scheme.

[58] Terms of Reference for the National Consistency Forum were finalised in September 2012.

[59] Specific approaches to improving national consistency and their overall effectiveness are discussed in Chapter 3.

2.22 To inform stakeholders about the reforms and allow them to provide feedback on proposed activities, DoHA:

- conducted stakeholder consultation on the complaints management framework through distribution of the *Complaints Management Framework Discussion Paper*, which called for submissions and led to subsequent amendments;
- worked with the Aged Care Commissioner in developing the Complaints Principles, and continues to consult on the reforms to the Scheme;
- consulted with stakeholders on the Scheme Performance Management Plan and the policy for Preventing and Managing Unreasonable Complainant Conduct;
- presented at industry conferences, where participants were invited to ask questions and provide feedback about the Scheme proposals; and
- undertook ongoing engagement with the National Aged Care Alliance[60], through a technical reference sub-group that was established initially to provide feedback on the proposed Scheme and subsequently to provide advice on the Scheme's strategies to engage with industry and consumers and to provide feedback on the progress of the reforms.

2.23 To engage and communicate with key stakeholders about the implementation of the reforms, DoHA focused on:

- encouraging the dissemination of consistent messages, especially for stakeholders who are based in more than one state or territory;
- tailoring information to the Scheme's audience (such as carers, providers, and care recipients);
- promoting what the Scheme does well;
- improving the DoHA website and creating a Scheme-specific website[61]; and

[60] The National Aged Care Alliance is an industry peak body comprising 28 national aged care organisations including service provider organisations, consumer groups, unions and health professionals.

[61] A Scheme-specific website went live in April 2011.

- maintaining good communication with stakeholders throughout the reforms.

2.24 Following consultation with key industry and consumer stakeholders at the end of 2010, a strategic plan[62] was developed and approved by the Minister for wider industry distribution. This plan set out a commitment to: raise awareness about the Scheme; encourage people to be empowered to raise concerns without the Scheme's assistance; encourage providers to develop effective complaints management systems; and to strengthen relationships with key stakeholders, in particular the Aged Care Commissioner and the Aged Care Standards and Accreditation Agency.

2.25 An Aged Care Complaints Scheme *Communications and Engagement Strategy 2010–14*, was initially developed in December 2010 and updated in March 2012, to take account of benchmark research by an external consultant that identified, amongst other issues, the preferred methods for aged care recipients to receive information.

2.26 DoHA provides a website dedicated to the Scheme, available at <http://agedcarecomplaints.govspace.gov.au/>. The website provides extensive information about the implementation and operation of the Scheme including two types of publications to facilitate systemic improvement in residential aged care. These publications are *What can we learn* reports and *Industry alerts.* To date:

- *What can we learn* reports have covered one topic—*Residents who go missing*[63]; and
- *Industry alerts*[64] have covered processes in relation to smoking and bed poles (both coronial findings) and call bells.[65]

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62 Department of Health and Ageing, 2011, *Strategic Plan 2010–14: Aged Care Complaints Scheme.*

63 Associated with this is the publication *Clinical perspectives—A guide to understanding and managing wandering behaviour* which provides possible explanations for wandering behaviour and suggests ways to avoid residents going missing.

64 DoHA, <http://agedcarecomplaints.govspace.gov.au/toolkit/#industryalerts>, [accessed 10 July 2012].

65 The investigation on call bells was conducted by the Scheme. However, as the report provides data but no recommendations for better practice, it does not clearly promote improvement in the quality of residential aged care services.

2.27 Overall, industry stakeholders consulted by the ANAO expressed satisfaction with the way in which DoHA consulted on the new Scheme, on the grounds that they were invited to participate in a range of activities during the implementation phase, and were pleased to see their suggestions being incorporated into a range of Scheme materials, such as promotional approaches, procedures and changes to legislation.

Resourcing the Scheme's administration

Using additional funding to increase staffing levels

2.28 In the 2010–11 Budget, DoHA received funding of $50.6 million over four years for enhancements to the CIS. Most of this funding was for additional staffing, with $47.9 million provided for extra resources within DoHA and a further two full-time departmental officers within the Office of the Aged Care Commissioner.[66] The basis for the funding was to address the Walton Review's recommendations, primarily to: reduce caseloads to 60 cases per officer per annum; and undertake increased and ongoing training for complaints scheme staff.

2.29 In 2010–11, STOs received funding for an extra 54 full-time positions (based on average staffing levels (ASL)) to finalise backlogs of CIS cases in the lead up to the new Scheme and to allow for training time. Four of these positions were for clinical staff who were subsequently accounted for through Central Office. Funding for Central Office staffing increased to allow for an extra three ASL on an ongoing basis, and a provision for an extra five staff to implement the initiative in 2010–11 only. As shown in Table 2.3, the funding was used largely as intended, with Scheme staffing increasing by 59 officers from 2009–10 to an average of 267 staff in 2010–11.

[66] Of the Scheme funding, $2.7 million was to supplement the work of the Aged Care Standards and Accreditation Agency based on the assumption that the revised scheme would generate increased referrals to the agency.

Table 2.3

Average staffing levels for State and Territory Offices and Central Office for the aged care complaints schemes

Year	NSW/ ACT	VIC	QLD	SA	WA	TAS	NT	Central Office	Total
2009–10	52.3	48.3	35.5	17.9	13.9	6.0	4.5	30.0	208.4
2010–11	64.3	59.3	50.5	18.9	14.9	6.0	4.5	48.7	267.1
2011–12	56.2	53.0	38.1	15.8	16.0	8.1	3.1	46.8	237.1
Change in 2011–12 over 2010–11	-8.1	-6.3	-12.4	-3.1	1.1	2.1	-1.4	-1.9	-30.0

Source: ANAO analysis of DoHA documents.

2.30 Government funding initially allowed for an extra 19.5 ASL in 2011–12 over 2010–11 but as Table 2.3 shows, the number of ASL actually fell by 30. Had DoHA provided the Scheme with its allocated funding, a total of 252 ASL could have been employed in 2011–12, once the Government's 1.5 and 2.5 per cent efficiency dividends and 8 per cent strategic reform dividend had been applied. An ASL of 252 would have reflected an extra 15 staff, or 6 per cent more than the number actually employed in 2011–12.

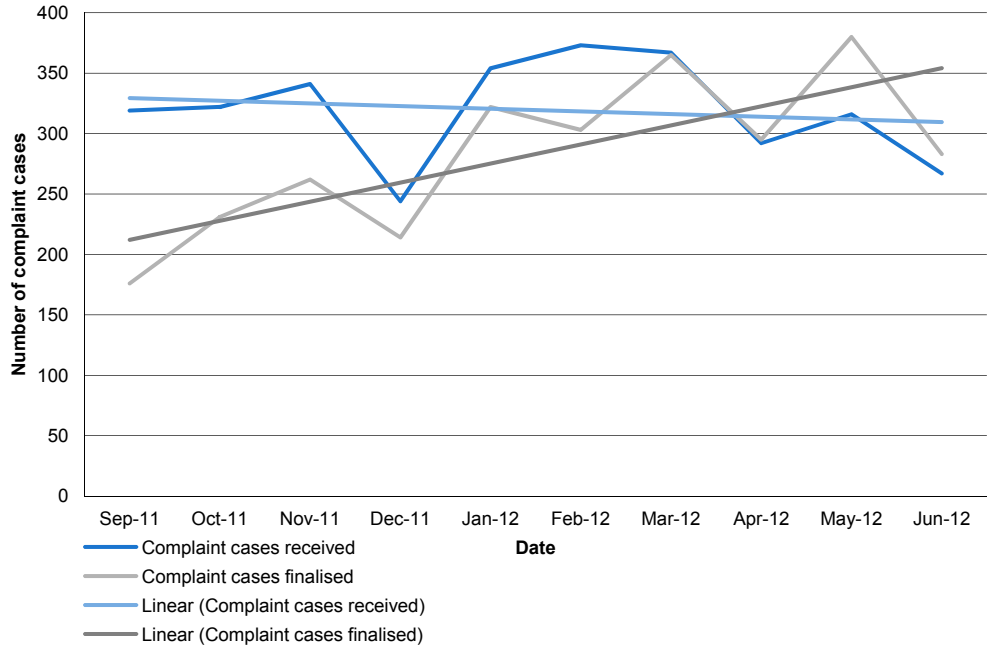
2.31 The decrease in resourcing for the Scheme has not had a significant impact on the timeliness of finalising complaints. Over the ten months from the start of the Scheme, the number of complaints received decreased marginally and the number of cases finalised increased marginally, as shown in Figure 2.2.[67] The number of long-wait cases subsequently increased marginally. As at the end of November 2011, 58 cases had been open for more than 80 days. Six months later there were 61 cases open for more than 90 days.[68] Over the period 1 September 2011 to 30 June 2012, DoHA finalised more complaints than it received.

[67] The ANAO assessed changes over time in the number of complaints received and the number of cases finalised on the basis of linear regression trend lines.

[68] In March 2012, DoHA changed its definition of long-wait cases from over 80 days to over 90 days.

Figure 2.2

Number of complaints received and finalised by month, September 2011 to June 2012



Source: ANAO analysis based on DoHA internal data.

2.32 The increase in finalised cases is partly due to:

- DoHA continuing to clear the backlog from the CIS;
- the new resolution options in the Scheme, which allow some complaints to be resolved earlier than they were under the CIS; and
- complaints that are referred for early resolution and to mediation are closed on referral as the Scheme plays no further role.[69]

2.33 Greater numbers of complaints are expected following the transfer of the administration of Commonwealth HACC services for over 450 000 clients[70] from state and territory governments (except for Victoria and Western Australia) to DoHA from 1 July 2012. As HACC complaints do not come under

[69] For the period 1 September 2011 to 30 June 2012, 2097 cases were closed due to referral to early resolution. Two cases were closed due to referral for mediation over the same period.

[70] Department of Health and Ageing, *Home and Community Care Program Minimum Data Set, 2009–10 Annual Bulletin*, p. 9 (excludes Victoria and Western Australia).

the *Aged Care Act 1997*, complaints officers have had to become familiar with the documentation and structures supporting HACC services in order to assess HACC complaints. This expected growth in the number of complaints, with associated workloads, increases the risk that the length of time in which complaints are finalised will rise. There would be merit in the department reviewing the allocation of resources for managing aged care complaints in light of other departmental and program priorities.

Skilling staff to implement the reforms

2.34 The Walton Review identified a range of issues in DoHA's management of complaints that could be addressed through improved learning and development opportunities for the staff handling complaints. The review recommended that DoHA conduct a mapping of training needs and develop an in-house investigation training program for all complaints staff based on better practice standards, with a particular focus on procedural fairness.

2.35 Training has been a major focus of the Scheme's implementation since its approval by the Government in early 2010. Rather than postpone training until the new complaints management framework was developed, DoHA initially focused on providing complaints investigation officers with access to a training program based on better practice principles for complaints investigations. This interim training program was delivered in the second half of 2010 following: a review of previous training programs; identification of training gaps and areas for improvement; and consultations with external agencies, such as the Commonwealth Ombudsman, to identify strengths and weaknesses in existing complaints investigations approaches. The evaluation of this program identified significant differences in approaches to handling complaints across STOs and recommended a structure for delivering consistent training for staff in the lead-up to the implementation of the Scheme and associated competency testing.

2.36 Following this evaluation, Central Office / STO consultative groups were established to integrate STO complaints operations and training through a nationally-consistent approach. Based on a *Training Management Plan 2011–12*, developed to provide strategic direction for training on the Scheme, training was delivered to all relevant staff in August 2011, supported by a range of materials, including the Scheme Guidelines, 'how do I' fact sheets, templates and workbooks.

2.37 To help ensure that staff have adequate training, a suite of Performance Development Scheme measures were developed in October 2011 to provide managers with the means to recognise and manage good and poor performance and to identify training needs. In addition, the Strategy and Policy Committee meeting in October 2011 discussed the option of certifying training and competency testing for staff engaged in complaints management, determining at the time that further information on the costs and benefits of such developments needed to be identified and discussed. A preliminary assessment subsequently suggested that the likely costs would outweigh the potential benefits.[71]

2.38 Feedback to the ANAO from STO staff engaged in complaints management was overwhelmingly that the training they received assists them to effectively handle complaints. One course that was cited by staff in the Queensland STO as being particularly helpful in preparing for conciliations was a five-day mediation course run by a Queensland Government agency. This course is nationally recognised as a requirement for accreditation as a mediator. A shorter course was delivered to STO officers on a national basis.

2.39 A training needs analysis for the ACCB was undertaken in May 2012 by an external consultant in order to develop a medium-term training plan that was specifically focused on complaints resolution officers. This analysis identified a range of issues indicating that there were still gaps in the skills of, and support available for, complaints officers, including for conciliation functions. The report's recommendations included: conducting a skills audit; development of national minimum training requirements; and learning and development opportunities delivered through formal and informal means. In June 2012, in response to the report recommendations, the Regulatory Strategy and Policy Committee agreed to the identification of training needs across OACQC with input from STOs, and to further identify the training areas that require specific OACQC training initiatives. The effective implementation of these recommendations should contribute to enhanced staff capability in complaints management and handling. Feedback from STO staff, and more

[71] DoHA's preliminary assessment of the benefits of certifying training and competency testing for staff engaged in complaints management was conducted in May 2012. The department has deferred detailed cost/benefit analysis pending the outcome of the Commonwealth Complaints Forum's consideration of broader, cross-agency approaches to training complaints staff. DoHA is a member of this forum through the Scheme.

generally from other stakeholders, indicates that there have been meaningful improvements in skills and knowledge over the past two years.

Development of policies and guidance

2.40 The Australian Standard ISO 10002–06[72] on complaints handling emphasises the importance of organisations establishing an explicit customer-focused complaints handling policy, which should be made available to customers and other interested parties and the organisation's own staff. Consistent with the Standard, an important activity identified in the project plan, through both the project deliverables and risk management elements, was the need to develop policies and guidance to support staff to implement the expanded range of complaint management options available.

2.41 The Scheme is backed by a range of policy and guidance, available to staff and other stakeholders. Most comprehensive of these is the *Guidelines for the Aged Care Complaints Scheme* (the Guidelines). The Guidelines operationalise the Walton Review recommendations involving: a variety of resolution options; fairness; transparency; increased communication with stakeholders; risk management of complaints and natural justice. The Guidelines are supported by a subsequently developed policy on *Preventing and Managing Unreasonable Complainant Conduct*. In addition, potential complainants have access to a fact sheet that outlines the key features of the Scheme, including the service that they can expect if they make a complaint.[73]

2.42 The basis for the Guidelines was the recommendations of the Walton Review accepted by government, with DoHA's responses included in the Guidelines outlined in Table 2.4.

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[72] Standards Australia: *Australian Standard ISO 10002–06: Customer satisfaction—Guidelines for complaints handling in organizations.* See <http://infostore.saiglobal.com/store/Details.aspx?ProductID=341668&gclid=CP67pPzex7ECFUZQpQodVzMASw> [accessed 2 August 2012].

[73] Department of Health and Ageing, *Aged Care Complaints Scheme: Our Service Commitment*, 2011. See <http://www.health.gov.au/Internet/main/publishing.nsf/Content/C2CB9B8304C4490BCA25791400122E20/$File/5595%20DoHA%20-%20Aged%20Care%20Complaints%20Scheme-FACTSHEET_Commitment_FA-TAGGED_v2.pdf> [accessed 2 August 2012].

Table 2.4

Responses to Walton Review recommendations included in the Guidelines

Walton recommendation	Incorporation in the Guidelines
Introduce a range of alternate resolution approaches comprising conciliation, service provider resolution, investigation and mediation, as well as increase the emphasis on early resolution.	The Guidelines identify the conditions for early resolution of a complaint and, if unsuitable for early resolution, the options to be considered for resolution, and the considerations underpinning those decisions.
Improve timeliness.	The timeframes for early resolution, escalation, and internal and Aged Care Commissioner review processes are reflected in the Guidelines. While specific timeframes are not included in the Guidelines for other resolution types, the importance of timely resolution of complaints is emphasised.
Improve robustness of risk assessment.	The Guidelines include a description of the risk assessment tools, the Risk Assessment and Resolution Plan process and the Intake Escalation Matrix and details their use.
Increase access to clinical advice.	The Guidelines include reference to the Scheme's clinical unit. The unit also developed internal standard operating procedures that outline the referral process and how Scheme officers can receive both formal and informal clinical advice.
Increase natural justice and procedural fairness, including communication.	The Guidelines address the following aspects of procedural fairness identified in the Walton Review and supported by legislation: • all complainants are able to seek review by the Aged Care Commissioner; • opportunity for providers to respond to a complaint before the Scheme decides that there is non-compliance, unless a serious or immediate risk is identified regarding the safety and/or wellbeing of a care recipient, in which case the Scheme will issue Directions; • greater time to apply to the Aged Care Commissioner for a review; and • provision of a copy of the complaint in writing to the complainant and provider.

Source: ANAO assessment of Walton, Associate Professor Merrilyn, *Review of the Aged Care Complaints Investigation Scheme,* 2009 and DoHA, *Guidelines for the Aged Care Complaints Scheme*, 2011.

2.43 The Guidelines were developed in consultation with the Aged Care Commissioner and the Commonwealth Ombudsman, with consideration of the ISO Australian Standard on complaints handling. In their development, DoHA also took account of feedback on the *Complaints Management Framework Discussion Paper,* which was released in February 2011 by the Minister, for stakeholder consultation. Focus groups in each STO and the National Aged

Care Alliance technical reference group provided feedback on the discussion paper, and amendments to the Guidelines were made on the basis of the submissions and focus group feedback.

2.44 The Guidelines were issued to Scheme officers and made available to service providers via the Scheme's website[74] in December 2011, shortly after the *Complaints Principles 2011* came into effect. Training in the use of the Guidelines was provided to all STOs, with a working draft introduced from July 2011 to prepare staff for the changes scheduled to take effect in September 2011.

2.45 Following the commencement of the Scheme there has been ongoing development of guidance for complaints officers as issues arise. These issues are raised through the committees, comprising Central Office and STO managers and staff as outlined at paragraph 2.18. Draft policies and guidance for complaints management are considered and endorsed through the Regulatory Strategy and Policy Committee for dissemination to complaints officers. Staff are informed of changes to procedures and policies by their managers, and through the 'Fortnightly five pointer' emails which are sent to all staff. There are also fact sheets and templates available for Scheme staff to access on the intranet to supplement the Guidelines.

2.46 The development of policies and guidelines has focused on the practical management of complaints through the Guidelines. Stakeholder feedback to the ANAO on the Guidelines and related policies was generally positive, and noted that the Guidelines reflect the change in emphasis from investigation to resolution.[75] The ACCB intends to review the Guidelines over time and to implement improvements on an ongoing basis.

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[74] Department of Health and Ageing, *Aged Care Complaints Scheme Guidelines*, 2011, available from <http://agedcarecomplaints.govspace.gov.au/toolkit/#schemelinks> [accessed 2 August 2012].

[75] Some stakeholders were concerned about the application of parts of the Guidelines. These issues are discussed in Chapter 3.

3. Operation of the Scheme

This chapter examines the effectiveness of DoHA's administration of the Aged Care Complaints Scheme from its inception in September 2011 until July 2012, including the application of fair and responsive processes that are focused on the care recipient.

Introduction

3.1 By 30 June 2012 DoHA had largely implemented Phases 1 and 2 of the Scheme. It had received over 11 800 contacts and resolved around 3200 complaints since the Scheme's inception on 1 September 2011.

3.2 The main difference in the complaints management processes for the new Scheme compared to the previous CIS is the greater range of options and outcomes available for the resolution of complaints—particularly early resolution, service provider resolution, conciliation, and mediation. These resolution methods are in addition to the option available under the CIS to investigate the concerns of individual care recipients about their residential aged care services, and the assessment of compliance against certain responsibilities of approved providers under the Act. These processes, and the broader management framework for the new Scheme, are shown in Figure 3.1.

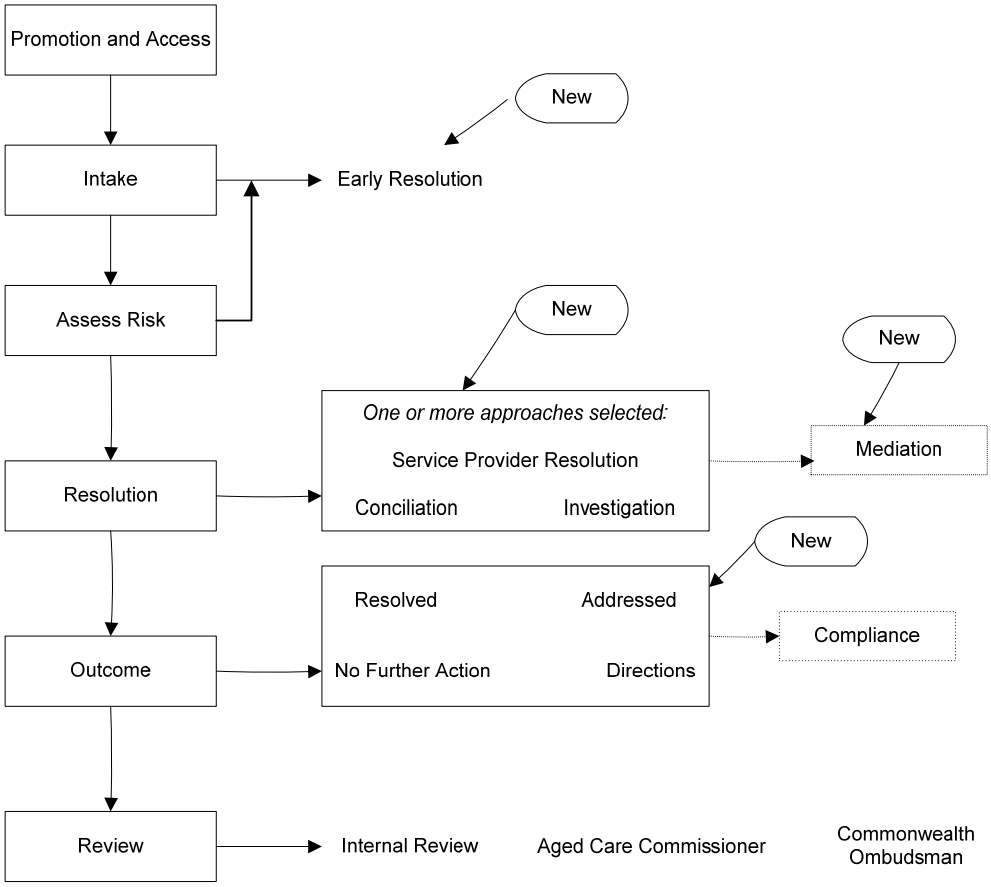
3.3 The change in emphasis from investigating concerns and identifying breaches of accreditation standards to resolving the concerns at hand has been welcomed by all major parties. In particular, providers advised of a 'gotcha', adversarial approach under the previous CIS, compared to a more conciliatory, problem solving approach focused on the care recipient under the Scheme.

3.4 The ANAO examined the effectiveness of DoHA's administration of the Scheme, focusing on the operations of key complaints management processes. These are:

- providing clients with ready access to the Scheme through promotion and service arrangements;
- receiving complaints and other contacts and determining options for their management through intake and assessment processes; and
- resolving complaints through the various options, and applying processes that are fair and responsive.

Figure 3.1

Framework and processes for managing complaints under the Scheme



Source: DoHA.

Access to the Scheme through promotion and service arrangements

Promotion of the Scheme

3.5 Australian Government funding for the new Scheme included approximately $80 000 in 2010–11 for promotion and communication activities and the development of the risk management framework. DoHA consequently developed a range of promotional material, taking account of industry feedback and consumer testing and research on the means by which older people access information. This material, available free of charge for providers and other interested parties, includes: Scheme brochures and posters (available

in 18 community languages); booklets; posters; service charters; and fact sheets on related topics. The brochure, for example, identifies the means by which complainants may access the Scheme, including for those requiring advocacy, translation or hearing assistance.

3.6 In addition, DoHA publishes a blog—the Aged Care Complaints Scheme News.[76] Research into the use of the blog from August to October 2011 indicated that many users had experienced difficulties accessing the site and that it was more likely to be accessed by families and carers than by residents themselves.[77] A number of stakeholders also advised that it would be difficult for people in remote areas to access Internet information on the Scheme because of limited Internet access. This view is supported by data from the Australian Bureau of Statistics, which indicated that in 2010–11 79 per cent of households in Australia had access to the Internet[78] compared with 62 per cent of people living in 'very remote' areas.[79] Notwithstanding these limitations, users were generally positive about DoHA's implementation of a website dedicated to the Scheme.

3.7 From August to October 2011, a benchmark survey was conducted to measure baseline awareness of, and attitudes to, the reformed Scheme. The survey sought feedback from care managers and their staff, care recipients, their friends and family members.[80] The survey sought information about:

- awareness of the Scheme and associated reforms;
- knowledge of the Scheme's scope;
- attitudes towards the Scheme and reforms; and
- preferences for accessing information and the ease with which information can be found (discussed in paragraph 3.6).

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[76] The Aged Care Complaints Scheme News is available at <http://agedcarecomplaints.govspace.gov.au/> [accessed 30 July 2012].

[77] Roy Morgan Research, *Research into awareness of and attitudes towards the Aged Care Complaints Scheme,* November 2011.

[78] Australian Bureau of Statistics, Household *Internet and Computer Access*. 2011. See <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4E4D83E02F39FC32CA25796600152BF4?opendocument> [accessed 16 July, 2012].

[79] Australian Bureau of Statistics, *Patterns of Internet Access in Australia*. 2006. See <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/8146.0.55.001Main+Features12006?OpenDocument> (updated 2009) [accessed 16 July, 2012].

[80] The Roy Morgan Research was undertaken before the new Scheme promotional material was released in November 2011.

3.8 Analysis of the survey results indicated a high level of awareness of the Scheme among care managers, with care staff being less aware. However, only one in three care recipients and one in four friends or family members were aware of the Scheme, with lower rates among those from culturally and linguistically diverse (CALD) backgrounds. As a result of these findings, DoHA has recently taken steps to address the limited awareness of the Scheme among care recipients, their families and CALD staff members, whose languages may differ from those of care recipients. Developments include the launch by DoHA of two DVDs in July 2012: 'Video about complaints for aged care staff' and 'Video about complaints for aged care consumers and their representatives'. These DVDs are targeted at staff, care recipients and their carers respectively, including those from CALD backgrounds, to increase awareness of the Scheme, its options and boundaries.

3.9 On balance, DoHA's approach to promoting the new Scheme has been generally effective. It has widely distributed information on the new Scheme and is adjusting its promotion activities to take into account feedback on preferences for receiving information. While the Internet has a role in the distribution of information it is not the main focus. This approach helps ensure that those without access to the Internet, including those living in remote communities have sufficient information on the Scheme irrespective of their Internet access.

Service arrangements to assist accessibility

3.10 Complainants are able to access the Scheme through telephone, mail, email, in person and via a website form. Provision has also been made for those who do not speak English or have a hearing or visual impairment. These means of access are comparable with a range of other schemes.[81] Most complaints are made by care provider staff, care recipients' representatives and families, with only 5.7 per cent of complaints being made by care recipients themselves in 2009–10. This increased to 9.4 per cent in 2010–11 and 10.7 per cent in 2011–12. Stakeholders advised that the low rate of complaints from care recipients was due to a number of factors, including:

[81] The means of access to the Scheme are similar to those offered by the NSW Health Care Complaints Commission, the Commonwealth Ombudsman and the Australian Human Rights Commission, noting that access to the Commonwealth Ombudsman's Office also includes face-to-face contact.

- fear of adverse treatment by management and / or staff of service providers, and disability, including cognitive impairment; and
- the nature of the generation currently in aged care, who are unaccustomed to complaining.

3.11 DoHA addresses the fear of adverse treatment (or retribution) by allowing complainants to make confidential or anonymous complaints[82], consistent with guidance from the Commonwealth Ombudsman.[83] Promotional material has also been tailored to facilitate a cultural change among care recipients and provider staff in order to remove the stigma of complaints and to encourage people to raise concerns as a means of contributing to continuous improvement.

3.12 Other means of enhancing access to the Scheme have been through:

- advocacy services[84], which are promoted in DoHA's published material on the Scheme and by intake officers. Advocates assist complainants if they have difficulty communicating or understanding their rights and responsibilities, or are perceived to need support; and
- strengthening the Community Visitors Scheme, a Commonwealth funded program that arranges for volunteers to visit isolated care recipients on a regular basis for companionship and friendship. Volunteers can provide a point of access to the Scheme for care recipients who may not have any other visitors. Community Visitors Scheme coordinators were given a stakeholder kit with information on the Scheme in December 2011. Community visitors are expected to inform care recipients about the Scheme when necessary, but do not provide advocacy as this is the role of National Aged Care Advocacy Program advocates.

[82] 'Confidential' in this context means that the Scheme is the only involved party who knows the complainant's details and identity, while anonymous means that the Scheme does not record any information pertaining to the complainant's identity.

[83] Commonwealth Ombudsman, *Better Practice Guide to Complaints Handling*, April 2009, p. 13.

[84] Through the National Aged Care Advocacy Program, the Australian Government subsidises agencies in each state and territory to provide their advocacy services. In all states except for Victoria, agencies funded through this program also receive funding from state and territory governments to undertake additional activities such as education and disability advocacy. The National Aged Care Advocacy Program was allocated $2.75 million in the 2011–12 Commonwealth Budget.

3.13 Most complaints are made via telephone calls. Scheme promotional material advises that the Scheme is accessible 24 hours a day, seven days a week. To assist accessibility outside normal business hours (8.30 am–5.00 pm Monday to Friday) or if an intake officer is not available, calls are diverted to a voicemail service that the department requires to be checked three times per day during weekends to screen for issues that require urgent attention.[85]

3.14 Private access to telephones is of particular importance. One staff member at a service provider visited by the ANAO stated that she had not realised that having a public phone at reception only would restrict access to the Scheme for care recipients, and advised that she would consider installing a phone that could be accessed in private. Given the importance of private access to telephones, there would be merit in DoHA alerting providers to the benefits of enabling such access for all care recipients as a means of facilitating access to the Scheme. This is particularly important for care recipients in regional and remote areas, given that they may have limited access to Internet services and are less likely to complain to the service provider as they may have fewer options to relocate if they fear retribution as a result of the complaint.

3.15 There are differing views among stakeholders as to whether the current level of access for all care recipients is adequate. DoHA, some aged care service providers and provider peak bodies advised the ANAO that access is sufficient, reasonable, and the best that can be achieved within available resources. Other providers and provider peak bodies take the view that assistance through staff, chaplains, community visitors or guardians is available to all care recipients to access internal and / or external complaints mechanisms.

3.16 Family members, advocates and care recipient peak bodies were less satisfied with the Scheme's accessibility, particularly with respect to isolated care recipients. Such care recipients currently rely on staff who are prepared to complain on their behalf (and may be the cause of the complaint) or volunteers from the Community Visitors Scheme (who only report to their coordinator if they have a concern but are not empowered to act beyond this). The current *Community Visitors Scheme Handbook* has not been updated since 2007, and does not inform volunteers about providing information to care recipients about the

[85] The Scheme is not meant to be the primary contact for life-threatening or time-critical emergencies, as this is the role for the service provider and emergency services.

Scheme, advocacy services, or about how to make a complaint to the Scheme on behalf of a care recipient.

3.17 Aged care recipients who are isolated are among those at greatest risk. However, this sub-group has more limited access to the Scheme than other care recipients, as they generally do not have someone available to represent them in a complaint. DoHA should consider options to improve access to the Scheme for isolated care recipients. One opportunity is for DoHA to develop a closer relationship between the Community Visitors Scheme, whose target group is socially isolated care recipients, and advocacy agencies funded by the National Aged Care Advocacy Program in order to facilitate access to complaints mechanisms for those at greatest risk.

Recommendation No.1

3.18 The ANAO recommends that the Department of Health and Ageing considers options to provide isolated care recipients with appropriate access to the Scheme, recognising that they generally do not have someone available to represent them in a complaint.

DoHA response

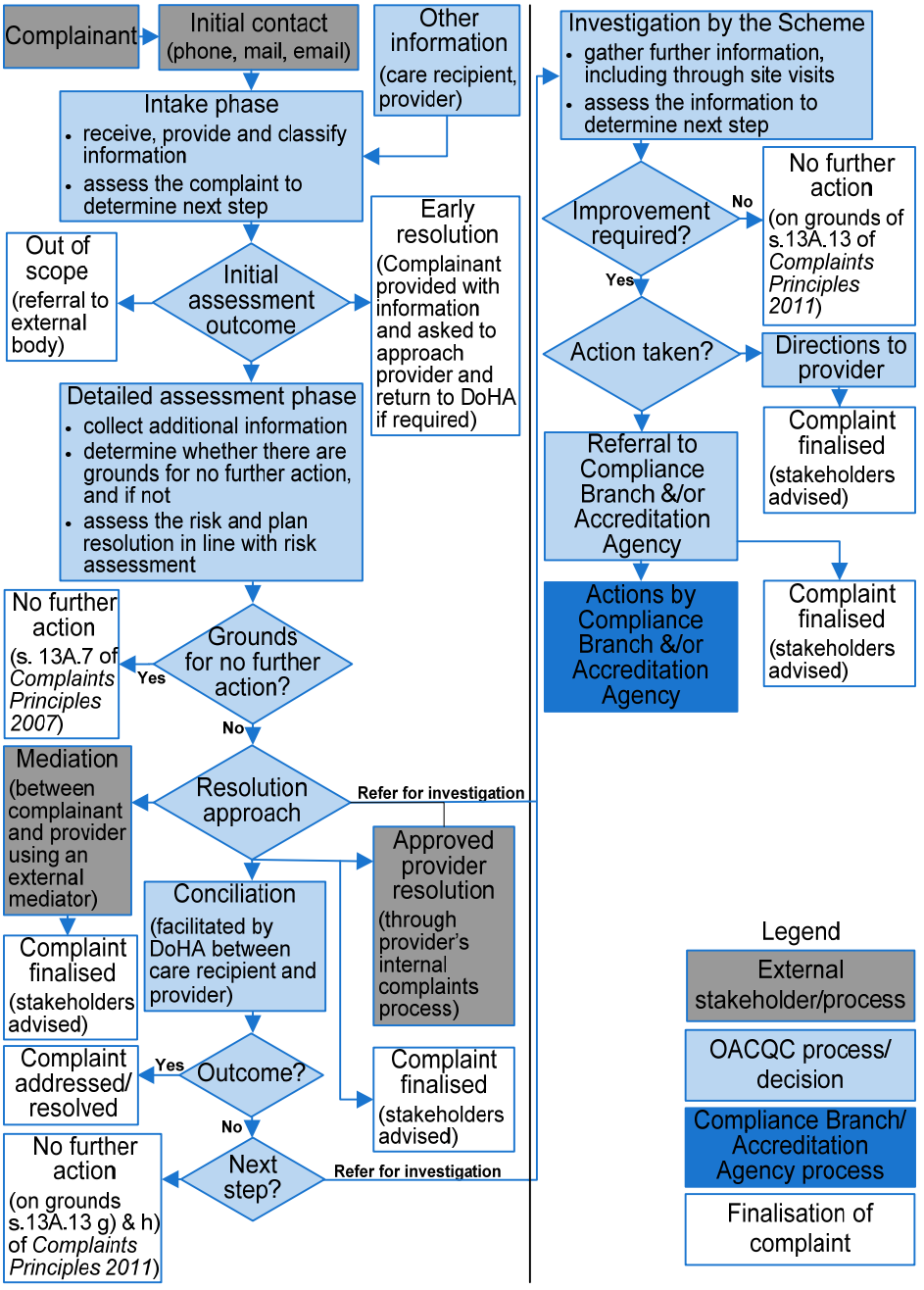
3.19 Agreed.

Receiving complaints and determining the handling method

3.20 The processes for receiving and handling complaints are illustrated in Figure 3.2.

Figure 3.2

Complaints management workflow



Source: ANAO analysis of DoHA *Aged Care Complaints Scheme Guidelines*, 2011.

Receiving complaints

3.21 From the commencement of the Scheme on 1 September 2011 to 30 June 2012, DoHA received 11 875 contacts about aged care matters. As shown in Table 3.1, there are many types of contacts other than complaints, which represented only 27 per cent of all contacts. Many of these contacts (31 per cent) were out of scope as they did not relate to a responsibility of a service provider as defined under the Act, or were inquiries (14 per cent) about aspects of aged care relating to the Scheme. The other major category of contacts was notifications (28 per cent).[86]

Table 3.1

Aged Care Complaints Scheme contacts, 1 September 2011 to 30 June 2012

Type of contact	Number	Per cent
Complaint	3204	27.0
Notification (total)	3309	27.9
– *missing resident*	807	6.8
– *reportable alleged assault*	1631	13.7
– *other*	871	7.3
Out of scope	3698	31.1
Inquiry	1418	11.9
Other (total)	246	2.1
– *compliance referral*	76	0.6
– *information from other source*	156	1.3
– *internal reconsideration*	13	0.1
– *other related matters*	1	-
Total	**11 875**	**100.0**

Source: ANAO analysis of DoHA data.

3.22 A feature of the contacts to the Scheme is the high incidence of notifications, which outnumbered complaints over the period

[86] As discussed in paragraph 1.17, the Act requires service providers to: notify DoHA of certain events, such as an infectious disease outbreak, a natural disaster, or an emergency incident; and report alleged or suspected assaults and unexplained absences of aged care residents. Notifications are reported to the area of DoHA responsible for managing aged care complaints but are not part of the Scheme. DoHA is advised of compulsory reporting incidents, which are not complaints and are managed by the service provider in consultation with the local police.

1 September 2011 to 30 June 2012. Providers and provider peak bodies raised a number of concerns with the ANAO regarding compulsory reporting such as the short duration of time after which a resident is often considered missing, the way these reports are presented in the *Report on the Operation of the Aged Care Act* and by the media (characterised more like an actual incident rather than a notification), and impacts on staffing if staff are stood down while an assault claim is investigated.

3.23 Provider peak bodies suggested that providers generally have risk-averse attitudes when complying with statutory obligations, which can result in them over-reporting missing residents and potential assaults, and standing staff down rather than considering other options for avoiding contact with complainants. One stakeholder involved in the development of the compulsory reporting legislation advised that compulsory reporting should be reviewed to better define when reports should be made in order to address the over-reporting currently occurring.

Out of scope contacts

3.24 Out of scope contacts accounted for 31 per cent of all contacts in 2011–12. As discussed in paragraph 3.21, out of scope contacts are those matters that do not relate to a responsibility of a service provider as defined under the Act. Research conducted by DoHA in 2011 found that most people obtained the Scheme's contact telephone number from promotional material such as brochures, the telephone book and the Internet. The review also found that people were confused about the difference between the Scheme and the Aged Care Info Line[87], which is often referred to in similar sources. DoHA has taken action to address some of this confusion.

Intake of complaints

3.25 The 'intake phase' is the initial point of contact with the Scheme for members of the public and providers. During this phase, DoHA officers: provide information on the rights and responsibilities of service providers under the Act; manage complainant expectations; assist complainants to clarify issues and outcomes sought; tailor communication; acknowledge the complaint; escalate complaints according to the risk management framework;

[87] The Aged Care Info Line provides a link to a wide range of community, aged care and support services that are available locally and nationally. Confidential and free information is provided on community aged care service to support people at home, local Aged Care Assessment Teams and carer support and respite services.

check and clarify information; facilitate the development of resolution options; and record all relevant information.[88]

3.26 The Guidelines[89] advise Scheme intake officers to be aware of, and sensitive to, the diverse range of people who call the Scheme as well as to treat all people equally. They also advise officers to take steps to reduce the barriers to access if necessary by using the Telephone Interpreting Service and the National Relay Service.

3.27 However, unlike many call based operations, DoHA does not monitor the quality of intake call interactions to gauge the extent to which the intake officer is satisfying the relevant service requirements. Monitoring a sample of complainant calls would help strengthen the Scheme's client communication practices, with the results potentially being used to provide performance feedback to staff, and more broadly to guide training and refinement of the Scheme Guidelines.[90]

Determining complaints handling methods

3.28 After intake, the two main options for determining how to handle complaints are early resolution and detailed assessment. Following detailed assessment a number of options are available for complaint resolution/finalisation.

Early resolution

3.29 Early resolution occurs where cases do not enter a formal resolution process. This outcome involves officers supporting complainants to resolve their complaints directly with providers. The determination of whether or not to attempt early resolution is based on the application of an initial risk assessment. The Scheme Guidelines state that officers should use a risk assessment tool, the Intake Escalation Matrix, either during or immediately after the first contact, to determine whether to seek an early resolution outcome or refer the case for resolution by other methods. However, DoHA staff advised that experienced officers do not need (or use) the Intake Escalation Matrix as they assess and manage such risks as a matter of course.

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88 Department of Health and Ageing, *Guidelines for the Aged Care Complaints Scheme*, 2011, p. 4.2.

89 ibid., p. 3.5.

90 Appropriate confidentiality arrangements would need to be implemented and callers alerted to the monitoring arrangements.

3.30 In practice, early resolution generally occurs within 48 hours of intake or else the case is referred for detailed assessment. If cases appear close to resolution, complaints supervisors have the discretion to continue with efforts to obtain early resolution. DoHA advised that officers have a maximum of 14 days to resolve a complaint in early resolution, although this timeframe was not specified in the Guidelines.

3.31 Early resolution of complaints is important for both the complainant and the provider as it can assist in preventing a breakdown of the relationship between the parties.[91] Maintaining this relationship is critical to care recipients as they are a vulnerable group and the service setting is their home.

3.32 Complainants who agree to early resolution are not followed-up by Scheme staff to check that their concern has been resolved. Scheme staff advised that they emphasise to the complainant, at the time of referral to early resolution, that they should contact the Scheme again if early resolution is not successful. However, as there is no follow-up or other analysis of complaints closed on the basis of early resolution, DoHA is not aware whether complaints closed due to early resolution have been successfully resolved. Assessing complainant satisfaction with early resolution outcomes as part of the implementation of Phases 3 and 4 of the Scheme would inform DoHA of any potential issues requiring remedial action.

Detailed assessment

3.33 The detailed assessment phase seeks to strengthen the Scheme's capacity to manage complaints in a tailored, effective and timely manner. The aim of this assessment is to decide how to address the complaint. During this phase, additional information on the complaint is gathered, if necessary, to assist in risk assessment and resolution planning.

3.34 The risk assessment and resolution planning (RARP) process is used during the assessment phase to escalate complaints in accordance with the Scheme's risk management framework and in so doing determine the action to resolve the complaint. The result of the assessment phase is a decision to: take no further action under 13A.6 of the *Complaints Principles 2011*; refer to

[91] According to the Commonwealth Ombudsman, simple complaints should usually be resolved on first contact with an agency. This will help ensure that clients are satisfied and have confidence in the agency, as irritation or fatigue on the part of clients can thwart successful complaint handling. Commonwealth Ombudsman, *Better Practice Guide to Complaint Handling*, April 2009, p. 14.

conciliation, service provider resolution, investigation or mediation; or refer to another organisation.[92]

Risk Assessment

3.35 The Walton Review found that there was limited guidance available for CIS officers regarding risk assessment and the management of complaints. Providers reported that the CIS was risk-averse and did not operate within a risk assessment framework. Walton recommended that:[93]

> all complaints should be assessed immediately after they have been received to identify the level of risk and the appropriate course of action that needs to be undertaken. The purpose of risk assessment at this stage is to identify high risk or serious risk to the health, safety and wellbeing of a care recipient(s).

3.36 Walton also recommended the use of a risk assessment matrix, as employed by many other complaints handling agencies, and provided an example of one used by the NSW Department of Health.[94] This matrix included assessment of both likelihood and consequence, a key feature of risk assessment matrices.

3.37 DoHA engaged a consultant to develop a risk assessment tool for use by the Scheme. That tool included a matrix that included both the likelihood and consequence of a risk event. The current RARP, however, omits assessment of likelihood from the risk assessment matrix, primarily on the basis that the incident that resulted in the complaint had already occurred. Consequently the RARP matrix only assesses the impact on the complainant and not broader risk. Officers, therefore, are assessing the impact of an incident that has occurred and not the risk of a similar incident occurring in the future, the risk it poses to the care recipient or other care recipients in that facility, or to the Scheme in the future.

3.38 The key information required to determine the likelihood of an incident recurring—the incident histories of the provider and the care recipient—is included in the RARP but does not explicitly contribute to the risk assessment as it is omitted from the matrix. The extent to which likelihood is taken into

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92 Department of Health and Ageing, *Guidelines for the Aged Care Complaints Scheme*, op. cit., p. 5.3.

93 Walton, op. cit., p. 53.

94 ibid., p. 99.

account in determining the approach to complaints resolution is therefore largely dependent on the experience and approach of the decision-maker.[95]

3.39 As illustrated in the case study below, assessors have considered provider history, and implicitly the likelihood of incidents recurring, in assessing the level of complainant risk. Nevertheless, to improve the consistency of conducting thorough risk assessments of aged care complaints, there would be benefit in DoHA considering the inclusion of the assessment of likelihood of an incident recurring, together with its consequence, in the RARP risk assessment matrix.[96] This is particularly important in situations where the consequence to the care recipient if an incident occurred would be serious.

Case Study
Complaint Assessment

Day 1: A complaint was made by the daughter of a care recipient who was concerned about the health and personal care of her mother. The complainant reported that her mother had been admitted to hospital with aspiration pneumonia as a result of being fed inappropriate food. In addition, whole pills had been administered to her mother when they should have been crushed, and medication was not administered on time.

Day 4: Complaint was acknowledged.

Day 9: The complaint was discussed at case review to develop a risk assessment and resolution plan. The risk was rated as major mainly due to the major impact on the health and wellbeing of the care recipient.

While the likelihood of these problems occurring in the future, for either the care recipient or other care recipients in the facility was not explicitly assessed, the service provider history was considered and had contributed to the 'major' risk rating. The facility had previously been found not to demonstrate the appropriate support and supervision of staff to ensure residents' care was in keeping with their needs, preferences and dignity. Issues in relation to care recipients' specialised nursing care, nutrition and hydration, continence management and behaviour management had been identified.

The assessment recommended that the complaint be referred for possible resolution in a conciliation meeting, as the complainant had been involved in previous conciliation meetings and due to the serious nature of the concerns raised by the complainant.

Source: ANAO analysis of DoHA complaints records.

[95] The RARP panel / triage meetings convened in STOs to assess the priority of complaints provide an opportunity for officers to discuss complaints at this stage of assessment. The history of the provider and the care recipient can be taken into account during these discussions. However, exclusion from the RARP risk assessment matrix of the need to consider provider history and the implications for recurrence means that comprehensive risk assessment is overly reliant on the practices of individual officers.

[96] Including the likelihood of an event recurring in the RARP risk matrix would also be consistent with better practice standardised risk management as recommended by the Walton Review. Walton, Associate Professor Merrilyn, *Review of the Aged Care Complaints Investigation Scheme*, 2009, p. 99.

Complaint resolution

3.40 The Walton Review recommended a range of 'assessment outcomes for complaints including local resolution, assisted resolution, and mediation.'[97] The greater range of resolution methods was proposed to support resolution of complaints without investigation as appropriate, to improve responsiveness to complainants and reduce the administrative burden on providers.

Resolution methods

3.41 DoHA implemented the resolution methods recommended by the Walton Review and agreed by government, namely:

- conciliation—which involves officers assisting the parties to work together to discuss the issues and reach agreement;
- service provider resolution—which involves DoHA referring a complaint (or issues within a complaint) to a service provider to resolve. Following resolution, the provider prepares a report for DoHA. If this is satisfactory, the Scheme delegate may end the resolution process. A copy of the report, or a summary, may be provided to the complainant by DoHA (although this is not mandatory);
- investigation[98]—which is used in circumstances where other approaches are not appropriate, possible or likely to achieve a positive outcome; and
- mediation—which involves an independent mediator working with the complainant, the care recipient (if appropriate) and the service provider to discuss the issues and attempt to reach agreement or an otherwise acceptable outcome. Mediation is not funded by DoHA.[99]

3.42 These options have provided DoHA with greater flexibility to resolve cases responsively for the benefit of the care recipient, and as illustrated in the case study below, also for the service provider.

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97 ibid, p. 11.

98 There are also provisions for own motion investigations, initiated by the Scheme when information is received through sources other than complainants, which indicates that a provider may not be meeting its responsibilities under the *Aged Care Act 1997*.

99 DoHA will finalise the resolution process if a service provider and a complainant decide to involve a mediator.

Case Study
Provider's perspective on conciliation

The provider had resolved a complaint through Scheme conciliation, and considered the process to be helpful and successful.

The complaint (about the complainant's mother's care) was an emotional one and the complainant's behaviour was generating significant stress for the residential care facility staff. The facility had tried several unsuccessful internal conciliations before DoHA became involved. The provider had recently attended a DoHA presentation on the conciliation process, and felt that the conciliation process applied to this complaint had progressed as they had anticipated, in line with the presentation at the DoHA forum.

The complainant has continued to complain about the care provided; however the results of the Scheme conciliation and the information obtained through that process have enabled the facility staff and management to support the care recipient and the complainant without the level of stress previously experienced.

The provider felt that conciliation was particularly useful where there is family conflict, providing the family with a chance to be heard and have their feelings and concerns considered by a third party.

Source: ANAO.

3.43 DoHA can issue a notice of intention to issue directions during any of the available resolution methods. The provider has an opportunity to respond indicating: that they have taken action to remedy the issue; the details as to how they propose to do so, or have done so; and timeframes applying to the remedial actions.

3.44 While these additional resolution methods are available, investigation has continued to be used for the more serious cases. The highest risk cases are also reported to the: Aged Care Standards and Accreditation Agency for monitoring and investigation at a facility level if required; or DoHA's aged care compliance area if the provider may not be meeting its legislated responsibilities.

3.45 At the conclusion of fieldwork in July 2012, DoHA had not compiled relevant data to enable an assessment of the effectiveness of the various resolution methods available under the Scheme[100] (such as the number and proportion of cases resolved, referred or not resolved, through each of resolution methods and outcomes described in the Guidelines—early

[100] In this regard, improving the alignment between the data collection categories and resolution approaches as part of the development of the new complaints management electronic system would facilitate robust analysis as part of Phases 3 and 4 of the implementation of the Scheme.

resolution, service provider resolution, conciliation, investigation and mediation).[101] The ANAO, therefore, has not commented on this issue.

Fairness

3.46 The Walton Review identified the importance of consistently providing fairness to all parties[102], particularly complainants and providers. Submissions to that review highlighted problems with fairness that included complainants: not being engaged in the complaint process; receiving insufficient information about complaint processes, reasons for decisions, and outcomes; and having inadequate protection if they were a recipient or staff member of a provider. For their part, providers raised concerns about: investigators being unfair and partial in favour of informants; and a lack of transparency in the investigative and referral processes, including about the nature and details of the complainant and the complaint.

3.47 The Commonwealth Ombudsman Better Practice Guide to Complaint Handling[103] describes fairness as one of the five fundamental principles that must be observed in effective complaint handling.

3.48 The Scheme Guidelines address the principle of fairness, including procedural fairness and natural justice. In particular, the Scheme commits to be fair through:

- providing clear, consistent and timely information;
- making evidence-based decisions that provide equal opportunity for parties to have a say;
- being thorough, robust and accountable;
- engaging with empathy and understanding;
- being ethical and transparent;
- ensuring accessibility; and
- engaging and working collaboratively in the resolution of complaints.[104]

[101] The appropriateness of the resolution method chosen could be assessed by analysing how many complaints move from one resolution method to another, within the context of time taken to resolve a complaint, and the level of customer satisfaction.

[102] The review used the terms 'procedural fairness' and 'natural justice' to refer to the common law duty on decision makers to observe fair procedures when making certain decisions. However, it adopted a broader interpretation of fairness, 'rather than be confined to a narrow legalistic interpretation'. Walton, op. cit., p .17.

[103] Commonwealth Ombudsman, op. cit., p. 9.

3.49 DoHA has addressed greater national consistency for the new Scheme through: the development and distribution of Guidelines and associated information; consistent training and ongoing guidance provided to all STOs; and the new governance structure. The use of the RARP, and meetings to discuss the RARP assessment of individual complaints, also supports consistency in administration. Nevertheless, consistency is likely to be an ongoing challenge for the Scheme due to officers working at a state and territory level and the possibility that they will, as they did in the CIS, create solutions to problems in isolation from the rest of the Scheme. This will require continuing active management by DoHA.

3.50 The ability to seek a review of a complaint is an important aspect of fairness, as reviews can address the elements of fairness listed in paragraph 3.48. If complainants are not satisfied with the outcome of their complaint they are able to seek internal review by the Scheme. They can also subsequently, or directly, seek review from the Aged Care Complaints Commissioner. The Commissioner is able to review the Scheme's processes and decisions. If complainants are still dissatisfied they can seek assistance from the Commonwealth Ombudsman who safeguards the community in its dealings with Australian Government agencies. If the Ombudsman considers that there has been defective administration, he can recommend that corrective action be taken. DoHA has addressed the need to inform complainants and providers of the options for review by including this information in template letters to be sent to stakeholders at the close of a complaint.

3.51 Stakeholders were generally very positive about the new Scheme and DoHA's management of consultation and implementation. Largely, stakeholders advised the ANAO that it is a fairer, less adversarial process. Many felt that the Scheme officers had always been courteous and well motivated, but that the reforms to the Scheme provided the officers much greater scope for working towards resolution of issues rather than ascertaining whether a breach of standards had occurred.[105] This view was not universal, however, as there were a number of dissatisfied complainants, some of whom took exception to the fairness of the processes.

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[104] DoHA, Aged Care Complaints Scheme Guidelines, 2011, op. cit., p. 1.3.

[105] In Western Australia, stakeholders noticed less change, as the office had implemented a resolution-focus under the CIS.

Responsiveness

3.52 A key element of responsiveness is the time taken to resolve complaints. The length of time taken to finalise investigations was raised in submissions to the Walton Review.[106] Irrespective of the total time taken to resolve complaints, an agency can be responsive to the complainants (and providers) through good communication. However, the review stated that 'nearly half of the 39 submissions from providers of aged care services raised poor communication as a significant factor in complaints concerning their services.'[107]

3.53 The Scheme addresses responsiveness in the Guidelines by advising that officers 'will promptly acknowledge receipt of all complaints, and that there will also be: risk-managed escalation of complaints; resolution of complaints in reasonable timeframes; fair, impartial and prompt decisions; and courteous treatment of complainants, including professional management of unreasonable conduct.'[108]

3.54 More generally, to address the lack of complainant focus identified by the Walton Review, DoHA undertakes that the Scheme will:

- ensure that the complainant agrees with the issues identified in the complaint;
- communicate on a regular basis with the complainant;
- provide information to the complainant to enable them to address their concerns with the service provider as part of early resolution;
- involve the complainant as a participant in resolution approaches in a way that matches their willingness and capacity to do so; and
- provide a written response on receiving the complaint (to clarify that their complaint has been interpreted correctly) and written notification, including reasons and review options, when a complaint is closed.[109]

[106] Walton, op. cit., p. 77.

[107] ibid, p. 24.

[108] DoHA, Aged Care Complaints Scheme Guidelines, op. cit., p. 3.10.

[109] ibid., p. 3.11.

3.55 Stakeholders with system-level visibility[110] generally advised of increased responsiveness of the Scheme, with complaints being resolved more promptly, appropriately and proportionately. However, a small number of individual complainants reported delays and poor outcomes under the Scheme, a lack of ongoing communication and little improvement following its implementation.

3.56 A particular focus on enhanced responsiveness has been demonstrating to complainants that DoHA understands their concerns. The department has been addressing this issue through coaching and training complaints officers, and through seeking feedback from complainants that their complaint has been accurately recorded. Stakeholders expressed increased satisfaction with this aspect, although some had concerns about the initial clarification of issues, considering that the issues articulated originally were not necessarily reflected in the complaint presented to the provider.[111] Overall, however, stakeholders reported a welcome increase in the focus on the care recipient and responsiveness in resolution of complainants' concerns.

Response timeframes

3.57 Setting timeframes to respond to complainants and resolve complaints provides predictability and assurance to complainants and providers as to when they can expect responses and outcomes. The Walton Review stated that 'best practice complaint management includes timeframes for completion of particular tasks associated with complaint handling.'[112]

3.58 The current timeframes for processes within the Scheme are outlined in Figure 3.3.

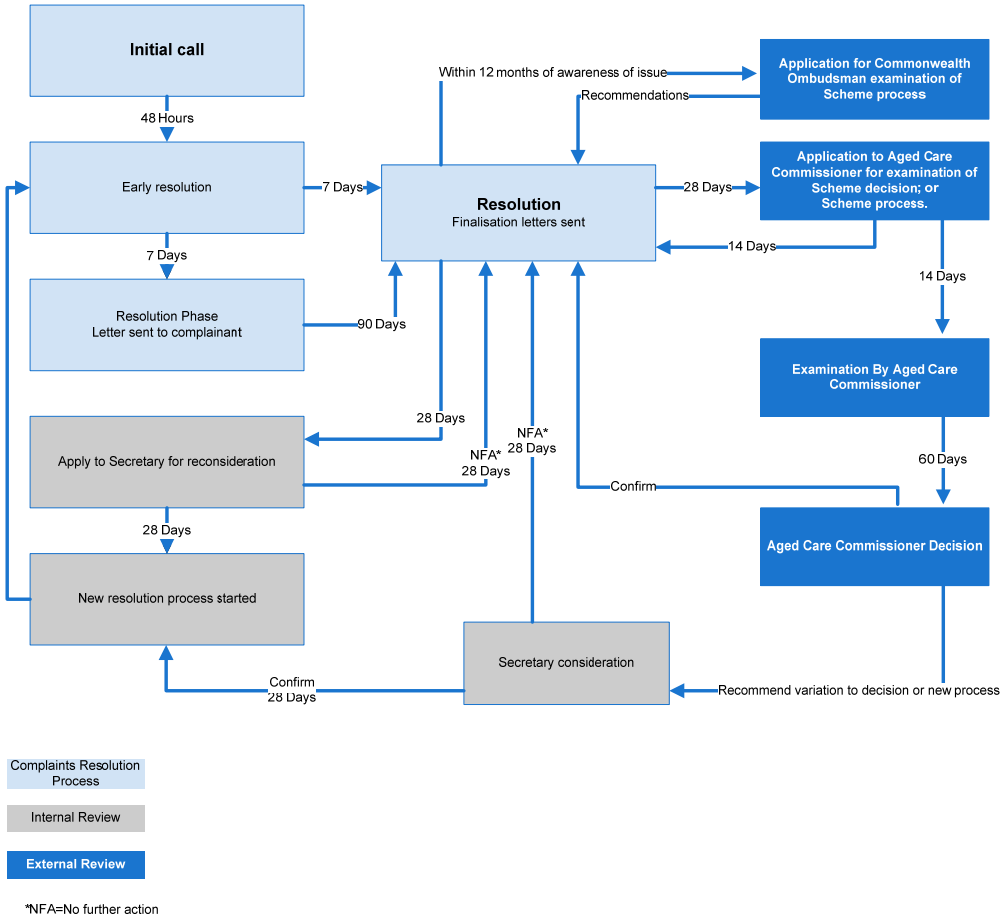
[110] These stakeholders included large providers, aged care peak bodies, and consumer representative peak bodies.

[111] During field work the ANAO observed a RARP meeting where the aim to develop succinct issues in line with RARP criteria resulted in a complaint being summarised in a way that may not have reflected the complainant's concerns.

[112] Walton, op. cit., p. 77.

Figure 3.3

Flow chart of review process



Source: ANAO analysis, Scheme Guidelines and *Aged Care Act 1997*.

3.59 Key resolution timeframes include:

- early resolution generally having to occur within 48 hours, with management having the discretion to continue if resolution is assessed to be imminent;
- response letters being sent to complainants within a week, acknowledging their complaints and clarifying issues and outcomes;

- the Scheme striving 'to resolve the complaint in a timely way—within three months where possible'[113]; and
- internal review and review by the Aged Care Commissioner being conducted according to timeframes that are mostly set by the Act.

3.60 Detailed Draft Key Timeframes[114] were presented to the CIS Operations Committee in June 2011, which, if accepted, would have allowed 'the scheme to monitor and evaluate its performance in the future, as part of a greater focus on continuous quality improvement.' These timeframes were not finalised until September 2012 and so are not reflected in the current Scheme Guidelines. To satisfy better practice complaints management, DoHA should include key timeframes in the Scheme Guidelines, communicate them to stakeholders and use them as a basis for monitoring and evaluating performance.[115]

Response timeliness

3.61 The ANAO calculated the average times by resolution method (including conciliation, investigation and service provider resolution) for all complaints received since the Scheme commenced to 30 June 2012, as shown in Figure 3.4.

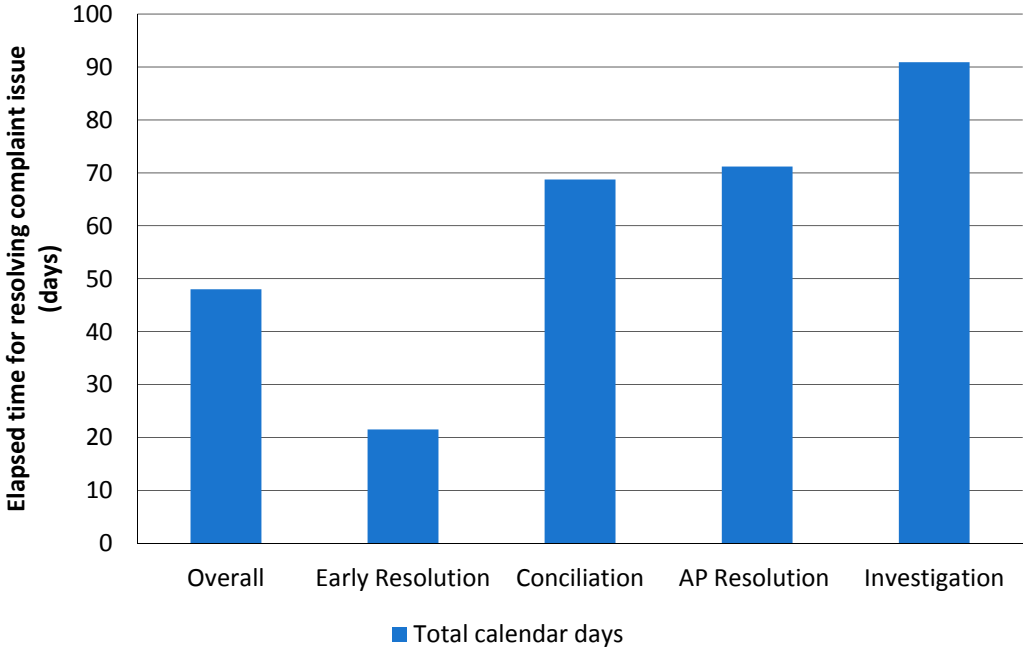
[113] DoHA, Aged Care Complaints Scheme brochure: *Our Service*.

[114] Draft timeframes were developed for: responding to phone messages; escalating complaints; sending response letters; moving to assessment; completing assessment and the RARP; moving to resolution; sending a letter to the provider articulating issues; conducting site visits and completing conciliation meeting reports; sending finalisation letters and reports on notifications; finalising complaints; releasing documentation to the Aged Care Commissioner; implementing recommendations of the Aged Care Commissioner; and ongoing communication with complainants / providers.

[115] Commonwealth Ombudsman, *Better Practice Guide to Complaint Handling*, April 2009, pp. 12, 21.

Figure 3.4

Time taken by complaint resolution method: 1 September 2011 to 30 June 2012



Source: ANAO analysis of DoHA data.

Notes: Data categories do not directly align with resolution approaches described in the Guidelines, which compromises evaluation of Scheme performance against prescribed resolution approaches. 'AP Resolution' is approved service provider resolution.

3.62 Over this period, the average time taken to resolve complaints was 48 days, well within the three month period stated in the Service Commitment. While DoHA could not provide reliable timeliness data for complaints received under the previous Complaints Investigation Scheme, it advised that investigations, which were the focus of that scheme, had a similar duration to resolve of around 90 days.

4. Continuing to Full Implementation of the Scheme

This chapter examines DoHA's preparation and planning for the full and timely implementation of the Scheme, including through planning for Phases 3 and 4, the development of a new electronic complaints management system, and enhancements to performance monitoring and reporting arrangements.

Introduction

4.1 In response to the Walton Review, the Australian Government committed $50.6 million over four years to improve the management of complaints about Australian Government subsidised aged care services. The new Scheme is intended to be more customer focused and responsive to complainants, working to achieve outcomes for care recipients, their families and other representatives.

4.2 The previous CIS was criticised in submissions to the Walton Review for: being difficult to access; not sufficiently engaging or providing adequate information to the complainant and provider; being biased against and unfair to providers; not being sufficiently focused on the care recipient; not addressing fear of reprisal for complainants; and having a restrictive appeals process.[116] Successful implementation of the new Scheme will overcome many of the difficulties that were experienced by aged care consumers, providers and staff working in the CIS.[117]

4.3 As discussed in Chapter 2, DoHA has made good progress in implementing Phases 1 and 2 of the Scheme in line with the deliverables and timing agreed by the Australian Government. Continuing to full implementation of the Scheme requires the department to complete Phase 3—communicating outcomes and influencing industry, and Phase 4—leading good practice in complaints management.[118]

[116] Walton, op. cit., p. 18.

[117] ibid., p. 11.

[118] Department of Health and Ageing, *Strategic Plan 2010–14: Aged Care Complaints Scheme*, 2011.

4.4 To complete these phases it is important that DoHA:

- conducts planning to determine strategies, priorities and deliverables;
- collects relevant complaints data through reliable information technology systems; and
- uses this data to monitor performance, which is reported internally and externally.

Planning for full implementation

4.5 To implement Phase 1, and much of Phase 2, DoHA developed a detailed project implementation plan, which included a list of actions to be addressed, resourcing requirements, project scheduling and risk management approaches (as outlined in Table 2.2). Rather than develop a separate detailed plan for the implementation of Phases 3 and 4, planning is being conducted and reported as part of the Aged Care Complaints Branch's business planning processes. Planning for Phase 3 was reported in the *2012–13 Operational Plan, Aged Care Complaints Branch*, which was finalised in September 2012.

4.6 The *2012–13 Operational Plan, Aged Care Complaints Branch* sets out proposed deliverables that focus on the third year of the Scheme's strategic plan (Phase 3), categorised to: improve transparency and accountability; influence industry; and improve accessibility and acceptability. Two key deliverables were: a report on the operation of the Scheme to communicate outcomes around Scheme learnings; and the further development and dissemination of a complaints handling toolkit to support better practice in handling complaints at the local level.[119]

4.7 If delivered effectively, the strategies, priority activities and deliverables set out in 2012–*13 Aged Care Complaints Branch Business Plan* have the potential to support the successful implementation of the Scheme. However, effective delivery of these approaches relies on data collection and trend analysis of the Scheme complaints. As discussed below, it will be challenging for DoHA to successfully conduct the systemic analysis of aged care complaints. Despite managing various aged care complaints schemes since 1997, the department has limited experience in using complaints data to

[119] DoHA, *2012–13 Operational Plan, Aged Care Complaints Branch,* p. 9.

identify and address systemic issues.[120] DoHA will need to use extensive manual processes to complete these tasks as the current electronic complaints information system poses significant challenges in terms of data integrity, functionality and analysis[121], and the new National Complaints and Compliance Information System (NCCIMS) being developed to overcome these and other shortcomings has been significantly delayed.

4.8 Further challenges to the implementation of the final two phases of the Scheme are likely to arise from emerging issues such as broader sectoral reforms that will affect the administration of aged care complaints. In particular, the Aged Care Complaints Branch faces uncertainly about the volume and nature of complaints following the transfer of responsibilities for the Commonwealth HACC Program (as discussed in paragraph 2.33), and the possible integration of complaints relating to a number of other aged care programs (such as the National Respite for Carers Program).

4.9 In light of these challenges, it is important that the department monitors the progress of strategies and actions to implement the Scheme's final two phases, and conducts more detailed planning if required.

Development of the National Complaints and Compliance Information Management System

4.10 Funding for a comprehensive IT solution for the management of aged care complaints and compliance activities was provided in the 2006–07 Budget for the CIS. By May 2007, the Investigation Management System (IMS) was developed as the interim solution to meet the timeframe for the introduction of the CIS. Since that time, while system enhancements have been made, DoHA has recognised that IMS compromises its ability to effectively and efficiently manage aged care complaints and compliance activities. The department cites the following examples of system limitations, which were also observed by the ANAO:

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[120] The main recent examples of the department identifying and addressing systemic issues are through the publication of a *What can we learn* report and *Industry alerts*. To date, the *What can we learn* report covered *Residents who go missing*; and *Industry alerts* have covered processes in relation to smoking and bed poles (both coronial findings) and call bells.

[121] By way of illustration, process and system improvements are listed as the first priority in the *2012–13 Operational Plan, Aged Care Complaints Branch,* in order to 'improve data integrity, security and functionality and provide better management and analysis tools.'

- data capture and storage limitations that lead to compromised integrity in the data;
- limited ability to analyse and assess performance of the Scheme and trends in the complaints;
- rudimentary security and audit capability, poor performance and reliability;
- reduced productivity through the compromised system functionality, workflow support and access to information; and
- resourcing impact and increased risk of regulatory failure.[122]

4.11 DoHA identified the high risk associated with continuing the existing system, rating the likelihood of an interruption to service capacity while relying on IMS to be 'almost certain'. To mitigate this risk, in mid-2010 the Strategy and Policy Committee identified the importance of implementing a new system. When fully operational, DoHA expects that NCCIMS functionality[123] will enable: the collection of substantially more business information; regular and ongoing analysis of complaint trends at a national, state and territory and agency level; and the ready production of reports. The new system is also expected to provide information to DoHA on how best to improve the Scheme's processes in order to ensure fairness, responsiveness, efficiency and a focus on care recipients.[124]

4.12 The department aimed to have the new system operational at the commencement of the Scheme in September 2011.[125] However, there have been considerable delays in deploying NCCIMS, as outlined in Table 4.1.

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[122] ANAO analysis also showed that IMS: has a limited reporting function; lacks capability to integrate with other systems that are required by frontline officers and management for day-to-day work; lacks the ability to correlate transactions related to the same provider/agency; has no feedback loop such as satisfaction survey results; is inconsistent; and is not able to contain sufficient information to support officers' day-to-day work, resulting in each state and territory office seeking additional information from other data repositories.

[123] NCCIMS functionality will include: automatic case status incorporating issue status; refining wording so that complaints automatically move to the next officer once the assigned process has been completed; automatic notification of cases emailed to state and territory offices; automatic referrals to external agencies; and cross referencing between cases.

[124] As noted in Chapter 3, better aligning data collection with the Scheme guidelines will further facilitate reporting on the outcomes of the Scheme to communicate to stakeholders.

[125] This includes the department-wide roll out of new IT hardware and software in 2012; and changes to IMS archiving arrangements to make it more stable and reliable.

Table 4.1

Timeline for implementing NCCIMS

Date	Element
September 2010	NCCIMS Project Control Group was established to oversee the development of the new system.
October 2010	At its first meeting in October 2010, the Group considered: a draft system specification document identifying requirements; a draft business case recommending the means to achieve the required outcomes; and a project plan for its implementation.
September 2011	The above documents were finalised—11 months later and when the new Scheme had commenced and NCCIMS was planned to be operational.
December 2011	Tender for NCCIMS was let.
January 2012	Tender responses due.
Mid-March 2012	Evaluation of the eight responses to the Request for Tender was completed.
April 2012	Approval to commence negotiation with the successful tenderer required sign-off by DoHA's Chief Information and Knowledge Officer.
May 2012	Delay in negotiating with preferred tenderer, as the Chief Information and Knowledge Officer requested that the successful tender be compared with a case management system in which DoHA already has significant investment.
June 2012	Recommencement of negotiations with the preferred tenderer, and execution of the contract.
December 2013	Scheduled completion of the project.

Source: ANAO analysis.

4.13 Scheduled implementation of NCCIMS in December 2013[126] is over five months after Phase 3 is due for completion. DoHA advised that the key reason for the delays in delivering NCCIMS was the concurrent resource requirements for the development and implementation of legislation, policy, procedures, training and stakeholder engagement associated with the new Scheme from 1 September 2011.

4.14 The delay in implementing NCCIMS has impacted on the processes and practices that DoHA can employ to complete Phase 3 on schedule by 30 June 2013, as the current IMS system is significantly limited in its ability to analyse and assess the performance of the complaints scheme and trends in complaints—which are critical for progressing Phase 3. The timeframe for the

[126] This was the scheduled implementation date according to the NCCIMS project schedule.

implementation of NCCIMS will also affect processes and practices required to complete Phase 4, as leading good practice in complaints management is dependent on the information collection and analytical capacity developed in Phase 3.

4.15 As a result of delays in implementing NCCIMS, and ongoing IT system limitations, DoHA has assigned a small team that will use extensive manual processes to extract and interrogate data to identify systemic trends in complaints. One of the team's main challenges will be to ensure the integrity of the data used given the limitations of the data held in IMS.

Prepayment of NCCIMS licence fees

4.16 A further issue in the implementation of NCCIMS involved the prepayment of licence fees.

4.17 The preferred NCCIMS tenderer's proposed system requires system licences that include an initial fee and annual ongoing licence fees. DoHA sought a discount for providing an advance payment of the second and third years' licence fees during the negotiation phase. The supplier offered a total discount of two per cent over the licence fees for three years, which was substantially less than the Reserve Bank of Australia's annual cash rate target at the time of 3.5 per cent.[127] DoHA advised the supplier on 22 June 2012 that it would not be prepaying the annual licence fees, which was consistent with the Chief Information and Knowledge Officer's advice to the Office of Aged Care Quality and Compliance in early May 2012. Nevertheless, the contract offered to, and signed by, the supplier five days later (on 27 June 2012) included payment of $1.26 million (GST exclusive) for the initial licence fees and annual fees over three years before 30 June 2012, without any discount for the pre-paid items.[128] The prepayment imposed a cost to the Commonwealth in terms of interest foregone.

[127] Reserve Bank of Australia, *Cash rate target* (effective from 6 June 2012). Available from <http://www.rba.gov.au/statistics/cash-rate.html> [accessed 19 July 2012]. According to the Department of Finance and Deregulation's Finance Circular 2004/14, *Discounts for prepayment and early payment*, agencies should calculate the cost of the interest forgone in accepting prepayment using the Reserve Bank of Australia cash rate target. The circular is available at <http://www.finance.gov.au/publications/finance-circulars/2004/docs/FC_2004-14.pdf>

[128] The supplier invoiced DoHA for the initial fees and full licence fees over three years on 28 June 2012, which were paid from 2011–12 departmental funds in early July 2012 on an accrual basis.

4.18 The FMA Regulation 9 approval, signed on 18 April 2012, did not take into account the financial implications of prepayment.[129]

4.19 The prepayment limited the department's ability to manage the contract risks associated with delivery of required outcomes. The prepayment also weakens DoHA's position should it wish to exercise the contract options allowing it to terminate the contract after 12 or 24 months.[130]

Scheme monitoring and reporting

4.20 Monitoring and reporting is fundamental to assessing the fairness, responsiveness and timeliness of the Scheme, and to achieving good practice in residential aged care in Australia. The Commonwealth Ombudsman's Better Practice Guide to Complaint Handling states that:

> '(r)esolving a person's grievance is not the last step in effective complaint handling. The person's complaint might point to a systemic administrative problem in the agency ... It is therefore important that complaint issues and trends are reported to and analysed by the executive and senior managers in an agency'.[131]

4.21 The value of this better practice was noted by DoHA in the *Draft Scheme Reform Project Plan* in September 2011, which commits the department to 'the establishment of outward-focused initiatives which utilise the Scheme's data to provide information to the sector on trends and emerging issues; and to report publicly on the Scheme's work as part of effective governance.' The ANAO assessed the Scheme's monitoring and reporting arrangements and DoHA's analysis of complaints to support systemic improvement within the Scheme and in residential aged care. The development of performance measures within the monitoring and reporting framework provides the basis for DoHA's implementation of Phases 3 and 4 of the Scheme.

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[129] Prepayment issues were also considered in ANAO Audit Report No.45 2011–12, *Administration of the Health and Hospitals Fund: Department of Health and Ageing*, p. 27. Available from: <http://www.anao.gov.au/~/media/Uploads/Audit%20Reports/2011%2012/201112%20Audit%20Report%2045/201112%20Audit%20Report%20No%2045.pdf> [accessed 26 July 2012]. In that report, the ANAO recommended that to enable decision-makers to form a considered view on the proper use of Commonwealth resources, DoHA should provide advice to: a) the Health Minister on the risks, if any, and opportunity costs of making payments to funding recipients in advance of need; and b) the FMA Regulation 9 approver on government decisions, if any, relating to payments in advance of need and the implications of those decisions for spending proposals requiring consideration under FMA Regulation 9.

[130] The contract states that the initial contract period is 12 month with two further options of a year, noting that the system is not scheduled to go live until over 17 months into the contract.

[131] Commonwealth Ombudsman, *Better Practice Guide to Complaint Handling*, April 2009, p. 26.

4.22 DoHA reports on Scheme performance both internally and externally through a number of avenues, as shown in Table 4.2.

Table 4.2

Reporting on the Scheme as at July 2012

Internal reporting to the:	External reporting via the:
• Scheme directors and State and Territory Office Managers via business reports; • National Aged Care Regulatory Strategy and Policy Committee; • National Aged Care Regulatory Operations Committee; and • Minister for Mental Health and Ageing.	• DoHA Annual Report and Portfolio Budget Statements; • Report on the Operation of the *Aged Care Act 1997*; • Scheme website; and • use of other sources, including direct contact with providers.

Source: ANAO analysis.

4.23 The reports prepared by DoHA contain a variety of performance measures, which were approved by the National Aged Care Regulatory Strategy and Policy Committee (Regulatory Strategy and Policy Committee) in February 2012. Approximately half of the performance measures use Scheme data to analyse trends and emerging issues. The remainder are based on the satisfaction survey. DoHA expects these performance measures, and the related analysis and reporting, to be substantially improved with the full implementation of NCCIMS.

Internal reporting

Business reports

4.24 In July 2012, one of the main internal reporting mechanisms was the suite of business reports. The reports are produced monthly and cover aged care contacts, complaints and compulsory reports. They are provided to the Regulatory Strategy and Policy Committee, the Regulatory Operations Committee, state and territory managers, directors of the Scheme and staff they consider relevant, and the National Consistency Forum. It was agreed at the June 2012 Regulatory Strategy and Policy Committee that 'business reports should predominantly focus attention on the key areas that ... State and Territory Managers ... and Directors should pay particular attention to at both the state and national level.'[132] While important, this does not necessarily

[132] Regulatory Strategy and Policy Committee June 2012 meeting minutes.

provide the 'outward focus' referred to in the *Draft Scheme Reform Project Plan* discussed in paragraph 4.21.

4.25 Business reports have typically included a limited number of performance measures, often focusing on timeframes such as long-wait cases and the average number of days taken to finalise complaints. These reports have the potential to provide useful information to DoHA management regarding key indicators of the performance of the Scheme, although only basic analysis has generally been applied. Since February 2012 some business reports have included commentary on data and identified trends, and on jurisdictional differences in performance. Fewer reports have provided conclusions as to the possible reasons for trends.[133] In June 2012 the Agenda Paper accompanying the report provided more detailed analysis and identified some areas for future monitoring, however few conclusions were drawn.

Development of performance measures

4.26 Performance measures for the Scheme have been identified by DoHA as a tool to ensure 'nationally consistent delivery of complaints management'. Those measures to be included in Business Reports were initially drafted in January 2011, and revised during the following months to incorporate feedback from staff in STOs and Central Office. In October 2011, the Strategy and Policy Committee tasked the Operations Committee with interim monitoring of the performance measures, as it was considered too early to finalise them. Interim monitoring would enable the Scheme to set realistic targets, analyse benchmarking data and consolidate operational information.

4.27 Performance measures and targets were discussed at the Strategy and Policy Committee meeting in December 2011. Performance measures were then approved by the Regulatory Strategy and Policy Committee and the Regulatory Operations Committee in February 2012 and are due to commence in 2012–13, subject to ongoing review.[134] The measures include output and outcomes based measures of Scheme processes, and include:

[133] Examples of analysis of possible reasons for observed trends include: a decrease in the average number of days to finalise a complaint was likely due to a focus to close long-wait cases opened in 2010; decreases in site visits and external referrals were attributed to the new scheme; and a jurisdictional difference identified was the frequency of Own Motion investigations, subsequently explored at the Complaints Case Review Committee.

[134] External reporting of performance measures will also commence in 2012–13.

- customer satisfaction;
- staff retention;
- successful calls to the Scheme 1800 number;
- timeframes for confirmation letters to complainants;
- resolution of cases within 90 days;
- finalisation at the intake or assessment phase;
- in scope contacts; and
- review of decisions by the Aged Care Commissioner.

4.28 While it is too early to comment on the usefulness of the performance measures they cover a broad range of relevant indicators.[135]

National Aged Care Regulatory Strategy and Policy Committee

4.29 The Strategy and Policy Committee was established in August 2011 to provide executive level oversight of the administrative arrangements and policy matters relating to the Scheme.[136] The committee meets on a three-monthly basis and provides high-level strategies, policy and decision-making for the Scheme. It also provides direction to the Regulatory Operations Committee regarding risks, policy issues, emerging trends and continuous quality improvement. A key responsibility includes developing a national framework for managing performance and improvement in the Scheme.

4.30 The Regulatory Strategy and Policy Committee examines a selection of business reports produced in the quarter for a variety of purposes, including to identify inconsistent practices or emerging issues in the work of Scheme officers. While the committee has addressed many administrative processes, practices and outputs highlighted in these reports,[137] the minutes of Regulatory Strategy and Policy Committee meetings from February 2012 to June 2012

[135] The Customer Satisfaction Survey is discussed later in this chapter.

[136] The Strategy and Policy Committee had its responsibilities broadened in early 2012 to support the Community Care Quality Review Program and the Aged Care Funding Instrument Review Validation Program, both within the Office of Aged Care Quality and Compliance.

[137] By way of illustration, the Regulatory Strategy and Policy Committee has considered ways to finalise long-wait cases and regularly addressed problems raised in the *Top 5 Issues* monthly reports, such as in the categories of health and personal care, abuse and requests for information.

record little discussion of systemic issues, and few related action items.[138] Discussing and documenting systemic issues arising from the Committee's work would contribute to the implementation of Phases 3 and 4 of the Scheme.

National Aged Care Regulatory Operations Committee

4.31 The Regulatory Operations Committee[139] meets every two months, with a primary role of focusing on the day-to-day management and administration of the Scheme and is accountable to the Regulatory Strategy and Policy Committee. Business reports are a regular agenda item, with members noting 'the purpose of the Scheme's business report (is) to inform business improvement and progress following implementation of the Scheme reforms' and agreeing to monthly circulation 'to be used to identify operational trends, both nationally and across STO profiles'.[140] As discussed in paragraph 4.25, business reports are infrequently being used to identify and act on operational trends, nationally or at a state and territory level.

4.32 At the May 2012 Regulatory Operations Committee meeting the role of the National Consistency Forum in 'continual business improvement' was discussed, as were the Terms of Reference, which are to ensure a 'broad scope focusing on operational consistency and quality improvement, including but not limited to analysis of the business report'.[141] The Terms of Reference for the National Consistency Forum were endorsed by the Regulatory Operations Committee on 25 July 2012 and the Regulatory Strategy and Policy Committee on 6 September 2012. The National Consistency Forum will contribute to the implementation of Phases 3 and 4 through its role in quality improvement

Reporting to the Minister

4.33 Reporting to the Minister for Mental Health and Ageing on the progress of aged care complaints reforms occurred frequently throughout

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[138] Business reports were not considered at Strategy and Policy Committee meetings prior to February 2012. At the June 2012 Strategy and Policy Committee meeting, a member noted a jurisdictional variation in Notices of Intention to Issue Directions and suggested that further discussion was needed to understand the causes. The proposed action was for the Aged Care Complaints Branch to discuss the high number of issues in one jurisdiction with the relevant directors. This was the only example of analysis of trends in the June 2012 meeting.

[139] The Regulatory Operations Committee is chaired by the Assistant Secretary of the Aged Care Complaints Branch, and is attended by Scheme managers from the Central Office and STOs, as well as a secretariat.

[140] National Aged Care Regulatory Operations Committee, *Minutes 2 May 2012*.

[141] ibid., p. 3.

implementation, including on training, communications activities, risks to implementation and the progression of legislation. Ministerial approval was required for the release of several Scheme documents for industry consultation including the policy on *Preventing and Managing Unreasonable Complainant Conduct* (April 2011); the *Strategic Plan* (February 2011); and the *Performance Management Plan* (April 2011). Approval was also required for the initiation, release of and subsequent response to the Walton Review.

Summary of internal reporting

4.34 Delays in implementing NCCIMS (initially planned for September 2011 and now scheduled to be operational at the end of 2013) have delayed the development of reports drawing on Scheme data to identify trends in complaints about residential aged care. Current business reports provide data on a number of areas but these do not fully align with the resolution methods used in the Scheme and are infrequently used to identify, analyse and address issues.

External reporting

4.35 As outlined in Table 4.3, the main mechanisms for reporting externally about the operation of the Scheme, including about its impact on aged care recipients and providers, is through the DoHA annual report, the Portfolio Budget Statements, the Report on the Operation of the Aged Care Act 1997; and the DoHA website. There are also some other means of external reporting.[142]

DoHA Annual Report and Portfolio Budget Statements

4.36 The Scheme was reported in the DoHA *Annual Report 2011–2012* under Outcome 4.3, Ageing Information and Support. The report stated that the department had met five deliverables for the Scheme, including implementing the new complaints management framework.[143]

4.37 The 2012–13 Portfolio Budget Statements (PBS) for the Health and Ageing Portfolio include the Scheme in Outcome 4, Program 4.5: Workforce and Quality, as shown in Table 4.3.

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[142] The Complaints Assistance and Case Review, and Communications and Stakeholder Relations sections (within the Aged Care Complaints Branch) are examining the scope to increase reporting to providers about the Scheme, including about systemic issues that have been identified. DoHA officers reported that this work has been planned but very little had been completed by July 2012.

[143] DoHA, *Annual Report 2011–2012*, pp. 143–144.

Table 4.3

2012–13 Department of Health and Ageing PBS Quantitative and Qualitative Deliverables and KPIs

Qualitative Deliverables	2012-13 Reference Point or Target				
Increasing consumer awareness and supporting the industry in effective complaints handling through education	Update aged care complaints publications, brochures and poster targeting industry and consumers Publish online complaints resolution toolkit incorporating industry education alerts and resources				
Quantitative Deliverables					
Quantitative Deliverables	2011–12 Revised Budget	2012–13 Budget Target	2013–14 Forward Year 1	2014–15 Forward Year 2	2015–16 Forward Year 3
Percentage of complaints referred by the Scheme for investigation completed within 90 days	76%	77%	78%	79%	80%
Percentage of complaints resolved by the Scheme at intake	30%	31%	31%	32%	32%
KPIs					
Qualitative Indicator	Adequate progress is made on the development of quality indicators				
Satisfaction with the operation of the Complaints Scheme	Results of satisfaction surveys indicate that the majority of complainants and service providers responding to the survey are satisfied with the operation of the Complaints Scheme				

Source: Portfolio Budget Statements 2012–13, Health and Ageing Portfolio, pp. 140–142.

4.38 The quantitative deliverables provide measurable, specific, achievable, relevant and timed information (SMART criteria). The single KPI (satisfaction with the operation of the Scheme), while fulfilling the SMART criteria, is based on the satisfaction survey which would benefit from attention to improve the response rate. This matter is discussed further in paragraphs 4.41 to 4.45. In addition, the relevant target—that the majority of complainants and service providers responding to the survey are satisfied with the operation of the Scheme—is set at a much lower level than the target for the preceding CIS. The target could be achieved with only 51 per cent of respondents being satisfied with the operation of the Scheme, whereas the target rate of satisfaction with the effectiveness of the preceding CIS was 75 per cent, and the actual rate achieved for 2010–11 was 83 per cent. There would be merit in reviewing the target rate of satisfaction with the Scheme contained in future PBS, having regard to the previous target set for the CIS.

Report on the Operation of the *Aged Care Act 1997* (ROACA)

4.39 The ROACA is a legislated requirement of the Act (s 63.2). The report includes a chapter on the Scheme (Chapter 10)[144], while another on Regulation and Compliance[145] (Chapter 9) includes a section on Protecting Residents' Safety—which covers the compulsory reporting requirements of the Act. Chapter 10 provides data on complaints and contacts including most commonly reported issues, referrals to external agencies, external review and other Scheme specific data.

4.40 DoHA advised that it is proposing to publish a Scheme report focusing on its performance, following completion of the ROACA after October 2012. The annual publication of this report, a Walton Review recommendation[146], is partly to address the limited nature of relevant information currently contained in ROACA. DoHA is also planning to include performance measures in future editions of the ROACA.

Satisfaction surveys

4.41 Agencies that can expect to receive client complaints should regularly review and analyse their complaint handling systems to gauge the system's efficiency and effectiveness. According to the Commonwealth Ombudsman, both quantitative and qualitative measurement should be undertaken, including the degree of customer satisfaction with the processes.[147]

4.42 DoHA uses satisfaction surveys as part of performance reporting on the Scheme. As discussed in Chapter 3, from August to October 2011 benchmark research was conducted by an external market research consultant to assess awareness of and attitudes towards the Scheme, and communication and experiences with the Scheme.[148] DoHA has advised that it is preparing to repeat the research.

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144 DoHA, *2010–11 Report on the Operation of the Aged Care Act 1997*, p. 88.

145 ibid., p. 82.

146 Walton, op. cit., p. 16. DoHA has yet to determine the frequency of the proposed report.

147 Commonwealth Ombudsman, *Better Practice Guide to Complaint Handling*, April 2009, p. 28.

148 One general survey has been conducted to July 2012: Roy Morgan Research, *Research into awareness of and attitudes towards the Aged Care Complaints Scheme,* November 2011. The survey was conducted from August to October 2011, and found that 'attitudes toward the Scheme are generally positive, particularly in regards to agreement that the Scheme's main concern is the safety and wellbeing of care recipients', (p. 59).

4.43 DoHA also has processes in place to survey the satisfaction of stakeholders through a survey sent to the relevant parties after the finalisation of each complaint. Table 4.4 presents the results of the finalised surveys returned during 2011–12. It shows a high level of satisfaction across each of the questions, including 82 per cent being satisfied with the overall operation of the Scheme.

Table 4.4

Aged Care Complaints Customer Survey Responses: 2011–12

Survey Question	(8) We acted fairly and without judge-ment	(9) You were provided with adequate opportunity to have your say	(10a) We clearly explained the process	(10b) We kept you informed about the complaint's progress	(10c) Our letter clearly explained the reasons for our decision	(11) The operation of the Aged Care Complaints Scheme
Total Responses	880	880	880	880	880	880
Total satisfied	744	771	762	730	740	722
Per cent satisfied	84.5	87.6	86.6	83.0	84.1	82.0

Source: DoHA satisfaction survey data provided to ANAO.

4.44 While the identity of the respondent is not known, since July 2011 DoHA has been able to identify whether the respondent is the complainant or the service provider. While DoHA is yet to analyse this data, it has undertaken to do so in 2012–13 if a sufficient number of responses are received to make this analysis meaningful.

4.45 The response to these satisfaction surveys has been moderate, with only 34 per cent of those surveyed responding in 2011–12. To increase the level of confidence in the feedback obtained from the finalised complaint surveys, it will be necessary for DoHA to take steps to increase the response rate. Including complainants referred to early resolution and mediation in the aged care complaints satisfaction surveys would provide DoHA with additional data regarding the success of these approaches.

Recommendation No.2

4.46 To increase the level of confidence in feedback obtained from surveys of customer satisfaction with aged care complaints processes, the ANAO recommends that the Department of Health and Ageing considers opportunities to increase survey responses.

DoHA response

4.47 Agreed.

Ian McPhee
Auditor-General

Canberra ACT
13 November 2012

Appendices

Appendix 1: Agency Response

Australian Government
Department of Health and Ageing

ACTING SECRETARY

File Ref: 2011/036035

Dr Tom Ioannou TI 29/10
Group Executive Director
Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

Dear Dr Ioannou Tom

PERFORMANCE AUDIT: MANAGING AGED CARE COMPLAINTS

I refer to your letter of 9 October 2012 and the enclosed proposed report on *Managing Aged Care Complaints*.

I note the report and the suggestions for improvements to the Aged Care Complaints Scheme (the Scheme). I am pleased to advise that work continues on the implementation of Phases 3 and 4 of the Scheme's Strategic Plan and the suggested improvements will be considered in this context.

The Department's formal comments on the audit report and recommendations are as follows:

> *The Department of Health and Ageing notes the audit report and agrees with the recommendations.*

If you have any further questions about the Department's response, please contact Colin Cronin, Assistant Secretary, Audit and Fraud Control Branch on (02) 6289 7877.

Yours sincerely

Kerry Flanagan

Kerry Flanagan
A/g Secretary
23 October 2012

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