ACT Auditor-General's Office

Performance Audit Report

The Aged Care Assessment Program

and

The Home and Community Care Program

November 2007

ACT AUDITOR-GENERAL'S OFFICE

PA07/01

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Mr Speaker

I am pleased to forward to you a Performance Audit Report titled 'The Aged Care Assessment Program and the Home and Community Care Program' for presentation to, and subsequent tabling in, the Legislative Assembly pursuant to Section 17(5) of the *Auditor-General Act 1996*.

Yours sincerely

Tu Pham
Auditor-General
29 November 2007

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GLOSSARY

ACAP	Aged Care Assessment Program
ACALU	Aged Care Assessment and Liaison Unit – ACT Health
ACAT	Aged Care Assessment Team
ACCR	Aged Care Client Record (a standard federal DoHA and Medicare Aged Care Client Record – completed by the ACAT)
ACE	The Assessment and Care Evaluation System, used by ACATs
ACRS	Aged Care Rehabilitation Services – ACT Health
AHMAC	COAG's Australian Health Ministers' Advisory Council.
Amending Agreement	An agreement between the Commonwealth and the ACT on the provision of HACC services in the ACT. This agreement was superseded by the *Review Agreement* from 1 July 2007.
ANAO	Australian National Audit Office
CACP	Community Aged Care Package Program
CHI	Community Health Intake – ACT Health
CMD	ACT Chief Minister's Department
COAG	Council of Australian Governments
DoHA	Commonwealth Department of Health and Ageing
EACH	Extended Aged Care at Home Program
EACH-D	Extended Aged Care at Home – Dementia Program
GSO	ACT Government Solicitor's Office
HACC	Home and Community Care Program
MHLO	Multicultural HACC Liaison Officer
MDS	Minimum Data Set – a statistical collection on aged care program delivery maintained by DoHA. Separate data collections are maintained for ACAT and for HACC.
NGO	Non-Government Organisation
RACF	Residential Aged Care Facility
Residential Care (high level)	High level aged care provided in dedicated facilities, formerly known as nursing homes.
Residential Care (low level)	Low level aged care provided in dedicated facilities, formerly known as aged care hostels.
Review Agreement	An agreement between the Commonwealth and the ACT for the provision of HACC services in the ACT, current from 1 July 2007.
Transitional care	The Transitional Therapy and Care Programme (TTCP) is a community-based program for older adults, providing up to 12 weeks' support and therapy at the end of a hospital stay.

1. REPORT SUMMARY AND AUDIT OPINION

INTRODUCTION

1.1 This report presents the results of a performance audit of the delivery to ACT residents of the Aged Care Assistance Program (ACAP) through the Aged Care Assessment Team (ACAT); and the Home and Community Care (HACC) Program.

BACKGROUND

1.2 The ageing of the population continues to pose challenges for all Governments and their agencies to deliver services to meet the needs of aged people. Over the next 40 years, Australia's population will grow in number and become older. The fastest rate of growth will be in the numbers of people aged 65 and over. Twenty five per cent of the population is projected to be aged 65 and over by 2047.

1.3 In 2006, there were 47 000 people aged 60 years and over in the ACT - 14 per cent of the population. By 2031 there will be 106 000, representing 27 per cent of the population.

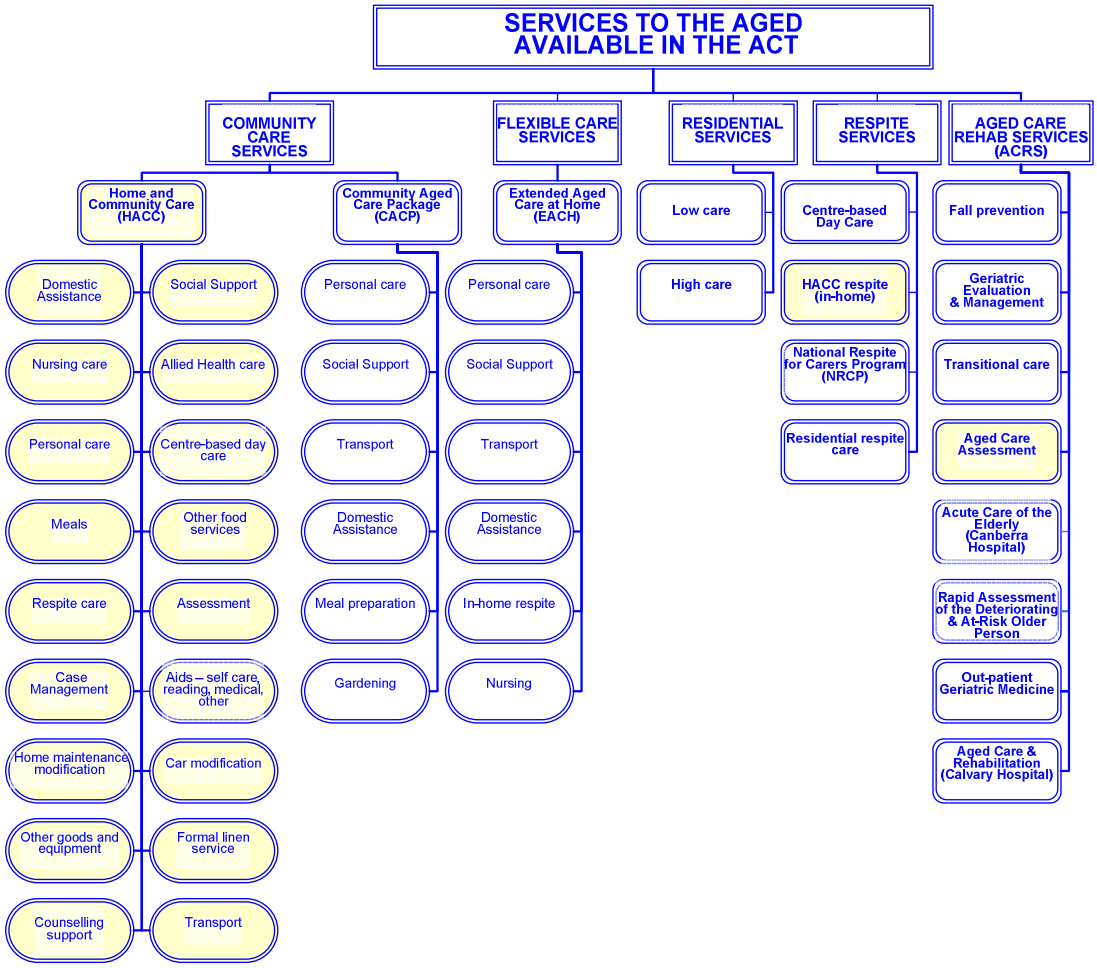
1.4 With increasing life expectancy, the projected shift to an older average age in the population will change the health profile of the population, and bring about changes in health priorities. The number of people with age-related conditions such as injuries from falls, dementia, diseases of the circulatory system and cancer, will increase. In common with all Australian residents, ACT residents aged over 65 years are more likely than younger adult residents to have a disability or poor health status.

1.5 In the ACT, ACT Health is the key ACT agency responsible for the delivery of aged care services, through a number of programs funded by the Commonwealth and by the ACT Government. Figure 1.1 on the following page shows the wide range of services delivered to aged persons in the ACT provided through the Commonwealth and ACT Governments, including the ACAT and HACC services, which are the subject of this audit.

1.6 The ACT and Commonwealth governments make a substantial investment in services to the aged. In 2006-07, actual ACT and Commonwealth funding provided to the Aged Care and Rehabilitation Services Unit in ACT Health for all aged persons programs was $47.255 million. Budgeted funding is projected to be $49.622m in 2007-08. The Commonwealth provided funding of $51.561 million during 2005-06 (the latest figures) for residential aged care provision in the ACT.

1.7 Total funding provided by the Commonwealth and ACT Governments in 2006-07 for ACAT was $1.3 million and for HACC was $22.5 million. ACT service providers supplemented the HACC funding with a further $2.2 million (in 2005-06), representing fees collected from clients.

Figure 1.1: Provision of aged services in the ACT[1]



Source: ACT Auditor-General's Office

[1] Figure 1.1 shows the range of services available to the aged provided through the Commonwealth and ACT Governments. Information on programs and services available for older persons is contained in a number of publications, including the ACT Government's *A Society for all Ages: the ACT Government Policy Framework* for Ageing: 2007-2009, published in July 2007.

AUDIT OBJECTIVE AND SCOPE

1.8 The objective of this Audit was to provide independent opinions to the Legislative Assembly on the efficiency, effectiveness, and accountability of ACT Health in assessing the needs of aged persons through ACAT, and delivering the HACC program.

1.9 These two programs were established by the Commonwealth, and are run in partnership with ACT Health, which also provides funding for them. The ACT ACAT is operated by ACT Health, while the HACC program is delivered mainly through community-based service providers with some direct service provision by ACT Health.

1.10 The audit assessed ACT Health's performance in:

- assessing the needs of aged people in the Territory through ACAT;
- managing the delivery of HACC services; and
- monitoring, evaluating and reporting on its administration of the ACAT and HACC programs.

1.11 The audit did not review the operation of the non-government organisations (NGOs), other external service providers and their contractors, nor the individual services provided by them under funding agreements with ACT Health.

AUDIT OPINIONS

1.12 The audit opinions drawn against the audit objectives are set out below.

Aged Care Assessments

- Overall, the ACT Aged Care Assessment Team has delivered appropriate assessment and referring services to meet the needs of frail older people.
- There are opportunities for ACT Health to improve the efficiency of the Aged Care Assessment Team's services through:
  - developing policies and guidelines specific to the ACT to provide operational guidance for staff;
  - improving its assessment procedures and documentation, to increase consistency in the application of assessment tools and improve documentation to support assessment decisions; and
  - providing better information to the community, GPs and residential facilities.
- ACT Health can improve the public accountability of the ACT Aged Care Assessment Team by reporting annually in the Annual Report of ACT Health against the key performance indicators and providing data that would facilitate comparison of ACT performance to national and State and Territory performance.

Home and Community Care

- The ACT Home and Community Care program delivers community services to support people to remain at home by providing domestic assistance, personal care, community transport, and activities to reduce social isolation.
- There is scope for ACT Health to improve the delivery of Home and Community Care program services to ACT residents through better assessment of unmet need, and monitoring of HACC service providers. In particular, ACT Health should:
  - consolidate data on unmet need;
  - implement long term planning;
  - develop and implement formal written procedures for the key aspects of the agreement acquittal; and
  - enhance the service funding agreement regarding the treatment of unspent funds and the disposal of assets.
- Improvement in funding acquittal procedures and practices would reduce the current risk to ACT Health of failing to identify, document and address instances where service providers did not deliver the level or quality of services required under the funding agreement.

KEY FINDINGS

1.13 The audit opinions are supported by the following key findings.

Aged Care Assessment

Planning and Coordination

- Under the Commonwealth Aged Care Assessment Program, the ACT Aged Care Assessment Team is responsible for assessments of the needs of frail older people and facilitation of their access to appropriate care services.
- The ACT Health's Aged Care and Rehabilitation Services 2006-07 *Business Plan*, which included the Aged Care Assessment Team, was not sufficiently specific to assist the Aged Care Assessment Team's operation. The Plan did not include key information such as goals for the financial year, key priorities and tasks, or performance targets and indicators.
- The ACT Aged Care Assessment Team staff were skilled and experienced, but would further benefit from access to a wider range of skills than those currently available within the team. ACT Health had not assessed the training needs of current and prospective ACT Aged Care Assessment Team staff. Skills development can be improved by implementation of a targeted learning and development program and recruitment planning.

From referral to assessment of the client

- ACT Health did not have in place standards of services and communication protocols for the Community Health Intake, which provides a single point of

referral to the ACT Aged Care Assessment Team. This has reduced the effectiveness of the Community Health Intake as an integral part of the aged care system within ACT Health.

- The ACT Aged Care Assessment Team's performance in assessing clients was mixed, as measured by the Commonwealth Department of Health and Ageing's data collection, the Minimum Data Set. In 2005-06:
  - the ACT performed well in seeing 87 per cent of Priority 1 clients, and 89 per cent of Priority 2 clients, 'on time', compared to the national average of 84 per cent and 84 per cent respectively; and
  - the ACT took 44.3 days on average from referral to have a face-to-face contact for all Aged Care Assessment Team clients, compared to the national average of 19.3 days. The delay in assessments was occurring mainly for Priority 3 clients, most of whom were assessed in the community, rather than in hospital.
- The ACT Aged Care Assessment Team gave priority to assessing hospital patients who could move to residential facilities, thus assisting hospitals in reallocating acute care beds. This approach, however, could be at the expense of clients outside the hospital system, in residential facilities and in the general community, who may have the same or higher needs for services.
- About 9 per cent of the cases Audit examined were withdrawn when the Aged Care Assessment Team determined that the client was ineligible for, or did not yet need, an assessment. The number of withdrawals, while small, diverted resources that could be allocated to eligible and needier clients and reduce the waiting time. These referrals may have been avoided or minimised if more complete information was available about the Aged Care Assessment Team to clients and service providers.
- At the time of the audit, the ACT Aged Care Assessment Team had not completed development of policies and guidelines specific to the ACT, and instead used the Commonwealth's general guidelines as operational guidance for staff.
- The assessment tools and forms used by the ACT Aged Care Assessment Team to support assessment decisions were used in only 60 per cent of assessments and were inconsistently applied. They also required review to ensure their general relevance, and to remove duplicated questions.
- Delegates of the Secretary of the Commonwealth Department of Health and Ageing within the ACT Aged Care Assessment Team often did not review the assessment documentation prior to approving the recommendation, increasing the risk of inconsistent or poor quality assessments. Enhancements to systems, such as the introduction of assessment software, should improve the quality of the Aged Care Assessment Team's assessment documentation.
- Overall, the assessments conducted by the ACT Aged Care Assessment Team properly focused on the needs of clients. Staff were responsive to the needs and attitudes of clients and their carers.

Performance information

- Reports based on Minimum Data Set data from the ACT may not be as reliable as those from the other jurisdictions, due to persistent data entry and extraction problems in information input by the ACT Aged Care Assessment Team to DoHA's data collection, the Minimum Data Set. Several significant initiatives undertaken by the ACT Aged Care Assessment Team, including the recent introduction of a new assessment database system, should improve data collection and management.
- The ACT Aged Care Assessment Team did not effectively measure client and carer satisfaction in the delivery of its services. Although the Aged Care Assessment Team was part of ACT Health's generic annual satisfaction survey, the team did not use the results of this survey in reviews of its performance. Redesigning the generic survey to incorporate the range of Aged Care Assessment Team service users will provide the Aged Care Assessment Team with more relevant data to gauge users' satisfaction with its services and identify improvement opportunities.

Admission to residential aged care facilities

- Although Commonwealth guidelines and other relevant documents included a role for the Aged Care Assessment Teams in care coordination, the ACT Aged Care Assessment Team assessors were not involved in planning for the care of clients after assessment. Moreover, the team did not have procedures to ensure the client's assessed care needs were met.
- A Residential Liaison Nurse is co-located with the ACT Aged Care Assessment Team and, if requested, assists clients and families in accessing residential care. The Liaison Nurse's role did not extend to assisting clients into community-based programs.
- ACT Health did not maintain a consolidated waiting list for residential aged care facilities in the ACT, and hence was not fully aware of the unmet and future demand for planning purposes. The list of priority clients for residential aged care maintained by the Residential Liaison Nurse did not include the clients on waiting lists maintained by the residential facilities.

Other issues

- The ACT was well allocated with residential aged care places by the Commonwealth. However, the ACT was slow at converting the allocated places to operational beds, compared to other jurisdictions – only 72 per cent of the ACT's allocated residential places were operational at 30 June 2006, whereas all other jurisdictions achieved 84 per cent or better. The responsibility for this issue lies with the private sector and ACT Government agencies other than ACT Health.
- The ACT was performing above the national average at making allocated community care places available.

Home and Community Care

Planning for service delivery

- The ACT Home and Community Care program delivers community services to support people to remain at home by providing domestic assistance, personal care, community transport, and activities to reduce social isolation.
- ACT Health has an effective annual Home and Community Care program plan, the preparation of which included extensive consultation with service providers and other stakeholders. Since 1999, the Commonwealth intended for each jurisdiction to produce a triennial plan for the delivery of HACC services. The Commonwealth did not act on this intention, and consequently no State or Territory produced a triennial plan. The current intention is for the first triennial plan to be in place by early 2008.
- ACT Health maintained effective oversight of the submission of Home and Community Care program data to the Commonwealth's data collection program.

Access to Home and Community Care program services

- ACT Health did not collect data on the numbers of potential clients who make enquiries of service providers about Home and Community Care program services. Without a central intake point for Home and Community Care program clients, ACT Health was unable to measure with reliability the extent of unmet needs for services, and instead relied on ad hoc and optional reports from service providers to make estimates of unmet demand.
- The NGO service providers assessed clients for eligibility. There was no evidence that clients were accessing more services than they should reasonably expect to receive.
- ACT Health has established a position of Multicultural Home and Community Care program Liaison Officer, but the Liaison Officer's role and accountability and working arrangements are not well defined or structured.
- Similar to other jurisdictions, people from culturally and linguistically diverse backgrounds in the ACT do not access HACC services in numbers proportionate to their representation in the HACC target population. This tends to support views expressed by some stakeholders that this group still experiences some barriers to services.
- Currently, an individual client seeking to access several HACC services may be required to undergo assessments from each of the service providers, creating inconvenience and uncertainty for the client, and increasing the administrative burden on the service providers. A well coordinated access program, which for example encourages the central collection and one-off assessment of client needs, would improve this situation. The ACT is working to implement a COAG initiative on this issue.
- COAG, through *The Way Forward* initiatives, had set a goal of improving access to Home and Community Care program services. ACT Health had completed the first stage of the initiative, which involved mapping community care provision and supporting infrastructure. This process identified strengths including the

presence in the ACT of the Community Health Intake as a central contact point, but also weaknesses including inconsistent assessment processes.

Service delivery

- ACT Health had not formalised a policy on the management of fees that service providers may charge Home and Community Care program clients for some services, as required under the Home and Community Care program *Review Agreement,* which became effective from 1 July 2007. ACT Health intends to adopt a proposed national fees policy, due to be promulgated by July 2008.
- Service providers collected $2.2 million in fees from Home and Community Care program clients during 2005-06. Audit found no evidence that ACT Health had reviewed the financial returns of ACT service providers, to determine whether providers put the fee revenue back to the services from which they were derived, as required under the Home and Community Care program funding agreement.
- Some service providers engage contractors (known as 'brokers') to deliver Home and Community Care program services. However, they did not always use a written agreement that requires brokers' compliance with Home and Community Care program standards. ACT Health should encourage and assist service providers to minimise the risk that brokers are not meeting service delivery standards by providing a 'template agreement' for use in engaging brokers.

Quality assurance of services

- An independent agency evaluated the performance of service providers every three years. ACT Health relied on this process for quality assurance purposes, and did not routinely collect information to ensure compliance with Home and Community Care program service standards. Standards relating to such items as police checks, waiting lists, complaints and the protection of client details were not tested by ACT Health, nor were service providers asked to report on these, even annually.
- ACT Health did not have any written funding acquittal procedures that facilitated their review of reports required by the Home and Community Care program funding agreements, and follow-up (as necessary) of any outstanding or unsatisfactory matters.
- The processes adopted by ACT Health to review the financial reporting by service providers were not sufficiently robust to identify and follow-up inadequate or incomplete reporting, unexplained variances of expenditure against the approved budget or significant sums of unspent funds at the end of the reporting period.
- Funding agreements between ACT Health and service providers are silent on the treatment of unspent funds at the end of the reporting period and on the disbursement of any proceeds from the disposal of assets (e.g. motor vehicles, computer equipment) purchased with Home and Community Care program funds during the life of the funding agreement.
- ACT Health had not conducted joint Annual Reviews (between ACT Health and service providers) to consider performance in service delivery for at least 12 months preceding audit fieldwork. There is a risk, therefore, that ACT Health

may not be identifying and treating any instances where service providers have failed to deliver the level or quality of services for which they have been funded.

RECOMMENDATIONS AND RESPONSES TO THE REPORT

1.14 Audit made 19 recommendations to address the audit findings detailed in this report.

1.15 In accordance with section 18 of the *Auditor-General Act 1996*, a final draft of this report was provided to the Chief Executive of ACT Health for consideration and comment. The Chief Executive's overall response is set out in the following paragraphs:

> *Thank you for the opportunity to respond to the Performance Audit Report, Services to the Aged: Aged Care Assessment Program & Home and Community Care Program.*
>
> *The Audit reported that the Aged Care Assessment Team is delivering appropriate assessment and referral services that are responsive to the needs and attitudes of clients and carers within the Canberra Community, while noting that there are some opportunities to further improve the program.*
>
> *As noted in your report, the Home and Community Care program is a joint Commonwealth, State and Territory program providing community care services to eligible persons. This is an extensive program and requires effective partnerships with the Commonwealth and with a wide range of community service providers funded to deliver the program. This program is subject to the highest level of scrutiny by the Australian Government through the Annual Plan and Business Report.*
>
> *… the Audit findings in Chapter 3 report positive findings in relation to explaining the role and function of HACC services to clients, referral services and access to services through service providers. Client eligibility is clearly defined and there is no evidence of clients being over serviced.*
>
> *… ACT Health reviews both output and financial reports on a six monthly basis. While the procedures are not formally documented, there are strong work practices in place for the review of all reports including the 'Service Funding Management and Risk Assessment' checklist.*

1.16 Relevant sections of the report have been provided to the Chief Minister's Department, the ACT Planning and Land Authority and the ACT Land Development Agency (LDA). The LDA commented that:

> *The Land Development Agency (LDA) notes the Audit Office conclusion that 'the current development proposals and the construction now underway should address to a large extent the current ACT needs for residential (aged) care'. The LDA also notes that a number of other applications for purchase of land for residential aged care purposes are under consideration. This indicates that, over time, further bed capacity will become available to address future needs.*

1.17 The Chief Executive of ACT Health also provided responses to each recommendation, as shown below.

Recommendation 1 (Chapter 2)

ACT Health finalise internal procedures and guidelines for the operation of the ACT Aged Care Assessment Team, consistent with the Commonwealth's guidelines and legislation.

ACT Health Response:

Agreed

The operation of the ACT ACAT is currently being reviewed against the Commonwealth guidelines and legislation. An action plan is being developed from that review, and will be supported by the implementation of policies and protocols for the service.

Recommendation 2 (Chapter 2)

ACT Health finalise the 2007-08 Business Plan for Aged Care Rehabilitation Services, including the ACT Aged Care Assessment Team, which should include:

- a timetable or plan to guide the implementation of better practices observed in other jurisdictions;
- the identification of the outputs of the Aged Care Rehabilitation Services, and which units were responsible for them;
- the identification of client groups, and services available to them;
- the identification of stakeholders and their interest in the Aged Care Rehabilitation Service;
- applicable legislation and policy;
- resources – financial and human;
- goals for the financial year;
- key priorities and tasks;
- performance targets and indicators, including those in the *Operational Guidelines*; and
- risk analysis and management.

ACT Health Response:

Agreed

It is noted that the ACRS 2007-08 Business Plan is now finalised, with the ACAT plan currently being developed with the recommendations included. Similarly, risks within the Aged Care & Rehabilitation Service have been comprehensively documented, with associated risk mitigation plans developed.

Whilst outputs expected of the Aged Care Assessment Team are articulated throughout the ACT Government budget papers and the service regularly reports against these, it is accepted that these should also be expressed within the ACAT business plan.

Recommendation 3 (Chapter 2)

ACT Health:

- conduct a training needs assessment for the Aged Care Assessment Team (ACAT) and, as necessary, introduce a targeted learning and development program to both meet the needs of ACAT members, and to assure the availability of skilled staff for ACAT in the future; and
- consider recruiting a diverse range of health professionals to broaden the skill base upon which the ACAT may draw in servicing clients.

ACT Health Response:

Agreed and partly actioned

The Commonwealth has partly funded and provided specific education for an education officer (0.1 FTE) who has implemented a training calendar for the ACT ACAT team. An ACAP training package covering all staff from Administration, Assessors to Manager is awaiting finalisation by the Commonwealth. The ACT ACAT team participated in the trial of this package in October 2007. Commonwealth implementation of this package to all ACAT teams nationally is expected early 2008.

Current recruitment of health professionals is generic and seeks to fit 'the right person' to the job, rather than be profession-specific, hence the ACT ACAT positions are multi-classified. The ACT team comprises a geriatrician, allied health professionals and nurses. A comparison with best-practice staffing of Aged Care Assessment Teams in other jurisdictions will be undertaken to benchmark.

Recommendation 4 (Chapter 2)

The Aged Care Assessment Team (ACAT) establish performance standards and regular reviews with Community Health Intake in referring clients to ACAT.

ACT Health Response:

Agreed

Revised business rules guiding intake criteria have been provided to Community Health Intake (CHI). Regular meetings have been established between the ACAT Manager and the senior staff of CHI.

Recommendation 5 (Chapter 2)

The Aged Care Assessment Team ensure that clients of the same care needs, particularly those in category 1, have the same priority for assessment, whether they are community or hospital-based at the time of assessment.

ACT Health Response:

Agreed and already in place

A performance target of 2 working days from referral to assessment has been implemented for all Priority 1 patients, whether community or hospital-based. Performance against this target is being monitored and reported against on a monthly basis to ACT Health, as well as to the Commonwealth on a quarterly basis. A team leader role has been established to identify and make appointments for referrals to ensure Priority 1 patients are seen within the 2-day timeframe.

Recommendation 6 (Chapter 2)

ACT Health:

- review and improve the Aged Care Assessment Team's (ACAT's) clinical assessment tools as well as the supporting documentation, and reinforce their use by ACAT members through formal guidelines and an internal checklist; and
- review the exercise of delegations under the ACAT, to ensure that approvals of assessments are supported by documented evidence and proper review.

ACT Health Response:

Agreed

The ACT ACAT visited Victoria to review best practice procedures including assessment tools. Validated tools are now used by the team with a checklist at time of assessment. Formal guidelines are being developed.

Policies and procedures developed for the ACT ACAT will also define the functions of the delegates with a checklist to ensure proper review undertaken. At a Commonwealth level delegation training and updating of operational processes is planned for 2008.

Recommendation 7 (Chapter 2)

The ACT Aged Care Assessment Team report annually in the Annual Report of ACT Health against the key performance indicators used by the Commonwealth in compiling the Minimum Data Set, and include data that will enable comparison of ACT performance to national and State and Territory performance.

ACT Health Response:

Agreed

The ACT ACAT's performance against Commonwealth performance indicators and a comparison against other jurisdictions will be included in ACT Health's Annual Report 2007-08.

Recommendation 8 (Chapter 2)

ACT Health redesign the Aged Care Assessment Team (ACAT) client satisfaction questionnaire to incorporate the range of ACAT service users (assessed clients, care recipients, their carers and families, referrers and service providers) to gauge their satisfaction with the ACAT's service and identify improvement opportunities.

ACT Health Response:

Agreed

Aged Care & Rehabilitation Services have developed and implemented a comprehensive patient / client / carer satisfaction tool that will be utilised by individual services for their own client groups. This will be applied by ACT ACAT.

ACAT will also develop a referrer satisfaction survey.

Opportunities for improvement identified from those surveys will be incorporated into the ACAT Quality Improvement Plan.

Recommendation 9 (Chapter 2)

ACT Health inform residential aged care providers, medical practitioners and the community of the role and capacity of Aged Care Assessment Team to assess and refer clients.

ACT Health Response:

Agreed and already in place

It is noted that this already occurs, but would be enhanced by a greater focus on this activity.

Recommendation 10 (Chapter 2)

ACT Health seek the co-operation of Residential Aged Care Facilities to establish a consolidated record of the total number of persons waiting for residential care in the ACT, including those on the separate waiting list of Residential Aged Care Facilities, and use it for planning services to address unmet need for residential facilities in the ACT.

ACT Health Response:

Agreed

ACT Health does not have the capacity to mandate Residential Aged Care Facilities to contribute information to a consolidated waiting list. At the time of report, some Residential Aged Care Facilities voluntarily participate in a consolidated waiting list, and ACT Health will continue to strongly encourage participation by facilities.

Recommendation 11 (Chapter 2)

ACT Health expand the role of the Liaison Nurse to include liaison with clients who are receiving community aid packages such as the Extended Aged Care at Home and Community Aged Care Package, and their service providers.

ACT Health Response:

Agreed in principle

ACT Health will consider expanding the role of the Liaison Nurse to include patients wishing to receive either CACP or EACH packages.

Clients with existing CACP or EACH packages have an identified case manager and care coordinator, and use of the RACLN for this would be a duplication of services.

It must be recognised that the first priority for this resource is for clients requiring residential aged care.

Recommendation 12 (Chapter 2)

- The Aged Care Assessment Team (ACAT) co-ordinate with service providers to plan client care, based on the Team's assessment of the type and extent of care required; and
- The ACAT seek input from service providers to improve the quality of documentation given to them, in particular the assessment and summary documentation.

ACT Health Response:

Agreed

ACAT will be expanding partnerships with service providers to ensure that care-planning is effective and that there are no gaps in continuity for care provided to patients.

The new ACE program provides capacity to send a summary document to service providers with detailed information on client assessment and summary of client needs.

Recommendation 13 (Chapter 3)

ACT Health clarify the role of the Multicultural Home and Community Care program Liaison Officer and establish an appropriate accountability framework for the position, including development of an annual work plan and regular structured reporting against the plan.

ACT Health Response:

Agreed

The Multicultural HACC Liaison Officer currently has an annual performance plan and clear reporting accountabilities within the Aged Care & Rehabilitation Service.

ACT Health will review the role of the Multicultural HACC Liaison Officer and will consider any recommended changes to the accountability framework for this position.

Recommendation 14 (Chapter 3)

ACT Health:

- develop an ACT fees policy consistent with the requirements of the Home and Community Care program *Review Agreement* and the emerging national policy;
- analyse the financial returns of all ACT service providers and determine the extent to which providers return the fee revenue back to the services from which they were derived, and
- take appropriate actions to recoup the money/or an equivalent quantity of services in cases where fees have been used for purposes other than as specified in the service funding agreement.

ACT Health Response:

Agreed

ACT Health has already agreed with the Australian Government to implement a fees policy that is consistent with the national fees framework currently being developed by the Australian Government.

Service providers provide financial returns every six months. The Chief Executive of each funded organisation signs a declaration on each report that states, 'The fees collected were utilised to enhance or provide additional outputs for the service under which fees are collected'. The annual audited financial statements show expenditure against the combined income of funds provided by Government and fees.

Analysis of the financial returns is undertaken by ACT Health and will be clearly documented and appropriate actions taken if necessary. While the audit perceived that there was a risk that organisations may have used fees for other purposes, there is no evidence that this has occurred.

Recommendation 15 (Chapter 3)

ACT Health prepare a 'template agreement' for use by service providers when engaging Home and Community Care contractors/brokers, which should include the need to comply with various conditions under the service funding agreements between ACT Health and service providers.

ACT Health Response:

Agreed

ACT Health will request that the ACT Government Solicitor prepare a template agreement that may be used by non-government organisations when they broker client services.

Recommendation 16 (Chapter 3)

ACT Health collect and analyse selected data from service providers, to assess whether service provision is meeting Home and Community Care (HACC) program objectives. This information should then be used to assist the planning of service provision by the ACT HACC program.

ACT Health Response:

Agreed

ACT Health relies extensively on client level data from the minimum data set and written reports from service providers on unmet demand in planning for service delivery expansion.

An analysis of this data was presented to the ACT HACC Sector Day on 3 April 2007. This review provided feedback to the sector on the levels of service delivery in the ACT compared to the national benchmarks.

Client satisfaction will again be independently assessed through the external assessment of all HACC funded organisations against the HACC National Service Standards.

Recommendation 17 (Chapter 3)

ACT Health develop and implement procedures (including a checklist) for the acquittal of funding to Home and Community Care (HACC) program service providers. These procedures should:

- cover key aspects of the agreement acquittal such as output and funding reports, compliance with funding conditions and results of Annual Review meetings;
- require the scrutiny of financial returns and accompanying audit certificates to ensure service providers and their auditors have complied with the specific requirements of the HACC program funding agreement; and
- require appropriate remedial action be taken in the case of non-compliance.

ACT Health Response:

Agreed and in progress

ACT Health has strong practices in place for the review of all output and funding reports.

Formal procedures will be documented to address this recommendation.

ACT Health has developed a checklist as a component of the funding plan 2007-2010. This 'Service Funding Management and Risk Assessment' tool became effective on 1 July 2007.

In the rare occasion of non-compliance, organisations will be requested to explain any reason for non-compliance.

Recommendation 18 (Chapter 3)

ACT Health ensure the funding agreements with service providers contain provisions regarding:

- the treatment of unspent funds and fees collected ; and
- the disposal of assets acquired with Home and Community Care program funds during the life of the funding agreement, including the disbursement of any proceeds realised from the disposal of such assets.

ACT Health Response:

Agreed

The current Service Funding Agreement is silent on these two items. Additional clauses will be included in the Service Funding Agreement to cover these two provisions.

Recommendation 19 (Chapter 3)

ACT Health ensure that:

- Annual Reviews are conducted as a minimum opportunity to provide service providers with the feedback they need to adequately deliver Home and Community Care program services; and
- output reports are subject to an appropriate degree of scrutiny, to ensure that service providers have complied with the funding agreement, and that any substantial variances of budgeted to actual output are documented and resolved in a timely manner.

ACT Health Response:

Agreed

ACT Health ensures that all output and financial reports are reviewed and performance analysed against service targets and funding six monthly.

Analysis of service delivery and financial performance will be clearly documented annually or more frequently if there is a substantial variance to either service delivery or financial performance.

2. AGED CARE ASSESSMENT

INTRODUCTION

2.1 This chapter examines ACT Health's performance in assessing the needs of aged people in the ACT through the Aged Care Assessment Program (ACAP) as delivered by the ACT Aged Care Assessment Team (the ACT ACAT). In particular, Audit examines whether the assessment service is delivered efficiently and effectively, and how it can be improved to meet the increasing needs of an ageing population.

KEY FINDINGS

Planning and Coordination

- Under the Commonwealth Aged Care Assessment Program, the ACT Aged Care Assessment Team is responsible for assessments of the needs of frail older people and facilitation of their access to appropriate care services.
- The ACT Health's Aged Care and Rehabilitation Services 2006-07 *Business Plan*, which included the Aged Care Assessment Team, was not sufficiently specific to assist the Aged Care Assessment Team's operation. The Plan did not include key information such as goals for the financial year, key priorities and tasks, or performance targets and indicators.
- The ACT Aged Care Assessment Team staff were skilled and experienced, but would further benefit from access to a wider range of skills than those currently available within the team. ACT Health had not assessed the training needs of current and prospective ACT Aged Care Assessment Team staff. Skills development can be improved by implementation of a targeted learning and development program and recruitment planning.

From referral to assessment of the client

- ACT Health did not have in place standards of services and communication protocols for the Community Health Intake, which provides a single point of referral to the ACT Aged Care Assessment Team. This has reduced the effectiveness of the Community Health Intake as an integral part of the aged care system within ACT Health.
- The ACT Aged Care Assessment Team's performance in assessing clients was mixed, as measured by the Commonwealth Department of Health and Ageing's data collection, the Minimum Data Set. In 2005-06:
  - the ACT performed well in seeing 87 per cent of Priority 1 clients, and 89 per cent of Priority 2 clients, 'on time', compared to the national average of 84 per cent and 84 per cent respectively; and
  - the ACT took 44.3 days on average from referral to have a face-to-face contact for all Aged Care Assessment Team clients, compared to the national average of 19.3 days. The delay in assessments was occurring

mainly for Priority 3 clients, most of whom were assessed in the community, rather than in hospital.

- The ACT Aged Care Assessment Team gave priority to assessing hospital patients who could move to residential facilities, thus assisting hospitals in reallocating acute care beds. This approach, however, could be at the expense of clients outside the hospital system, in residential facilities and in the general community, who may have the same or higher needs for services.
- About 9 per cent of the cases Audit examined were withdrawn when the Aged Care Assessment Team determined that the client was ineligible for, or did not yet need, an assessment. The number of withdrawals, while small, diverted resources that could be allocated to eligible and needier clients and reduce the waiting time. These referrals may have been avoided or minimised if more complete information was available about the Aged Care Assessment Team to clients and service providers.
- At the time of the audit, the ACT Aged Care Assessment Team had not completed development of policies and guidelines specific to the ACT, and instead used the Commonwealth's general guidelines as operational guidance for staff.
- The assessment tools and forms used by the ACT Aged Care Assessment Team to support assessment decisions were used in only 60 per cent of assessments and were inconsistently applied. They also required review to ensure their general relevance, and to remove duplicated questions.
- Delegates of the Secretary of the Commonwealth Department of Health and Ageing within the ACT Aged Care Assessment Team often did not review the assessment documentation prior to approving the recommendation, increasing the risk of inconsistent or poor quality assessments. Enhancements to systems, such as the introduction of assessment software, should improve the quality of the Aged Care Assessment Team's assessment documentation.
- Overall, the assessments conducted by the ACT Aged Care Assessment Team properly focused on the needs of clients. Staff were responsive to the needs and attitudes of clients and their carers.

Performance information

- Reports based on Minimum Data Set data from the ACT may not be as reliable as those from the other jurisdictions, due to persistent data entry and extraction problems in information input by the ACT Aged Care Assessment Team to DoHA's data collection, the Minimum Data Set. Several significant initiatives undertaken by the ACT Aged Care Assessment Team, including the recent introduction of a new assessment database system, should improve data collection and management.
- The ACT Aged Care Assessment Team did not effectively measure client and carer satisfaction in the delivery of its services. Although the Aged Care Assessment Team was part of ACT Health's generic annual satisfaction survey, the team did not use the results of this survey in reviews of its performance. Redesigning the generic survey to incorporate the range of Aged Care Assessment Team service users will provide the Aged Care Assessment Team

with more relevant data to gauge users' satisfaction with its services and identify improvement opportunities.

Admission to residential aged care facilities

- Although Commonwealth guidelines and other relevant documents included a role for the Aged Care Assessment Teams in care coordination, the ACT Aged Care Assessment Team assessors were not involved in planning for the care of clients after assessment. Moreover, the team did not have procedures to ensure the client's assessed care needs were met.
- A Residential Liaison Nurse is co-located with the ACT Aged Care Assessment Team and, if requested, assists clients and families in accessing residential care. The Liaison Nurse's role did not extend to assisting clients into community-based programs.
- ACT Health did not maintain a consolidated waiting list for residential aged care facilities in the ACT, and hence was not fully aware of the unmet and future demand for planning purposes. The list of priority clients for residential aged care maintained by the Residential Liaison Nurse did not include the clients on waiting lists maintained by the residential facilities.

Other issues

- The ACT was well allocated with residential aged care places by the Commonwealth. However, the ACT was slow at converting the allocated places to operational beds, compared to other jurisdictions – only 72 per cent of the ACT's allocated residential places were operational at 30 June 2006, whereas all other jurisdictions achieved 84 per cent or better. The responsibility for this issue lies with the private sector and ACT Government agencies other than ACT Health.
- The ACT was performing above the national average at making allocated community care places available.

THE COMMONWEALTH AGED CARE ASSESSMENT PROGRAM

2.2 The Commonwealth established the Aged Care Assessment Program (ACAP) in 1984. The main objective of the ACAP is to assess comprehensively the needs of frail older people and to facilitate access to available care services appropriate to their care needs.[2] To achieve this objective, the ACAP aims to:[3]

- ensure that older persons who belong to the following groups have equitable access to Aged Care Assessment services:
  - Aboriginal and Torres Strait Islander people;
  - People of culturally and linguistically diverse backgrounds;
  - People living in rural and remote areas;

[2] The *Aged Care Assessment Program Operational Guidelines 2002*, Section 2.
[3] The *Aged Care Assessment Program Operational Guidelines 2002*, Section 3.

  - Veterans, their spouses, widows and widowers; and
  - People with dementia.

- ensure that access to Aged Care Assessment services is based on need;
- prevent premature or inappropriate admission to residential care homes;
- help frail older people in the community;
- facilitate access to the combination of services that best meets the needs of assessed clients;
- ensure that assessments of the care needs of frail older people are comprehensive; incorporating the restorative, physical, medical, psychological, cultural and social dimensions of care;
- involve clients, their carers and other service providers in assessment and care planning;
- promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people; and
- optimise assessment services provided within available resources.

2.3 Under the ACAP, younger people with disabilities are not precluded from receiving care in residential aged care facilities, and are entitled to approval for residential care if they need the intensity, type and model of care provided; and all other care options have been exhausted.

THE AGED CARE ASSESSMENT TEAMS - RESPONSIBILITIES AND DUTIES

2.4 ACATs have a unique role under the Commonwealth *Aged Care Act 1997*. They are regarded as the 'gatekeepers' of Commonwealth-funded residential and community care programs for eligible clients. These clients are unable to access certain Commonwealth programs without an ACAT assessment and referral.

2.5 An assessment (and accompanying recommendation) by an ACAT is required before an eligible client can access the following programs funded by the Commonwealth:

- Residential care (either high level care or low level in a residential aged care facility);[4]
- Community Aged Care Packages (CACP);[5]
- Extended Aged Care at Home (EACH) packages;
- Extended Aged Care at Home - Dementia (EACH-D) packages;

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[4] Residential care is provided to clients who are unable to remain in their own homes. As their care needs change, residents often move from low to high level care while remaining in the same aged care residential aged care facility.

[5] Community Aged Care Packages (CACPs) are individually tailored packages of low level care to support frail older people with complex conditions in their own homes. They are complemented by Extended Aged Care at Home (EACH) packages, which provide high level care.

- Transitional Care Program (TCP); and
- Residential Respite Care.

2.6 ACATs also refer older people to a range of other community-based services that do not require a formal assessment, such as the Home and Community Care program (HACC), which is considered in Chapter 3 of this report.

2.7 Broadly, ACATs endeavour to: [6]

- conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of care, and provide a choice of appropriate services to meet clients' needs; and
- provide information on, and refer clients to, services that are appropriate and available - including facilitating access to broader community services such as HACC, mental health or disability services - to meet their needs and preferences.

2.8 Specifically, the ACATs:

- focus on the needs and preferences of people being assessed, and take into account the needs and preferences of the carer or advocate, and other interested parties;
- have the capacity to refer to a range of services, including community and rehabilitation services;
- actively encourage client and provider involvement in planning, development and management of assessment services at the regional and State or Territory level;
- promote community awareness of ACATs and how they can assist the target groups (listed at paragraph 2.2 at page 22);
- establish and maintain links with providers of residential care, community care, health services and general practitioners in their region;
- ensure equity of access to assessment services by clients and potential clients, including those from special needs groups;
- ensure that their clients understand and are able to exercise their rights;
- advise health professionals and the public on aged care issues; and
- participate in ACAP data collection.

Guidelines for assessment

2.9 The Commonwealth developed the following guidelines to set the framework for the ACAP and the operation of the Aged Care Assessment Teams:

- The *Aged Care Assessment Operational Guidelines 2002* (the *Operational Guidelines*) outline policy for implementing the ACAP through the ACATs. The

[6] The *Aged Care Assessment Program Operational Guidelines 2002*, Section 3, page 9.

Operational Guidelines set out the national objectives of the ACAP and the roles and the responsibilities of all parties involved in its administration - the Commonwealth, State and Territory Governments, ACATs and Evaluation Units;[7] and

- The *Aged Care Assessment and Approval Guidelines 2006* (the *Assessment Guidelines*) provide information and guidance to ACATs in approving care recipients for residential, community or flexible care under the *Aged Care Act 1997*. They identify the main considerations for delegates of the Secretary of Commonwealth Department of Health and Ageing (DoHA) when approving a client as a care recipient. These guidelines replace the previous *Aged Care Assessment and Approval Guidelines* released in 1999, and are read in conjunction with the *Operational Guidelines*.

2.10 The *Assessment Guidelines* and the *Operational Guidelines* provide generic (non-jurisdictional specific) guidelines for ACAT members to use in exercising their functions under the *Aged Care Act 1997*. They do not include assessment tools used by the team in conducting assessments.

2.11 The Commonwealth guidelines recognise that the diversity of health systems and local environments within which each ACAT operates will influence the team's work practices and internal guidelines. Thus, while the core principles set by the Commonwealth underpin the establishment of ACAT teams and the way in which they meet the objectives of the ACAP and the legislation, DoHA accepts that teams will not be uniform in their operation and work practices.

2.12 The ACT ACAT's internal policies were still in draft at the time of the audit. In the absence of ACT-specific guidelines, the team relied on the Commonwealth's guidelines to perform its work. Although these guidelines are useful and relevant, they do not include matters particular to the ACT ACAT, such as the proper use of assessment tools, and the health provision context within which the ACAT works.

Recommendation 1

ACT Health finalise internal procedures and guidelines for the operation of the ACT Aged Care Assessment Team, consistent with the Commonwealth's guidelines and legislation.

FUNDING AND PLANNING

2.13 The ACAP is funded by the Australian Government and the States and Territories. The States and Territories also provide the infrastructure and the broader health system within which ACATs operate. In 2006-07, the Commonwealth provided total funding of $71.84 million for aged care assessment nationally.

[7] Evaluation Units (EUs) have responsibility for the collation and evaluation of ACAP data.

2.14 Although the Commonwealth sets policy and strategic direction for ACATs, day-to-day management is left to the States and Territories. They provide infrastructure and support such as office accommodation, cars, and administration.

2.15 There is only one ACAT in the ACT, known as the ACT ACAT, currently managed by the Aged Care Assessment and Liaison Unit (ACALU) and operated within ACT Health. The team comprises 15.8 full time equivalent staff, including one manager, one administration officer and professional staff, the majority of whom are registered nurses or allied health professionals. All staff are employed by ACT Health.[8]

2.16 For the year 2007-08, the ACT ACAT will receive an approved total funding of $726 908 from the Commonwealth. This is composed of:[9]

- annual recurrent funding of $661 957 for the ACAT; an 8.6 per cent increase over 2006-07 funding. This funding provides for the operation of the ACAT, the Evaluation Unit, ACAT training and additional funding for Extended Aged Care at Home - Dementia assessments;
- $62 089 for the implementation of the Council of Australian Government's (COAG's) decision to improve the timeliness and consistency of aged care assessments; and
- $2 862 for an ACAT education officer.

2.17 ACT had the lowest Commonwealth funding for aged care assessment per person in the target group in 2004-05 (latest available data). This reflects the compact and discrete nature of the ACT community, which does not have a large rural population.

Table 2.1: Commonwealth funding per ACAT assessment, all States and Territories, 2004-05 (the latest figures available)

	Commonwealth ACAT Funding 2004-05	Completed Assessments	Cost per Unit Output
	$m	No.	$
NT	0.7	831	845.66
SA	4.8	13 943	343.84
Qld	8.5	28 482	300.14
WA	4.8	16 293	297.78
Tas	1.3	4 525	291.65
NSW	17.6	62 895	280.78
Vic	12.0	47 041	254.28
ACT	0.5	2 867	168.17
Australia	**50.2**	**176 877**	**284.49**

Source: National Data Repository Annual Report 2004-05.

[8] Organisational Chart for Aged Care Assessment and Liaison Unit (ACALU).
[9] Aged Care Assessment Program Funding 2007-08.

2.18 The ACAT is funded also by the ACT Government. Table 2.2 shows the mix of funding for the years 2005-06 and 2006-07.

Table 2.2: Funding of the ACAT for the years 2005-06 and 2006-07

Year	Total $m	Commonwealth Funding $m	ACT Funding $m
2005-06	$1.113	$0.525	$0.588
2006-07	$1.266	$0.670	$0.596

Source: ACT Health.

Business Planning

2.19 Effective planning is important for meeting the performance expectations of the community, and the ACT and Commonwealth Governments.

2.20 The Aged Care Assessment and Liaison Unit, including the ACT ACAT, was part of the 2006-07 Business Plan for Aged Care and Rehabilitation Services (ACRS) in ACT Health. At the time of audit, a 2007-08 Business Plan had been drafted but not finalised.

2.21 The ACRS 2006-07 Business Plan recognised the challenges of succession planning and capability development of the ACRS; however, it did not appear to consider any specifics related to ACAT. Audit was therefore unable to conclude what intentions, if any, ACT Health or ACRS had to review and improve ACAT's performance for the delivery of its services, to meet the demands of the ACT's ageing population, or to serve the newly emerging special needs groups.

2.22 The ACRS 2006-07 Business Plan did not contain, or contained insufficient detail on:

- identification of the outputs of the ACRS, and which units were responsible for them;
- identification of client groups, and services available to them;
- identification of stakeholders and their interest in the ACAT;
- applicable legislation and policy;
- resources – financial and human;
- goals for the financial year;
- key priorities and tasks;
- performance targets and indicators; and
- risk analysis and management.

2.23 Audit noted that in June 2007 the ACT ACAT was funded by the Commonwealth to visit ACAT teams in Victoria, with the aim of sharing better practices in business operation, conducting assessments, and using information systems. After the trip, the team

had a planning day to discuss the good practices they observed, how they could be applied in the ACT, and any changes that were needed in the team's operation.

2.24 At the time of audit, the ACAT had neither documented nor implemented the changes to work practices agreed at their planning day. Audit considers it important the ACT ACAT document the outcome of the Commonwealth's funding initiative and incorporate agreed better practices in the 2007-08 Business Plan, to ensure that good practices are actually adopted in its day-to-day operations.

Recommendation 2

ACT Health finalise the 2007-08 Business Plan for ACRS, including the ACT Aged Care Assessment Team, which should include:

- a timetable or plan to guide the implementation of better practices observed in other jurisdictions;
- the identification of the outputs of the Aged Care Rehabilitation Services, and which units were responsible for them;
- the identification of client groups, and services available to them;
- the identification of stakeholders and their interest in the Aged Care Rehabilitation Service;
- applicable legislation and policy;
- resources – financial and human;
- goals for the financial year;
- key priorities and tasks;
- performance targets and indicators, including those in the *Operational Guidelines*; and
- risk analysis and management.

Resource planning and training

2.25 Older people's care needs are often complex and require multi-disciplinary, holistic assessments. This is recognised in the ACAT Agreements between the Commonwealth and the ACT Government, and in the *Aged Care Assessment and Approval Guidelines*, which recommend that ACATs have access to or include a wide range of disciplines, skills and expertise sufficient to make accurate and complete assessments of the client's needs.

2.26 The current ACT ACAT members are registered nurses, occupational therapists and social workers. A geriatrician attends the weekly case conferences to provide professional support to the team. Although the ACT ACAT members appear to have the depth and breadth of experience and skills needed to perform their daily tasks, Audit suggests that to achieve the goals and objectives of the ACAP (to provide multi-

disciplinary, comprehensive and holistic assessments), the team would benefit from a wider range of medical and other health expertise.

2.27 ACT Health advised that the ACT ACAT has access to a wide range of health professionals from whom it can draw clinical and professional support.

2.28 Audit considers that, where possible, ACT Health should recruit staff from different professional backgrounds to enhance the team's expertise and skills.

2.29 Audit was advised that the ACT ACAT will need to replace some skilled and experienced members as they retire from the workforce. ACT Health should consider the regular provision of training for ACAT members to enhance existing staff's skills, and to prepare for the replacement of skilled and experienced staff.

2.30 Audit was advised that training is available locally via various programs and fora, such as ACT Health's weekly Geriatrics Education Program, the Staff Development Unit's education program, and ACAT's monthly in-service education. However, ACT Health has not assessed the skill needs of the team and the effectiveness of these programs in meeting their training needs.

2.31 Audit notes that DoHA has recently developed a *National Training Strategy* to recognise and build on training practices currently being utilised in each State and Territory; and to formalise a nationally consistent and sustainable training infrastructure.

2.32 Audit considers that analysis of training needs would draw attention to the specific skills required to enhance the performance of the ACT ACAT, and could lead to the development of a targeted learning and development program to supplement the Commonwealth's training strategy. Training in the use of improved ACAT systems should be a priority.

Recommendation 3

ACT Health:

- conduct a training needs assessment for the Aged Care Assessment Team (ACAT) and, as necessary, introduce a targeted learning and development program to both meet the needs of ACAT members, and to assure the availability of skilled staff for ACAT in the future; and
- consider recruiting a diverse range of health professionals to broaden the skill base upon which the ACAT may draw in servicing clients.

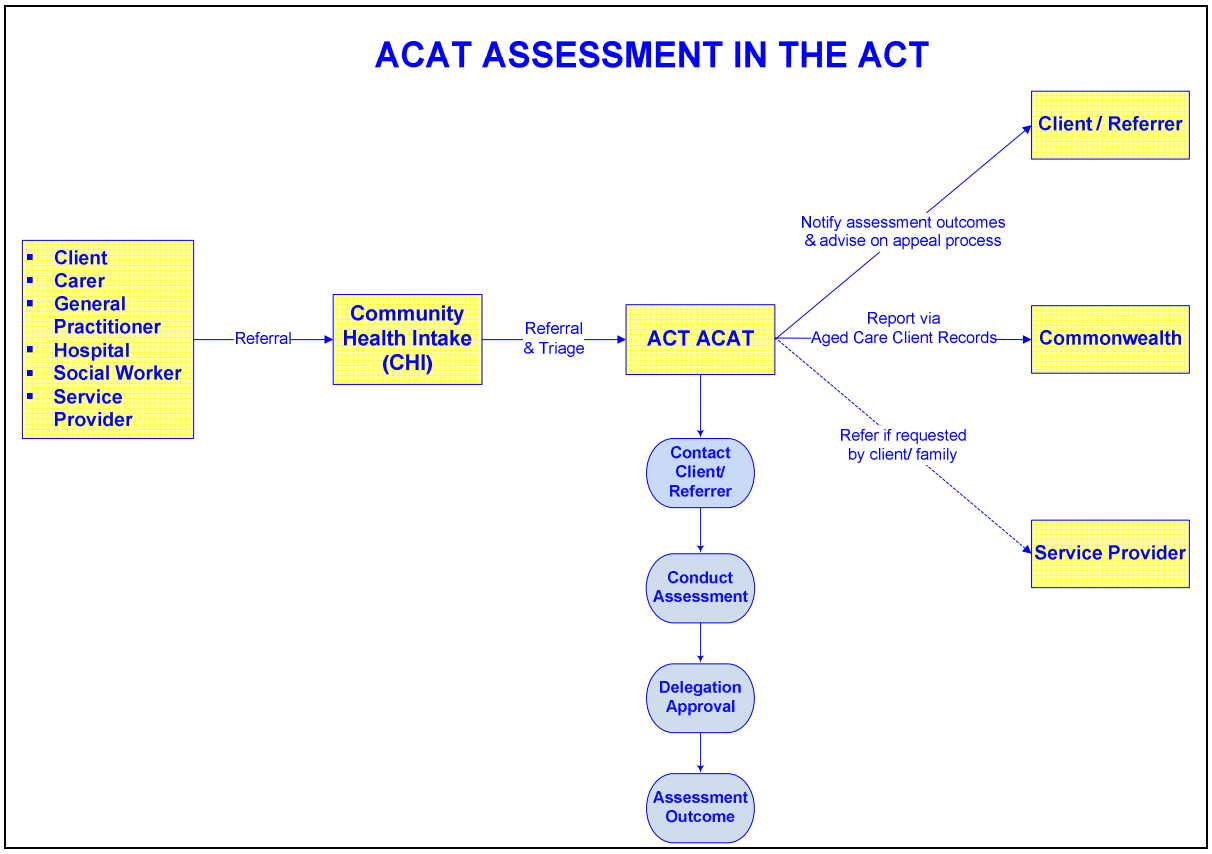
ACAT ASSESSMENT IN THE ACT

2.33 Statistics from the *Minimum Data Set Annual Report 2005-06* show that in 2005-06 the ACT ACAT accepted 2 853 referrals, all of which were assessed. Some 2 832 assessments were completed - a 99 per cent completion rate. Assessments were not

completed for various reasons, such as the unwillingness of the client to proceed or a change of their personal circumstances.

2.34 The figure below is an overview of how assessments are initiated and processed through to completion and possible referral to a service provider.

Figure 2.1: ACAT Assessment in the ACT



Source: ACT Auditor-General's Office

2.35 The Commonwealth *Aged Care Act 1997* and the *Operational Guidelines* provide that 'older people can be referred to an ACAT by anyone who is concerned that they may not be coping well in their current living arrangements'.

2.36 Commonly, hospitals, GPs and service providers such as 'Meals on Wheels', family or friends, or aged care facilities refer clients to the ACAT.

2.37 The following case studies illustrate the circumstances that can lead to referrals to the ACT ACAT, and the resultant assessments.

Case study 2.1: Single woman referred to residential and respite care

Mrs X is 79 years old and has no immediate family. She suffers from Alzheimer's disease and osteoporosis and has been receiving a community aged care package (CACP) for the past year. Mrs X receives personal care, medication monitoring and assistance with housework.

Her neighbour submitted a referral to the ACAT for re-assessment, because he had found her wandering amongst heavy traffic late at night. The ACAT contacted the CACP provider who confirmed that Mrs X's condition had deteriorated and they were concerned for her safety.

The ACAT undertook an in-home assessment of Mrs X's care needs with a representative from the Public Trustee. It was agreed that Mrs X could no longer manage at home and approval was given for placement in a low level residential aged care home as the most appropriate option.

The case was discussed at the ACAT case conference and approval was granted by the delegate for low level residential care and low level respite care.

Case study 2.2: Widow referred for respite care

Mrs M is a 86 year old widow, and a DVA gold card holder.[10] She lived alone until she had a fall which caused a severe wound, and loss of mobility. After she recovered, she was admitted to an ACT Health funded respite care, which did not require an ACAT assessment. Her family requested an ACAT assessment for future care needs, and the ACAT assessed her at the respite care facility.

Mrs M was approved for respite care service and referred to Veteran Home Care services for domestic assistance. There is a possibility that she may need another assessment if she requires admission to a residential care facility in the future.

Case study 2.3: Married man referred for respite care and high level residential care

Mr R is 91 and was living at home with his wife. He had poor appetite, and difficulties with mobility, continence, hearing and eyesight. His wife handled his medication and provided other care and assistance, but following a knee operation, she had difficulties coping with his care. Mr R's family then arranged domestic help to assist him with showering each day.

After a fall, Mr R was admitted to hospital and was referred to the ACAT by the hospital social worker. ACAT assessed him in hospital with the co-operation of Mr R's daughter. He was approved by ACAT to receive assistance under the community-based programs CACP and EACH; and respite care and, if necessary, high level residential care.

Mr R's family did not ask for ACAT assistance in approaching care providers.

Source: ACT ACAT client files. Names have been changed to protect privacy.

Referral Intake and Triage – the Community Health Intake

2.38 To arrange an ACAT assessment in the ACT, the client or their representative firstly contacts the Community Health Intake (CHI), which provides a single point of referral to the community health system for ACT residents, practitioners, health professionals, and Community Health Services.

2.39 CHI's operation is two tiered: Level 1 operators use prepared scripts to handle simple inquiries and to collect mainly demographic information. The average call length is

[10] A Gold Card may be a veteran or the widow or dependant of a veteran. The Gold Card entitles the holder to services for a wide range of health care needs.

2.5 minutes. More complex queries are transferred to Level 2 officers, who are registered nurses and have a general knowledge of all services available to aged persons and others. The average call length is 6.5 minutes.

2.40 CHI staff uses the ACT Patient Administration System (ACTPAS) to register ACT Health clients and generate referrals to treating services. ACTPAS can be accessed by all ACT Health's internal providers, including ACAT assessors.

2.41 Before referring a client to ACAT, CHI is required to determine whether the client is eligible for, or requires, an ACAT assessment. To assist CHI in this task, ACAT provides CHI with information on ACAT criteria and assessment requirements. CHI also refers persons directly to other aged care services that do not need an ACAT assessment, such the Home and Community Care program.

2.42 To be eligible for an assessment and referral by the ACT ACAT, clients must:

- be resident in the ACT;
- be a member of the ACAT target group:
  - frail older person over 70;
  - under 70 and suffering from dementia or a disability; or
  - indigenous, and over 50 years;
  - medically stable; and
- require at least low level residential care at the time of the referral or within 12 months.

2.43 Community Health Intake also assists the ACT ACAT in collecting basic information on the clients' health status and their current care support; and in prioritising clients. CHI's initial triage is expected to reduce ACAT assessors' time spent in collecting clients' information, and to screen out inappropriate referrals.

2.44 Audit examined 57 referrals from CHI to the ACAT for the period July 2006 to March 2007. Of these, five cases (approximately 9 per cent) were withdrawn when ACAT determined that the client was ineligible for, or did not yet need, an ACAT assessment. The number of withdrawals, while small, diverted ACAT resources which could be allocated to eligible and needier clients and reduce the waiting time. Audit considered that these referrals may have been avoided or minimised if more complete information had been collected by CHI at initial contact with the client or their carers.

2.45 Audit also observed some cases where ACAT assessors spent much time in contacting clients and their carers or advocates to obtain information which, according to ACAT, could have been collected by CHI. This would appear to be inefficient, and not the best use of the skills of the ACAT staff. However, because of the diversity and number of calls to CHI,[11] the limitations of phone conversations, and the limited numbers of Level 2

[11] Audit was advised that CHI took about 8 000 – 9 000 calls each month.

CHI staff (8.4 full time equivalent), it has not been possible for CHI to offer a specialised referral service to ACAT clients.

2.46 There is no documented understanding between CHI and the ACAT on the criteria and protocols that CHI should use when referring clients to ACAT. Audit was advised that CHI and ACAT do meet; however, these meetings are irregular and unscheduled. Audit was unable to obtain any record of the matters discussed in these meetings, or to evaluate any changed and improved practices arising from any agreements between the two groups.

2.47 Audit was advised that the relationship between the CHI and the ACAT will change, with Level 2 referrals being handled by ACT Health staff who are more familiar with ACAT's operations and environment. Nevertheless, Audit considers that established protocols or agreements between the ACAT and CHI, improved liaison, and regular review of these agreements would enhance the capacity of CHI and the ACAT to work together to better serve clients.

Recommendation 4

The Aged Care Assessment Team (ACAT) establish performance standards and regular reviews with Community Health Intake in referring clients to ACAT.

Meeting assessment priority targets

2.48 When a client is referred for assessment, the ACAT assessors contact the client or their carer to arrange an assessment time and obtain further information on the client's situation. Where possible, assessors seek to involve the person's family or carer in the assessment, as required by the *Aged Care Assessment Program Operational Guidelines 2002* (the *Operational Guidelines*). This procedure was documented in 95 per cent of the cases Audit examined.

2.49 For the client, timely ACAT assessments facilitate their transition to supported care at home through community assistance packages, and admission to an aged care residential service or other service. The *Operational Guidelines* provide that ACATs should respond to referrals in a timely manner by allocating a priority category at the time of referral.

2.50 The three categories of response priorities are:

- *response within 48 hours:* the client's safety is at risk or there is a likelihood that the client will be hospitalised or required to leave their current residence because they are unable to care for themselves, or their carer is unavailable;
- *response between 3 and 14 days:* the client is not at risk of harm, but their physical, mental or functioning status is progressively deteriorating. Alternately, the level of care currently available to the client does not meet their needs or is not sustainable in the long term; and
- *response more than 14 days:* usually for routine clients or clients with future care needs, that is, the client has sufficient support available at present, but needs an

assessment in anticipation of their future care requirements. In these cases ACAT needs to judge whether delaying an assessment for more than 14 days will jeopardise the client's health and well-being.

2.51 The Community Health Intake classifies clients to priority categories based upon information it collects on patient needs at the time of allocation to community service providers, including the ACAT. However, once CHI refers the client to them, the ACAT assessors make their own judgement on the client's priority and how soon the client should be contacted.

2.52 Indicators of performance for the ACT ACAT are discussed later in this chapter. Table 2.3 (page 41) shows that, according to preliminary 2005-06 figures, 87 per cent of clients in Priority 1 and 89.1 per cent in Priority 2 were contacted by the ACT ACAT within the times specified by the priority category.

2.53 The length of time from initial referral to when the assessment is conducted - the first face-to-face contact date - is an indication of how long the ACAT takes to initiate an assessment. Table 2.3 (page 41) also shows that the ACT recorded an average elapsed time from referral to face-to-face assessment in 2005-06 of 44.3 days, with a median elapsed time of 18 days. This was considerably longer than the national average of 19.3 days (median 9 days). Audit sighted evidence of significant improvement in the ACT's average wait from referral to assessment in the last quarter of 2006-07 – the average elapsed time had dropped to 24.3 days.

2.54 The ACT ACAT sets an internal waiting time target of two working days for in-patient assessments. The average waiting time for assessment of in-patients (i.e. people staying in hospitals) was 1.45 days for the last quarter of 2006-07, and 1.34 days for the full year.

2.55 Although this is a good performance indicator of ACAT's response to in-patient clients, it raises the question of whether in-patient clients in hospital are seen before those in the community, who have a greater or equal priority ranking. Among the cases examined by Audit, 92 per cent of the clients who were not seen within the target time were at home or in another living situation at the time of assessment.

2.56 Other patients are unable to occupy a hospital bed if it is occupied by an ACAT client who is waiting for assessment for longer term care. This has justified the timely attention provided to inpatient clients. Nevertheless, priority given to assessment of in-patients in hospitals should not be made at the expenses of clients outside the hospital and in the community, leading to increased delay of ACAT services to them.

2.57 Audit considers that ACT Health should ensure an equitable access to its assessment services by all client groups. A regular comparison of waiting times for assessment of in-patients and community clients will indicate whether in-patient clients are receiving disproportionate attention, at the expenses of clients in the community.

Recommendation 5

The Aged Care Assessment Team ensure that clients of the same care needs, particularly those in category 1, have the same priority for assessment, whether they are community or hospital-based at the time of assessment.

Use of assessment tools and documentation

2.58 The ACT ACAT uses a range of clinical assessment tools based on its understanding of the ACT's client population's needs. These are:

- the Comprehensive Assessment Tool - the main clinical tool to conduct assessments;
- the Mini-Mental State Examination; and
- the Geriatric Depression Scale.

2.59 These tools are intended to ensure that assessors gather sufficient, accurate and objective information to identify and measure the need for, and type of, care for the client. Audit found, however, that the Comprehensive Assessment Tools and other tools were used in only 61 per cent of assessments. Where the tools were used, only just over half (57 per cent) contained all the required information; and only about two thirds (68 per cent) were scored or rated using the scoring system included in the assessment tools.

2.60 Audit also found that ACAT staff use the Commonwealth's Aged Care Client Record (ACCR) to document decisions. Their own clinical tools supplement the ACCR in supporting the assessment, and could be used in explaining or defending the assessment, should it be called into question by the approving delegate, the client or other parties. Audit observed that ACAT staff feel able to make an aged care assessment without resorting to all the assessment tools.

2.61 Audit considers that the application of assessment tools could be improved by better internal monitoring and review of supporting documentation by delegates when approving assessments. In so doing, delegates can assure the transparency, accuracy, equity and consistency of ACAT assessments. Further, development of formal guidelines on use of assessment tools, and an internal checklist would also contribute to greater consistency in the use of assessment tools within the ACAT.

2.62 Audit also observed that in some cases, clients reacted with frustration or discomfort when asked some questions required by the assessment tools, and in some cases, refused to answer. Such reactions suggest that questions asked in the assessment may be in need of review for continuing relevance and appropriateness.

2.63 The reluctance of ACAT staff to use the assessment tools to their full potential may be partly explained by the nature of the records they must complete when conducting assessments. A full-time assessor is expected to complete seven assessments per week. This expectation is based on an average four hours for each assessment, including time with the client and report writing time.

2.64 If all documentation was completed as required, a complete assessment file would consist of:

- a Referral Form (completed by CHI);
- Client Progress Notes;
- a Collection and Use of Personal Information Form;
- Comprehensive Assessment Tool and other tools;
- a Comprehensive Assessment Summary;
- a Care Coordination Plan;
- a Care Coordination Sheet; and
- an ACCR.

2.65 Although each form serves a different purpose, Audit noted that duplicate or very similar information was required in multiple forms. The Comprehensive Assessment Summary, for example, summarises how assessments are done; information which is also covered in the assessment tools. In particular, most of the information required by the ACCR is also gathered in other forms.

2.66 Audit observed that assessors often had insufficient time to complete all the documentation during assessments. To save time, assessors in many cases asked clients to sign blank or partly completed ACCRs, and took notes with which to complete other documentation. Of the 57 cases examined, Audit noted:

- two cases where the consent of clients for the use of their personal information was not obtained; and
- many cases where Client Progress Notes, Comprehensive Assessment Summary, Care Coordination Sheet and Care Coordination Plan were incomplete or not used.

2.67 The ACAT acknowledged that better practice would be to record information recorded during the assessment, thereby reducing the time spent transcribing information from notes; thus preventing oversights and assuring complete record keeping.

2.68 Audit understands that DoHA has revised the ACCR, with a new version in use during the 2007-08 financial year.[12] DoHA is also working with Medicare Australia to deliver e-business capabilities that will allow aged care providers and ACATs to electronically sign and submit aged care information. These initiatives will assist in keeping accurate, complete and current records of aged care clients.

2.69 The ACAT will be considering how it may integrate its newly introduced assessment monitoring software system, ACE (Assessment and Care Evaluation), into the new Commonwealth systems. The ACE system is discussed at paragraph 2.97 at page 42.

[12] http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-acat-acatchat-2007-june.htm

Conduct of assessments

2.70 Audit attended five face-to-face assessment sessions conducted by the ACAT assessors. All the assessments were client-oriented and in accordance with procedures set out in the *Operational Guidelines*. Assessors focused on the needs and preferences of the client, but also took into account other factors such as the client's:

- carer's or advocate's needs and preferences;
- usual accommodation setting and its suitability;
- financial status;
- need for legal assistance; and
- access to transport.

2.71 At the end of the assessments, the choices and options which the assessors considered appropriate to meet the client's care need were discussed with the client and their carer or advocate.

2.72 Audit observed that the ACT ACAT assessors formed their initial opinion on the type and level of care for a client following a face-to-face assessment. If the assessor felt the need, the case was further discussed with ACAT colleagues. Audit observed regular discussions on cases amongst team members that allowed the assessor to draw on and apply the experience and expertise of other team members to the individual circumstances of the case.

2.73 Complex assessments are discussed with the team at a case conference each Wednesday morning. The conference usually invites a geriatrician to assist in resolving difficulties in these complex assessments. Audit attended two case conferences and found them to be constructive, open and productive.

Delegate's approval of the assessment

2.74 Under section 22.1 of the *Aged Care Act 1997*, only the Secretary of DoHA has the power to approve a person as a care recipient. Under section 96.2 of the Act, however, the Secretary's power to approve a person to receive care can be delegated to identified positions in the ACATs.

2.75 There are nine delegates of the Secretary of DoHA in the ACT ACAT. Recommendations for the type and level of care, prepared by assessors following their review of client needs, are made to the delegates for approval.

2.76 Audit found that all recommendations made in the ACCRs were approved by a delegate. However, as discussed previously, Audit observed that there was no formal review by the delegate of the assessment documentation. Instead, they tended to rely on the expertise and judgement of the assessor making the recommendation. Discussions between assessor and delegate on the case, if they occurred, were informal and undocumented.

2.77 According to the National Delegation Training Workbook for ACATs, delegate accountability includes ensuring that there is appropriate documentation to support assessment findings. As discussed above, Audit observed that in many files documentation was incomplete.

2.78 The risk to ACAT in continuing these practices is that the quality of assessments may be compromised and the recommendations may be inappropriate. Delegates are responsible to the Commonwealth for the Aged Care Client Records they approve, and in the absence of complete documentation may not be able to fully explain or justify the decisions for which they are accountable, particularly if they are required to appear before an external review body.[13]

2.79 Improvements that will enhance the consistency of assessments have been mentioned previously. A well-defined role for the delegate in reviewing the assessment documentation, including the use of improved assessment tools, should be considered for the revised system environment.

Recommendation 6

ACT Health:

- review and improve the Aged Care Assessment Team's (ACAT's) clinical assessment tools as well as the supporting documentation; and reinforce their use by ACAT members through formal guidelines and an internal checklist; and
- review the exercise of delegations under the ACAT, to ensure that approvals of assessments are supported by documented evidence and proper review.

Type and level of approval

2.80 The type and level of care approved by ACAT assessors varies from client to client. Audit testing did not disclose any trend in the assessments toward particular services; however, most assessment approvals related to low and high residential care, with more approvals for low level community care than high level.

2.81 ACAT approvals for admission to residential care or community packages are valid for one year. Within this time, approved clients may visit service providers and their facilities, and make arrangements to either enter a residential aged care facility or receive community-based services using their chosen provider. In emergencies, however, clients may be placed in care before an ACAT assessment is conducted.[14]

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[13] The *Aged Care Assessment and Approvals Guidelines 2006*, section 5.3.

[14] An emergency is the only circumstance in which there is provision for the date of effect of an approval to be the day on which the care started rather than the day the approval was signed and dated. Under Section 22-5 (2), *Aged Care Act 1997*, emergency approval will be granted if … the person urgently needed the care when it started, and that it was not practicable to apply for approval before hand.

2.82 Audit observed some cases where clients requested assessment 'just in case', or returned for another ACAT assessment when their initial referral had expired. Despite having no intention of using the new assessment, some older people and their families need reassurance of their status in relation to future aged care. In addition, some Residential Aged Care Facilities (RACFs) required an ACAT assessment for a placement on a waiting list, although Audit was advised that this practice is no longer widespread, and is being phased out.

2.83 Audit considers that the ACAT resources should be conserved for higher priority clients, rather than those with low prospects of entering a residential facility or community-based aged care. Many in the community misunderstand ACAT's role and believe that it is involved in directly providing aged care services, rather than providing an assessment and referral service. Further, the practice of clients seeking 'just in case' assessments may reflect a lack of confidence in ACAT's capacity to respond to clients when their need for residential or community-based aged care becomes immediate and urgent.

2.84 There is scope for ACT Health to better inform aged care providers, medical practitioners, carers and the community of the role of the ACAT and its ability to respond to client's needs, to minimise unnecessary workload on the ACAT.

2.85 If the clients and their carers have more confidence about the ACAT process and its ability to respond effectively to high priority needs, then there may be less applications for assessments from clients with low prospects of immediate care needs, or who do not need ACAT assessments for access to other care services.

Notification of assessment outcomes

2.86 Once the type and level of care recommended by an assessor is approved by a delegate, an approval notification letter is sent to the client or their carer to advise them the assessment results. Clients are advised of the type of care approved, date of approval and how long the approval remains valid. The letter is accompanied by a copy of the client's ACCR.

2.87 Where appropriate and with the client's consent, the referrer or the client's GP is informed of the assessment's recommendation after it has been approved by the delegate.

2.88 The ACAT will refer a client to a particular service provider or providers when needed or requested by the client or carer. No referrals were made in cases where the client was not in immediate need of aged care services, or desires more time to select a service provider.

Appeals against the recommendation of the ACAT

2.89 When informed of the assessment outcomes, ACAT clients are also advised how to appeal should they not agree with the recommendation.

2.90 The *Assessment Guidelines* provide instructions on review procedures. Appeals must be made in writing within 28 days of the date when the client receives written notice of the assessment decision, and referred to the ACT Office of DoHA. The Secretary of DoHA has power to reconsider reviewable decisions, and this power has been delegated to certain officers in DoHA. The Secretary or their delegate may request a reassessment by an ACAT not involved in the original decision. In circumstances where this is not possible, such as in the ACT, a member of the ACAT who was not involved in the original decision may conduct the reassessment.

2.91 Appeals against the ACAT approvals are rare. Audit was advised that there have been no appeals since 2005, and noted that complaints about assessment outcomes are informal and to some degree substitute for formal appeals. Audit was informed that referring a client for low level residential care may be a source of complaint against the ACAT. Low level residential care requires an entrance bond and payment of on-going costs while in care. High level care, on the other hand, does not require such contributions from clients.

PERFORMANCE MONITORING

Performance monitoring through the MDS

2.92 The Evaluation Unit of ACT Health reports the ACAT's performance to DoHA both quarterly and annually in Minimum Data Set (MDS) Reports. The data set is composed of:

- assessment numbers and rates;
- times from referral to each stage of the assessment process;
- times and assessments by priority category;
- assessments for low-level to high-level care;
- reasons for ending assessments; and
- recommendations.

2.93 The ACAP MDS is an important source of information on progress in achieving these objectives. The ACAP MDS is designed to:

- provide ACAP program managers access to data for policy and program development, strategic planning and performance monitoring against agreed outcomes;
- assist ACATs to provide high quality services to their clients by facilitating improved internal management and local/regional area planning and co-ordinated service delivery; and
- facilitate consistency and comparability of ACAP data with other relevant information in the health and community services field.

2.94 The *Aged Care Assessment Program National Data Repository Annual Report 2004-05* observed some data extraction problems in the ACT, in particular, a higher level

of missing data than other jurisdictions. The Report notes that towards the end of 2005, the ACT put some effort into producing a complete and accurate record of assessments.

2.95 Audit observed that data entry and extraction problems persist in the draft *Aged Care Assessment Program National Data Repository Annual Report for 2005-06*, and that reports based on MDS data from the ACT may not be as reliable as those from the other jurisdictions. Nevertheless, Audit extracted the following figures on the ACT's relative performance from this draft Annual Report.

Table 2.3: Timeliness of ACAT service, National and ACT 2005-06 (preliminary figures)

Criteria	National	ACT
Number per thousand of the target group assessed in 2005-06	82.9	111.8
Waiting time for assessment: all clients, and by priority		
Average time from referral to first face-to-face contact (days)	19.3	44.3
Median time from referral to first face-to-face contact (days)	9	18
Percentage of Priority 1 clients seen 'on time'	84.1%	87%
Average time from referral to first face-to-face assessment – Priority 1 clients (days)	2.3	4.9
Median time from referral to first face-to-face assessment – Priority 1 clients (days)	0	1
Percentage of Priority 2 clients seen 'on time'	83.8%	89.1%
Average time from referral to first face-to-face assessment – Priority 2 clients (days)	9.7	9.6
Median time from referral to first face-to-face assessment – Priority 2 clients (days)	4	4
Percentage of clients that received their first face-to-face contact within 2 days of referral	37.1%	25.3%
Waiting time for assessment: place of assessment		
Average waiting times for assessments in hospitals (days)	8.4	5.7
Median waiting times for assessments in hospitals (days)	4	3
Percentage of all assessments completed by ACAT in acute hospital settings	22.6%	17.5%
Average waiting times for assessments in residential facilities (days)	13.1	20.4
Median waiting times for assessments in residential facilities (days)	7	9
Average waiting times for assessments for community clients (days)	26	54.8
Median waiting times for assessments for community clients (days)	15	26

Source: National Data Repository Annual Report 2005-06 (draft), May 2007

2.96 In relation to the above data:

- the ACT and the NT include only completed assessments in their MDS data, unlike other States. Thus, overheads incurred in screening out ineligible clients and incomplete assessments are not reflected in the figures above;

- the long waiting times in the ACT appears to be for clients who are assigned a Priority category 3, since the ACT performed close to the national average for clients assigned Priority 1 or 2. The category 3 clients are more likely to be found in residential care or community settings; and
- in all jurisdictions, hospital-based clients had shorter waiting times than community-based clients, and residential care assessments were completed more quickly than community-based assessments.

2.97 The ACT ACAT has undertaken several significant initiatives to improve data collection and management, including recently introducing ACE as its principal assessment database system.[15] ACE is an ACAT specific database system, which allows for timely and accurate data collection, and will integrate with the Commonwealth's electronic record system, due to be introduced in 2008. Audit notes that the Commonwealth plans to encourage the use of ACE nationally.

2.98 Audit considers that these initiatives will assist ACT Health to enhance the quality of MDS data entry and extraction, to enable better measurement of ACT ACAT's performance, and comparison with other States and Territories.

2.99 Audit notes that the main performance indicator the ACT ACAT uses is the waiting time for ACAT assessments of hospital clients, measured by the mean waiting time in working days between request for, and provision of, an in-hospital assessment by the ACAT.[16] This is reported fortnightly to the ACRS Manager and the General Manager of ACT Health Clinical Operations; and quarterly in the ACT Health Performance Quarterly Reports.

2.100 Although the waiting time of hospital clients for ACAT assessments is a key performance indicator, it does not provide the ACT community with a full reflection of ACAT's performance. To do so, the ACT ACAT should report against the key MDS performance indicators in the Annual Report of ACT Health.

Recommendation 7

The ACT Aged Care Assessment Team report annually in the Annual Report of ACT Health against the key performance indicators used by the Commonwealth in compiling the Minimum Data Set, and include data that will enable comparison of ACT performance to national and State and Territory performance.

Measuring customer satisfaction

2.101 The ACAT is required by the Commonwealth to record complaints by clients on the services they receive. The ACAT uses ACT Health's Patient Safety and Quality Unit

[15] The ACAT assessors also have to access to ACTPAS (ACT Health's community health database) to receive referrals and record their assessment outcomes.
[16] ACT Health Public Services Performance Quarterly Reports.

to manage consumer feedback or complaints. It is the task of the Executive Director of the ACRS to respond to the complaints about the ACAT.

2.102 ACT Health advised that complaints regarding the ACT ACAT are rare.

2.103 As noted by a number of DoHA reports, however, the number of formal complaints received is not, in its own, a reliable way of judging whether clients are satisfied with the assessment or its outcome. That said, ACT Health has no other formal means of seeking feedback from clients, carers or advocates to assess client satisfaction or identify opportunities for improvement.

2.104 Satisfaction surveys of ACAT clients are conducted yearly by ACT Health's Patient Safety and Quality Unit as part of ACT Health's annual survey of all programs. Audit observed that the survey form was designed to serve the entire information needs of ACT Health, and was not specific to ACAT. The ACAT has a limited role in drafting the survey, and consideration of survey results does not appear to be a factor in the planning or performance of ACAT's functions.

Recommendation 8

ACT Health redesign the Aged Care Assessment Team (ACAT) client satisfaction questionnaire to incorporate the range of ACAT service users (assessed clients, care recipients, their carers and families, referrers and service providers) to gauge their satisfaction with the ACAT's service and identify improvement opportunities.

Encouraging awareness of ACAT services

2.105 As the ACAT has a central role in enabling access to a wide range of community-based and residential aged care programs, it follows that ACAT should promote community awareness of its functions to the target group and their carers and medical professional. The ACT ACAT advised Audit that the team has met with community groups from time to time to enhance their awareness and understanding of ACAT's role. Records of these meetings were not kept, however.

2.106 The Commonwealth's *Operational Guidelines* specifies that ACATs' performance should be fulfilled with advising health professionals and the public on aged care issues. This was not observed as a regular and official activity of the ACT ACAT.

2.107 As also stated previously, in 2007-08 the ACT ACAT will receive additional funding of $2 862 to partly support an ACAT Education Officer. The Education officer's role is to represent the ACAT at various fora to explain the role and operations of the team.

2.108 Audit considers that the ACT ACAT would benefit from better promotion of its functions. As discussed previously, greater understanding of the ACT ACAT's role and activities would mean that assessments of clients who will not need community and residential aged care in the 12 months following assessment may decrease. Also, clients

and their carers would understand better that the ACAT's role is assessment and referral, and not allocating placement within care programs or delivering direct services.

Recommendation 9

ACT Health inform residential aged care providers, medical practitioners and the community of the role and capacity of Aged Care Assessment Team to assess and refer clients.

ADMISSION TO RESIDENTIAL AGED CARE FACILITIES

Applications for residential aged care facilities

2.109 Clients and their carers or advocates apply for a place in Residential Aged Care Facilities (RACFs) of their choice, following assessment and referral by ACAT. All approved clients are entitled to decline an offer or offers of residential aged care, and to choose the RACF that suits their needs. Correspondingly, no agency or person can direct an RACF to offer a place to a client.

2.110 Audit selected four weeks' data on waiting times for clients awaiting admission to high level and to low level RACF care. These are priority clients known to the ACT ACAT. It is probable that the facilities' own waiting list includes persons who were not clients of the ACT ACAT, but were assessed by other ACAT teams. They might also include persons who have applied to multiple facilities; who have failed to remove their names from waiting lists in other facilities upon admission to another, and who apply for a place at a RACF as a contingency.

2.111 ACT Health does not maintain a comprehensive list for numbers of persons waiting for residential care. The totals would be derived from the RACFs own figures, merged with those on the ACT Health's priority lists. Such data would be useful for ACT Health as an indication of the extent of unmet need for RACFs in the ACT, and would assist its planning for services.

2.112 Table 2.4 below shows the number of clients waiting for admission to a RACF for **high level** residential care (formerly known as nursing home care), where they were when they were assessed, and how long they had been on the waiting list. The 'other' category includes clients in rehabilitation and independent living units, and interstate clients.

Table 2.4: Numbers of clients awaiting high level residential care in the ACT, by place of assessment, selected weeks in 2007

		Week Ending			
		31 May	14 June	31 July	16 August
Average waiting time for all clients (days)		39.85	30.18	43.88	41.79
No. of clients awaiting placement		27	17	43	43
Community-based clients	No.	5	5	9	12
	Average waiting time (days)	63.00	54.2	49.56	45.33
In-patients in hospital	No.	14	10	27	24
	Average waiting time (days)	34.71	17.60	38.30	33.71
Respite care clients	No.	4	1	4	6
	Average waiting time (days)	35.25	28.00	56.75	70.17
Clients in RACF (low level care)	No.	2	1	1	0
	Average waiting time (days)	24	38	85	0
Other	No.	2	0	0	1
	Average waiting time (days)	43	0	0	23

Source: ACT Health

2.113 The table shows that:

- about half of clients on the high level waiting list are in-patients in hospital;
- in-patients have the shortest waiting time of the groups in the table – overall 31 days on average, although one or two very long stay in-patients have increased this average disproportionately;
- community-based clients wait longer than in-patients – up to 3 times as long, but there are much fewer of them than in-patients. Only 1 in 5 clients waiting for high level care is a community-based client. On average they wait 53 days for a placement in high level care;
- other clients – interstate, living in ACT Health facilities – comprise up to 2 per cent of clients; and
- the average total number of RACF clients waiting for high level care is approximately 32. Of these eight are community-based, and 18 are in-patients.

2.114 Table 2.5 below is the equivalent for **low level** residential care (formerly known as hostel care) recorded during a 4 week period. It shows the number of clients waiting, where they were assessed and the average waiting time.

Table 2.5: Numbers of clients awaiting low level residential care, by place of assessment, at selected weeks in 2007

		Week Ending			
		24 May	14 June	19 July	16 August
Average waiting time (days)		8	19	23	41
No. of clients awaiting placement		11	13	14	20
ACT Health facilities	No.	7	5	4	3
	Average waiting time (days)	11	33	9	49
In-patients in hospital	No.	1	0	4	4
	Average waiting time (days)	2	0	14	21
Respite care clients	No.	0	0	0	1
	Average waiting time (days)	0	0	0	44
Interstate clients	No.	1	7	4	3
	Average waiting time (days)	2	9	45	77
Community and other	No.	2	1	2	9
	Average waiting time (days)	2	22	290	36

2.115 The table shows that:

- there are fewer clients waiting for low level care, possibly reflecting the relative independence of these persons compared to high level care clients. These numbers appear to be growing, however, with 20 clients awaiting placement for an average of 41 days in the week ending 16 August 2007;
- clients are located in ACT Health care facilities, hospitals, the community and interstate; and
- hospital in-patients appear to have the shortest waiting times, reflecting a priority to move these clients to more suitable care, and to free hospital beds for other patients.

2.116 Audit was advised that in-patients recovering from illness, and who are without community support are a priority for transfer to an RACF. Most clients in the community with the same priority for admission as in-patients have support from family and carers, although if they deteriorate (and require admission to hospital) they would then have priority over an in-patient.

Recommendation 10

ACT Health seek the co-operation of Residential Aged Care Facilities to establish a consolidated record of the total number of persons waiting for residential care in the ACT, including those on the separate waiting list of Residential Aged Care Facilities, and use it for planning services to address unmet need for residential facilities in the ACT.

Residential Aged Care Liaison Nurse

2.117 ACT Health employs a Residential Aged Care Liaison Nurse. The Liaison Nurse is co-located with the ACAT and works independently of it, but reports to the Manager of the team. The ACT Government has funded the position to streamline the process of accessing residential aged care beds, as well as to improve information sharing and communication between the community and acute sectors and residential aged care facilities, and to work towards the development of a low-level care waiting list.[17]

2.118 The Liaison Nurse meets with clients and carers to facilitate placement. She also maintains priority waiting lists and engages in discussion with the RACFs on the placement of clients. Audit found that the Liaison Nurse assisted clients in their transition to high or low level aged care, but appropriately did not recommend any particular facility to the client.

2.119 The Liaison Nurse's integration into the ACT ACAT assists her to place clients who have been assessed and require residential care, despite ACAT itself stopping short of formally adopting a role of assisting clients in accessing residential aged care services.

2.120 Audit considers there is scope for the expansion of the role of the Liaison Nurse to include clients and programs which are not within the Liaison Nurse's current scope of operations. These would include community programs such as Extended Aged Care at Home and Community Aged Care Package.

Recommendation 11

ACT Health expand the role of the Liaison Nurse to include liaison with clients who are receiving community aid packages such as the Extended Aged care at Home and Community Aged Care Package, and their service providers.

ACAT'S ROLE IN SERVICE PROVISION: WHEN IS ITS JOB DONE?

2.121 The ACT ACAT sees its job as completed when the client has been assessed for aged care services. However, the team advised Audit that it will assist clients to access service providers if requested during the assessment, or if the client is experiencing difficulties. The Residential Aged Care Liaison Nurse, for example, provides a liaison and placement service using ACAT's assessments.

[17] The ACT Chief Health Officer Report 2006.

2.122 The *Operational Guidelines* provide that ACATs should, where possible, work with service providers to develop a care plan for the client, in line with their assessed care needs. This co-operative approach should:

- minimise duplication of assessment of the care recipient;
- combine the professional expertise of the ACAT with knowledge of the service provider's capacity to deliver care services (within available resources);
- ensure the best choice of care for an individual; and
- ease the transition from assessment to provision of service.

2.123 The *Operational Guidelines* further provide that:

> ACATs need to establish strong links with service providers in their local regions and be informed of service availability and capacity … Where a particular care service is not available, the ACAT will need to recommend alternative care options to meet the person's needs.

2.124 ACAT's role in case coordination is emphasised also in the training workbook: the *National Delegation Training for ACATs*. This includes the following steps:

- developing a care plan;
- arranging the care plan to the point of effective referral;
- ensuring that the care plan is implemented where no alternative case coordinator has assumed responsibility; and
- reviewing the overall care plan.[18]

2.125 The workbook says that:[19]

- ACATs should facilitate the provision of services to meet assessed needs, as identified in the care plan, to the point where an alternative case coordinator is identified and assumes the responsibility for coordinating service provision on behalf of the client. Referral for a type of care without that care being provided (that is, client on a waiting list) does not represent an effective referral. In these cases, the ACAT will need to arrange alternative options (for example, HACC) to meet client needs;
- where no alternative case coordinator has assumed responsibility, the ACAT case coordinator should organise the provision of services to meet assessed needs until an alternative case coordinator is identified; and
- ACATs should follow up clients at a predetermined date set in the care plan to ensure care plans are still relevant and recipients are satisfied with the care provided.

2.126 Audit noted that the ACT ACAT had a care coordination plan sheet that assessors were requested to complete after conduct of assessments. However, as noted at paragraph

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[18] National Delegation Training for ACATs – Workbook, pages 19-20.
[19] Ibid

2.66 at page 36, they were either not completed or used as another summary of assessment outcomes.

2.127 RACFs assess and plan for the care of new residents. Audit considers the quality of documentation which RACFs received from the ACAT could be improved. A summary sheet on a client is only provided occasionally, but is a useful source of information. As noted in this chapter, assessment documentation is only partly filled out, and is in need of review. Audit suggests that the views and feedback from the RACF sector would assist ACT Health in revising forms used to gather information on clients.

2.128 Further, Audit's view is that it is in the client's interest for ACT ACAT and service providers to work closely to assess the need for and extent of care required by the client; and to plan for its provision. Although RACFs and other service providers have responsibilities to the client, there is scope for greater cooperation in planning for the longer term needs of the client in care.

Recommendation 12

- The Aged Care Assessment Team (ACAT) co-ordinate with service providers to plan client care, based on the Team's assessment of the type and extent of care required; and
- The ACAT seek input from service providers to improve the quality of documentation given to them, in particular the assessment and summary documentation.

CONCLUSION

2.129 The ACT ACAT operates under the Commonwealth's Aged Care Assessment Program, and its policies and activities are strongly influenced by the Commonwealth's policies and initiatives. The ACAT is an assessment and referral service that facilitates access to Commonwealth funded programs for aged persons, but does not in itself deliver any aged care services.

2.130 Overall, Audit found that there was little reported unmet need for ACAT assessment and referral services and that ACAT generally has delivered appropriate assessment and referring services to meet the needs of frail older people. In particular, Audit noted that ACAT staff were responsive to the needs and attitudes of the client and their carers.

2.131 The ACAT's performance as measured by the national statistical collection was mixed. The ACT significantly exceeded the national average in average and median time from referral of a client to the face-to-face contact, and also provided timely first contact with Priority 1 and 2 clients. The delay in assessments was occurring mainly for Priority 3 clients, most of whom are assessed in the community, rather than in hospital. Although this delays the provision of services to clients outside a hospital situation, it reflects the ACAT's priorities in assisting hospitals in reallocating acute care beds for other patients.

2.132 Audit noted that there are opportunities for the ACT ACAT to improve its business planning, its assessment procedures and documentation, reporting and public accountability.

2.133 Aside from the national data collection, the ACT ACAT does not extensively use other sources of performance information to review the teams' performance and identify opportunities for improvement. Initiatives currently underway should improve data collection and management within the ACAT, and coupled with the redesign of a client satisfaction survey, will facilitate collection of data to identify further improvement opportunities.

OTHER ISSUES

Provision of residential aged care places

2.134 The provision of Residential Aged Care Services is primarily the responsibility of the Commonwealth through DoHA. Aged care places are allocated to aged care providers through an annual Aged Care Approvals Round (ACAR). Each State and Territory has an Aged Care Planning Advisory Committee (ACPAC) run by the State or Territory DoHA office.[20]

2.135 The ACT ACPAC[21] provides advice and recommendations to DoHA for the ACAR. This advice focuses on the extent and priority of need (for residential and community care places) within the ACT. ACPAC meetings are held at least twice yearly.

2.136 Places allocated through the ACAR are known as provisional allocations. They have been allocated to a provider but are not yet operational. Providers have two years to convert provisional places to operational places. The conversion of allocated places to operational places is discussed from paragraph 2.134 at page 50.

2.137 The tables below show the allocated and operational residential, community and transition care[22] places per 1 000 population over 70 at 30 June 2006 for all States and Territories.

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[20] The *ACT Chief Health Officer's Report 2006*.

[21] The Committee includes representatives from the Australian Government Department of Health and Ageing, ACT Planning and Land Authority, the ACT Ministerial Advisory Council on Ageing, the Department of Veterans Affairs, Alzheimer's Australia ACT and other Government and community representatives with relevant knowledge and experience in the delivery, or the ability to contribute to the planning, of aged care.

[22] Transition care is assistance to clients returning to the community following discharge from hospitals.

Table 2.6: Provisional allocated residential, community and transitional care places per 1 000 population over 70 at 30 June 2006

Allocated places	High level care	Low level care	Total residential care	Community care	Transitional care	Total
NSW	47.9	49.2	97.1	19.5	0.8	117.4
Vic	45.0	52.9	97.9	20.1	0.8	118.8
Qld	44.8	51.3	96.1	19.0	0.8	115.9
SA	48.1	49.3	97.4	19.9	0.7	118
WA	43.9	51.7	95.6	20.6	0.6	116.8
Tas	49.3	46.1	95.4	21.3	1.0	117.7
NT	63.8	45.9	109.7	135.1	0	244.8
ACT	41.2	58.7	99.9	24.3	1.6	125.8
Aust	**46.3**	**50.8**	**97.0**	**20.1**	**0.8**	**117.9**

Source: Report on the Operation of the *Aged Care Act 1997* 1 July 2005 to 30 June 2006, DoHA, 2007

Table 2.7: Operational residential, community and transitional care places per 1 000 population over 70 at 30 June 2006

Operational places	High level care	Low level care	Total residential care	Community care	Transitional care	Total
NSW	44.4	39.7	84.1	19.2	0.5	103.8
Vic	39.7	46.3	86.0	20.0	0.1	106.1
Qld	39.6	45.9	85.5	18.9	0.2	104.6
SA	45.6	46.2	91.8	19.9	0.5	112.2
WA	38.5	46.1	84.6	19.8	0.3	104.7
Tas	44.8	42.8	87.6	20.6	0.3	108.5
NT	59.5	44.3	103.8	135.1	0	238.9
ACT	29.7	41.8	71.5	23.9	0.4	95.8
Aust	**41.8**	**43.8**	**85.6**	**19.9**	**0.3**	**105.8**

Source: Report on the Operation of the *Aged Care Act 1997* 1 July 2005 to 30 June 2006, DoHA, 2007

2.138 Audit's analysis of the tables reveals that:

- The ACT is doing well in the allocation of aged care places from the Commonwealth. Of the eight States and Territories, the ACT ranked 2nd at 107 per cent of national average for the total number of places for all types of care allocated at 30 June 2006.
- The emphasis of the Commonwealth's allocation of **residential** places to the ACT is in the low care area. The ACT ranked 8th out of the 8 States and Territories for the number of allocated high care places, 1st for low care places, and 2nd for overall allocations. Some 59 per cent of the allocated places for residential care were for low care places.
- The ACT is slow at converting the allocation of **residential** places by the Commonwealth to beds for clients. The ACT ranked 8th in the number of

allocated places that had become operational per 1 000 population over 70. Only 72 per cent of the ACT's allocated residential places – high and low care - were operational at 30 June 2006. All other States and Territories had 84 per cent or better of allocated places that were operational.

- The ACT is converting well its allocation of **community** places into services to clients. Non-operational allocated places were only 2 per cent of total allocated places.

2.139 From 1 July 2007, the Commonwealth seeks to achieve and maintain 113 operational aged care places for every 1 000 people in the population aged 70 years or over. The number of places is made up of:

- 44 residential high care places;
- 44 residential low care places; and
- 25 community care places.

2.140 The Commonwealth informs the States and Territories of the number of places in community and residential aged care that they will receive each year, and provides estimates for the two following years. This is to allow for building approval, construction and certification of residential aged care places.

2.141 On 1 May 2006, the Commonwealth announced the new aged care places to be made available in 2006-07 as well as indicative releases for 2007-08 and 2008-09.

Table 2.8: Allocation of aged care places by program 2007-08, 2008-09 and 2009-10

	ACT	Australia
Residential	158	6 811
CACP	25	2 327
EACH	35	1 566
Total for 2007-08	218	10 704
Total for 2008-09 (indicative figures)	214	11 728
Total for 2009-010 (indicative figures)	135	8 067

Source: Annual Report 2005-06 on the Operation of the *Aged Care Act 1997*

Note: indicative figures may vary, as population projections and the rate of allocation of places are updated.

Building residential aged care facilities

2.142 As mentioned previously, it is the Commonwealth's responsibility to allocate aged care bed places, as follows:

- the Commonwealth Minister for Ageing determines the number of new aged care places to be made available in each State and Territory for the coming financial year;

- each year, the Aged Care Approvals Round (ACAR) invites service providers to apply for places, which are distributed across Aged Care Planning Regions. The ACT is a single Aged Care Planning Region; and
- the Commonwealth Minister for Ageing announces the successful applicants for aged care places (called provisional allocations until they are made operational) and community care packages in December, with written confirmation in the following February.

2.143 The Commonwealth allows providers two years to make a provisional allocation operational. In the ACT, in order to provide operational places, service providers in the ACT must:

- complete the purchase of land if necessary to build a new RACF. Land sales are made directly to service providers, and are thus approved by the ACT Government. Alternatively, a service provider can purchase land through a competitive land release, before the approvals round (ACAR); and
- lodge a development application for the land with ACT Planning and Land Authority (ACTPLA), which invites public comment on the application. Refurbished premises also must lodge a development application for major renovations, additions or reconstruction.

2.144 Audit's analysis above shows that 28 per cent of allocated residential care places are not operational in the ACT. Of the total Commonwealth allocated ACT places of 99.9, the ACT has 71.5 operational (per 1 000 of the over-70 population).

2.145 Audit acknowledges that it is unrealistic to suggest that the number of available residential care places and clients awaiting placement will always be in balance. However, the delay in taking up all the Commonwealth allocated places has led to the apparent current shortage of places in RACFs, and contributed to the longer waiting time in the ACT than in other jurisdictions.

2.146 Audit was informed that nearly 700 beds were in train with nine different providers, including 100 beds adjacent to Calvary Hospital that opened in 2007.

2.147 Audit was advised that the delays in converting allocated places to operational beds can be attributed, in part, to:

- negotiations are underway but incomplete regarding the size of the facility to be located on a parcel of land (60 beds);
- a Development Application has been approved but the provider is yet to finalise the relevant land purchase (40 beds);
- a Submission to the ACT Government is under consideration for the purchase of land (100 beds);
- a provider was preparing a Development Application following a land purchase (60 beds); and

- Development Approvals have been granted in 2006 and 'sod turning' ceremonies to commence construction are to be held before the end of 2007 (240 beds).

2.148 The current development proposals and the construction now underway should address to a large extent the current ACT needs for residential care.

2.149 The audit indicates that the ACT is adequately provided by the Commonwealth with residential aged care places, although the ACT is slower than other jurisdictions in converting its entitlement to operational places. Audit considers that with sound planning and coordination, an efficient and effective aged care system should be able to provide services to the older people, which are appropriate to their needs and with the minimum waiting time.

3. HOME AND COMMUNITY CARE (HACC)

INTRODUCTION

3.1 This chapter examines ACT Health's performance in delivering the Home and Community Care (HACC) program. It discusses whether appropriate policies, procedures and structures are in place to identify the need for, and ensure the efficient and effective delivery of, HACC services in the ACT.

3.2 The HACC program is a joint Commonwealth, State and Territory program providing community care services to eligible persons. During 2006-07, the program cost $22.5 million to deliver in the ACT, 49 per cent of which was funded by the Commonwealth. It delivered services to some 15 000 ACT residents (2005-06), which is approximately 56 per cent of the target population.

KEY FINDINGS

Planning for service delivery

- The ACT Home and Community Care program delivers community services to support people to remain at home by providing domestic assistance, personal care, community transport and activities to reduce social isolation
- ACT Health has an effective annual Home and Community Care program plan, the preparation of which included extensive consultation with service providers and other stakeholders. Since 1999, the Commonwealth intended for each jurisdiction to produce a triennial plan for the delivery of HACC services. The Commonwealth did not act on this intention, and consequently no State or Territory produced a triennial plan. The current intention is for the first triennial plan to be in place by early 2008.
- ACT Health maintained effective oversight of the submission of Home and Community Care program data to the Commonwealth's data collection program.

Access to Home and Community Care program services

- ACT Health did not collect data on the numbers of potential clients who make enquiries of service providers about Home and Community Care program services. Without a central intake point for Home and Community Care program clients, ACT Health was unable to measure with reliability the extent of unmet needs for services, and instead relied on ad hoc and optional reports from service providers to make estimates of unmet demand.
- The NGO service providers assessed clients for eligibility. There was no evidence that clients were accessing more services than they should reasonably expect to receive.

- ACT Health has established a position of Multicultural Home and Community Care program Liaison Officer, but the Liaison Officer's role and accountability and working arrangements are not well defined or structured.
- Similar to other jurisdictions, people from culturally and linguistically diverse backgrounds in the ACT do not access HACC services in numbers proportionate to their representation in the HACC target population. This tends to support views expressed by some stakeholders that this group still experiences some barriers to services.
- Currently, an individual client seeking to access several HACC services may be required to undergo assessments from each of the service providers, creating inconvenience and uncertainty for the client, and increasing the administrative burden on the service providers. A well coordinated access program, which for example encourages the central collection and one-off assessment of client needs, would improve this situation. The ACT is working to implement a COAG initiative on this issue.
- COAG, through *The Way Forward* initiatives, had set a goal of improving access to Home and Community Care program services. ACT Health had completed the first stage of the initiative, which involved mapping community care provision and supporting infrastructure. This process identified strengths including the presence in the ACT of the Community Health Intake as a central contact point, but also weaknesses including inconsistent assessment processes.

Service delivery

- ACT Health had not formalised a policy on the management of fees that service providers may charge Home and Community Care program clients for some services, as required under the Home and Community Care program *Review Agreement,* which became effective from 1 July 2007. ACT Health intends to adopt a proposed national fees policy, due to be promulgated by July 2008.
- Service providers collected $2.2 million in fees from Home and Community Care program clients during 2005-06. Audit found no evidence that ACT Health had reviewed the financial returns of ACT service providers, to determine whether providers put the fee revenue back to the services from which they were derived, as required under the Home and Community Care program funding agreement.
- Some service providers engage contractors (known as 'brokers') to deliver Home and Community Care program services. However, they did not always use a written agreement that requires brokers' compliance with Home and Community Care program standards. ACT Health should encourage and assist service providers to minimise the risk that brokers are not meeting service delivery standards by providing a 'template agreement' for use in engaging brokers.

Quality assurance of services

- An independent agency evaluated the performance of service providers every three years. ACT Health relied on this process for quality assurance purposes, and did not routinely collect information to ensure compliance with Home and Community Care program service standards. Standards relating to such items as police checks, waiting lists, complaints and the protection of client details were

not tested by ACT Health, nor were service providers asked to report on these, even annually.

- ACT Health did not have any written funding acquittal procedures that facilitated their review of reports required by the Home and Community Care program funding agreements, and follow-up (as necessary) of any outstanding or unsatisfactory matters.
- The processes adopted by ACT Health to review the financial reporting by service providers were not sufficiently robust to identify and follow-up inadequate or incomplete reporting, unexplained variances of expenditure against the approved budget or significant sums of unspent funds at the end of the reporting period.
- Funding agreements between ACT Health and service providers are silent on the treatment of unspent funds at the end of the reporting period and on the disbursement of any proceeds from the disposal of assets (e.g. motor vehicles, computer equipment) purchased with Home and Community Care program funds during the life of the funding agreement.
- ACT Health had not conducted joint Annual Reviews (between ACT Health and service providers) to consider performance in service delivery for at least 12 months preceding audit fieldwork. There is a risk, therefore, that ACT Health may not be identifying and treating any instances where service providers have failed to deliver the level or quality of services for which they have been funded.

THE HOME AND COMMUNITY CARE PROGRAM

3.3 The HACC Program is a joint Commonwealth, State and Territory program that provides community care services to frail aged and disabled persons, and their carers, who may be at risk of premature or inappropriate admission to long-term residential care. Services to the HACC 'target population' are provided within each jurisdiction by local government, community organisations, religious and charitable bodies, State and Territory Government agencies, and for-profit private organisations.

3.4 The program was established by the *Home and Community Care Act 1985*. The original agreement with each State and Territory for the provision of HACC funding is a schedule to the Act. The HACC *Review Agreement* is the latest version of these inter-government bilateral agreements, and commenced on 1 July 2007. It supersedes the *Amending Agreement*, which had been the basis of the funding relationship between the ACT and the Commonwealth since 1999.

3.5 The Commonwealth took the lead in policy development and issued *National Program Guidelines for the Home and Community Care Program* (the Guidelines) and a *Program Management Manual* for the HACC Program. The Guidelines specify, amongst other things, seven HACC Service Objectives for service providers, and 27 attending Service Standards (see Appendix A for further detail). Funding agreements between ACT Health and service providers in the ACT should include reference to the HACC standards.

3.6 Aside from three-yearly quality assurance reviews of service providers, and the quarterly receipt of data for its statistical collection, the Commonwealth dealt solely with the ACT Government through ACT Health.

3.7 In 2004, the Commonwealth released *A New Strategy for Community Care - The Way Forward*: a major national reform for the delivery of community care, including the HACC program. Among other things, *The Way Forward* 'outlines the intention (of the Commonwealth) to work with State and Territory Governments to review the current HACC Agreement and to redevelop a new HACC Agreement'. The new strategy reviewed and reformed many aspects of the HACC program, including assessment for need and eligibility, access to services and eligibility criteria, information management and data collection, and planning.

The HACC target population

3.8 The *Home and Community Care Act 1985* (Schedule 3) defined the 'target population' as:

> (a) persons living in the community who, in the absence of basic maintenance and support [from family and others], … are at risk of premature or inappropriate long term residential care, including -
>
> (i) frail or at-risk aged persons, being elderly persons with moderate or severe disabilities;
>
> (ii) younger disabled persons, being persons with moderate or severe disabilities;
>
> (iii) such other classes of persons as are agreed upon by the Commonwealth Minister and the State Minister, and
>
> (b) the carers of those persons [23].

3.9 The HACC program includes carers within the target population in recognition of the often considerable efforts and sacrifice that carers made for the sake of aged family members or friends.

HACC funding in the ACT

3.10 Total expenditure nationally on HACC was $1.409 billion in 2005-06, consisting of $857.8 million (60.9 per cent) from the Commonwealth Government and $551.1 million (39.1 per cent) from the State and Territory governments.

3.11 Expenditure in the ACT on the HACC Program totalled $20.7 million in 2005-06, with the ACT Government contributing $10.6 million (51 per cent) and the Commonwealth the remaining $10.1 million (49 per cent).[24] For the period 2007 to 2011, Commonwealth and ACT Government funding of the program is expected to total $110.5 million, which includes annual indexed and growth funding.

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[23] *Home and Community Care Act 1985*, Schedule 3, Part III, Clause 6(a) and (b).

[24] Productivity Commission, Report on Government Services 2007 - 12A Aged care services – attachment, Table 12A.43.

3.12 Service providers were funded for a triennium, in accordance with the ACT Government's *Community Sector Funding Policy*. An extra year, 2007-08, has been added to the 2004-07 triennial funding period to enable ACT funding agreements to align with the new national agreement triennial funding periods.

3.13 To be eligible for funding, service providers were required to be:

- incorporated;
- able to demonstrate an ability to meet priority needs;
- likely to maintain services;
- actively improving the quality of service provision; and
- able to demonstrate a satisfactory track record of compliance and performance.

3.14 In recent years, the Commonwealth had increased the amount of the annual HACC payment to the ACT by approximately 8 per cent – which incorporates indexation for existing providers and a growth component. ACT Health invited any service provider, including but not restricted to those with current agreements, to tender for the growth component. In 2006-07, $1.76m in extra funding was allocated to existing and successful tenderers. The ACT and the Commonwealth provided $1.9m in extra funding for growth and indexation in 2007-08.

3.15 There were 30 NGOs and two ACT Health HACC service providers funded in 2006-07. The eight largest incorporated NGO service providers received $12.1 m, which is 54 per cent of the total annual funding of $22.5m. These providers were:

- Australian Red Cross Society;
- Communities@Work;
- Community Options;
- FaBRIC;
- Handyhelp;
- Home Help Service Inc;
- Northside Community Services; and
- Respite Care ACT.

The delivery of ACT HACC through community service providers

3.16 There is a wide range of HACC services provided generally to people in their own homes or through services in their local community, such as domestic assistance, activities at community centres and transport for medical treatment (see Figure 1.1 at page 3).

3.17 The HACC Policy Unit within ACT Health is responsible for the administration of individual HACC service providers in the ACT. In the 2005-06 financial year, the 30 non-government community-based HACC service providers serviced approximately

15 000 HACC clients from the target population of 26 700. During 2005-06 the ACT HACC program delivered:

- 541 000 hours of services;
- 138 000 meals;
- 5 500 linen service deliveries;
- $331 000 in home modifications;
- $189 000 in equipment; and
- 93 700 one-way transport trips.

3.18 The following table compares delivery of HACC services in the ACT with national averages for 2005-06 (latest available figures).

Table 3.1: Average HACC Service received per client in the HACC population, selected assistance type, 2005-06

HACC MDS Category	National Average	ACT Average	ACT Avg /Nat Avg %
Measured in hours			
Assessment	2.8	7	250
Case Management & Planning	Not published		
Nursing Care – Centre	5.8	19.1	329
Nursing Care – Home	16.6	10	60
Allied Health – Centre	4.1	3.9	95
Allied Health – Home	5.9	2.8	47
Care Counselling Support	2.6	8.4	323
Carer Counselling Support	5.4	7.6	141
Home Maintenance	8.1	7.4	91
Domestic Assistance	30.7	19.5	64
Social Support	38.9	42.3	109
Personal Care	57.2	57.1	100
Centre Based Day Care	140.5	100.7	72
Other Food Services	28.3	Not available	
Respite Care	80.6	85.8	106
Measured in dollars			
Home Modification	1.3	17.6	1354
Measured by numbers			
Formal Linen Service (deliveries)	21.5	28.4	132
Transport	35.6	36	101
Meals at home	106.8	67.4	63

HACC MDS Category	National Average	ACT Average	ACT Avg /Nat Avg %
Meals at a community centre	30.3	19.2	63

Source: MDS 2005-06 HACC Bulletin, Table A17

3.19 The table above shows that in 2005-06, the ACT delivered substantially above the national average in assessments, home modification, nursing care at centres and care counselling support, but substantially below the national average in home delivery of allied health and nursing care. However, in the absence of comprehensive information about current need and unmet demand, Audit was not able to determine if the ACT pattern of HACC services reflects the appropriate mix based on ACT-specific need, or reflects historical trends in supply. For example, it is not clear that the lower than national average HACC services provided per client of the HACC population under the category of home-based allied health is a result of low demand in the ACT for this service or a shortage in capacity.

3.20 Service funding agreements between ACT Health and service providers specified service outputs required, depending on the type of services. Measurement of outputs is described later in this chapter.

PLANNING FOR THE DELIVERY OF HACC SERVICES

Plans required under the Commonwealth funding agreements

3.21 The *Amending Agreement* covered the period 1 July 1999 to 30 June 2007. It included an intention to create a triennial plan, but in the eight year life of the agreement, no such plans were agreed between the Commonwealth and the ACT, or any other State or Territory. The absence of the triennial plan meant that the opportunity to specify priorities and strategic directions for the Program was delayed.

3.22 The *Review Agreement*, which took effect from 1 July 2007, requires the ACT to prepare triennial and annual plans. The first triennial plan is due by 31 March 2008.

3.23 The triennial plan, when it is drafted, will include analysis of both quantitative and qualitative information, and input from consultation with consumers and providers of community care to identify the requirement for services, trends and emerging issues. The plan will also consider the broader national policy agenda for community care and how this can be incorporated in program priorities.[25]

3.24 The funding agreements with the Commonwealth also require annual HACC plans. Audit reviewed the Territory's HACC *Annual Plan 2006-07*, and found that planning activities listed consisted of consultations with peak bodies, the community sector and stakeholders - which assisted ACT Health to determine priorities for the allocation of

[25] 2007 HACC guidelines, page 11.

growth funds in 2006-07. An Annual Plan for 2007-08, covering actual funding and planned outputs, was prepared based on templates provided in the HACC *Program Management Manual* and provided to DoHA by 30 September 2007 as required.

Submission of statistical data to the Commonwealth

3.25 ACT Health and service providers are required by the agreements to submit data four times per year to the Commonwealth's national HACC data repository, the Minimum Data Set (MDS).

3.26 The HACC MDS was a planning tool that aimed to:

- provide the Commonwealth with data required for policy development, strategic planning and performance monitoring;
- assist service providers with planning for and provision of client services through the facilitation of improvements in the management of national program service delivery; and
- facilitate consistency and comparability between program data and other collections of data covering the community care and health fields.[26]

HACC planning by ACT Health

3.27 Audit noted that ACT Health complied with the planning requirements of the HACC agreements, including extensive community consultation, and co-operated with the Commonwealth to gather statistics for the MDS from service providers. A major annual HACC planning activity is a day-long meeting facilitated by the ACT Council of Social Service on behalf of ACT Health. This day was attended by senior representatives of the community sector and government representatives from ACT Health, ACT Department of Disability, Housing and Community Services and the Commonwealth.

3.28 Audit also noted that ACT Health and other agencies had produced policy documentation on future aged care needs, including the need for more and better services to HACC eligible clients.

3.29 Audit observed that ACT Health had at its disposal detailed projections and estimates of the future HACC eligible population, and current and past costs of providing HACC services. Although it was widely acknowledged that aged care budgets will face increasing pressures, Audit was informed that ACT Health does not plan for the longer term provision of services under the HACC program.

3.30 Audit acknowledges that ACT Health has responsibilities under national agreements to administer the upcoming triennial agreement. Audit considers that regardless of the Commonwealth requirement, better practice would require ACT Health to have longer term strategic planning that would also enable ACT Health to anticipate and

[26] 2007 HACC guidelines, page 14.

estimate demand for services, and hence any future cost pressures on its own HACC budget, which provides for approximately 50 per cent of total HACC expenditure in the ACT. It would present an opportunity for ACT Health to specify longer term goals, objectives and strategies to meet the ACT's needs through the HACC program.

Planning initiatives under *The Way Forward*

3.31 Under the banner of *The Way Forward*, the Commonwealth aims to determine the feasibility of a nationally consistent planning framework for community care programs.[27] A *National Planning Framework Project*, which commenced in May 2007, will develop 'a streamlined and co-ordinated approach to planning that helps to reduce the potential for gaps and overlaps in service delivery'. The framework will develop a more co-ordinated approach to planning, based on common principles such as client needs, service mix, regional capacity, and the availability of data and protocols for sharing it. The development work will continue throughout 2007.

3.32 At the time of audit, ACT Health had completed a 'mapping study' which considered the requirements for access points to community care and mapped current infrastructure and access pathways. The study recommended options for access pathway demonstration agencies, that are testing various options for access to the aged care system. The study also highlighted where community care planning connects with other health and aged care programs and joint planning initiatives. It will be used to develop suggestions for common planning principles and data sharing protocols to be used to deliver community care programs.

PROMOTION OF, AND ACCESS TO, HACC SERVICES

Explaining the role and function of HACC services

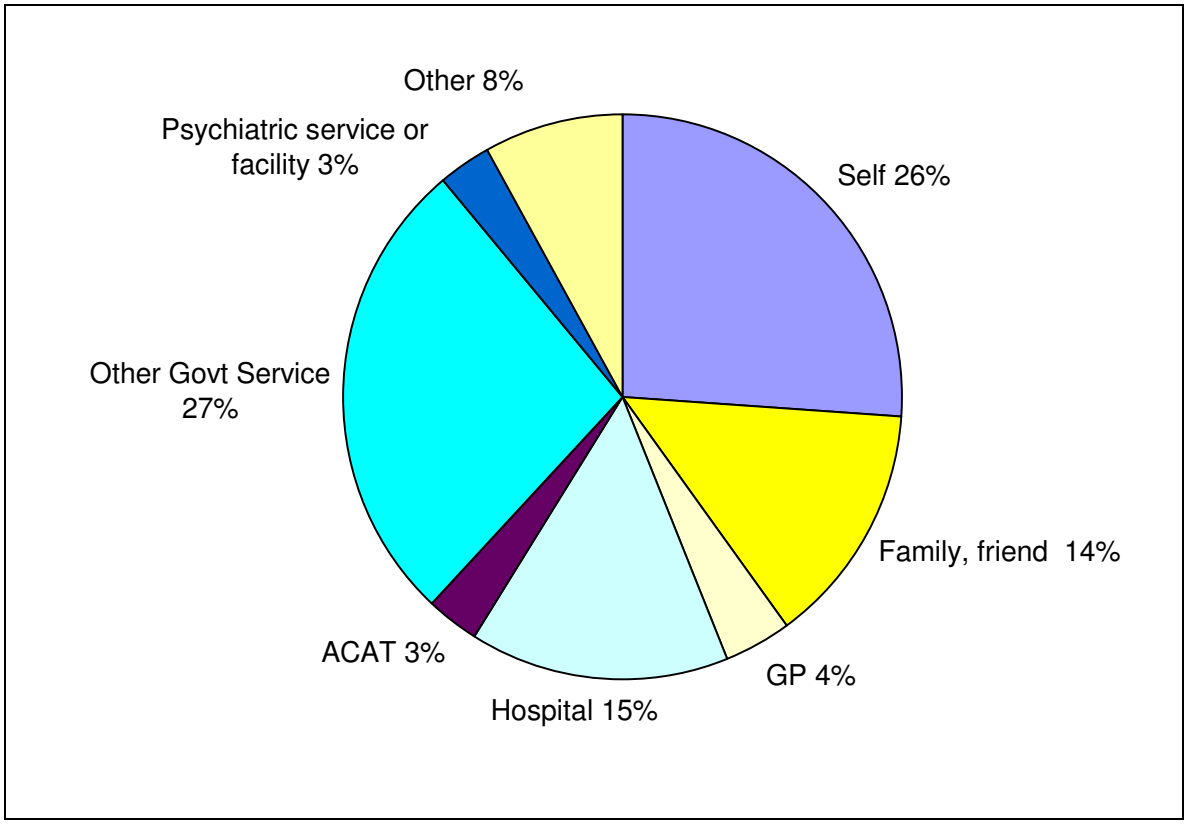
3.33 The complexity of the aged care environment, and the variety of services available, means that it is important to inform potential clients of the range of services available through the HACC program. Audit observed that HACC service providers actively promoted their services through literature, public fora and community meetings. In recent times, the Commonwealth had also undertaken substantial media promotion of in-home services for the aged.

Referrals to HACC services

3.34 The figure below shows the sources of ACT referrals to HACC service providers in 2005-06 – the latest published MDS bulletin.

[27] Source: June Way Forward newsletter.

Figure 3.1: Sources of referral to HACC in the ACT, 2005-06



Source: HACC MDS 2005-06 Annual Bulletin, Table A13

3.35 About half (53 per cent) of referrals came from HACC clients themselves or a government health service. Family or friends referred another 14 per cent. A significant number of referrals arose from a variety of other health related services, including hospitals (15 per cent), GPs (4 per cent) or ACAT (3 per cent).[28]

3.36 Unlike other aged care programs that are funded wholly by the Commonwealth, HACC clients do not require an assessment by an Aged Care Assessment Team before they can access services.

HACC referral services in the ACT

3.37 The role and functions of the ACT Community Health Intake (CHI) service is described in Chapter 2, Aged Care Assessment. It is a referral service, maintaining information on the role and functions of ACT Health units and service providers. Through a call centre, it informs clients of services available, recommends suppliers of those services, and makes appointments for clients with ACT Health services.

3.38 *Carelink* is the Commonwealth's aged care information service. Through its offices, a freecall phone number and a website, it informs clients of Commonwealth and

[28] HACC MDS 2005-06 Bulletin Table A13. This is the latest published data at the date of this report.

ACT Government services and service providers. ACT Health co-operates with *Carelink* in providing information on the aged care service providers in the ACT, including details about HACC service providers.

Access through service providers

3.39 The HACC *National Standards* specifies that 'each consumer's access to a service is decided on the basis of relative need'.[29] The HACC *National Program Guidelines* state that funding agreements with service providers should include priority of access policies.[30]

3.40 In making assessments, service providers are required to consider the level of service to be provided, vulnerability of the client, the effect on the carer, the likely effect in assisting individuals (such as reduced risk of admission to residential care), the effect on others and safety for consumers and staff. Service providers are required, under the terms of their agreement with ACT Health, to assess clients before they provide services to them. They commonly used the standard *HACC Client and Information Referral Record* in conducting the assessments.

3.41 Audit observed that:

- funding agreements specified priority of access criteria;
- service providers ranked potential clients by need;
- larger providers had central assessment functions, which triaged applicants for services;
- for some clients, a case manager co-ordinated service delivery and, as necessary, recommended that the client be assessed by the ACAT if a more intensive care package was indicated;
- some services, such as meals on wheels, did not require in-home assessment; and
- as NGO staff became available to assess clients, service providers sought to meet standards for the timeliness of service provision.

Client eligibility to HACC

3.42 Any person within the target population is eligible to receive HACC services, subject to a service provider assessment of relative need, and the availability of the service. Those receiving a service are able, without discrimination, to join the queue for additional services. [31]

3.43 There is a risk that some clients are over-using HACC services, by applying for more services than they are reasonably entitled to. ACT Health considers that the service providers should monitor the extent of services they offer to individual clients, and apply

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[29] 2007 HACC Guidelines, page 17.
[30] 2007 HACC Guidelines page 21.
[31] HACC objective 1, Access to Services.

criteria for access to services to minimise this risk. Audit noted that the *HACC Client and Information Referral Record* included questions about services the client was currently receiving from other programs.

3.44 Audit did not find evidence of over servicing. Service providers advised Audit that the risk of over-use of services was small because:

- services such as transport were defined geographically based on a residential address. Clients would not be able to obtain services from another transport services provider; and
- services such as meals on wheels and personal or dementia alarms had one provider for all of the ACT.

3.45 In the absence of a consolidated and central source of information on clients and services, Audit understands that service providers rely on their informal network to enable them to be generally aware if some clients more heavily use HACC services.

Co-ordination between service providers

3.46 The *Review Agreement* and the HACC *Program Guidelines* recognise the need for co-ordinated assessment and service provision. The *Program Guidelines*, for example, contain 'jointly agreed assessment principles' including that 'a co-ordinated, integrated regional or local approach should be established between service agencies, assessment teams and assessors to ensure a smooth provision of the necessary mix of services and to avoid unnecessary multiple assessments and/or the duplication of services for clients.' [32]

3.47 The ACT is a discrete and compact jurisdiction, and has no remote or isolated areas - a factor that can complicate service delivery in other States and Territories. Audit was informed by ACT Health that the small size and close nature of the community service sector in the ACT contributed to service efficiency.

3.48 It was suggested to Audit that given the size of the ACT jurisdiction, efficiencies and savings were more likely to be achieved if a single services provider was used to deliver each HACC service category. Audit considers this is a matter generally resolved through 'market forces' and sound procurement practices by ACT Health. Audit observed that some ACT HACC services are already available from just one service provider - Meals on Wheels, for example, is run by the Australian Red Cross. Also, at one stage, after-hours transport was provided by one community service for the whole of the ACT; however, the dispersed nature of the service meant that it was more efficient and effective to provide transport services from various points around the ACT.

3.49 The emphasis of *The Way Forward* program has been on avoiding duplication of assessment rather than duplication of service provision. The mapping study of service provision conducted by ACT Health under the auspices of *The Way Forward* noted that assessment components, classifications and definitions were not consistent.

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[32] Pages 21 and 22.

3.50 Audit noted that multiple assessments occurred when HACC clients required different services from different service providers. There is currently no structured or formal system for service providers to share information on clients and many cited privacy protection as an issue preventing more efficient co-ordination between them to improve HACC services..

3.51 Audit also observed that better co-ordination of service delivery can result when a case manager is responsible for assisting a client in obtaining necessary services and assessments. The 2004-05 MDS collection, which is the latest information on case management available, shows that ACT service providers are using case management and planning at a rate some four times the national average.[33] Audit was advised by service providers that client demand for case managers is putting pressure on their resources, leaving them with a decision regarding whether the benefits of expanding case management practices exceeds the cost.

Unmet demand for services

3.52 Service providers responded to unmet demand for services by:

- making every effort to accommodate all eligible applicants, even if this sometimes meant that minimal or reduced services were provided to the client;
- closing their books to new clients until resources became available to service them; and
- sub-contracting services to private, for-profit service providers, known as brokers. These brokers are discussed later in this chapter.

3.53 ACT Health, however, was unable to formally measure the amount of unmet demand for services, particularly in the absence of a central intake point for HACC clients. ACT Health commented that:

> In assessing the extent of unmet demand for service, ACT Health relies on written reports provided by funded organisations. These reports received each 6 months note if there is a waiting list for services. Funded organisations may also submit a report that is referred to as an 'optional' report in Schedule 3 of the funding agreement. This report may include details on:
>
> > Planning and policy implications including, new or unmet needs; service gaps; innovations in service delivery; suggestions for policy change and any systemic issues.
>
> In addition to this formal reporting, ACT Health holds a monthly network meeting of service providers. During the network meeting, organisations provide a verbal update on their current services including their capacity to respond to the needs of new client.

3.54 Audit found that information on unmet demand was only submitted to ACT Health by some service providers through optional reports. Audit found no evidence that the information available through the optional reports was regularly consolidated and

[33] Table A24 of the 2004-05 HACC MDS Bulletin, showing services delivered per 1 000 of the target population

comprehensively analysed. Further, it is possible that service providers are not aware of the extent of unmet demand as not all potential clients will present to service providers for inclusion on a waiting list. The current process was not sufficiently robust for ACT Health to have a sound knowledge of the quantity and type of unmet need.

3.55 Increases in funding from the Commonwealth and the ACT, that are distributed to existing and new service providers each year, are devoted to responding to new clients and providing more services to additional clients.

3.56 To better co-ordinate services and meet the needs for HACC services it is desirable for ACT Health to have a robust and central source of information rather than relying on ad hoc contacts and optional reports from service providers.

Access by culturally and linguistically diverse clients

3.57 The table below shows the ACT's mix of culture and language. By comparison to the national data, the ACT had a below average number of Australian and New Zealand clients, but a larger representation of European (Anglophone and non-Anglophone), and Asian clients.

Table 3.2: HACC clients by country of birth, 2005-06

Country of birth	ACT %	National %
Australia	64.3	73.6
New Zealand	1.0	0.8
Other Oceania	0.3	0.2
North-West Europe	16.2	11.1
Southern and Eastern Europe	11.5	9.2
North Africa and the Middle East	0.7	1.3
South-East Asia	1.5	1.1
North-East Asia	1.1	0.7
Southern and Central Asia	1.8	1.0
Americas	1.1	0.5
Sub-Saharan Africa	0.5	0.5
TOTAL	100	100

Source: Table A5 HACC MDS 2005-06 Annual Bulletin

3.58 Audit was informed that a number of factors contributed to a reluctance by culturally and linguistically diverse clients to seek HACC and aged services, including:

- a shortage of funding for interpreters; and
- culturally and linguistically diverse persons often had less knowledge of HACC services and may misunderstand their purpose and intentions. They do not generally access services until their needs become deeper, and their resources and networks fail.

3.59 Data presented in the 2007 *Report on Government Services*, published by the Productivity Commission[34] indicated that, similar to other jurisdictions, people from culturally and linguistically diverse backgrounds in the ACT do not access HACC services in numbers proportionate to their representation in the HACC target population. This tends to support views expressed by some stakeholders that this group still experiences some barriers to services.

3.60 Funding agreements with service providers were extended from 1 July 2007 to 30 June 2008, and do not yet contain provisions for access by special needs persons. This requirement was introduced by the 2007 *Program Guidelines,* which had effect from 1 July 2007.

3.61 The fact that this client population may not seek assistance until their families and networks are unable to cope, and may be reluctant to leave the family home, can further complicate the delivery of services to meet their needs.

3.62 ACT Health funds a Multicultural HACC Liaison Officer through the HACC program, who is co-located with the ACT ACAT team. The Liaison Officer position provided services under MDS (version 1) category 18: counselling and support; information and advocacy. Audit was advised that HACC related activities by the Liaison Officer were:

- service promotion to service providers, not clients;
- training for service providers; and
- community information and education to promote other aged care services.

3.63 Audit observed that the functions of the Multicultural HACC Liaison Officer appear broader than HACC alone. For example, the Liaison Officer works with two Commonwealth funded officers employed under the *Partners in Culturally Appropriate Care* program, and the *Community Partners Program*.

3.64 The Liaison Officer's work plan was signed off by the ACAT manager, apparently without any consultation with the ACT Health's HACC Policy Unit. Audit found that, in the absence of a co-ordinated work plan, the Liaison Officer's involvement with service providers was not regular, and arose from specific invitations and opportunities. Further, Audit noted that the position does not appear to have any approved output or outcome targets and, except for an annual narrative report, there was no structured reporting by the Liaison Officer to the HACC Policy Unit.

3.65 Audit considers that the role of the Multicultural HACC Liaison Officer in the ACT Health HACC team should be better defined to be more effective in serving culturally and linguistically diverse clients. Improved planning and reporting arrangements would make the position more effective, and it would benefit from any synergies, particularly in relating to service providers, flowing from working closer with the HACC Unit.

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[34] Pages 354-357 and Figure 12.12, Volume 2, 2007 *Report on Government Services,* Productivity Commission, 2007

Recommendation 13

ACT Health clarify the role of the Multicultural Home and Community Care program Liaison Officer and establish an appropriate accountability framework for the position, including development of an annual work plan and regular structured reporting against the plan.

Improving access - *The Way Forward* and COAG initiatives

3.66 Currently, an individual client seeking to access several HACC services may be required to undergo assessments from each of the service providers, creating inconvenience and uncertainty for the client, and increasing the administrative burden on the service providers. A well coordinated access program, which for example encourages the central collection and one-off assessment of client needs, would improve this situation. The ACT is working to implement a COAG initiative on this issue.

3.67 A major aim of *The Way Forward* initiative is to improve access to community aged care programs, including the HACC program. An element of *The Way Forward* is the establishment of access points that can be easily identified by people seeking services. The functions of these access points would include:

- providing information about services and advice on eligibility for services;
- conducting a broad assessment of a person's needs (including the carer);
- providing HACC services; and
- facilitating referrals to community care service providers or to other specialised or comprehensive assessors as appropriate.

3.68 The first stage of the access points project, which commenced in early 2007, was a mapping of community care and its infrastructure intended to highlight the diverse needs and features of client access, service provider infrastructure and capacity. ACT Health had completed this mapping, and found, inter alia, that:

- current strengths of the ACT community care sector included strong inter-agency links and the presence of the Community Health Intake as a central contact point;
- programs such as HACC had inconsistent assessment processes;
- self and family referrals were the most common form of referral, and these were conducted mostly over the phone;
- the *Client Information and Referral Record* was the most usual screening assessment form (also used for HACC clients);
- some of the larger service providers had developed central intake points; and
- there were multiple client information systems, with the potential for inconsistency between them.

3.69 The second stage of the access point project, which is due to commence in December 2007, will involve the commissioning of demonstration sites in various

jurisdictions, including the ACT. The information gathered in the mapping and demonstration point stages will then inform the development of an implementation plan for the establishment of access sites across Australia.

3.70 As part of the access points project, the Commonwealth is developing an electronic Continuous Client Record (eCCR). If a client agrees, and subject to privacy requirements, the information they supply to one service provider is available as necessary to other service providers. Clients will then provide their personal details once only, with a commensurate decrease in the administrative overburden on service providers.

HACC SERVICE DELIVERY

Delivery of services through community-based service providers

3.71 These case studies are illustrative of how clients are served by the HACC program.

Case Study 3.1: Single man, isolated and mobility reduced

Mr B was a single man who, because of an old leg injury, was isolated at home. He was reluctant to ask for help, partly because he did not want anyone knowing his personal affairs but also because he did not want to be a burden. However, following a short admission to hospital and with the persistent urging of friends, he eventually accepted offers of transport, gardening and house maintenance from a community service. He was also assessed by a falls prevention team. The only cost to him is for transport, at $5 per return trip, with other services provided free to him. Mr B now has a HACC case manager, who feels that he would qualify for an upgraded care package.

Case Study 3.2: Couple, isolated and husband with reduced mobility

Mr C suffered a stroke, and was unable to drive. HACC provided transport for him and his wife (his carer) to weekly community group sessions, where they were provided lunch and activities. They were also provided with transport for shopping and medical appointments. All services are free of charge to them, except their lunches and transport, for which a $5 return trip fee is charged.

Case Study 3.3: Widow, isolated with reduced mobility

Mrs G was an aged widow who could not drive. HACC provided Meals on Wheels to Mrs G three times a week, and regular transport to community group sessions, shopping and medical appointments. A volunteer also took her on occasional outings. The only cost to her was for the $5.20 thrice-weekly home-delivered HACC meals; and for transport.

Case Study 3.4: Group for disabled and isolated men

Four volunteers and a staff member ran a weekly men's group that provided social contact and $6 barbecue lunches to disabled and isolated men. In so doing, they also provided respite for the carers of these men. Some in the group repaired toys for local pre-schools and community centres. This service had been running for 12 years and about 15 men attend, some using the HACC transport to and from the 'shed', the group's venue.

Source: HACC files and training material. Where applicable, details have been changed to protect privacy.

Fees for services

3.72 Service providers may charge fees for the provision of a service. The HACC *Program Guidelines* affirm that fees are important as they improve '… the ability of the HACC program to respond to the needs of its clients by supplementing the already substantial financial contribution to the costs of community care'. During 2005-06 ACT service providers collected $2.2 million in fees from HACC clients.

3.73 The HACC *Program Guidelines* contain a draft fees policy, and the HACC *Review Agreement* committed the Commonwealth and the ACT to formalise this draft policy. At the time of Audit, ACT Health had not formalised a fees policy.

3.74 There are 15 principles defined in the draft HACC fees policy, which deal with access, equity, affordability, user rights and privacy. The draft fees policy acknowledges that more than 90 per cent of all HACC clients are dependent upon some form of pension or benefit for income support, and that a large proportion of HACC clients need high levels of services, often from multiple sources.

3.75 Audit observed that service providers generally adopted the draft principles in charging fees for services, and administering their own fees policies. Nevertheless, the Council on the Ageing (COTA) advised Audit that HACC clients currently face uncertainty about the cost of services imposed by various service providers, and there was inconsistency in both the fees and the charging practices.

3.76 Audit examined information from all States and Territories (except Queensland, for which no information was available). Audit noted that jurisdictions have differing fees arrangements but all jurisdictions had a fees policy except NSW and the ACT.

3.77 The Commonwealth, in co-operation with the States and Territories, plans to finalise a national fees policy, by mid 2008. ACT Health intends to introduce a fees policy for service providers that will conform to the Commonwealth's requirements.

3.78 Service providers generally reported to ACT Health six-monthly on the total fees collected and the service under which it was collected. The funding agreement specified that fees collected must be re-invested in the service for which the fee was charged, to assist with defraying the costs of services. It did not specify what should be done with any surpluses of re-invested fees over the cost of service delivery.

3.79 Audit examined financial returns from service providers, and was unable to establish in a number of cases if fees were returned to the service from which they were earned. Moreover, annual audited statements of receipts and expenditure for the funding amounts were not always available, although required by the funding agreement. Audit found no evidence that ACT Health had properly reviewed the financial returns of ACT service providers to determine whether providers were observing the requirement of the funding agreement to re-invest fees in the services from which they were derived.

3.80 ACT Health commented that:

> ACT Health reviews both output and financial reports on a six monthly basis. While the procedures are not formally documented there are strong work practices in place for the review of all reports including the 'Service Funding Management and Risk Assessment' checklist.

Recommendation 14

ACT Health:

- develop an ACT fees policy consistent with the requirements of the Home and Community Care program *Review Agreement* and the emerging national policy;
- analyse the financial returns of all ACT service providers and determine the extent to which providers return the fee revenue back to the services from which they were derived; and
- take appropriate actions to recoup the money/or an equivalent quantity of services in cases where fees have been used for purposes other than as specified in the service funding agreement.

Service delivery through sub-contractors – contracts for engagement of brokers

3.81 ACT Health funds service providers to deliver HACC services. The service providers in turn use subcontractors, known as brokers, to:

- extend the reach of their services;
- fill temporary gaps in service delivery; and
- deliver enhanced quantity and quality of HACC services.

3.82 Brokers therefore provide support, expertise and extra capacity to service providers. Audit found that significant numbers of service providers used brokers. Services delivered by brokers included in-home respite care, domestic assistance (house cleaning, washing, ironing and shopping) and personal care (bathing, toileting, dressing, eating and personal grooming).

3.83 Audit reviewed a selection of service providers and noted that each had their own method of selecting brokers, who have often been associated with the service provider over a long period. Audit noted that not all service providers used a written agreement with the broker to define the conditions of engagement. Further, those agreements that were used

did not typically include reference to some of the conditions of service provision stipulated by ACT Health in their agreements with the service providers.

3.84 Audit considers it highly desirable for service providers to engage brokers under a written agreement. The advantage of a written agreement is that the service provider, and through it ACT Health, can ensure the broker complies with quality and quantity standards for the HACC services the client receives. Audit observed that few, if any, brokers were required to meet HACC standards of service, although some were members of industry bodies which set some performance standards. A written agreement would clarify the broker's obligations in relation to, for example:

- HACC objectives and standards;
- agreeing a schedule of fees for services delivered by the broker;
- collection of fees from HACC clients; and
- obtaining police clearances for staff.

3.85 It is possible that brokers as agents of the service provider may be bound by the service provider's agreement with the ACT Government.[35] To promote certainty, service providers should enter into written agreements with brokers so that brokers are aware of their obligations. ACT Health can encourage and assist service providers in doing this, by providing a 'template agreement' for use in engaging brokers.

Recommendation 15

ACT Health prepare a 'template agreement' for use by service providers when engaging Home and Community Care contractors/brokers, which should include the need to comply with various conditions under the service funding agreements between ACT Health and service providers.

Volunteers

3.86 Volunteers were an essential part of service delivery by community-based organisations to HACC clients. Relevant ACT service providers recognised this and have in place measures to recruit and retain volunteers.

3.87 Census 2006 data indicates that the ACT has the highest proportion of volunteers in Australia (at 38.6 per cent of the population) and it is on the increase. For example, in 1995, 28.7 per cent of the population were engaged in volunteering.

3.88 Audit found that the longer term supply of volunteers is a concern to service providers and Volunteering ACT, the peak volunteer body in the ACT. Service providers informed Audit that they needed to devote more resources to managing volunteer labour,

[35] Clause 18 of the Standard Funding Agreement states that: 'Subject to any Special Conditions in Schedule 6, the Organisation will not assign or otherwise deal with its rights and obligations under this Agreement without the prior written consent of the Territory.'

which is in itself an increased cost. Volunteers themselves faced rising costs and new compliance requirements, which can affect their commitment to the services and clients. For example, fuel was of particular concern, notably for its effect on transport services. Some service providers reported substantial increases in reimbursements to volunteers for fuel costs – in one case nearly doubling to $70 000 per annum.

3.89 Audit observed that volunteers were principally from older aged groups, and viewed their service as a commitment to helping others. Audit did not observe any instances where services were curtailed or cancelled due to a lack of volunteers, although some service providers had replaced volunteers with paid staff, with consequential budgetary impacts.

3.90 Audit considers that the potential decrease in the supply of volunteers may be a risk to the effective delivery of the program by ACT service providers. That being the case, ACT Health should include this risk in a compilation of risks which are particular to the HACC program and develop measures to address this risk. Risk management is discussed later in this chapter - from paragraph 3.129 at page 83.

QUALITY ASSURANCE OF SERVICES

Three yearly DoHA review of service quality

3.91 In April 2005, a DoHA funded three-year appraisal of service providers in all States and Territories was published. Its aim was 'to assess the overall impact of the HACC National Service Standards instrument in appraising agencies …. to establish whether HACC agencies are meeting the HACC Standards and providing a quality service.'[36]

3.92 ACT Health advised that it relies on these evaluations to monitor the performance of ACT service providers in meeting the HACC Standards. In its view HACC:

> has the most formalised quality assessment program in place in the community sector. All HACC funded organisations are required to implement the National Service Standards, These comprise 7 objectives and 27 service standards, covering;
>
> - access to services;
> - information and consultation;
> - efficient and effective management;
> - coordinated, planned and reliable service
> - privacy, confidentiality and access to personal information
> - complaints and disputes; and
> - advocacy.

[36] *Evaluation of the HACC Program – National Standards,* DoHA, April 2005, page 6

3.93 At the completion of the external assessment, each service provider has in place a quality improvement plan. The service providers are required to fully implement all aspects of the quality improvements required within the action plan. Where an organisation partially met a standard, the quality improvement plan identified the required actions to ensure that the standard was fully met. Organisations provided ACT Health with progress reports that demonstrated their full compliance with the quality improvements identified.

3.94 The April 2005 appraisal found that over 80 per cent of ACT service providers achieved a high rating in compliance with HACC service standards. A further 7 per cent achieved a good compliance rating. The overall proportion of service providers that did not meet service standards was 6 per cent - the second lowest of all States and Territories.

3.95 The report notes that a focus group of ACT service providers sought feedbacks from ACT Health on they may continue to improve the quality of their services. ACT Health accepted the findings of the report as an accurate reflection of the quality of HACC service in the ACT, although Audit did not find evidence that ACT Health had advised on how service providers may improve their service quality.

Reporting on service delivery

3.96 Typically, a service provider would provide about three of the 19 HACC services identified and classified by the MDS, the Commonwealth's database collection. The service providers input data on their service delivery into the MDS four times each year. Data collected relates to:

- personal details (name, date of birth and gender);
- recipient circumstances (living arrangements, Government benefit or pension status and functional status);
- carer (relationship to client, name, date of birth, gender); and
- service episode (source of referral, date of entry into HACC service episode, date of last update, date of exit from HACC service episode and reason for cessation of services).

3.97 Audit found that ACT Health maintained effective oversight of this national data collection effort, achieving a 100 per cent submission rate of MDS data to the Commonwealth – the best of any State or Territory. However, this data related primarily to client details and quantity of services, and are not necessarily useful in improving service delivery.

3.98 Audits of HACC and home-based aged services by the Auditors-General of Victoria[37] and of WA[38] found that while health and disability authorities went to some

[37] Victorian Auditor-General's Office, *Delivery of HACC Services by Local Government*, Report 69, May 2004.

[38] Office of the Auditor-General for Western Australia, *A Helping Hand: Home-Based Services in WA*, Report 6, June 2007

trouble to collect MDS information, they neglected their own need for information that could be used to improve the supervision of service providers. These findings are similar to issues identified by Audit in relation to ACT Health.

3.99 Audit found that ACT Health did not routinely collect information to ensure compliance with HACC service standards. Some information that could be usefully collected to assist with management of the program includes:

- whether employees and volunteers had undergone a police clearance; [39]
- number of clients on waiting lists for specific services;
- summaries of the numbers and types of client complaints; and
- how personal client information is protected.

3.100 Information on the level of satisfaction amongst clients of the program is useful to estimate the effectiveness and efficiency of program delivery by service providers, and overall program supervision by ACT Health.

3.101 Although client satisfaction surveys and questionnaires could be used to assess client satisfaction, Audit noted that ACT HACC service providers in 2005 suggested focus groups as a better way to gain meaningful feedback from HACC clients. Also, in June 2007, the Auditor-General of Western Australia suggested the use of a wellbeing index, that 'unlike satisfaction surveys … has stronger objective dimensions, and is … comprehensive.'[40]

3.102 These emerging ideas aside, whether current clients are satisfied with the service delivery, for example, is an important test of the success of service delivery. The 2006-10 ACT Health *Corporate Plan* sets an objective of providing access to appropriate services through appropriate care, as measured by (amongst other things) consumer satisfaction with treatment and care. ACT Health's *2007-10 Strategic Sub-Sector Plan* for community-based health related services also records improved client satisfaction as a control against the risk of an unsafe environment for clients and staff.

3.103 ACT Health gathered information from the service providers through a variety of means, as discussed later in this chapter. Likewise, service providers may go to considerable efforts, to the point of phoning every client each year, to determine if they are satisfied with service delivery. What appears to be lacking is a collection and collation of client satisfaction data from all service providers, to form an overall sector view of satisfaction with HACC service provision. In addition, ACT Health should consider obtaining independent and objective data on client satisfaction with service providers.

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[39] An internal audit report also recommended this in 2005.
[40] Office of the Auditor-General for Western Australia, op cit, page 35.

Recommendation 16

ACT Health collect and analyse selected data from service providers, to assess whether service provision is meeting Home and Community Care (HACC) program objectives. This information should then be used to assist in planning of service provision by the ACT HACC program.

Acquittal of funding by service providers

3.104 Service providers are required, under their funding agreements with ACT Health, to provide ACT Health with audited financial statements and other information to acquit the funds they receive.

Acquittal procedures

3.105 Audit found that ACT Health did not have any written funding acquittal procedures that facilitated their review of reports required by the HACC funding agreements, and follow-up (as necessary) of any outstanding or unsatisfactory matters. The lack of documented procedures had been identified in 2005 by an ACT Health internal audit report of contract management for non-government service providers, which found that guidance in contract management was lacking. ACT Health accepted this audit finding, and in response cited work underway to identify and document processes and controls in contract management. Nevertheless, procedures had not been formalised by the time of the current audit.

3.106 Audit considers the lack of procedures exposes ACT Health to the risk of failing to identify, document and respond to difficulties or opportunities that may arise in the administration of the program. ACT Health considers this risk is reduced by the variety of sources from which ACT Health may derive intelligence on funded organisations, for example:

- MDS data, which is compiled by service providers four times per year;
- financial, output and optional reports submitted by service providers;
- feedback obtained through HACC provider meetings;
- information provided to ACT Health through its annual visits to service providers; and
- complaints (which are rare) made through official channels.

3.107 While this is, to some extent, reasonable, Audit considers acquittals are an integral and important part of prudent management and provide a measure of assurance that public funds allocated to funding recipients have been spent for their intended purposes. Adequate and well-documented arrangements to ensure administrative and financial accountability are the basis of effective acquittal. Reliable, timely and adequate evidence is required to demonstrate that funds have been expended in accordance with the terms and conditions of the funding agreement. Administrative procedures to acquit funds on a regular basis are an important management control. The stringency of acquittal procedures

should be balanced against the level of risk and take into account the cost of compliance. Risk management strategies will help achieve this balance.[41]

3.108 Audit noted that as part of the *2007-10 Strategic Sub-Sector Procurement Plan* ACT Health compiled a checklist and this could form the basis to develop an acquittal checklist of service provider funding. The checklist is aimed at determining whether service providers have complied with funding conditions such as police checks and insurances, and submission of reports.

Financial reporting

3.109 Under 2002 and 2007 *HACC Program Guidelines*, ACT Health was and is to ensure efficient and effective program management, including proper and regular monitoring, review and audit of agreement expenditure.

3.110 The ACT funding agreements with service providers provide for:

- half yearly reports prepared in the approved format;
- yearly financial reports consisting of:
  - a statement from the organisation providing full details of expenditure of HACC funds; and
  - an audit report from a 'qualified accountant'[42]:
    - detailing expenditure of the HACC funds and other moneys such as fees used in providing HACC services (very small service providers may be exempted from this requirement); and
    - stating that expenditure was in accordance with the specific financial conditions of the funding agreement.

3.111 Audit reviewed annual audit reports from service providers and supporting documentation, and noted that:

- some audit reports related only to the overall financial statements of the service provider; such reports being prepared in compliance with corporate or association incorporation legislation. They were not therefore directed to expenditure of HACC funding as required by agreements;
- one audit report simply attested to the correctness of income and expenditure accounting, and not to compliance with HACC funding program conditions; and
- one audit report where non-grant funding, including fee revenue from the grant-funded service, was ignored by the auditor. It was not apparent how the auditor was able to certify that all HACC fee income was returned to the service from which it derived, as required by the funding agreement.

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41 From *Administration of Grants Better Practice Guide* ANAO May 2002.

42 A 'qualified accountant' is defined as a member of CPA Australia, or the Institute of Chartered Accountants in Australia who is not an officer of the service provider.

3.112 The processes adopted by ACT Health to review the financial reporting by service providers were not sufficiently robust to identify the above matters as concerns. Notwithstanding this, the auditor's certificate is a key control over the risk that expenditure might not comply with the funding agreement conditions. ACT Health should therefore improve their scrutiny of these annual audit reports.

3.113 The funding agreements require that the biannual and annual financial submissions by service providers to ACT Health should explain variances of expenditure against the approved budget of greater than 10 per cent.[43]

3.114 Audit noted instances where expenditure exceeded the budget by greater than 10 per cent, but this budget over-run was not explained. Audit was unable to find evidence that ACT Health sought an explanation for this variance.

3.115 Another case was noted where a service provider accumulated $80 000 in unspent HACC fees collected over two years. Audit was unable to find evidence that ACT Health had queried the unspent funds in either of the relevant years. The service provider advised Audit that the funds would be used for later capital purchases, notwithstanding the fact that the service provider had been funded for capital (purchase of a $40 000 bus) in the same triennium.

3.116 Audit noted that the funding agreement template was silent on what action, if any, ACT Health and service providers should take when funding provided under the program, and associated fees, remain unspent at the end of a reporting period. ACT Health advised that they relied on service providers to contact it to discuss the future application of surplus funds. Such reports, however, were optional.

3.117 A funding agreement which meets better practices would contain clear provisions for the treatment of unspent funds. Such provisions could allow for unspent funds to be added to the budget for the following year or require the return of unspent funds to ACT Health, which can then re-allocate them according to its priorities.

3.118 Since 1999, ACT Health's agreements with the Commonwealth, the *Program Guidelines* and internal guidelines required that funding agreements with service providers commit them to repaying an amount equivalent to the value of property acquired with government funds when the property is disposed of, destroyed or no longer used for project purposes. The template funding agreement used by ACT Health contains no corresponding provision, nor do the actual funding agreements that ACT Health has with HACC service providers.

3.119 Audit did not observe any instance where assets purchased with HACC funds were disposed of and funds therefore became payable to the Commonwealth. Nevertheless, to be consistent with the HACC *Program Guidelines* and better practices, the funding agreements with service providers should clearly specify how the proceeds from

[43] Standard HACC Template Agreement Attachment A (Item 2, Schedule 3).

the disposal of assets (e.g. motor vehicles, computer equipment) purchased with HACC funds during the life of the funding agreement should be disbursed.

Recommendation 17

ACT Health develop and implement procedures (including a checklist) for the acquittal of funding to Home and Community Care (HACC) program service providers. These procedures should:

- cover key aspects of the agreement acquittal such as output and funding reports, compliance with funding conditions and results of Annual Review meetings
- require the scrutiny of financial returns and accompanying audit certificates to ensure service providers and their auditors have complied with the specific requirements of the HACC program funding agreement; and
- require appropriate remedial action be taken in the case of non-compliance.

Recommendation 18

ACT Health ensure the funding agreements with service providers contain provisions regarding:

- the treatment of unspent funds and fees collected; and
- the disposal of assets acquired with Home and Community Care program funds during the life of the funding agreement, including the disbursement of any proceeds realised from the disposal of such assets.

Acquittal of outputs statements

3.120 HACC funding agreements also required six-monthly and annual reporting by service providers to ACT Health on program outputs. Output measures are prescribed by the Commonwealth's statistical collection, the MDS, which describes the units of output for each of the 19 MDS services.[44] Time spent on service provision (for example) was used to measure outputs for services such as respite care; quantity for services such as linen service and meals; and cost for home modifications.

3.121 Details of twice-yearly and annual budgeted outputs are defined in each service provider's agreement together with a requirement for a joint Annual Review – ACT Health and service providers - to consider performance in service delivery. Audit noted that ACT Health had provided useful information at some feedback sessions. However, ACT Health had not conducted these meetings in the 12 months preceding audit fieldwork. As a result (and as with financial reports), variations to budgeted outputs were not systematically reviewed, and files contained only occasional analysis or records of communication with service providers regarding shortfalls or extra outputs from funding. ACT Health indicated that it was their intention to return to annual performance reviews.

[44] HACC *Program Management Manual* Appendix C.

3.122 There is a risk, therefore, that ACT Health may not be identifying and treating any instances where service providers have failed to deliver the level or quality of services for which they have been funded.

Recommendation 19

ACT Health ensure that:

- Annual Reviews are conducted as a minimum opportunity to provide service providers with the feedback they need to adequately deliver Home and Community Care program services; and
- output reports are subject to an appropriate degree of scrutiny, to ensure that service providers have complied with the funding agreement, and that any substantial variances of budgeted to actual output are documented and resolved in a timely manner.

Reporting on service provision through optional reports

3.123 Audit noted that some service providers discussed demand for their services in optional narrative reports to ACT Health under Schedule 3 to agreements. Audit was informed by service providers that ACT Health did not routinely comment on information provided in these optional reports. Nevertheless, service providers thought it worthwhile to put ACT Health on notice of excess demand before they applied for additional growth funding.

3.124 ACT Health informed Audit that its constant contact with service providers individually and in meetings, such as the monthly HACC providers' network meetings, enabled it to become aware of and respond to matters such as relevant unmet demand, without the need for mandatory reporting by service providers. Although Audit found some deficiencies in documented evidence of meetings and scrutiny of output reports on ACT Health's files, service providers' comments to Audit supported the claim that ACT Health was aware of what was happening in service delivery. Audit also found that service providers would nevertheless welcome increased involvement and feedback by ACT Health in how they delivered HACC services.

3.125 An ACT Health internal audit of contract management of non-government organisations in 2005 had similar findings. Although contract managers maintained that they had regular contact with service providers, documentation on file did not always reflect this claim.

3.126 ACT Health commented that any increase in the reporting burden on service providers diverted scarce resources from service provision. Audit acknowledges that better and more complete reporting on service provision may require some increased efforts from both the service providers and ACT Health. However, as some service providers are currently reporting through optional reports, mandating the reporting of matters such as unmet demand and waiting time should not be onerous for the community provider sector, especially for key services.

3.127 It is equally important for ACT Health to analyse necessary data from service providers about unmet demand and other matters to:

- identify problems in and opportunities for the program, including adoption of better practice in monitoring of service provision;
- plan for HACC service provision; and
- allocate growth funding to places where the need is greatest.

3.128 Audit suggests that ACT Health consider whether information that is currently reported optionally by some service providers, such as unmet demand for services, could be usefully included in the output reports regularly provided to ACT Health. For service providers who are currently reporting additional 'optional' information, Audit also suggests that ACT Health should provide feedback as to the usefulness of such information. The deficiencies identified in this audit relate generally to the lack of evidence of analysis and use of existing information for improving services.

RISK MANAGEMENT AND RECORD KEEPING

Risk plans by ACT Health

3.129 Chief Executives were responsible for developing risk management strategies and practices within their agencies and for ensuring these strategies are communicated to, and practised by, all employees. Implementation of risk management plans is based on the *Australian and New Zealand Risk Management Standard (AS/NZS 4360:2004)*, which defines risk and provides guidelines on policies, strategies and procedures to manage it.

3.130 ACT Health's *Corporate Plan* under Key Performance Area 4 – Accountability and Internal Systems - has as an objective the implementation of a comprehensive risk management system.

3.131 As part of the *2007-10 Strategic Sub-Sector Plan,* ACT Health identified a number of risks to community-based health related services, which included HACC and other community health programs. This risk plan commenced from 1 July 2007, replacing a previous three year procurement risk plan.

3.132 Audit's review of the ACT Health risk register revealed that some treatments of risks did not appear to be fully effective. These controls have been considered at other parts of this chapter. For example:

- 'improved client satisfaction' is a treatment to minimise the risks of an unsafe environment for service providers and staff; however, currently client satisfaction with the HACC program is not measured or centrally collected by ACT Health; and
- 'monitoring of service providers and acquittal of funding returns' are treatments to minimise the majority of risks to the program (including fraud), which of itself illustrates the importance of sound oversight of service providers. Audit has made a number of observations and recommendations to address inadequate monitoring

and acquittal of financial, output, and optional returns submitted by service providers.

3.133 The presence of controls mitigates risk; however, the program's residual risk increases if the controls are only partly effective. Those risks that rely on sound monitoring of service providers were rated currently by ACT Health as a low residual risk. Audit's view is that these risks need to be reassessed and moved to a higher category in light of the audit findings and recommendations.

Risk plans by ACT HACC service providers

3.134 The risk register in the *2007-10 Strategic Sub-Sector Plan* noted that funded community organisations were developing individual risk management frameworks. ACT Health encourages service providers to self-assess their public liability and other risks at an ACT Treasury website, and to lodge a risk plan with the Treasury if the risk score is high. These risk plans assist service providers in the management of the HACC program.

3.135 The Treasury website is tailored specifically for community groups, and covers all aspects of risk management, including its practical application to the community sector. It includes checklists, advice and steps to creating a risk plan; and covers insurable and non-insurable risks.

3.136 The information available to service providers from the Treasury website is generic and can be further tailored specifically to the HACC program. Audit considers that ACT Health is well placed to facilitate the consistent use of the risk plans by service providers by identifying those risks that are particular to the HACC program and communicating that information to providers. Risks that could be considered included a potential shortage of personnel – volunteers and qualified case managers - and details of insurable risks.

Recordkeeping

3.137 Recordkeeping standards were set by the ACT's *Territory Records Act 2002* and ACT Health internal policy.

3.138 During testing, Audit noted instances where records were incomplete or not accurate including:

- certificates of insurance, audit reports, annual reports and letters missing from files. The ACT Health 2005 internal audit on management of NGO contracts report also noted that evidence of insurance cover was absent in its sample of examined funding agreement files;
- records being held in informal action officer e-mail accounts, shared electronic folders or files, rather than in official files; and
- errors in the publication of some funding agreement amounts.

3.139 Given the significance of sound records management to the efficient management of the HACC program, and to providing evidence of appropriate government accountability, Audit suggests that ACT Health take steps to ensure managers and staff are fully aware of, and comply with, the requirements of the *Territory Records Act 2002* and sound recordkeeping practices.

CONCLUSION

3.140 The HACC program is a joint Commonwealth, State and Territory program providing community care services to eligible persons. During 2006-07, the program cost $22.5 million to deliver in the ACT; 51 per cent of which was funded by the ACT. ACT Health is responsible for administration of the program, which was delivered (in 2005-06) through 30 non-government community-based HACC service providers to some 15 000 ACT residents, representing around 56 per cent of the target population.

3.141 ACT Health maintains effective oversight of the submission of HACC MDS data to the Commonwealth's data collection program, but it does not appear to either collect, use or analyse other information submitted by service providers to plan for service provision, nor does it collect reliable data to respond to unmet demand.

3.142 ACT Health should improve its monitoring of service providers to ensure they comply with the terms and conditions of the service agreements. These include the re-investment of fees collected back to services, use of unspent fee and funding amounts, the use of sub-contractors or brokers, and better scrutiny of financial and output reports.

3.143 At present, the processes applied by ACT Health to assess the performance of the service providers were not evident, and expose ACT Health to the risk of failing to identify and address instances where service providers did not deliver the level or the quality of services required under the HACC funding agreements.

APPENDIX A HACC QUALITY STANDARDS OF SERVICE DELIVERY

The National Program Guidelines for the Home and Community Care Program (the Guidelines) specified seven HACC Service Objectives for service providers, and 27 attending Service Standards.

The Standards were designed to ensure that:

- all clients received the highest possible standard of service from providers;
- the services they received met their individual needs; and
- providers strived for continuous improvement in service planning, management and delivery.

The Standards had been developed around seven Service Objectives:

- Access to Services
  - to ensure that each consumer's access to a service is decided only on the basis of relative need
- Information and Consultation
  - to ensure that each consumer is informed about his or her rights and responsibilities and the services available, and consulted about any changes required
- Efficient and Effective Management
  - to ensure that consumers receive the benefit of well-planned, efficient and accountable management
- Co-ordinated, Planned and Reliable Service Delivery
  - to ensure that each consumer receives co-ordinated services that are planned, reliable and meet his or her specific ongoing needs
- Privacy, Confidentiality and Access to Personal Information
  - to ensure that each consumer's right to privacy and confidentiality is respected, and he or she has access to their personal information held by the agency
- Complaints and Disputes
  - to ensure that each consumer has access to fair and equitable procedures for dealing with complaints and disputes
- Advocacy
  - to ensure that each consumer has access to an advocate of his or her choice, if required.

The 2002 *Program Guidelines* and their 2007 successors required that funding agreements should include reference to the HACC standards in all contracts.

There were two template agreements that ACT Health uses in making agreements with service providers:

- the common template for all community programs run by ACT Health. This template has been reviewed and approved by the ACT Government Solicitor; and

- a variation on the common template for use by the HACC program and modified to incorporate the specific needs of the HACC program.

APPENDIX B AUDIT OBJECTIVES, CRITERIA AND APPROACH

AUDIT OBJECTIVE

The audit aimed to provide an independent opinion to the Legislative Assembly on the efficiency, effectiveness, and accountability of ACT Health in assessing the needs of aged persons through ACAT, and delivering the HACC program.

AUDIT SCOPE AND FOCUS

The audit assessed ACT Health's performance in:

- assessing the needs of aged people in the Territory through ACAT;
- managing the delivery of HACC services; and
- monitoring, evaluating and reporting on its administration of the ACAT and HACC programs.

The audit did not review the operation of the non-government organisations (NGOs), other external service providers and their contractors, nor the individual services provided by them under funding agreements with ACT Health.

AUDIT APPROACH

The audit approach includes:

- reviewing documentation on policies, plans and procedures for conducting aged care assessments for those eligible for ACAT and HACC services;
- reviewing documentation on evaluating and benchmarking aged care assessments and home and community care services;
- interviewing and corresponding with management and relevant staff responsible for aged care assessments and HACC services;
- discussing community care services with service providers responsible for providing home and community care services to aged people; and
- consulting with relevant aged care associations and community groups.

Discussions were held with the following stakeholders:

- Australian Medical Association;
- Australian Red Cross – ACT Branch, and their volunteers;
- Belconnen Community Services and their volunteers;
- Care On Call;

- Communities@Work and their volunteers;
- Council on the Ageing;
- Directors of Nursing of RACFs;
- Public Advocate, ACT;
- Volunteering ACT; and
- Departmental contacts including Department of Disability, Housing and Community Services, ACT Health, Chief Minister's Department and, federally, Department of Health and Ageing and Department of Veterans' Affairs.

AUDIT CRITERIA

The audit criteria are specific questions which the audit sought to answer in order to form an opinion as specified in the audit objective.

Aged Care Assessment

- Are appropriate aged care assessment structures in place to ensure assistance is provided to elderly people where, and when they need it?
- Are ACAT services delivered efficiently and effectively?
- Is there sufficient reporting on, and accountability of, ACAT performance?

Home and Community Care

- Are appropriate policies and procedures in place to identify need for home and community care services for aged people?
- Are appropriate structures in place, and appropriate policies and procedures followed, to ensure proper home and community care services are provided by service providers to elderly people?
- Are services timely and consistent, and provided equitably?

AUDIT REPORTS

Reports Published in 2007-2008

Report No. 7 / 2007	The Aged Care Assessment Program and the Home and Community Care Program
Report No. 6 / 2007	Annual Report 2006-2007
Report No. 5 / 2007	The FireLink Project

Reports Published in 2006-2007

Report No. 4 / 2007	Regulation of ACT liquor licences
Report No. 3 / 2007	Collection of fees and fines
Report No. 2 / 2007	Agency implementation of audit recommendation
Report No. 1 / 2007	Credit Card Use, Hospitality and Sponsorship
Report No. 9 / 2006	Sale of Block 8, Section 48, Fyshwick
Report No. 8 / 2006	2005-06 Financial Audits
Report No. 7 / 2006	Annual Report 2005-2006
Report No. 6 / 2006	Vocational Education and Training
Report No. 5 / 2006	Rhodium Asset Solutions Limited

Reports Published in 2005-2006

Report No. 4 / 2006	Road Safety
Report No. 3 / 2006	Management of Trust Moneys and Other Non-Public Moneys
Report No. 2 / 2006	Public Housing
Report No. 1 / 2006	Regulation of Charitable Collections and Incorporated Associations
Report No. 7 / 2005	2004-05 Financial Audits
Report No. 6 / 2005	Government Procurement
Report No. 5 / 2005	Annual Management Report for the Year Ended 30 June 2005
Report No. 4 / 2005	Courts Administration
Report No. 3 / 2005	Reporting on Ecologically Sustainable Development

Reports Published in 2004-2005

Report No. 2 / 2005:	Development Application and Approval Process
Report No. 1 / 2005:	Management of Government Grants to the ACT Multicultural Council Inc.
Report No. 10 / 2004:	2003-04 Financial Audits
Report No. 9 / 2004:	Administration and Monitoring of Youth Service Contracts
Report No. 8 / 2004:	Waiting Lists for Elective Surgery and Medical Treatment
Report No. 7 / 2004:	Annual Report 2003-2004
Report No. 6 / 2004:	Workers' Compensation Supplementation Fund
Report No. 5 / 2004:	Leave Management
Report No. 4 / 2004:	Data Reliability for Reporting on the ACT 'No Waste by 2010' Strategy
Review Report:	Matters Relevant to the Office of the Special Advisor, Council of Australian Governments and Inter-Governmental Relations

Reports Published in 2003-2004

Report No. 3 / 2004:	Revenue Estimates in Budget Papers 2002-03
Report No. 2 / 2004:	Travel Arrangements and Expenses
Report No. 1 / 2004:	Administration of Policing Services
Report No. 10 / 2003:	Financial Audits with Years Ending to 30 June 2003
Report No. 9 / 2003:	Annual Management Report for the Year Ended 30 June 2003

Details of reports published prior to 2003-2004 can be obtained from the ACT Auditor-General's Office or the ACT Auditor-General's homepage: http://www.audit.act.gov.au.

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