Submission by the Australian Nursing and Midwifery Federation

Department of Health and Aged Care Consultation Paper No. 2 – A new model for regulating Aged Care

27 June 2023

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

INTRODUCTION

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 320,000 nurses, midwives and carers across the country.
2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.
3. Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.
4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.
5. ANMF members work across all settings in which aged care is delivered, including over 45,000 direct aged care workers. Many more deliver health care to older people moving between ~~s~~ health care settings (acute, residential, community and in-home care), depending on their health needs. Being at the centre of care delivery makes them ideally placed to determine risk to people receiving care and make recommendations.
6. The ANMF welcomes the opportunity to provide feedback on a new model for regulating aged care. This second consultation paper provides more detail on the proposed model, however, the ANMF has extensive ongoing concerns which will be articulated in this paper. The ANMF maintains that aged care is a social good with the primary aim of supporting older Australians with high quality and safe aged care services in a dignified, respectful, and person-centred way. While aged care continues to be largely privatised and market driven, it is likely there will be an ongoing tension between aged care providers and social expectations of what aged care should be.
7. The regulatory model for aged care must be informed by the underlying principle of ensuring that people who access aged care services are provided with safe, quality care and the assessment of any legislation, regulation or standard must be viewed through the lens of ensuring quality care received by every individual.

BACKGROUND

8. The current aged care reform process offers a once in a generation opportunity to build an aged care sector that is fit for purpose, delivers high quality, safe aged care and is sustainable so that older Australians can have the confidence that appropriate services will be available if and when they need them.
9. Effective regulation of the sector is a critical element of the reform process, and if undertaken in the comprehensive direction set out by the Royal Commission into Aged Care Quality and Safety (the Royal Commission), offers the chance to reverse years of policy and regulatory failure.
10. The ANMF and its branches have campaigned for meaningful aged care reform for many years and despite the compelling evidence of many enquiries, reports and consultations over this time, little has changed until recently.

PRINCIPLES OF AGED CARE REFORM

11. The issues in the aged care sector are many and interconnected and cannot be addressed in isolation. The ANMF believes that any fit for purpose aged care regulatory framework must be underpinned by the following principles:
    - 11.1 Aged care is a context of health care. It must be recognised as such and aligned with other health care contexts such as the acute sector and primary care. The regulatory model, care standards, and outcomes should be consistent.
    - 11.2 Like health care, aged care is a human right and a social good. A market based approach to care provision is inconsistent with human rights ideology.
    - 11.3 Care provided in the aged care sector is health care and requires a workforce with the capability and capacity to deliver this care to a high standard.
    - 11.4 Person centred outcomes can be achieved through a model which recognises that aged care is health care.
    - 11.5 Regulatory alignment with the NDIS standards is less appropriate than alignment with health service standards. Given the level of often complex health care that occurs in the aged care sector in both the residential and community settings (which would be significantly more than in the disability sector) it is more appropriate to align with health sector standards as identified by the Royal Commission.

11.6 The Australian Commission on Safety and Quality in Health Care (ACSQHC) should be responsible for standards development and maintenance for aged care.

11.7 The findings of the Royal Commission provide clear evidence that any aged care regulatory framework must:

11.7.1 Have a comprehensive, effective, and contemporary legislative basis that reflects the lessons of the Royal Commission.

11.7.2 Have a strong and effective regulator, with the appropriate regulatory powers to ensure that aged care providers are accountable for the services they provide.

11.7.3 Ensure risk rests primarily with the Government, Commonwealth Government Department of Health and Aged Care, the aged care regulator, and aged care providers and not shifted to those receiving aged care services under the guise of 'empowerment of the individual'.

11.7.4 Have clear, effective, measurable, and enforceable quality and safety standards, including a separate workforce standard, which provide a baseline to exceed rather than being a ceiling of compliance.

11.7.5 Be data and research driven, implementing evidence based care delivery.

11.7.6 Learn the lessons of regulatory frameworks from other sectors such as the pending final report from the Disability Royal Commission, the health sector, and the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.

12. As per Recommendation 146 and 147 of the Royal Commission, there must be coordination and oversight of the process to achieve reform. For example, implementing a Taskforce or Unit to sequence and coordinate the reform process. Failure to effectively coordinate, schedule, and sustain the work associated with the Royal Commission recommendations may jeopardise this once in a generation opportunity. Without effective oversight:

12.1 Older Australians will continue to be put at risk.

12.2 The aged care sector, in which workers are employed, will continue to limit their ability to deliver high quality and safe aged care.

12.3 Government and regulators will suffer reputational risk when there is a failure of reality to meet promises made regarding reforms, including where the community perceive public resources being used with no real change to the experience of older people in Australia.

OVERVIEW

13. The ANMF notes that Consultation Paper No.2 is an improvement on Consultation Paper No.1. However, concerns remain regarding some aspects of this second consultation paper. These issues include: consultation processes; language; worker registration; quality standards; the workers voice and the corporate structures of aged care providers.

Consultation processes

14. Whilst the ANMF has often been provided with the opportunity to be a voice for its members in the consultation process around the new federal government aged care reforms, we are concerned that this significant voice is not being strongly considered and translated into policy change. As an example, we are disturbed that the recently communicated revised Quality Standards have changed little on their previous version, despite calls for more detailed, measurable standards including embedding workforce requirements throughout. They have also adopted few of the ANMF's strong recommendations[1] and we question the validity of the consultation process. The ANMF expects that this consultation on a new model for regulating aged care will be robust, transparent and open to change to improve regulation in aged care to make a real difference for residents and the workforce providing care.

Language used

15. The ANMF has concerns regarding the language used throughout the consultation paper. The paper outlines the importance of a human rights approach in the new model, which will empower older Australians. While the ANMF is supportive of this view, it is important to note that use of words such as "empower" fail to acknowledge that older Australians, particularly those in nursing homes are often powerless and vulnerable. It will take real cultural change to redress this power imbalance.
16. Further, the ANMF is also concerned that terms such as "choice" and "empowerment" can be utilised to shift risk to older people and their families. A person-centred approach must not be used as an excuse to shift risk and scrutiny from government, policy makers, regulators and providers who are responsible and accountable for service delivery and outcomes, to "consumers" under the guise of empowerment and choice.

Worker Registration for Aged Care

17. The ANMF reiterates its concerns regarding the proposed worker registration model including the Code of Conduct for Aged Care within the broader aged care regulatory framework.
18. The Code of Conduct duplicates and overlaps existing codes for registered health practitioners with

the potential that a registrant could be investigated by two or more regulatory authorities.

19. The ANMF is concerned that the aged care reform process has looked more to the National Disability Insurance Scheme (NDIS) for inspiration rather than health care. Given the many issues exposed as a result of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability this seems neither appropriate nor wise. As pointed out earlier in this paper, aged care is health care, not disability or social care and as such, regulatory frameworks must be aligned with a health, rather than a disability model.
20. The ANMF has raised ongoing concerns about the Aged Care Quality and Safety Commission (ACQSC) managing ongoing worker registration processes including the Code, and in the absence of findings from the independent capability review of the ACQSC, this lack of confidence remains. The role of Ahpra is underpinned by the national law and prior to there being a national system of health practitioner regulation, there were many years of experience of regulation in the state and territory jurisdiction. The ANMF is concerned that handing a system over to the ACQSC to administer is inherently risky. It would be more reasonable to expand the scope of Ahpra, of an existing regulator of workers under the Health Practitioner Regulation National Law Act 2009 (National Law), which has necessary experience and understands what is required to regulate practitioners and workers.

Aged Care Standards

21. As a core element of the new regulatory framework, the aged care quality standards must be fit for purpose and be suitably robust to underpin a continuous quality improvement approach. The ANMF identified that significant changes were required in the first exposure draft of the standards in 2022 to broaden their scope and content to set minimum benchmarks for safety and quality in the sector. The revised aged care quality standards currently being piloted are an improvement on previous versions of the quality standards/principles, but considerable scope for further improvement remains.
22. The ANMF offers the following feedback.
    - 22.1 The basis for all quality standards must be that aged care is a context of health care and that to set lower standards for aged care contexts is ageist and contrary to a human rights approach.
    - 22.2 Aged care standards setting and maintenance must be transferred to the ACSQHC as an independent statutory body.

22.3 Aged care quality and safety standards must reference other established standards, e.g., nursing standards for practice, palliative care standards and guiding principles for medication management.

22.4 Alignment with the NDIS standards is less appropriate than alignment with health service standards. Given the level of often complex health care that occurs in the aged care sector in both the residential and community settings (which would be significantly more in the disability sector) it is more appropriately aligned with health sector standards as identified by the Royal Commission.

22.5 As a matter of principle, the same standards of care must apply across sectors irrespective of where the older person is accessing services, e.g., aged care, hospital sector, primary care.

22.6 Standards must be clear, effective, measurable, and enforceable that clearly signal to providers that continuous quality improvement and not just minimum compliance is the accepted approach to service delivery to drive the development of this culture and infrastructure within aged care service organisations. They must:

22.6.1 Be research and data driven, implementing evidence based care delivery.

22.6.2 Learn the lessons of the flaws in on regulatory frameworks in other sectors.

22.7 Sanctions for deviation from standards must be sufficient to act as a significant deterrent and should extend up to and include:

22.7.1 A provider being forced to leave the sector.

22.7.2 Sale of a facility or facilities.

22.7.3 Takeover by a state or the commonwealth, e.g., in cases of market failure or high-level wrongdoing.

22.8 The voice of those providing care, in relation to compliance, continuous quality improvement and safety, must be considered and supported as a rich source of information on system performance.

22.9 Consideration should be given to allowing accrediting bodies such as the Australian Council on Healthcare Standards (ACHS) to support the ACQSC in accreditation surveys. Such an approach would open up survey teams to relevant expertise and expand the pool of surveyors to undertake more rigorous surveys. Without a significant expansion of capacity, it is difficult to see how the ACQSC will have the capacity to undertake sector surveillance around standards compliance. As with the hospital sector, aged care providers should be required to bear the costs of accreditation surveys.

22.10 In accreditation processes, providers must be required to demonstrate that they create the conditions for registrants, for example, to meet their professional standards, e.g., NMBA Standards for Nursing Practice.

Development of a workforce standard

23. While the revised aged care quality standards quite rightly include an expectation statement for older people, the ANMF believes that the standards should also include expectation statements for those who care for older Australians, reflecting the fact that without an aged care workforce there would be no aged care system and they are integral to ensuring the safety of those they care for, often despite what aged care providers do, rather than because of it.
24. Given the significant and systemic issues identified for workforce by the Royal Commission, the ANMF believes that a separate workforce standard would provide a defined minimum standard and clear signalling to the sector about workforce expectations. While workforce planning is dealt with in Outcome 2.8 (Workforce Planning) of Standard 2 in the revised standards, the ANMF does not believe this goes far enough, given the significant attention to staffing and skill-mix by the Royal Commission and the Government's mandates for registered nurse (RN) 24/7 and minimum minutes of care.
25. Key elements of a residential aged care standard which could be modified for other settings, such as home care must include the following:
    - 25.1 Nurses are provided with a working environment which enables them to practice within professional frameworks.
    - 25.2 Nurses and care workers are enabled to identify situations which compromise professional standards and the aged care quality standards.
    - 25.3 There is a system in place to ensure matters are reported and resolved within 24 hours.
    - 25.4 Employees are enabled to undertake training and education which:
        - 25.4.1 Is consistent with the assessed needs of the resident cohort.
        - 25.4.2 Includes both mandatory and non-mandatory learning opportunities.
        - 25.4.3 Enable nurses to comply with NMBA continuous professional development.
        - 25.4.4 Enable career progression and meets individual learning needs.
    - 25.5 Nurses are provided access, and enabled to, receive clinical supervision in work time.
    - 25.6 Nurses are supported to network with external healthcare providers and any other entity deemed appropriate to maintain and update their clinical knowledge and skills.

25.7 Direct care workers are provided in sufficient numbers and skills mix to meet the assessed needs of the resident cohort but not less than those numbers required through Direct Care Minute funding and other legislation.

25.8 Direct care workers are provided opportunity to raise issues of concern relative to staffing and skills mix with the regulatory authority and a workforce representative.

25.9 Employees are enabled, without disadvantage or adverse consequence relative to their employment, to engage with a workforce representative for industrial and or other matters including professional advice, undertaking a union position or being a union member in the workplace, including Health and Safety Representative roles, and through education, networking and advisory groups and

25.10 Employees know the whistleblowing policies and procedures and are enabled to raise concerns in good faith and are protected against reprisal.

26. This standard should also incorporate the clinical performance and effectiveness elements of the Clinical Governance Standard (Standard One) of the Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards.

27. The ANMF is concerned that the existing aged care quality standards and the various regulators over the years have comprehensively failed to address staffing and skill-mix in the sector. The development of a workforce standard would provide clarity and certainty that has not existed to date. The ANMF suggests a separate working group is established with broad stakeholder representation including unions and peak professional bodies, similar to the clinical care standard advisory group, specifically to develop this standard.

Worker voice role

28. A clear finding of the Royal Commission has been the lack of oversight of the aged care system resulting in widespread failure to protect the safety of those receiving care and those providing it. The Royal Commission also identified widespread deficiencies and risks associated with non-compliance relative to standards and regulatory requirements.

29. The voice of those providing care, in relation to compliance, continuous quality improvement and safety, must be considered a rich source of information on system performance. While the perspective of those receiving care is important, as is that of service providers, those providing care are ideally placed to act in a surveillance capacity for safety and quality issues. Such an approach would give a voice to a relatively powerless group who have carried the sector for many years despite poor working conditions, low pay and often oppressive workplace environments.

30. The extent of reforms being undertaken will test regulatory authorities and will require significantly more resources for the regulator to undertake the comprehensive range of activities outlined in Consultation Paper No. 2. Using workers as on site safety and quality resources would complement the external assurance role of the regulator.
31. The ANMF proposes that the aged care regulatory environment should consist of the following:
    31.1 An external regulator fully resourced to undertake comprehensive and proactive oversight of the aged care sector.
    31.2 A clearly identified, and legislatively supported, assurance role supported by a committee comprised of workers within nursing homes. It should focus on organisational safety and quality improvement, staffing and skills mix as well as identification and escalation of issues where standards are breached. It is recommended that this role be embedded in a workforce standard.
32. The ANMF believes that embedding a worker's voice in the regulatory and compliance system for Aged Care will complement the external regulatory function and enhance the safety of older Australians and the quality of care delivered by keeping providers accountable. Our view is that aged care workers, with appropriate training and support can be authentic and powerful voices for older people in the aged care system and provide a quality assurance process that complements and amplifies regulatory oversight of the sector.

Corporate structures of aged care providers

33. While not mentioned in Consultation Paper No. 2, the ANMF believes that the corporate structures of aged care providers should be included in the broader regulatory framework. The ANMF refers the Department of Health and Aged Care to a series of reports compiled by the Tax Justice Network and the Centre for International Corporate Tax Accountability and Research (CICTAR) which draw attention to the tax and financial practices of for-profit, non-profit and family-owned aged care providers.
34. Given a major thrust of the aged care reforms is increased scrutiny, transparency and accountability of aged care providers, the complexity of aged care provider corporate structures requires review. The ANMF suggests that there is scope for regulatory intervention to ensure that aged care provider corporate structures are clearly visible and are organised to maximise the effectiveness of public funding for care rather than minimising tax liabilities and public scrutiny.[2 3 4]

CONSULTATION QUESTIONS

Raising the quality of aged care

35. The findings and recommendations of the Royal Commission, as well as numerous aged care inquiries, investigations and reports have identified that much work is required for the aged care sector to provide consistent, appropriate, high quality and safe aged care services. The complexity of the aged care sector is underlined by the many systemic factors that have intersected to cause the current crisis in aged care as well as the considerable work that will need to be sustained to achieve a fit for purpose aged care system.

What regulatory interventions are needed to raise the quality of aged care?

36. The ANMF believes that regulatory and policy failure over many years has been a key reason for the crisis in aged care most recently identified by the Royal Commission and many previous enquiries. This failure has involved government decision making, policy making, regulatory failure from successive regulators and a marketised, predominately privately owned and delivered aged care sector primarily focused on revenue rather than aged care as a social good.
37. The consultation paper proposes that the new model of regulation should be characterised by a relational regulation model focused on relationship building, trust and transparency and a light-touch approach. It is also noted that cultural change is required.
38. While a regulatory framework predicated on a relational model and a light-touch approach is a noble ideal, the ANMF believes that any assumption that the sector is mature enough for such a regime is premature and concerning especially given the findings of the Royal Commission. In general, the ANMF often finds aged care providers difficult to deal with in relation to issues such as enterprise bargaining and agreements, treatment of members in relation to industrial, safety, quality of care and governance issues, where a trust and interest-based relationship might be expected to produce better outcomes than an adversarial approach which providers persist in using.
39. The ANMF believes that at least initially, a more directive regulatory model is warranted, until aged care providers can demonstrate ongoing high quality, safe aged care. This may take time. The regulatory model must assertively signal and encourage aged care providers towards higher standards of care quality and safety and require a model of continuous quality improvement.
40. The ANMF considers tougher regulatory sanctions must be enforced where regulatory failures occur. There currently exists a situation where when it is identified that providers are providing poor quality care and are found to be non-compliant they remain able to provide ongoing services and care

delivery. Legislation must ensure that services are unable to provide care and services if they do not meet clear regulatory expectations. Further, individual accountability must be placed at both the Board and managerial levels.

Regulatory Risks

41. One potential risk associated with a relationship based regulatory approach is that of "Regulatory Capture" which is defined as a situation where "… regulators and their employees potentially align their values and actions with that of the industry they are regulating – rather than with the values and legislated purpose of the regulator".[5] This issue was noted by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry in relation to the financial sector and can arise as a result of:
    - 41.1 staff moving between industry and regulatory jobs
    - 41.2 secondments and
    - 41.3 where regulatory staff are embedded in private sector organisations (that is, required to conduct their work within the workplace of industry participants, away from their home base at the regulator).
42. Given the current issues and alarm in relation to the use of consultants by government, it is also timely to consider the use of consultants within any aged care regulatory arrangement as well. The situation reported by the Guardian on 5 May 2023 where PwC collected data from aged care providers for a costing study and at the same time provided the industry with pricing advice is concerning from a potential conflict of interest perspective at the very least.[6]
43. The ANMF recommends that the government, the Department of Health and Aged Care and the ACQSC take active measures to reduce the risk of regulatory capture, particularly the movement of people between the sector and regulatory roles, as well as ensuring that there is sufficient capacity and capability at government and regulatory levels so a reliance on consultants is unnecessary.

To raise the quality of care, what role should government and nongovernment stakeholders play?

44. If the lessons from the health care system are to be learned, raising the quality of care in the aged care sector will take time. In the health sector, issues of safety and quality became prominent following the release of the Institute of Medicine report "To Err is Human: Building a Safer Health System" in 1999.[7] Demonstrably, the aged care sector lags behind the health sector in relation to safety, quality and oversight, which, as the Royal Commission demonstrated, will require a considerable and sustained reform effort.
45. Many of the issues identified by the Royal Commission have been failures of regulation and policy

and this must not be allowed to continue. Aged care providers have a fundamental responsibility to those they care for, where issues of the financial bottom line and shareholders must take a secondary position, and they must be held to this responsibility first and foremost. The ANMF is not supportive of the terms used in the consultation paper such as relational regulation and right-touch. These terms do not reflect the lessons clearly identified by the Royal Commission.

46. It is unfortunate that the results of the ACQSC capability review are not publicly available to inform this response.

47. The ANMF is encouraged to see that worker protections, e.g., for whistleblowers, as part of a broader and more robust complaints management process are proposed. Members working in the aged care sector routinely report oppressive workplace conditions, retribution by management if staff speak out, e.g., loss of shifts or hours, and failure of aged care providers to respond to genuine worker concerns around working conditions and safety and quality of care. It would be reasonable to argue that the high turnover rate (29%)[8] and intention to leave (39.2% planning to leave within three years)[9] are critical metrics that indicate lack of worker voice in the sector.

48. Worker protections must be included within the new Aged Care Act. These protections must include Whistleblower protections (whistleblowing, making a complaint and identification of wrongdoing) whether in the act or in related or supporting/subordinate legislation. There must be a balance between privacy and a complainant's right to know how their complaint has been handled and the outcome.

49. As already mentioned in this paper, older Australians receiving aged care services are often a marginalised and relatively powerless group. A rights-based approach to aged care services is supported but this must be an approach where there are redress mechanisms available if these rights are not met. Barriers to redress, such as cost, must be removed. The new Aged Care Act, or supporting legislation, must address this issue and form part of the regulatory and redress framework needed to make the cost of compliance and doing the right thing less than the cost of non-compliance.

Culture change is key to raising the quality of aged care. Who can be the culture change champions, either at the local or the sector level? What support will they need to champion culture change?

50. While culture change champions are important at the local level, their capacity to drive change is limited if there is not organisational and sector support. The ANMF believes that a key driver of cultural change is to acknowledge that aged care is primarily health care rather than social care, or

influenced by disability care, which requires the sector to adopt the same relevant standards. It has long been the contention of the ANMF that the same standards of care must apply across sectors irrespective of where the older person is accessing services, e.g., aged care, hospital sector, primary care. This outcome can only be achieved if aged care is seen as integral to the broader health care system.

51. Much work has gone into embedding and sustaining continuous quality improvement, a safety culture, effective standards and good governance cultures in the health sector and sadly, the aged care sector is considerably behind in terms of standards, clinical indicators, incident and complaints monitoring, and clinical governance arrangements for example. Frequently used euphemisms such as “home like environment” “de-institutionalisation” and “ageing in place” by policy makers, aged care providers and the ACQSC has provided the impetus for a diminution of the health and clinical care aspects of aged care and the resulting safety and quality failures that have been so well detailed in the final report of the Royal Commission.
52. Unless there is a fundamental philosophical change at the government, policy and regulatory levels about aged care, there will not be a culture change by aged care service providers. The ANMF believes that a dual approach of encouraging quality care delivery, supported by effective regulatory controls, is the only way to create an environment where culture change can germinate and flourish. Recognising that people enter aged care to receive health care, and that a significant proportion of health care will be delivered in-home should shift aged care towards a service-delivery rather than a market-driven model. Aged care must not only be a market transaction involving a consumer and provider of care. This fundamental shift must be a starting point in legislative and regulatory reform and be a philosophical underpinning for aged care regulation.

Supporting quality care

53. The ANMF has long been concerned that aged care providers have adopted a culture of minimum standards compliance rather than a broader and more proactive approach of continuous quality improvement. This culture, combined with a regulator that appears to lack the capacity, capability and organisational will to move the sector from a minimum compliance to continuous improvement approach, has resulted in a sector where much improvement is yet to occur. As the Royal Commission stated in their final report:

> *The primary function of the aged care regulator is to protect and enhance the safety, health, wellbeing and quality of life of people receiving aged care. Ineffective regulation has been one of the contributing factors to the high levels of substandard*

care in Australia's aged care system.[10]

54. The ANMF believes there has been failure of the previous federal government to ensure the objectives set out in the *Aged Care Quality and Safety Commission Act 2028 (fed)*[11] have been met by the ACQSC, an oversight only uncovered through the scrutiny of a Royal Commission. It is vital for older people and the workforce that there is a transparent system for governance of any regulatory model.

What are your views on the proposed approach to supporting quality care?

55. The ANMF agrees that the actions outlined in the consultation paper are reasonable strategies for supporting quality care but would need to go much further. They need to include:

55.1 Additional information about services will help some older people and their significant others, however, a Cochrane Library review of the *Impact of public release of performance data on the behaviour of healthcare consumers and providers,* found no compelling evidence that publicly available data influenced the services that consumers chose to access, decisions undertaken by health care providers, or overall provider performance.[12] It is likely that these findings are also applicable to the aged care sector.

55.2 Education and engagement with providers will possibly help some providers, particularly those smaller providers who may have resource constraints. However, this seems to be presented as a new initiative when these processes should have been comprehensively in place for a long time. As indicated earlier in this submission, the ANMF does have reservations on the willingness of some providers to move to an organisational culture where capacity building and continuous improvement are core business. As a whole, the sector has failed to invest in workforce, education and training and is compliance, rather than improvement, focused.

55.3 While publishing performance data, promoting good performance and a graded assessment (rather than a pass or fail approach) are all useful strategies for incentivising high quality and safe care, it has to be questioned why these "incentives" are presented as a new approach. These are all aspects of an effective system, and more fundamentally, it has to be questioned why aged care providers have to be provided with incentives to do their job with the considerable public funding they already receive ($30 billion in 2022-23 increasing to $42 billion in 2026-27).[13]

55.4 There must be clear, measurable, and enforceable standards. Alignment of aged care standards with the form and function of the ACSQHC Health Service Standards to remove ambiguity, is supported and will reduce duplication between the two sectors. Unfortunately,

the newly released revised quality standards do not engender confidence the employer, regulator, consumer or worker will know what compliance looks like and how it will be measured.

What challenges can you identify for implementing the proposed approach to engagement and capability building? What could be the solutions?

56. If the strategies outlined in the Consultation Paper No. 2 are to be implemented, both the Department of Health and Aged Care and the ACQSC will require considerable investment in both capability and capacity to drive this agenda in the short, medium and long term. Unless this occurs, what is achieved will fall far short of what is promised, to the detriment of older Australians and those who work in the sector.

How else could provider capability be improved in aged care at the individual provider and sector wide levels?

57. In addition to regulatory capability issues raised, the following are identified:

57.1 Creating a fit for purpose aged care workforce is an essential capability building strategy. A quadripartite (government, unions, providers and consumers) workforce planning agenda must be in place to safeguard the future workforce demands. There must also be further investment in the nursing component of the aged care workforce, i.e., registered nurses and enrolled nurses (ENs), recognising that people enter aged care to receive health care, and that a significant proportion of health care will be delivered in-home. While the pending mandates around RN 24/7 and minimum RN minutes of care per resident per day are a good starting point, the ANMF believes that the significant percentage of direct care workers in the sector must be rebalanced (70% care workers in the residential sector, 88% in the Home Care Packages Program and 80% in the Commonwealth Home Support Programme).[14]

57.2 Legislated, safe levels of staffing and skill-mix including RNs being employed in aged care facilities 24 hours per day, with ratios that align with the assessed needs of residents, is fundamental. While the move to a mandatory average minimum of 200 minutes of care per resident by October 2023 and 215 minutes of care per resident by October 2024 is supported and is an important start, there is more work to do. Staffing levels and skills-mix must be evidence based and meet the assessed needs of older people. As identified in the ANMF National Aged Care Staffing and Skills Mix Research Project Report (2016), residents in nursing homes should receive an average of 4.3 hours of care per day with a skill-mix requirement of 30% RN care, 20% EN Care and care worker care of 50%.[15]

57.3 The essential part that enrolled nurses play in the aged care workforce must be explicitly recognised. The Royal Commission did not adequately address the role of enrolled nurses and while it is essential that the role of registered nurses in aged care is recognised, it is also important that the role of nursing (both registered and enrolled) is considered as part of any broader aged care workforce strategy. Not doing so risks a focus on just registered nurses and the care workforce. The shorter training cycle of enrolled nurses (18 months as opposed to three years for registered nurses), combined with fee-free TAFE places has the potential to assist with the skill-mix issues being experienced in the sector. While there is currently a focus on registered nurse minutes of care, it is recommended that a clear mandate for specific enrolled nurse care minutes be part of any workforce solution going forward. Therefore care minutes mandates should be divided to include EN minutes, beginning with the separation from care worker minutes. Total minutes of care should be split in the following percentages or similar: 50% care worker; 20% EN; 30% RN.

57.4 There must also be mechanisms to ensure that RNs and ENs can be supported to undertake their roles in accordance with their regulated professional standards and codes of practice outlined by the Australian Nursing and Midwifery Board of Australia (NMBA). This significant quality of care issue is not currently assessed during the accreditation process and therefore there is no incentive for aged care providers to create workplaces where RNs and ENs can meet their professional practice obligations which are designed to protect the public. As outlined above a workforce standard would:

57.4.1 Clearly identify that employers are responsible for ensuring workers are supported to maintain their professional practice requirements.

57.4.2 Contain mechanisms for registrants to escalate issues relating to professional practice obligations.

57.5 Since the introduction of the Aged Care Act (1997), the core workforce trend has been towards a poorly paid, compliant and disenfranchised aged care workforce. An essential element of any regulatory reform must be empowerment of aged care workers to act as an essential safety mechanism as aged care “experts” who are ideally placed to identify quality and safety issues. As outlined above the worker voice is key to improving quality care delivery.

57.6 Like the Royal Commission, the ANMF believes an important safety and quality driver for the sector is a direct employment model. Indirect workers, as independent contractors, are responsible for their own training, ongoing development and upskilling. While directly

employed workers also share this responsibility, employers also have obligations in relation to training and education to maintain standards of care and safety and continuous quality improvement which would be inherently more difficult in an indirect employment model, particularly if this practice became more widespread. Reliance on an indirect workforce, with less rights of control by the employer, may exacerbate the safety and quality issues identified by the Royal Commission rather than offer a solution. Recently completed Australian research clearly identifies the safety and quality risks of using agency staff in aged care.[16] An educated and skilled workforce that is valued and secure in their employment is central to providing safe, high quality aged care services to consumers.

57.7 Regulation of health care practitioners through the Australian Health Practitioner Regulation Agency (Ahpra) supports practice that is safe and protects the public. The ANMF has supported and campaigned for regulation for care workers since 2004. As outlined above the ANMF believes that care workers should be included in the Health Practitioner Regulation National Law Act 2009 (National Law), like registered and enrolled nurses. The purpose of this positive regulation scheme is public safety – consumers and employers know that health practitioners registered under Ahpra meet a national minimum standard of education, English proficiency, and are a fit and proper person for their role, thereby ensuring minimum levels of care regardless of where that care is delivered.

57.8 State and territory legislation impacting aged care must be recognised and aligned as much as possible to promote consistent standards across jurisdictions, e.g., state and territory health regulators (e.g., The Queensland Health Ombudsman, NSW Health Care Complaints Commission), Workplace Health and Safety and Medicines.

57.9 Memorandums of understanding with organisations responsible for enforcing state and territory-based legislation must also be embedded into the regulatory strategy where this impacts aged care, to ensure there are no gaps in compliance monitoring and enforcement. An alternative approach could be like that of the national law regarding health practitioner regulation with complementary state/territory and national laws creating a level of uniformity across jurisdictions. Two areas of concern would be medication management and workplace health and safety.

What types of education or engagement do you think would support providers to continuously improve?

58. The ANMF notes that there are already considerable resources available to support aged care

providers in delivering safe, high quality services. There is also an ongoing responsibility of government and regulators to provide information and training relevant to provider responsibilities and obligations that is timely and contemporaneous.

59. However, aged care providers themselves must take responsibility for ensuring that, at an organisational level, they have the capacity and capability to meet their obligations as service providers.

60. Assistance, where provided, should be based on need. Such an approach would ensure greater support for those smaller or single site aged care providers that lack organisational depth. The ANMF would question the motivation of larger aged care providers (for-profit and not-for-profit) that failed to invest in the resources needed to continuously improve.

61. Reiterating a previous point, the ANMF believes that a failure by the sector to view aged care through a health care lens has resulted in many of the quality and safety issues endemic to the sector. The inadequate response by the nursing home sector generally during the COVID-19 pandemic is emblematic of this failure. Suggested strategies that larger aged care providers could easily undertake to support the aged care reform process include:

    61.1 Drawing health management expertise from the health sector, given the significant component of health care required by those receiving aged care services. It is the experience of the ANMF that aged care managers and decision makers often have no experience of working in a healthcare setting and are not health practitioners. This results in a lack of appreciation or understanding of the complexities of delivering aged care services.

    61.2 Increasing the nursing component of the aged care workforce and placing nurses in middle to senior level decision making positions would also go far to improve the quality of services, particularly from a clinical governance perspective. The ANMF believes that the long-term decline in nursing positions in the sector, in favour of significantly increased care workers, has precipitated many of the quality-of-care issues experienced by the sector.

    61.3 Positive registration of care workers through the National Law.

    61.4 Greater numbers of health care professionals on governing bodies would go some way to focusing providers on quality-of-service issues and delivery.

    61.5 Investing in staff training and skill building. A complaint often heard by the ANMF members is the failure of aged care providers to invest in staff skill and capacity building beyond essential minimum requirements.

How could the Regulator, the Department and providers improve the provision of information to older people and their representatives so that they have access to the right information, at the right time, in the right way?

62. As discussed earlier, it is still unclear how the provision of information impacts on the capacity of older Australians and their representatives to access this information when needed. A range of factors must be considered:

62.1 Older Australians are often less digitally engaged, so services such as on-line portals and internet-based information resources may not necessarily reach their target audience. Admissions to nursing homes are often of an emergent, rather than planned nature where there is simply not enough time to rigorously review information and where convenience, location and bed availability are often overriding factors which may outweigh other considerations relating to care quality.

62.2 As indicated earlier, the utility of provider scorecards, rating systems and other online decision support resources is not yet established. The issues experienced by older Australians and their representatives in accessing and using the My Aged Care and other online services were highlighted by the Royal Commission.[17]

62.3 While online resources may be useful for some people who use aged care services, it is important that the Department of Health and Aged Care and the ACQSC invest in more human resources for those older Australians who may be trying to navigate the aged care system and have difficulty accessing online services. These in person resources need to include:

62.3.1 Appropriately trained call-centre staff.

62.3.2 Specialised roles such as nurse navigators who can assist vulnerable and at-risk older Australians, often with complex care needs, through the aged care maze.

62.4 Greater funding and support for advocacy groups such as the Older Persons Advocacy Network (OPAN) so that they can expand their reach and capacity is also important. As independent organisations, they can provide invaluable information and support to individuals, but also have the capacity to identify and escalate system level issues.

Becoming a provider

63. The ANMF is concerned about the resourcing and capability increases that will need to occur for the new regime of registering as a provider to be supported and managed effectively. The ANMF strongly urges the Department and the ACQSC to look to the issues experienced by the NDIS in relation to provider entry in the scheme and management of these organisations, with the NDIS being described

as a "Wild West" situation where entry into the sector is seen as a "modern-day goldrush" rather than being client focused.[18] [19] This situation must not be allowed to occur in aged care.

What are your views on the proposed registration categories?

64. The ANMF has a number of concerns relating to the proposed registration categories. These include:

64.1 The need to maintain a high bar for entry as a registered provider to avoid an NDIS like situation.

64.2 Moving domestic assistance into category 1 with home maintenance etc. with the least amount of regulatory oversight is of concern. Entering a person's home is an intimate practice. If this service was to remain in Category 1, how would the new regulatory model ensure the person providing this assistance is a fit and proper person attending the home of a potentially vulnerable population and how will they be connected and escalate any ongoing concerns.

64.3 The significant potential resource and capacity requirements for the regulator to undertake the registration process and ongoing oversight for a large increase in aged care providers offering services.

Which registration category should care management and personal care be in and why?

65. Care management and personal care should be placed in Category 4. The rationales for included personal care in these category include:

65.1 Personal care is a domain of nursing care and requires appropriate clinical governance and oversight.

65.2 The impending registration regime for care workers will undoubtedly begin a process of enhancing the training, knowledge, and skills of this group.

66. The ANMF also believes that medical practitioners should be included in the service types identified for Category 4 providers. Medical practitioners are an important part of the health care services provided to older Australians and it seems unusual to identify care workers, nursing, and allied health without also including the medical component of aged care.

How should online platforms that connect older people to aged care services (but are not themselves Approved Providers) be regulated under the proposed new model?

67. The ANMF believes that online platforms should be regulated. Indirect workers, as independent contractors, are responsible for their own training, ongoing development and upskilling. While directly employed workers also share this responsibility, employers have obligations in relation to training and education to maintain standards of care and safety and continuous quality improvement which would be inherently more difficult in an indirect employment model, particularly if this

practice became more widespread. Reliance on an indirect workforce, with less rights of control by the employer, may exacerbate the safety and quality issues identified by the Royal Commission rather than offer a solution. As outlined above recently completed Australian research clearly identifies the safety and quality risks of using agency staff in aged care.[20]

68. The ANMF has long been concerned about the increase in digital platforms supporting an individual contractor model of work, both generally and more specifically in relation to health and aged care (and also in the disability sector). These concerns regarding what is often referred to as the "Uberisation" of work relate to:
    - 68.1 Lack of benefits such as sick leave, superannuation and holidays available to paid employees.
    - 68.2 A focus on being paid per job rather than an hourly rate (the "gig" economy concept).
    - 68.3 While being touted as a flexible mode of work, in reality these workers live "on-demand" of those that utilise their services.
    - 68.4 Lack of financial security, award and enterprise agreement conditions, employment rights and work certainty.
    - 68.5 Collateral issues associated with insecure work such as access to mortgages and loans.
69. It should also be remembered that individuals and organisations that promote the "Uberisation" of work and the platforms that support this model are not accountable for the quality of care delivered by workers.
70. Digital platforms such as Mable Pty, engaged by the Commonwealth Government as part of its pandemic surge workforce strategy for aged care, promote this "Uberised" or "gig economy" business model, yet this approach is characterised by the following features which seem incompatible with the workforce and safety and quality requirements identified by the Royal Commission. They are not service providers, they are not covered by labour hire licensing regulation, they do not provide oversight or supervision of care workers and they have no responsibilities for employment or care.[21]
71. Indeed, the Royal Commission identified Mable Pty workers sent to Newmarch House at the peak of their COVID-19 outbreak in which multiple residents died, had 'little or no past experience in aged care and/or Infection Prevention and Control training'.[22]
72. The extensive evidentiary processes and deliberations of the Royal Commission have pointed to the advantages of a permanent, well paid, supported and trained workforce in ensuring quality of care and safety of care recipients. Until other models of care, such as indirect employment can be empirically shown to provide a superior result, it is the view of the ANMF that such models be viewed

with a healthy scepticism.

What are your views on how the proposed model will allow other business types, such as sole traders and partnerships, to enter the sector?

73. The ANMF has concerns about the proposed model enabling other business types such as sole traders and partnerships being able to easily enter the sector. As outlined above there must be a high bar for entry into the sector with ongoing rigorous oversight. The new regulatory model must ensure quality services and care is delivered with providers delivering these being held accountable. Also, as outlined above direct employment should be the preferred model of service and care delivery.

What, if any, alternatives are there to 3-year re-registration periods, and why would they be appropriate?

74. The ANMF agrees in principle that as a general rule, a three-year registration cycle strikes a balance between ensuring that registered organisations have relative recency of registration and the resource requirements of a shorter cycle, e.g., two yearly.

75. Irrespective of the general re-registration period there must be rigorous processes for identification and management of those service providers that require more frequent review, e.g., due to poor performance. The three-year cycle must not be deemed as a rationale to leave services unregulated for lengthy periods, as has been the case in the past, with services left up to four years between compliance visits.

What challenges can you identify for implementing the proposed registration model? What could be the solutions?

76. As already identified, the ANMF believes that the main challenges in implementing the proposed six category registration model are:

    76.1 The capacity of the regulator and the clear need for significant additional resourcing to manage the logistics of the registration and ongoing oversight process sustainably.

    76.2 The need for processes to prevent a repeat of the current service provider issues experienced by the NDIS.

What are your views on the proposed approach to provider obligations?

77. Clearly articulating provider responsibilities as well as the consequences of failing to meet them is essential. The ANMF is supportive of the proposal to introduce an overarching duty on providers to ensure that those persons in their care are not unnecessarily put at risk.

78. In relation to a rights-based approach and Statement of Rights, there must be mechanisms to seek redress when these rights are ignored or curtailed. As older Australians are a potentially vulnerable, and at risk, group these mechanisms must be accessible at minimal or no cost and with sufficient support and resources available to them. Penalties associated with a proven breach must be of a magnitude to provide a realistic deterrent.
79. Framing expectations using human-rights motherhood statements whilst appropriate, should be qualified through quality standards that are measurable and enforceable, otherwise there is potential for providers, workers, consumers and regulators to lack clarity on what compliance looks like and to identify noncompliance.

What challenges can you identify for implementing the proposed approach? What could be the solutions?

80. As identified earlier in this submission, the ANMF believes that the primary challenge is resourcing the regulator so that it has both the capacity and capability to undertake this oversight of provider responsibilities and obligations. This capability can only be achieved through appropriate and sustained funding so that the regulator can recruit the required number of suitably skilled and experienced staff. Given the large component of health and clinical care required in nursing homes in particular, but also in the community where there is increasing acuity, this enhanced capacity must involve significant numbers of nurses who have the requisite knowledge, skills and experience to provide effective oversight capabilities.

Do you think there are any key areas of risks that are not addressed by the core conditions proposed to apply to all providers?

81. The key risk is the capacity of the regulator to provide the level of oversight to effectively operationalise the regulatory model and ensure that aged care providers are actually meeting their responsibilities and obligations to an appropriate standard. Without the regulatory capacity, there is likely to be a loss of faith in the regulator to undertake its role effectively.

Are there any other category-specific obligations that you think should apply?

82. As outlined above, the ANMF has always maintained that providers must be required to demonstrate that they create the conditions for health practitioners, for example, to meet their professional standards, e.g., NMBA Standards for Nursing Practice for RNs, ENs and Nurse Practitioners (NP). Too often, ANMF members report that they are working in situations where they find it impossible to meet their professional obligations to provide safe, high-quality care due to decisions and circumstances created by their employer and beyond the capacity of the individual nurse to alter,

e.g., inadequate staffing and skill-mix. Ensuring that providers are aware of, and ensure the workplace conditions where registrants can meet their professional standards, is essential.

What are your views on the proposed application and audit of the Quality Standards to categories 4 to 6?

83. The ANMF has concerns about the robustness of a digital declaration process for Category 1 to 3 providers, there must be random auditing processes in place to confirm quality service delivery, detect fraud, gaming and exaggeration of provider information.
84. A robust process of auditing for Category 4 to 6 applicants is supported.

What does high quality care mean to you?

85. The definition of high quality care does encompass the elements expected of such a definition. However, some of the language used is problematic. The use of terms such as compassion, respect, and trauma aware are subjective and difficult to measure.
86. The ANMF would urge the Department of Health and Aged Care to look to the health sector when defining high quality care, in particular the World Health Organisation definition which could be adapted for the aged care sector, and states:

    Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for achieving universal health coverage. As countries commit to achieving Health for All, it is imperative to carefully consider the quality of care and health services. Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be:

    Effective – providing evidence-based healthcare services to those who need them

    Safe – avoiding harm to people for whom the care is intended

    People-centred – providing care that responds to individual preferences, needs and values.

    To realize the benefits of quality health care, health services must be:

    Timely – reducing waiting times and sometimes harmful delays

    Equitable – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status

    Integrated – providing care that makes available the full range of health services throughout the life course

    Efficient – maximizing the benefit of available resources and avoiding waste.[23]
87. It is also essential to consider the worker who is providing care when defining quality. The ANMF believes that those working in direct care roles such as nurses and care workers are ideally placed to

assess the quality of care and help to define it in terms of what they do and how they keep those they care for safe.

What are your views on the proposed features of this safeguard that seek to hold providers accountable?

88. The features of the new approach to holding providers accountable are what the ANMF expects should be part of safeguard mechanisms and have been accepted practice in the health sector for many years. Risk based monitoring, incident and complaints management, information sharing, compliance monitoring, enforcement and compensation are all features of a fit for purpose aged care sector and while these aspects are welcomed, it is concerning that a Royal Commission had to take place for them to be proposed.
89. Again, the ANMF urges the Department of Health and Aged Care to use the health sector as the exemplar for such processes rather than those of the NDIS and disability sector, due to health's expertise and natural linkages between aged and health care.
90. For more extreme violations, the ANMF suggests that services must not be permitted to provide care and services if they do not meet clear regulatory expectations. Individual accountability must also be placed at both the Board and managerial levels, signaling strong deterrence to those providers tempted to game the system.
91. The ANMF strongly supports the need for critical failure provisions for the ACQSC in relation to situations such as sudden provider collapse, e.g., the Earlhaven collapse in 2019, or for provider insolvency.

Do you think the proposed new complaints model will help older people to raise concerns about the standard of services and have them addressed? Please include your reasons for this view.

92. A safety culture where incident reporting and complaints management are seen as providing opportunities to learn and improve service delivery, will take considerable time to develop in a sector where our members report that reporting adverse events and complaints is discouraged or results in a "shoot the messenger" situation. Just as the patient safety movement has taken many years to evolve and mature in the hospital sector for example, there will be no quick fixes in the aged care sector.
93. It must be pointed out that complaints are not just an avenue for those using aged care services, but must be a mechanism for workers as well for issues that relate to the safety and quality of care, worker safety and for unacceptable provider behaviour or illegality.
94. Worker protections must be included within the Act. These protections must include Whistleblower

protections (whistleblowing, making a complaint and identification of wrongdoing) whether in the new aged care act or in related or supporting/subordinate legislation. There must be a balance between privacy and a complainant's right to know how their complaint has been handled and the outcome. Options for how unions (as representatives of members) could be involved in this process must also be explored to redress the power and authority differentials between management and workers that can be misused to silence dissent or concerns.

Do you think the proposed enforcement mechanisms will be sufficient to address poor performance by providers where required?

95. The ANMF supports the enforcement provisions identified in the consultation paper, however emphasises that consideration be given to criminal sanctions for some high level offences for their signaling and deterrent effect.
96. As with all such mechanisms there must be regular review of their effectiveness and a willingness on the part of the authorities to evolve these processes to meet emergent needs and changed circumstances.

How should restorative justice outcomes be reflected in the new Act?

97. A rights-based approach must clearly establish what these rights are and establish accessible and effective mechanisms for redress when these rights are breached. The new Aged Care Act, or supporting legislation, must address this issue and form part of the regulatory and redress framework needed to make the cost to providers of compliance and doing the right thing less than the cost of non-compliance.
98. A rights-based approach to aged care services is supported but this must be an approach where there are redress mechanisms available if these rights are not met. Barriers to redress, such as cost, or advocacy services, including legal support, must be eliminated.
99. However, as outlined above a person-centred approach must not be used as an excuse to shift risk and scrutiny from government, policy makers, regulators and providers who are responsible and accountable for service delivery and outcomes to "consumers" under the guise of choice or preference. As a social good, aged and health care are human rights, not a market transaction involving a "consumer" and provider of care. While the ANMF acknowledges that older Australians must have the right to make choices about their care, even if those choices involve some risk (dignity of risk), this must not be used as an excuse by government, policy makers, regulators and aged care providers to shift risk to older Australians under the guise of choice.

How and when do you think access to financial compensation should be available?

100. Access to financial compensation must be one of the redress options available to older Australians when there has been a proven rights violation. A significant issue in any rights violation for older Australians must be the availability of support services to assist in their claim, low or no cost processes and timeliness. Timeliness is critical when the median length of stay for permanent residential care is approximately 21 months.[24] This period of time presents a narrow window for action so compensation mechanisms must reflect these timeframes.

What role should the Regulator have in seeking compensation on behalf of older people?

101. Given the potential issues around cost, navigating any compensation process, availability of advice and other support resources including significant others, as well as potentially short timeframes for elderly Australians, the ANMF is supportive of the regulator or other bodies supporting older people in seeking compensation.

Transitioning to the new model

102. As with any transition from old to new arrangements, effective planning, realistic and appropriate timeframes, the capacity to reconfigure the process based on assessment of progress with clear go, no-go decision points and milestones, and effective evaluation processes, are essential.

What are your views on the proposed transition arrangements?

103. The ANMF requires greater detail to commit to the proposed transition arrangements. Both "big-bang', go-live and phased approaches have risks and benefits. A single go-live commencement date would be a significant undertaking and would require a high level of preparation, information giving and support to transition. An assessment of the capacity of the regulator, the Department of Health and Aged Care and providers would be a significant undertaking and amplifies the risk of failure, at least in part.

104. A phased or staged transition, e.g., residential then home care providers etc., would reduce implementation risk, allow concentration of support to a smaller number of providers at any one time, focus readiness activities onto smaller target groups, and reduce the impact on the regulator and Department of Health and Aged Care. However, this approach would involve greater timeframes which could be reduced if there was some overlapping of transition periods.

What challenges can you identify for implementing the proposed transition arrangements? What could be the solutions?

105. Given the large number of aged care service providers (of all types), and the proposed single go-live commencement date, critical challenges will be:

105.1 Development of resources to support the preferred transition strategy.

105.2 Preparation of the large number of providers with information and resources and assessment of go-live readiness from a logistical perspective.

105.3 Realistic lead-in times.

105.4 An "all eggs in one basket" risk with the potential for widespread disruption if there are unintended consequences as the transition is undertaken. A phased approach would better contain untoward or unanticipated risks or consequences.

105.5 High demand on the regulator and the Department of Health and Aged Care to support a sector wide single go-live date.

106. A phased transition would mitigate some of these potential risks while adding to longer timeframes.

What support do you need as a provider to help you with a smooth transition to the new model?

107. A primary focus to assist providers must be the provision of information and transition resources, including transition readiness self-assessment. Information and education of the workforce would also be critical to prepare for a smooth transition.

What other transitional arrangements need to be considered?

108. Effective planning and scheduling of this transition will be necessary for success. However, to date the ANMF hasn't had a high level of confidence that the Department of Health and Aged Care has developed processes to plan, coordinate, program, schedule and oversight the significant aged care reform activities flowing from the 148 recommendations of the Royal Commission.

109. Given this view, the ANMF recommends further work needs to be done to better coordinate reform that balances the immediate need to improve care delivery and enough time to implement change in a sustainable way. Often a longer transition period is a small price to pay for decreased risk and greater overall project success.

CONCLUSION

110. The ANMF welcomes the opportunity to provide feedback on a new model for regulating aged care. The ANMF maintains that aged care is a social good with the primary aim of supporting older Australians with high quality and safe aged care services in a dignified, respectful, and person-centred way. The new regulatory model for aged care offers a long overdue opportunity to improve the quality of aged care services and the safety of those receiving them. The new model must be informed by the underlying principle of ensuring that people who access aged care services are provided with safe, quality care and the assessment of any legislation, regulation or standard must

be viewed through the lens of ensuring quality care received for every individual. The ANMF believes that urgent reform is necessary including a regulator with the capacity, capability and, most importantly, the organisational will to protect older Australians receiving aged care services, whether it is in their home or in a nursing home.

REFERENCES

1. Australian Nursing and Midwifery Federation submission to the Department of Health and Aged Care Consultation - Review of the Aged Care Quality Standards 2022. https://www.anmf.org.au/media/rmshhuty/anmf_submission_aged_care_quality_standards_25nov2022.pdf
2. The Tax Justice Network (May 2018) Tax Avoidance by For-Profit Aged Care Companies: Profit Shifting on Public Funds. Proposals for Transparency on Government Spending, retrieved from https://www.anmf.org.au/media/chqcr3s5/anmf_tax_avoidance_full_report.pdf
3. Tax Justice Network Australia and Centre for International Corporate Tax Accountability and Research (May 2019), All in the Family: Tax and Financial Practices of Australia's Largest Family Owned Aged Care Companies, retrieved from https://www.anmf.org.au/media/s1jkefqe/all_in_the_family_report.pdf
4. Centre for International Corporate Tax Accountability and Research (July 2020) Caring for Growth. Australia's Largest Non-Profit Aged Care Operators, retrieved from https://www.anmf.org.au/media/b5ocuvz3/caring_for_growth_np_aged_care_report.pdf
5. Parliament of Australia , Parliamentary Joint Committee on Corporations and Financial Services, Oversight of ASIC, the Takeovers Panel and the Corporations Legislation No.1 of the 45th Parliament Report, Chapter 3, Integrity Risks, retrieved from https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/No1of45thParliament/Report/c03
6. Belot, H., (5 May 2023), Warnings raised as PwC paid $8.7m to collect Australian aged care data while helping to set industry prices (The Guardian), retrieved from Warnings raised as PwC paid $8.7m to collect Australian aged care data while helping to set industry prices | Aged care | The Guardian
7. Institute of Medicine (2000) To Err is Human: Building a Safer Health System, retrieved from https://www.ncbi.nlm.nih.gov/books/NBK225182/
8. The Weekly Source (16 September 2021) 29% staff turnover vs 7.5%: workforce shortages to drive aged care consolidation, retrieved from https://www.theweeklysource.com.au/29-staff-turnover-vs-7-5-workforce-shortages-to-drive-aged-care-consolidation/#:~:text=aged%20care%20consolidation-,29%25%20staff%20turnover%20vs%207.5%25%3A%20workforce,to%20drive%20aged%20care%20consolidation&text=Aged%20care%20providers%20know%20that,other%20industries%20will%20shock%20you.
9. Aged Care Essentials (September 21 2021) Looming Aged Care Staffing Crisis: Summary of the Latest Workforce Report, retrieved from https://www.agedcareessentials.com.au/news/looming-aged-care-staffing-crisis-summary-of-the-latest-workforce-report#:~:text=A%20majority%20of%20first%2Dyear,%25)%20and%20Victoria%20(33.2%25).
10. Royal Commission into Aged Care Quality and Safety (2021), Final Report: Care, Dignity and Respect, Volume 1, Summary and Recommendations, retrieved from https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf
11. Australian Government (2018) Federal Register of Legislation: Aged Care Quality and Safety Commission Act (2018) available at: https://www.legislation.gov.au/Details/C2022C00332
12. Metcalfe D, Rios Diaz AJ, Olufajo OA, Massa MS, Ketelaar NABM, Flottorp SA, Perry DC. Impact of public release of performance data on the behaviour of healthcare consumers and providers. Cochrane Database of Systematic Reviews 2018, Issue 9. Art. No.: CD004538. DOI: 10.1002/14651858.CD004538.pub3
13. Hermant, N. (11 May 2023) Federal budget projects a shift in aged care, which promises to save Australia billions, ABC News, retrieved from https://www.abc.net.au/news/2023-05-11/budget-aged-care-measures-and-home-care/102328544
14. Australian Government Department of Health (2020) 2020 Aged Care Workforce Census Report, retrieved from https://www.health.gov.au/sites/default/files/documents/2021/09/2020-aged-care-workforce-census.pdf
15. Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J., Blackman, I., Toffoli, L and Currie, T. (2016) Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation
16. Ma, N, Sutton, N, Yang, JS, et al. The quality effects of agency staffing in residential aged care. Australas J Ageing. 2022; 00: 1- 9. doi: 10.1111/ajag.13132
17. The Royal Commission into Aged Care Quality and Safety (2020) Aged Care Royal Commission Final Report: Summary, retrieved from https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf
18. Allied Health, Industry News & Trends (March 2023) The NDIS Gold Rush: When Cowboys Ride into Town for Profits, Not Purpose, retrieved from https://www.cjco.com.au/article/the-ndis-gold-rush/

19. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (21 March 2023) Report finds disability service provider prioritised revenue over participants health and safety, retrieved from https://disability.royalcommission.gov.au/news-and-media/media-releases/report-finds-disability-service-provider-prioritised-revenue-over-participants-health-and-safety
20. Ma, N, Sutton, N, Yang, JS, et al. The quality effects of agency staffing in residential aged care. Australas J Ageing. 2022; 00: 1- 9. doi: 10.1111/ajag.13132
21. Baines, D., Macdonald, F., Stanford, J. & Moore, J. (2019). Precarity and job instability on the frontlines of NDIS support work. Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/theausinstitute/pages/3070/attachments/original/1569981935/Precarity_and_Job_Instability_Under_the_NDIS_Formatted.pdf?1569981935
22. Gilbert, L. and Lilly, A. (2020) Independent Review of Newmarch House COVID-19 Outbreak presented as evidence to The Royal Commission into Aged Care Quality and Safety, August 2020
23. World Health Organisation (2023) Quality of care, retrieved from https://www.who.int/health-topics/quality-of-care#tab=tab_1
24. Australian Institute of Health and Welfare (28 July 2022) People leaving aged care, retrieved from https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care#People%20leaving%20aged%20care%20in%202019%E2%80%9320