**Feedback/Comments from review of the Draft Aged Care Act and related matters arising from the Consultation Papers No 1 and 2 and the OPAN webinar 09/1/24.**

1. **Section 9 (2) (a) p17/18** Note residential care home means the place of residence of individuals who , by reason of sickness, have a continuing need for aged care services , including nursing services , and .(b) .". I think the emphasis on sickness as a single word description seems inappropriate and demeaning in its reflection of individuals in residential care and the uniqueness of their assessed need and their residence as their home. I think this is but one element of a reason why a person may reside in such a place and as indicated in the definition of Sickness ,defined page 14 of the Act "means an infirmity, illness, disease, incapacity or impairment". I think emphasis on sickness as the singular description is inappropriate.
   **Recommendation An alternate definition could be " Residential Care Home , is a home and place of residence of an individual (that may have infirmity , sickness ,illness , disease , incapacity and or impairment ) with a continuing need for such a home and aged care services, including nursing services ."**
   **Recommendation Also, uncertainty and concerns regarding the extent to which the new Act will impose greater obligations ( already implemented in Residential aged care ) on MPS and the extent to which such will detract from the flexibility element of MPS and unique nature of the mixed services and risk viability. Limits element applying to MPS.**

2. **Sect 10 P19/20 Who Delivers funded aged care services**
   a. **Recommendation Clarify 10 (4) (b) (i) the inclusion of volunteer and implication, if any, regards this new aspect**
      **Clarify if volunteers such as community visitors are assumed here as engaged as an associate provider of the provider ?**
   b. 10 ( 5 ) aged care worker does not include a responsible person ???
   c. 10 ( 6) re associate provider under an arrangement with a provider goes to the issue of continued responsibility of the Provider if associate providers are engaged to still be the responsible provider. How does this effect Providers sub-contracting processes and agreements per arrangements and insurance of both provider and sub-contractor (How does it affect RSS for example and services they may provider ??)

3. **Sect 18 p27 Re Meaning of significant failure and systemic pattern of conduct .**
   a. **Recommendation These are two new terms and have significance when considered re new provider and responsible persons duties and penalties and require greater clarity regards their significance relative to the current system. Terminology.**

4. **Sect 19 p27/28,Act re High quality Care .** I support seeking to define and recognise high quality. I have some confusion between the Standards and their compliance vs High Quality Care and these requirements. The Consultation paper 2 indicates all providers will be required to have in place a continuous improvement plan for High Quality Care, noting it is assumed a Provider would have a continuous improvement plan for its sustaining of the Standards where any improvement is required within the providers established systems and process to sustain such standards. Then there is or may be a continuous improvement plan arising from the Commission audit and suggested improvements and non-compliances and now a continuous improvement plan to show how the provider is working towards achieving high quality ! **Recommendation , greater clarity is required and in relation to 3 different continuous improvement plans obligations a) High Quality Care b) provider**

**sustaining the standards c) Arising from Audit outcomes requiring further improvement. then at least ? seems excessive to require all to do a continuous improvement plan for high quality. 3 is too many as a compulsory element.**

5. **Sect 20, p 29, Statement of Rights and P 33 Sect 22 Statement of Principles.**
    a. My initial view is the introduction of Principles over regulates by its inclusion within the Act , focus should be on the Rights and the Standards and Code of Conduct. I realise Principles were recommended in the Royal Commission.
    b. It appears to me that together there will be a risk of confusion by Providers and System Governor Officials and this will impact on their consistent assessment and interpretation across services and for individuals. How will a system governor identify a system to ensure consistency in interpretation of Rights and Principles in the manner to be transparent and fair?
    **c. <u>Recommendation .</u> Clarify how Principles will align with Standards , will require Providers to show performance against the Principles ( as well as Standards) and how there will be consistency in interpretations by those managing aged care systems e.g. Systems Governor, Department and Commission officers.**

6. **Sec 15 p34 Reportable Incident.** Seems similar or same as current regards an incident that has occurred, is alleged to have occurred ,or suspected to have occurred, in relation to the delivery of an aged care service funded for an individual**.**

7. **P 38 Part 4 Supporters and representatives**
    a. I have reviewed consultation paper 1 and 2 and the Draft Act. I have struggled to understand what is proposed with contrasting understanding from these documents and with current terminology. It is very important to ensure clarity of these important roles. In the great majority of cases there are never issues in such roles but it is where there is family conflict re what is in the best interest of an individual in care that can occur and have significant impact on providers and family members. Any ambiguity will be exploited and cause issues for individuals and providers.
    **b. Sect 24 Actions of supporters . <u>Recommendation</u> Clarify Who is to manage evidence of the consents that an individual gives a supporter ? Is this an obligation of the Provider , does it require a specific form be completed ? Does it require regular review ?**
    **c. <u>Recommendation</u> Clarify does a family member , not being a supporter or representative or EPOA have a right to access information and or convey information ? Is this defined ?**
    **d. Regards a representative.**
    It remains unclear how these are considered when a Provider is advised of a representative of an individual , and there is a different EPOA appointed , and what is the status of a medical directive or advanced care directive relative to a representative if both have been established. Who is obligated to clarify who is responsible when various people indicate they have one of these ?
    **<u>Recommendation</u> Clarify who is to manage evidence of the consents that an individual will give to a representative and for them to have this status ? Is this an obligation of the Provider , does it require a specific form completed ? Does it require regular review and by whom? Does a Representative usurp the wishes identified in an earlier advanced care directive or medical directive?**
    **e.** I remain confused between the role of supporter and representative in that a supporter per 24, (b) can communicate information, the will, preferences and decisions of an individual compared with the role of a representative per 27 (1) a

representative . " do anything that may or must be done by the individual under " **Recommendation Clarify the core difference in authority to act between a representative and a supporter . The material I have read has caused ambiguity. Also, what is different between 24 ( b) and 27 (1) in these roles and authorities , seems to me a representative can do everything.**

f. **Recommendation Can a representative sign a resident agreement and or application if the resident is not yet a resident under the Act until admitted ?**

g. The consultation paper 2 infers page 27-30 the representative makes resident decision if capacity is lost using a proposed decision making framework. The concept of lost capacity is more complex and transitionary than dealt with in papers. **Recommendation Clarify what is meant by lost capacity and in what circumstance. Recommendation Clarify. Once capacity is lost does the role of supporter continue to have any status as previously appointed ? How does section 35 (3) impact on these aspects regards obtaining information or receiving information as a family member.**

h. **P 288 Chapter 8 Miscellaneous .**
It is confusing to have identified in chapter 8 the power of systems governor to appoint a supporter or representative without clarity regards the formal appointment process ( e.g. no obligation to appoint in writing ) . Also says the system governor cannot appoint supporter and representative , only one category appointed .**Recommendation I think such appointment limits should be defined earlier in the Act ,Part 4 , particularly if it says only one category can be appointed not both.**
**Recommendation I think the majority of the Supporter and Representative elements should be considered within a subsidiary legislation or Rules , not within the Act itself. I foresee there will be a need to potentially adjust some aspects of these areas of the Act over time and this most flexibly occurs in subsidiary legislation. Also, this is important because it remains that each state has a variety of terms in place and whilst this is being considered there is no certainty it will happen before the Act comes into place.**

8. **P 45 Division 2 Protections relating to supporters and representatives**
   a. Given unacceptable behaviour and intimidation does occur by a minority of family members, or associates and will so with future supporters and representatives, such can seriously impact on the service delivery. I would have thought there be an obligation identified on supporters and representatives (and a related penalty) to have regard to the quality and safety for the individual person, ( resident) , other members within the service e.g. other residents , and visitors, aged care workers and responsible persons. Such would be consistent with Principles Section 22 (1) , (6) (13) . Hence protections offered in Sect 34 (a) re protection for "any act …" seems unreasonable on face value**. Recommendation Give further clarity to the limits of "any act" that is currently proposed to have protection and consider penalties for supporters and representative who do not have regard to health and safety.**

9. **Chapter 2 Entry to Commonwealth aged care system .**
   a. Chapter 2 p 72 Part 4 Prioritisation, Blank in Draft of the Act. The Consultation paper No2 p42 parts 4 and 5 of chapter ) refers to this . Whilst intent is HCP remains same (which means a wait list and not universal access rights continues, which I disagree with), **Recommendation Clarify how do the 3 new categorisations for residential care prioritisation work in a practical sense, what are they and where**

**are they defined? How do they effect the applicant , how do they effect admission decisions by the Provider and capacity to care for a particular individual?**

b. **<u>Recommendation</u> Clarify .How does or will prioritisation impact on individuals regards their use of an allocation to gain service access**
c. **<u>Recommendation</u> Clarify How will residential prioritisation impact on hospital stays and ensure that it does not encourage hospital admission as a quicker pathway to residential care and thereby create further pressures at hospital level and disadvantage an individual**

**10.** In Chapter 2 of the Act. It is unclear whether the System Governor has any timeframe obligation to respond to an applicant or provider with respect to responding to an application or a request for review such as a , reclassification . There should be a timeframe and no disadvantage clause for stakeholders. This not being the same as the requirement of advising within 14 days of a decision made. Currently there are long wait lists in accessing ACAT or Ras assessment causing risk to individuals. There should be obligations on Government in this area. **<u>Recommendation</u> Clarify and ensure the obligations for Systems Governor and assessors to ensure an applicant receives timely response and not be placed at risk due to untimely responses.**

**11. Part 3 Act and p47 Consultation Paper No 2 , re registration of providers Does it say at this stage, state govt providers will not be registered. XXX <u>Recommendation</u> Clarify if State Government providers will be registered and if not, what are the implications linked to registration for such providers. Is this still to be resolved before finalising legislation , if so Clarify as I cannot see exemption in the draft Act. Where will such an aspect be listed?**

12. P 51 Consultation Paper No 2 re Standards Note the Summary emphasis with the focus that "Safety , Health , Well Being , Quality of Life of individuals" is the Basic requirement and ( Providers and Responsible person) need to evidence that it's understood and in place.

**13. Chapter 3 Part 4 Regards Obligations of Registered Providers**

a. P 98 from sect 88 Conditions and obligations of registration to sect 119
b. Note sect 90 re compliance with aged care code of conduct
c. Note sect 92 re Rights and principles
    i. re the need to demonstrate understanding have in place re practices not incompatible with rights
    **ii.** must demonstrate that understands the safety, health, wellbeing and quality of life of individuals in delivery of aged care services . I assume this brings the establishment of Principles as another list for providers . <u>So, we have Rights, Code of Conduct , Principles , Standards, High Quality</u> , as separately worded documents which I think raises issues of inconsistency in the regulatory approach and risks excessive detail that will be to the detriment of service quality and workforce attraction to the sector compared with other sectors. **<u>Recommendation</u> Ensure and identify there is not an increased regulatory burden arising from the Act and proposed Rules as this will risk being detrimental to overall outcomes in aged care and smoother concepts of innovation.**

**d. Sect 97 Quality Standards.** The Consultation paper No 1 P 56 reaffirms the minimal continued obligations of a registered provider even though specific standards do not apply . (which may be the case in some current CHSP service types given the extension to not before mid-2027). There is confusion arising from this extension period for CHSP. **<u>Recommendation</u> Give far greater clarity the sector and others as**

**to what will apply to CHSP services up to mid-2027 and from the time this Act comes in.**

**e. Regards Note Sect 96 p101 Complaints and whistle-blower**

i. Sect 96 (d) re whistle-blower policy need to be consistent with what is prescribed in rules ( to be provided). A note regards clarifying State Govt use of Protected Information Disclosure Policy which currently does not include the word whistle-blower although similar or same principles

**ii. Recommendation It remains unclear whether all complaints are captured as whistle blower status , as related language does not define when a complaint is a whistle-blower complaint whether anonymous or not versus not included .When is a complaint not captured by whistle-blower obligations requires greater clarity.**

**f.** Note per consultation paper further definition re conditions to be developed which may include conditions re CHSP grant type services e.g. Meal related conditions. **Recommendation We need clarity regards such further information and definition.**

**g. P 48. Consultation Paper No 1 re Residential registration requirements .**
I am confused regards the comment that a condition of registration will include the approved number of places that can be occupied at the approved home vs the role of occupancy capacity approval of local govt plus noting the move of an aged care approval to the individual not the provider, it is the individual's choice to go to a facility . Single vs shared choices regard use of rooms and flexibility of this . What if a provider has more rooms than registration approves, what limits are being created via registration that are unreasonable. **Recommendation Review and remove the obligations to include in the registration process the number of rooms a provider can offer at a site, for example that are not used for an approved person, but a person with a need. It begins to challenge to notion of a co located service apartment or rental on the site. Clarify the intention of this in the registration.**

14. **Section 100 p103 Membership of governing bodies ,** re exemptions to this section 100 for a government entity or local government authority or registered provider of a kind prescribed ( consultation paper No 2 refers to Co Operatives ( what is a current example ?) may be exempt from some governance aspects of Boards e.g. independence ).
**Recommendation Clarify If it is correct that a government entity is not registered then how does it affect other clauses linked to registration re conditions and so on ?**

15. **Section 101 p104 Advisory body requirements**. It does not appear to provide such exemption for government entities at this point per sect 100 (which I think currently applies for a quality advisory committee and consumer advisory committee for a State Government entity ). **Recommendation Clarify if this is a change to current requirements for State owned.**

16. **Section 105 Delivery of Aged Care Services (re conditions of provision).** The Consultation Paper No 2 P 55 notes requirements remain unclear regards what standards will apply to Meal services but all providers will have an agreement in place for all funded recipients. Monitor this aspect. **Recommendation Clarify when such standards definition and others aspects of the proposed Act will be clear for CHSP providers.**

17. **Section 110 p111,112 Change In circumstances**
    a. 110 (1), (2), (3) (4) goes to the types of changes which must be notified by the Provider within 14 days, includes change in responsible persons ,per 110, (4) (a).

18. Section 111, p112 , re responsible persons must notify of change in circumstances within 14 days re change in circumstances and suitability .

19. Sec 114 p115 re Failure to comply to consider suitability matters , per 114 , (1) (a) re least every 12 months , review.

20. Sect 118 Aged Care workers must comply with Code of Conduct

21. Sect 119 p119 Responsible persons must comply with Code of Conduct , civil penalty.

22. Sect 120 p 120 (part 5 Salutatory duty and compensation) Registered provider duty.

23. **Sec 121 p122 Responsible Person Duty**
    a. **(**1) must exercise diligence to ensure provider duty is complies with sect 120 .
    **b.** 2. re Due Diligence to be undertaken ( an area of specific review from time to time re achievement I am thinking ). Note civil penalty in ( 7) re 1000 penalty and or 5 yrs. prison . We need to understand these aspects re new personal accountability and how diligence is evidenced for responsible persons and what if any protections exist ( does D &O insurance apply ??)XX Seek Legal Advice for this and sections 120 , 122 and 127 ? **Recommendation Further review the inclusion of these penalties. I believe they will act as a deterrent to individuals to be on aged care Boards**

24. **Section 122 p125 A Duty cannot be Transferred to another entity .**
    **a.** Important to understand this aspect regards role of sub contracted groups e.g. contractors and providers ((RSS and Government ) called associated providers. There may be unintended implications with this given the new penalties to providers and responsible persons and how we show diligence in ensuring duties are complied with and sustained **. Recommendation Further review the unintended consequences of this area in how it may impact on service provision.**

25. **Section 127 Compensation Pathway I have uncertainty re the meaning of this section in its practical impact on an entity and a responsible person .**
    a. (1) (2) (3) Note an application for compensation can occur within 6 years of offence
    b. XX This aspect needs legal clarity regards what it means for an entity and individual responsible persons and what the legal and insurance protections that exist in such a 6 year period.
    **c. Recommendation Further review the intent of this compensation pathway and the 6 year period in the context of a deterrent to join a Board , the limited life expectancy in residential aged care e.g. less than 18 months , and the ability for such future claims to be lodged well beyond an individual Board member retiring from the register provider.**

26. **Chapter 3 Part 6 Aged Care digital platform operators .**
    I cannot recall such regulation defined before. Important that our contractors and software providers are aware and adhere to this section albeit it seems they are individually responsible. Where is this managed in RMCLHN and other LHNs.

27. **Chapter 4 Fees, payments and subsidies ,** the area currently blank (assuming this will impact on whatever new means testing aspects are introduced) , the Consultation Paper No 2, indicates subsidies will be of two parts a) Person centred , funds linked to specific

services for individual b) provider based, funds related to fixed costs of providing services. **Recommendation Clarity is required as to how the two parts have significance in their regulatory application and the manner in which a provider uses funds and acquits the use of funds.**

28. **Chapter 5 p131 Governance of the aged care system , did not look at in detail.**

29. **Chapter 6 p 238 – p248 Part 12 Banning Orders .**By inference the previously proposed registration of aged care worker is not proceeding rather there will be the continued use of banning orders as currently applied as the means of aged care workforce screening . Banning orders to be applied to a provider ( seems like what was area conditions when a sanction is applied or a noncompliance occurs ) **Recommendation Review if the use of the term Banning order applied to workforce and Providers is helpful and ensure does not cause confusion in terminology.**

30. **Chapter 8 sect 362 p288 note ( f)** the use of computer programs to make decisions ( robodebt type risk ?? what are safeguards ) , how do we understand this risk re error ??) Note Part 7 Use of Computer Programs to Make decisions , Section 398 **Recommendation Clarify how government will ensure no disadvantage to individuals in or seeking care?**

31. **Part 4 p296 to p307 Appointment of supporters and representatives**
    a. **Sections 374 to 380** It includes the system governor making appointments and verbal appointments **. Recommendation Clarify How a provider knows or authenticate such an appointment is made by the systems governor for the purposes outlined re access to service but then also access to a specific service of a provider?**
    b. I became confused why this section is not located in the earlier Chapter 1 Division 2 are of the Act . Also confused between the System Governor appointment of supporters and representatives versus what happens when in an individual is in a specific provider service. There needs to be greater clarity and link between this section and related Sections earlier**. Recommendation combine in the act or preferably have detail in the Rules.**

32. **Section 413 Rules .** Seem to be subsidiary legislation. Yet to be provided but will be significant . Are they required to be tabled in parliament a similar subsidiary legislation is before becoming formally adopted, like how the current Principles of the act operate?

33. **At times language in the Act has referred to "a thing " ,** I was very surprised by this use of language in the Act and felt it inappropriate . I do not have an alternative term. Could not find the reference when I checked for the page**(s).** The broader use of Banning Order terminology to extend to Registered Services ( replacing sanctions terminology it seems may cause confusion with workforce related aspects. **Recommendation review language used to ensure no unintended consequences or ambiguity.**

34. **Re Intergenerational Programs . In OPAN webinar 9/1/24** the Panel encouraged intergenerational programs as one aspect of improving positive image of working in aged care and as part of a long term workforce strategy. However, the insurance Industry has ceased to insure organisations and directors for intergenerational programs re the risk of abuse ( I have been made aware through another Board I am on ). The impact will mean discontinuation of intergenerational programs for an under 18 years old and or greatly

reduced , given the exposure a non-insured organisation and for Board members. This has implications for programs like those on ABC, involvement in playgroups, schools , work experience and employing under 18 year old and so on. Government should ensure such programs are insured ,encouraged and in place**. <u>Recommendation</u> That the Federal Government own the encouragement of Intergenerational Programs in aged care services and underwrite the aged care sector (or a secondary insurer to the insurance sector) in the provision molestation cover of such intergenerational programs and encourage such opportunities in residential HCP and CHSP , MPS and related services.**

35. **The December reference to the Support at Home further changes and inferred significance and amendments in 2025, with the delay announced in December for CHSP to mid 2027 at least , this is now confusing re what is happening with Support at Home and its core vision of a single program and the impact of this Draft Act for CHSP moving forward. <u>Recommendation</u> give far greater and targeted clarity to CHSP services re what is happening to them and this Act.**