![KPMG logo — cutting through complexity]

Department of Health

Key findings and Outcomes

National Aged Care Quality Indicator Program – Consumer Experience and Quality of Life Pilot Outcomes for Residential Care

March 2017

Disclaimer

Inherent Limitations

This report has been prepared as outlined in the Section 'The Consumer Experience and Quality of Life Pilot'. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this report are based on a qualitative study and the reported results reflect the data and information provided by various residential aged care services providers but only to the extent of the sample surveyed and data provided. Any projection to a wider demographic is subject to the level of bias in the method of sample selection and level of meaningful data provided.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by residential care services consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

Third Party Reliance

This report has been prepared at the request of the Commonwealth Department of Health (formerly Department of Social Services) in accordance with the terms of KPMG's contract dated 28 October 2014 and is solely for the purpose set out in the Section 'The Consumer Experience and Quality of Life Pilot' and for the Department of Health's information. Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

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Acronyms and Glossary of Terms

Acronym	Meaning
AEST	Australian Eastern Standard Time
ASCOT SCT4	Adult Social Care Outcomes Toolkit four-level self-completion tool
CEO	Chief Executive Officer
FAQ	Frequently Asked Questions
ID	Identification
QIRG	Quality Indicator Reference Group
RACF	Residential Aged Care Facility
RACS ID	Residential Aged Care Service Identification
WHOQOL BREF	World Health Organisation Quality of Life questionnaire modified version
WHOQOL OLD	World Health Organisation Quality of Life questionnaire additional questions for older people
WHOQOL-OLD (BREF)	Used in this report to refer to both WHOQOL BREF and WHOQOL OLD together
YES	Your Experience of Service

Key Findings and Outcomes

Context

Quality indicators in aged care are one method which can drive quality improvement within services and facilitate benchmarking between services and jurisdictions. The collection and collation of consistent, validated information about quality of care can assist at the aged care sector level to target resources to support improvements, and provide consumers of aged care with independent information to make informed choices about the services they access.[1]

The implementation of quality indicators in aged care was recommended in 2011 by the Productivity Commission in the report *Caring for Older Australians*,[2] and the Australian National Audit Office in the report *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*.[3]

In response to the Productivity Commission's recommendations, and to support the broader aged care reform agenda of supporting consumer choice, the Commonwealth Government progressed work to develop quality indicators for aged care in 2012, and announced its intention to pilot a voluntary National Aged Care Quality Indicator Program (the National Program) for aged care services in 2014.[4]

The National Program is intended to encompass both residential aged care and home care services, and has the following two objectives:

- to give consumers transparent, comparable information about quality in aged care to assist decision making

- for providers to have robust, valid data to measure and monitor their performance and support continuous quality improvement.

The National Program is supported by a suite of quality indicators, which are defined measures that relate to the assessment of care and services. The National Program is being developed and implemented in a phased approach across residential and home aged care, and is expected to encompass a range of quality indicators and consumer experience and quality of life measures. Once it has been established as reliable and accurate, it is intended that data from the National Program will be published on the *My Aged Care* website. The development and implementation of the National Program has been supported by the National Aged Care

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[1] V. McLoughlin et al, 'Improving performance using indicators. Recent experiences in the United States, the United Kingdom, and Australia', *International Journal for Quality in Health Care*, vol. 13, no. 6, 2001, pp. 455-462.
[2] Productivity Commission, 'Summary of Proposals: Caring for Older Australians',
http://www.pc.gov.au/__data/assets/pdf_file/0019/111772/aged-care-summary-proposals.pdf, 2011, (accessed 16 February 2015), p 4.
[3] Australian National Audit Office, 'Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes', 2011, p 32.
[4] Department of Social Services, 'National Aged Care Quality Indicator Program', accessed June 2016 from https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/overview/advice-to-the-aged-care-industry/national-aged-care-quality-indicator-National Program

Alliance through the Quality Indicators Reference Group (QIRG), formed in 2013 to provide the Department with advice on the development and implementation of the National Program.

The Consumer Experience and Quality of Life pilot

KPMG was engaged by the Department of Health (the Department) to undertake a consumer experience and quality of life pilot with Australian residential aged care facilities (RACFs). The objectives of the consumer experience and quality of life pilot were to examine:

- the relevance, appropriateness and usability of the piloted consumer experience and quality of life tools for the purposes of the National Program for residential aged care
- the nature of data capture and data collection processes including implications for residential aged care service providers
- the accessibility and usefulness of support materials
- the format of the individual report summarising service provider results
- enablers for implementation and the learnings for consideration in the ongoing National Program.

An overview of the key consumer experience and quality of life pilot stages is provided in Table 1.

Table 1: Overview of consumer experience and quality of life pilot stages

Stage	Overview
Research and review	KPMG undertook two literature reviews which examined measurement of quality in aged care, including measurement of consumer experience and quality of life and identification of consumer experience and quality of life tools, and developed a short list of consumer experience and quality of life tools for piloting.
Pre-pilot consultation	KPMG undertook consultation with service providers, academics, consumer representatives and carers to gain insights into measuring consumer experience and quality of life in aged care and also to test and rank an identified short list of consumer experience and quality of life tools.
	At the conclusion of the research and pre-pilot consultation stages, the QIRG endorsed three consumer experience and quality of life tools for a road test:
	the Adult Social Care Outcomes Toolkit (ASCOT) SCT4
	the World Health Organisation Quality of Life BREF and OLD Surveys (referred to collectively as the WHOQOL-BREF (OLD))
	the Your Experience of Service (YES) Survey.

Stage	Overview
Road test	KPMG undertook a road test of the three selected consumer experience and quality of life tools with a small group of RACFs to determine if the tools were suitable for piloting.
Pilot initiation	KPMG worked with the Department to establish the pilot objectives and scope, information requirements and access procedures, governance structures and potential risks and mitigation strategies for the pilot.
Consumer experience and quality of life pilot	The consumer experience and quality of life pilot involved the following key activities: • Participant recruitment, including recruitment of a minimum of 140 RACFs across Australia • Resource development, including a Pilot Handbook to provide pilot participants with instructions for collecting and submitting data • Registration, including the development of an online portal to quickly and accurately capture key details of participating service providers and RACFs • Orientation sessions, including face-to-face and teleconference sessions • Participant support, including the operation of a telephone hotline and functional mailbox • Data submission, including the development of online data submission tools for pilot participants to submit pilot data to KPMG • Individual RACF-level reporting, in which KPMG developed individual reports for each participating RACF outlining pilot and aggregate results.

Stage	Overview
Post-pilot feedback	Post-pilot feedback involved collecting feedback from pilot participants via the following mechanisms: • a feedback survey distributed to all participating service providers at the conclusion of the pilot • a feedback survey distributed to consumers that participated in the pilot via RACFs • face-to-face and teleconference post-pilot consultations with participating service providers.
Reporting to the Department	KPMG analysed pilot data and participant feedback to report to the Department on key consumer experience and quality of life pilot findings and implications for the implementation of consumer experience and quality of life measures in the National Program for residential aged care.

Source: KPMG

For the purposes of the pilot, a number of definitions were established, informed by the literature, for the focus areas of consumer experience and quality of life. These were as follows:

• Consumer experience: *Gaining consumer perspectives on issues pertinent to their care and wellbeing, focusing on residents or consumers as "customers" of care*

• Quality of life: *An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.*

Pilot activity

The consumer experience and quality of life pilot attracted registrations from 347 RACFs from across Australia. Overall, KPMG received 310 tool submissions from 290 unique RACFs (some RACFs completed more than one tool) on behalf of 1,732 consumers who completed a consumer experience and quality of life tool (Table 2). This equated to just over one in ten of all RACFs (10.5 per cent) in Australia submitting data in the consumer experience and quality of life pilot.

Table 2. Count of RACFs that submitted tools and number of consumers

Tool	RACFs	Consumers
ASCOT SCT4	121	673
WHOQOL-BREF (OLD)	88	461

Tool	RACFs	Consumers
YES Survey	101	598
Total	**310**	**1,732**

Source: Data supplied by RACFs to KPMG.

A key aspect of piloting the tools involved administering the tools to consumers from special needs groups, as defined in the *Aged Care Act (1997)*. Table 3 presents the data captured by KPMG about participation of special needs groups (noting that the categories are not mutually exclusive, and that the question did not necessarily require a response).

Table 3. Does the consumer identify with any of the following special needs groups by consumer experience and quality of life tool?

Response	Total	Per cent
Parents separated from their children by forced adoption or removal	<5	<1 %
People from Aboriginal and Torres Strait Islander communities	<20	<1 %
People from non-English speaking background	171	9.9%
People from the Lesbian, Gay, Bisexual, Transgender and Intersex community	<20	<1 %
People who are care leavers	<20	<1 %
People who are financially or socially disadvantaged	124	7.2%
People who are homeless, or at risk of becoming homeless	27	1.6%
People who are veterans, including the spouse, widow or widower of a veteran	167	9.6%
People who live in rural or remote areas	314	18.1%

Source: Data supplied by RACFs to KPMG.

Likewise, the pilot sought to examine the feasibility of administrating consumer experience and quality of life tools with consumers with cognitive impairment. Information about the number of consumers who participated in the consumer experience and quality of life pilot with a cognitive impairment was captured by asking the RACF to submit proxy data about a consumer's behavioural assessment.

The pilot sought feedback from participants (service providers and consumers) via a number of mechanisms. A feedback survey was distributed to participating RACFs at the conclusion of the

data collection period. Service providers were also invited to post-pilot consultations, which were held in five Australian cities, as well as via three teleconferences. A consumer feedback survey was distributed to all participating consumers via their RACFs. Consumer feedback was also gained via responses to free text comments in the consumer experience and quality of life tools, 'nil' responses to consumer experience and quality of life tools, indicating a consumer may have chosen not to answer a question, as well as specific questions asked to service providers to understand consumer views on the consumer experience and quality of life tool.

KPMG received 108 responses to the service provider feedback survey and 80 responses to the consumer feedback survey. The post-pilot consultations with service providers had 63 registrations for the face-to-face workshops and 27 registrations for the teleconferences.

Pilot outcomes and considerations for the National Program

Piloted consumer experience and quality of life tools

The consumer experience and quality of life pilot tested the suitability of three consumer experience and quality of life tools for the Australian residential aged care sector to work towards meeting the pilot objectives.

There are a number of findings from the pilot that will inform the extent to which the pilot objectives can be achieved, which are outlined below.

1. Each of the three consumer experience and quality of life tools that were piloted were assessed on their relevance, appropriateness, usability and feasibility for use with consumers of Australian RACFs. This assessment was made based on the pilot experience, the data captured and the post-pilot feedback from consumers and service providers.

    The outcome of this assessment was that **the ASCOT SCT4 is considered a relevant, appropriate, usable and feasible tool for use with consumers of Australian RACFs**. The ASCOT SCT4 was considered usable without modification.

    The YES Survey in its current form was not considered to meet the criteria for the use in the National Program going forward. However, there may be potential to modify the tool in the future to make it applicable for residential aged care. Further work to explore its potential to be modified must be progressed in partnership with the tool's developers to ensure that the validity of the tool is maintained or reassessed.

    The WHOQOL-BREF (OLD) was not considered to meet the criteria for use in a National Program going forward.

2. The literature, as well as requirements for membership in the Organisation for Economic Cooperation and Development, indicate **tools used in a National Program must be valid**. That is, the tool must capture the underlying concept that it purports to measure.[5] The ASCOT SCT4, WHOQOL-BREF (OLD) and the YES Survey have all been validated and thus satisfy this criteria.

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[5] OECD, *OECD Guidelines on Measuring Subjective Well-being*, 2013.

3. **There may be benefits associated with using consistent consumer experience and quality of life tools in both the home and residential aged care settings**, noting that a consumer experience and quality of life pilot has been carried out concurrently to the pilot with Home Care Package services, which have both examined the same consumer experience and quality of life tools. If the ASCOT SCT4 is chosen for the National Program, this tool has shown applicability in both a residential aged care and Home Care Package setting.

Data collection and submission

The pilot tested the feasibility of data capture and submission from RACFs on a national scale. Considerations for these elements in a National Program are provided below.

Data collection

For the purposes of the consumer experience and quality of life pilot, online data collection portals were developed to enable participating RACFs to submit the data they had collected across the three consumer experience and quality of life tools. A 'log-in' functionality was added to ensure that only an authorised RACF representative was able to upload data and validations were added to questions in the data collection portals to enhance the completeness of responses. Participating RACFs underwent a structured data submission process within a defined collection period. The considerations for this process in a National Program are outlined below:

4. Participation in the National Program currently involves the collection and submission of data for three quality of care indicators on a quarterly basis. **Annual or six-monthly data collection and submission requirements for the implemented consumer experience and quality of life tool/s should align with existing National Program requirements.**

5. While the majority of RACFs in the pilot administered the tools face-to-face via a paper-based tool, increasing levels of comfort with technology by service providers and consumers may enable streamlined online data collection (e.g. via tablet or computer) in the future. Therefore, the **National Program could consider providing both paper-based and web-based consumer experience and quality of life data submission options to participating service providers.**

6. **Supporting the use of proxies should be encouraged to facilitate the inclusion of consumers with cognitive impairment.** However, there are a number of considerations relating to the use of proxies that must be considered:

   - Research suggests that proxy-completed responses tend to more accurately report conditions that are less private and more observable, but tend to underestimate less observable conditions such as emotional and affective states, while a number of studies have found systematic bias in the use of proxies – with results from proxy responses either over-reporting disability or quality of life values for older people.[6]

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[6] Ellis B, Bannister W, Cox J, Fowler B, Shannon E, Drachman D, Adams R, Giordano L: *Utilization of the propensity score method: an exploratory comparison of proxy-completed to self-completed responses in the Medicare Health Outcomes Survey*. Health and Quality of Life Outcomes 2003, 1: 47. 10.1186/1477-7525-1-47*PubMed CentralView ArticlePubMed*

- The use of proxies can reduce data quality by introducing bias into the survey estimates.
- Studies report fairly good agreement between subjects and proxies in assessments of functioning, physical health, and cognitive status, and fair-to-poor agreement in assessments of psychological well-being.

7. Consultations with service providers has confirmed that **the collection of consumer experience and quality of life data should be accompanied by demographic data**. This will be critical for providing context to the resulting consumer experience and quality of life data, support individual RACFs to interpret their results, and ensure that future work to develop a public reporting mechanism of results is palatable to service providers. Demographic data in the following areas should be included:

   - consumers' year of birth and gender
   - whether the tools were completed with assistance and who provided assistance
   - whether the tools were completed by a proxy and what the relationship of the proxy is to the consumer
   - whether a consumer belongs to any of the special needs groups as defined in the *Aged Care Act (1997)*
   - length of time a consumer has been a resident in the RACF
   - whether the consumer has an assessed cognitive impairment, noting that this is unlikely to capture consumers with cognitive impairment who have not been assessed, diagnosed, or who do not exhibit symptoms.

8. While the consumer experience and quality of life pilot requirements were for participating RACFs to administer a consumer experience and quality of life tool to five consumers, there are a number of options for deciding **sample sizes** when collecting data in the context of the National Program:

   - The first option is to collect data from **all of a RACF's consumers.** This would be the most representative method, noting it would likely pose resourcing challenges depending on how frequently the data is collected, particularly if it was more than annually.
   - The second option is to collect data from a **representative sample of consumers.** This would support the inclusion of all Australian consumers, but could pose challenges, as RACFs across Australia cater to widely varying numbers and cohorts of consumers, so the sampling technique would potentially require further investigation and be quite complex.
   - The third option is to collect data from a **random sample of consumers.** This enables RACFs to participate in the National Program with a smaller administrative burden and also theoretically supports the inclusion of a representative sample of Australian consumers in the National Program. The risk with this method is that results may vary widely between reporting periods and thus be difficult to interpret or compare between providers. This method also presents the risk that service providers may

select consumers that they believe would score their consumer experience or quality of life more highly.

- A representative or random sample of consumers may be based on the size of the RACF. This could occur by suggesting an appropriate number of consumer experience and quality of life tools for RACFs in certain size ranges, e.g. RACFs with less than 20 places may want to complete the consumer experience and quality of life tool with up to 5 consumers, while RACFs with between 21 and 60 places may want to complete the consumer experience and quality of life tool with up to 10 consumers.

9. There are a number of options in terms of **how frequently the data should be collected**. During consultations, service providers reported that collection should preferably occur annually to limit the administrative burden on RACFs. Options for the frequency of data collected include:

- **Collection of data annually within a time-limited data collection period and with a defined due date.** This has the following considerations:
   - A collection period would need to be established. Pilot experience suggests this should take place over at least a two-week period, though preferably as long as six weeks, however, this must be balanced against objectives of timely reporting of results. Pilot experience suggests that resourcing the collection and submission of data can be a challenge in residential aged care, which could present issues in determining a defined collection period that suits all Australian RACFs.
   - RACFs could encounter extenuating circumstances that may influence results captured during the collection period, such as RACF events, staff illness, consumer illness or other factors outside of a RACF's control. There would need to be capacity for the National Program to capture explanatory information in this respect, or to provide a number of time-limited data collection periods throughout the year, so that if a RACF was unable to participate in one collection period, there were others to choose from.

- **Collection and submission of data by RACFs once per sampled consumer over the course of the year.** This has the following considerations:
   - This method may reduce the administrative burden on RACFs by enabling them to spread data collection activities across a year, and would enable RACFs autonomy to develop an approach that would best suit their circumstances, e.g. integrating the tool into existing processes, doing all the tools within a short period of time, or staggering the tool administration across the year.
   - This would require RACFs to develop and maintain a system for recording which consumers have and have not completed a tool.
   - Consumers responses to consumer experience and quality of life tools may be influenced by different external events or different times in the year.
   - The data submission portal would need to be permanently open and a reporting process be established to consolidate and report back on results on an annual basis. The timeliness of the data may also be a risk if data is only reported annually,

> when it could potentially have been collected more than 11 months prior, and may report on consumers who have passed away.

- **Use of either of the above methods, but reported more frequently:**
  - For the census method in particular, there was a greater preference for conducting data collection annually and this may be unnecessarily burdensome for RACFs, with little additional benefit.
  - For the 'collect as you go' method above, there may be benefit to reporting on this data more frequently, or making the data able to be viewed on a "live" format. This would enable timelier decision-making for RACFs.

Data submission

The effectiveness of data submission processes and systems is a critical aspect of the National Program. Informed by the planning, delivery and review of one six-week data collection period, there is a need to consider the following:

10. **Data submission should ideally occur over the same time period as data collection.** This enables RACFs to submit data as they collect it, reducing the administrative burden associated with data submission and minimising risk associated with misplaced data, or that RACFs may collect data and then fail to submit data due to lack of capacity during the shorter data submission timeframes.

11. Allowing RACFs to **complete a submission in more than one sitting** is important to enable RACFs to more easily integrate collection and submission processes into business-as-usual activities. The data submission system should incorporate a function which allows services to save their progress and return to the entry at a later time.

12. Data submission systems should allow for **self-resetting of login and password details**, as well as **live self-entry and modification of key service contacts** (i.e. names, job titles and contact details), central contacts, CEO details and other contacts by participating services themselves. Data submission systems should also promote CEO or executive accountability by including internal approval mechanisms or by distributing automatic notifications.

13. Data entry forms should incorporate **'field validation'**. That is, if RACFs enter data that do not comply with certain criteria (such as needing to be a whole number), then the submission form should recognise this and prompt the user to review their entry.

14. To reduce the possibility of error, there is a need for any data collection system to **prompt RACFs to review an entry before it is submitted**, to ensure that the correct RACS IDs are used for the relevant data submission. This should also extend to **allowing RACFs to review and resubmit data that has already been submitted** in the case they identify errors.

15. An **automated reply following successful data submission** to key central or RACF contacts will provide assurance to RACFs and service providers that their data has been received and will subsequently avoid extra contacts to the hotline/mailbox from RACFs seeking confirmation.

Support materials

In order to participate in the pilot, RACFs were provided with a range of resource materials made available online for downloading via a central webpage. Resources included a Pilot Handbook, fact sheets and a frequently asked questions document. Resources provided guidance to pilot participants about how to collect and submit data, and also provided suggested communication material for RACFs to adapt and distribute to their consumers as they chose.

Outlined below are a series of considerations for the provision of these types of materials for a National Program:

16. RACFs that participated in the pilot generally found that the materials provided to them by KPMG were helpful. **It is recommended that a similar suite of resources is made available for the National Program**. In addition, it was raised that the following resources would be of value to a National Program:

    - Resources written in "plain English" to support consumers and carers to understand the purpose of the National Program and what is required to participate. It is recommended that these resources be **co-designed with a reference group of consumers and carers, or the appropriate peak bodies.**

    - Pilot resources should detail an easy to understand and succinct guide of the manual data collection options and requirements of RACFs, ideally provide a step-by-step pictorial guide, and provide detailed instruction for additional information required for each tool submission (e.g. clearly state what demographic information must be collected from each consumers). Resources should also emphasise timeframes for data submission and protocols for late data submission.

    - Resources should be made available via a **central webpage** to enable National Program participants to access them multiple times and as required.

    - Some resources, such as **text for posters and fact sheets, should be made available in editable format** to enable participants to adapt for inclusion in their existing communications and newsletters.

17. The **ongoing use of any of the piloted consumer experience and quality of life tools would need to be considered with their authors** as applicable.

18. The Pilot Handbook and the Instruction Manual cover sheets were developed specifically for the pilot and will require **redevelopment for use in the National Program.** Instruction Manual cover sheets will need to be developed with respect to negotiated terms for ongoing use of the Instruction Manuals, as applicable.

19. The National Program will need to **provide a range of resources and additional support to RACFs to include consumers with cognitive impairment or special needs.** In particular, guidance around interviewing consumers with cognitive impairment or procedures for using proxies to participate in the interviews.

    - Further support will be required to support RACFs to understand when the use of proxies is appropriate, and for participants to be comfortable with the use of proxies

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and the validity of the data captured. The National Program will need to consider the nature of the questions being asked of consumers and what caveats are required to ensure there is complete transparency if the consumer experience and quality of life tool is completed by a proxy, carer or family member on behalf of the consumer. This may, for example, **require information about the use of the proxy, and the nature of the proxy, to be recorded along with the tool's data.** This will allow for tracking of proxy data over time, in order to determine the influence, if any, of proxy responses.

- There is a need to have **translated resources available** for consumers who do not speak English. It may be more feasible to initially create translated resources for only the five most common languages spoken by older people who do not speak English, with the potential to add additional translated resources over the course of time. Translated resources will be required not only for consumers, but also for staff and family members who also may not speak English.

- For older people who speak a less commonly spoken language for which translated resources are not available, **the use of interpreters would be required.**

- Resources should include **specific scripts and guidance on how to use the tools with non-English speaking consumers and consumers with cognitive impairment,** as it is likely that these consumers will require prompts and explanation to complete a consumer experience and quality of life tool. Scripts and guidance (e.g. ensuring that key terms are translated using consistent meaning) will support RACFs to include representative consumers, and will also promote consistency in how RACFs include these consumers across Australia, contributing to robust data collection.

Program support

20. The support provided to participants in the National Program is a key consideration for implementation. Based on the conduct of the pilot, services require considerable support during the initial stages of participation and lesser support throughout the duration of the National Program. The pilot elicited a number of observations in relation to participant support.

21. Services that participated in the pilot were provided with extensive, customised support to participate in the pilot, including face-to-face and telephone-based orientation sessions, a dedicated KPMG pilot team, a hotline number and functional mailbox. From the pilot experience, there are a number of considerations for this type of support in a National Program.

22. The pilot has demonstrated that the use of an **online platform to register participation** will be an efficient recruitment method for the National Program. Integrating registration platforms with the Department's own database of providers and services should minimise the input errors by services, avoid the need for manual fixes, and support accurate reporting and communications activities.

- **Recruitment activities should be coordinated centrally through the Department and be consistent with existing communication and engagement strategies.** This aims to ensure that where recruitment communications might be undertaken by other external

stakeholders, information and messaging is consistent with agreed Departmental messages and instances of incorrect information being communicated are avoided.

- **Recruitment activities should be directed to multiple levels within an organisation,** such as to CEOs and also quality managers and quality teams, to promote interest in National Program participation within service providers of different sizes and different operational models (e.g. some CEOs of some service providers have more involvement in day to day operational considerations than others).

- Maintaining an **accurate up-to-date list of service provider contacts** will ensure that any recruitment communications are received.

Keeping track of RACF withdrawals during the National Program will be essential for the Department to ensure that it has accurate, up-to-date information on the RACFs participating in the National Program, especially if it chooses to publish the RACFs who are participating on its website. For example, RACFs that fail to submit data should be prompted to provide a reason and/or to indicate whether they have withdrawn from the National Program completely, or have missed one pilot cycle only. Analysis of the reasons why RACFs withdraw may provide insight to help the Department improve the National Program as it is implemented.

Participant support

23. **Training is essential for an effective orientation to the National Program.** Preferably, this training should be face-to-face. Feedback from service providers indicated that, while telephone-based orientation sessions were sometimes more accessible for services in regional and remote areas, this medium made it more difficult to get a clear understanding of how to participate in the pilot.

To promote sustainability of National Program knowledge within a service, it is recommended that a **train the trainer** approach is employed, where representatives from service providers and RACFs act as champions within their own organisations to train others in using the tools and participating in the National Program.

- **Training sessions should be held periodically for new service providers joining the National Program,** as well as for new staff members from existing participating RACFs who may be taking on responsibility for the National Program within their organisation. Feedback from the pilot hotline suggests that the there was no guarantee that leaving staff would provide information and support to new staff.

- Alternatively, the National Program could make **recordings of the training sessions or webinars available for new registrants.** This, coupled with face-to-face training sessions, would provide services with a level of accessibility and flexibility to self-manage their training via a method that best suits them. This method would also ensure that regional and rural services are able to access training sessions. However, recordings are considered a passive form of education and training, and should be used to supplement interactive sessions, and not replace them.

- Training sessions for the pilot were delivered as a presentation, with opportunities for participants to ask questions throughout the presentation. **An additional option is to**

structure training as a working session, with activities and exercises that mimic pilot activities. This would enable participants to understand better what is involved in the National Program from the beginning and learn from practice as they participate.

24. In addition to training, there will need to be a mechanism for support for participating services, such as a **hotline or email helpdesk** where services can access prompt advice on questions about participating in the National Program.

   - It is **crucial that any such service is staffed by appropriately skilled individuals** who have an understanding of the tools, data collection processes and the residential aged care sector. Inbound contacts require an informed and knowledgeable team to respond in order to ensure the timeliness of query resolution. In light of this, a smaller specialist team is more conducive to providing support than dispersing knowledge across a larger team.

   - The management of high volumes of telephone enquiries would benefit from a **call centre customer service solution.** The telephone line would need to be available during business hours for all of Australia, meaning staffing from 8:00am to 8:00pm AEST during daylight savings period.

   - An accessible and cogent **FAQs document** can potentially assist the National Program support team in managing the volume of calls and emails received. Revisiting the FAQs regularly will ensure that the content is still relevant and any emerging issues are covered in the document.

   - This service should **be capable of managing increased inbound calls during identified busy timeframes in the National Program, such as initial training weeks and data submission deadlines** to assist with queries, issues and questions as they arise.

   - There may be an expectation by participants that **inbound support staff have access to the data** in the event of the need to discuss data submissions or make any changes.

   - The use of **automated systems for resetting lost or forgotten passwords** will also serve to reduce volume of contacts.

25. There will **need to be a capacity to have email reminders sent to participating RACFs** if there is a timeframe associated with data submission in the National Program, for example one week prior to when the data is to be submitted.

26. **Strong communication between various parts of the National Program** is needed to ensure the processes, language and content of communications clearly delineates each individual element of the National Program, i.e. indicators within residential aged care versus indicators within Home Care Packages, given the possibility that within some organisations, both National Programs will be managed by the same quality team or quality manager.

Reporting

27. **Benchmarking is not likely to be feasible in the short term.** Whilst the tools are validated, it will take a number of years before use of the tools will be adequately implemented in the sector and there are not currently any appropriate 'population norms' already

available for the tools for Australian consumer groups. In the short term, once data collection is at a more mature stage, it will be possible to compare against the average of other services.

The aim should be for the program to reach a level of maturity where benchmarking is possible. Before data can be benchmarked, there will need to be clarity around what is driving consumer experience and quality of life tool results, for example sensitivities to age, gender, and use of proxy. To do this, it will be critical to collect and analyse the demographic information.

Benchmarking considerations will also need to take into account the consumer sampling approach used. For example, random sampling of consumers will not facilitate service benchmarking without caveats included about consumer factors such as age and cognitive ability.

Benchmarking should also be undertaken with caution and robust communication strategies to assure Program participants that the information is used to support quality improvement strategies and is not used to make negative comparisons or assumptions about a RACF without providing contextualising information.

Once the National Program reaches a point of maturity such that it is confident the data is robust enough for public reporting, there will be a need to provide sufficient context to the data (such as location, socio-economic status of consumers) so that the data fairly represents the RACF. Benchmarking of like RACFs only should be undertaken.

28. **There are a number of implications associated with the voluntary nature of the National Program**. The National Program seeks to achieve participation from a range of RACFs such that any aggregate results may be considered representative in nature. However, it should be acknowledged that there are inherent variations in the characteristics of those that participate as volunteers (also known as volunteer bias). Examples of the differences between volunteers and non-volunteers include the potential for more supportive services to be involved, compared with those that decline to participate in the National Program. This bias may influence the aggregate results in the National Program that are presented and reported on to services and the broader public.

29. There **will be a need to present accompanying RACF and consumer characteristic details in reports.**

  - RACF characteristic detail may include **location, operational size and organisation type** for RACFs that participate in the National Program. Without this, there is a possibility that the results may not be representative of select cohorts of RACFs, such as outer regional and remote services. There is also the potential for aggregate results to be influenced by the larger service providers nationally or services located in New South Wales and Victoria as the more populous states.

  - There is also, in general, **a need to ensure demographic data** are collected from consumers to give context to service level results, to ensure that over time, 'like' data (e.g. data collected using proxies) can be compared, and also to give RACFs more information to understand what might be driving overall scores at a local level.

- **RACFs value the ability to view individual consumer results in their reports,** so that changes in practices can be made for individual consumers.

Seeking feedback about the National Program

Feedback was sought on all aspects of the pilot and was used directly to inform the recommendations for the future National Program. Feedback is an important mechanism to improve the National Program. In order for the National Program to be of value in the long-term, there is a need to continue to collect feedback about the National Program's implementation and operation. There are a number of considerations for collecting feedback about the National Program:

30. **Seeking feedback from service providers and consumers should be a key mechanism by which the National Program can seek to continually improve.** It is important that the feedback cover all aspects of the National Program. Any issues identified through feedback should be acted upon to ensure continuing participation of service providers in the National Program. Additionally, seeking feedback from both service providers and consumers is an engagement mechanism to allow services and consumers the opportunity to contribute to the development of the National Program.

31. **The structured collection of feedback and ongoing review should continue on as the National Program is implemented.** The need to actively collect, listen and respond to feedback provided by service providers and consumers should be considered a business as usual function. There is the potential to strengthen transparency in relation to this, and report on how common themes arising from the feedback are being addressed or not, and the nature of any programmatic changes being made.

32. **The timing of the any feedback must be carefully considered.** The release of the feedback surveys in the pilot were relatively close to the distribution of the reports. This allowed participants to accurately respond to questions in the feedback survey pertaining to the distribution and usefulness of the reports. It is also acknowledged that there is the risk of 'information overload' and fatiguing participants with survey and feedback requests.

33. **If consumer consultations form part of the evaluation process for the National Program, consumer consultations need to be conducted in a timely manner.** There is value in seeking feedback from consumers, however, there is an inherent risk when working with older people who may also have dementia, where short term memory is affected. This is particularly true for consumers who may/may not have been diagnosed with dementia. By reducing the time taken to attain feedback from consumers, the risk of consumers not remembering undertaking the tool(s) would be mitigated to a certain extent.

Moving from a pilot to a National Program

Informed by the considerations above, there are a number of key steps that need to be undertaken in the short and medium term to transition from a pilot to a National Program. These have been outlined below.

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Short-term actions (<2 years)

Governance

1. It is important that **appropriate governance mechanisms oversee the consumer experience and quality of life measures in the National Program.**

   - This should include **a governance committee made up of representatives from across the aged care sector.** Consideration should be given to how consumer experience and quality of life governance combines with existing governance structures for the National Program. Consideration should also be given to whether governance of the National Program for residential aged care should be separate or combined with the oversight of the equivalent National Program for home care services.

   - It is critical that the governance committee includes individuals with **extensive expertise in the residential aged care setting,** including at the service delivery level.

   - The governance committee will need **mechanisms to understand what is going on at the "frontline" of service delivery.**

2. **The process for the management and governance of data collected as part of the National Program must be determined**. It will need to be determined which body will act as the data custodian and how it will manage this emerging dataset. This will be a unique and sought after dataset and there will likely be great interest in using the data for a range of purposes (e.g. academics may wish to use the data for research purposes).

Communications strategy

3. A **communications strategy** will be crucial to managing the implementation of a National Program. This communications strategy needs to consider several key aspects:

   - The communications strategy will need to be clear about the integration of the chosen consumer experience and quality of life tool/s with the existing quality of care indicators in the National Program for residential aged care.

   - Communications will be critical to ensuring that the use of consumer experience and quality of life tools in the National Program is linked to supporting quality improvement rather than performance management. This can be supported by using communications to share quality improvement strategies undertaken by Program participants.

   - In order for RACFs to acquaint themselves with the tools, there will be a need to provide as much as possible, notice about what the indicators and tools will be and what will be expected of RACFs as part of a voluntary National Program. The benefits of participating should also be highlighted, both for the sector and for individual RACFs.

   - The planned mechanisms for retrieving feedback from the sector in an ongoing way should be communicated upfront. This will demonstrate to the sector that the Department will listen to and respond to what is working and what is not.

   - Overall, the communications strategy should include standard messaging and communication materials for all levels, including service providers, RACF staff,

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consumers and carers, with content tailored to each audience. Assistance should be sought from the sector to tailor and distribute communications to stakeholders.

Implementation

Some key actions can occur in relation to implementing the National Program within the next two years, in line with the considerations outlined in the section above. These are:

4. **Developing training, tools and resources** to support the implementation of consumer experience and quality of life tools within the National Program.

5. **Training the National Program support mechanisms, specifically in relation to the consumer experience and quality of life tools,** to support adequate capacity to respond to queries from participating RACFs.

6. **Establishing the mechanisms and timelines for collecting feedback** and develop plans for the review and evaluation of the National Program.

7. In line with the considerations outlined above, **implementing the chosen tool(s) in the National Program** for residential aged care. This will include the following steps:

Recruitment → Training → Data collection → Data submission → Reporting
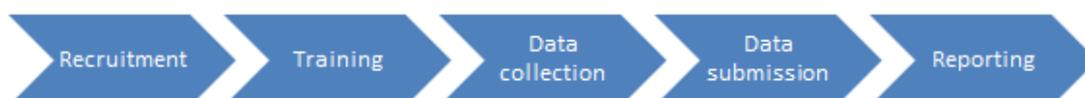
Mid-term actions (3 to 5 years)

There are some additional actions that can be taken in the mid-term. This will include:

8. Beginning to **establish benchmark scores for RACFs**, so that these can be used for ongoing quality improvement.

9. Starting to **identify trends** emerging from the quality indicator data, particularly those linked to demographic characteristics, to guide investment in Commonwealth Government services where there are particular needs identified.

10. **Evaluating the implementation of the National Program** to understand whether the tools are achieving the National Program's stated objectives, including consideration of whether additional indicators that should be collected, or indicators removed.