Oceana Consulting PL

Final Report

A REVIEW OF THE LICENSING OF PRIVATE SECTOR HEALTH CARE FACILITIES IN WESTERN AUSTRALIA

Health Department of Western Australia

[Submitted 30 April 1999]

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TABLE OF CONTENTS

INTRODUCTION

1. On 31 March 1999, Oceana Consulting PL submitted its ***Final Report on the Review of the Licensing of Private Sector Aged Care Facilities in Western Australia***. That Report was prepared in the interests of providing some policy certainty as to the future direction of licensing as it affects the aged care industry in Western Australia.

2. The Report assessed the original recommendations contained in the discussion paper in the light of the submissions and feedback received from participants in the industry, and, where appropriate, reconsidered those recommendations in that context.

3. The same process has been followed since 31 March with respect to those parts of the original report which dealt with the hospital sector, the psychiatric hostel sector, nursing posts and day surgeries.

4. By way of recapitulation, on 7 November 1998, Oceana Consulting PL submitted to the Commissioner of Health a report arising from its Review of the Licensing of Private Sector Health and Other Facilities in Western Australia.

5. That report, written as the basis for community consultation and discussion, was made public on 22 January 1999. The report was published on the Health Department of Western Australia's Internet site, while at the same time 1,054 printed copies of the report were distributed to the widest possible range of service providers, consumer groups, Government agencies, professional associations and industry bodies throughout Western Australia.

6. The recipients of the report, representing the aged care, hospital, psychiatric hostel, nursing post, and day surgery sectors, were invited to offer comment, suggestions and criticisms to the Department to enable the preparation by the Department of formal advice to the Minister for Health on the future of private sector licensing in the health and aged care sectors of Western Australia. A similar invitation accompanied the Internet publication of the report, while an advertisement was placed in the West Australian Newspaper on 30 January 1999 inviting members of the public to contact the Department to obtain copies of the report to enable them to have input into the policy development process.

7. Because of a perceived need to avoid undue delay in formulating policy proposals for Government consideration, respondents were asked to submit responses by 28 February 1999, a deadline which was treated with maximum flexibility; extensions of time to respond were granted to all potential respondents who so requested.

8. By 30 April 1999, a total of 75 responses had been received by the Department, being submitted either through the electronic feedback mechanism established on the Internet or in hard copy submissions made to the Department. We express our appreciation for the many positive and helpful contributions made during this feedback process.

9. Submissions were received from:

- Aged Care Western Australia
- Alzheimer's Association Western Australia
- Amaroo Retirement Village
- Anglican Homes
- Auditor-General
- Australian Association of Occupational Therapists
- Australian Nursing Federation (Western Australia)
- Australian Physiotherapy Association
- Baptist Care
- Belswan Group
- Brightwater
- Burrell, Geoffrey (Facilities and Assets Branch [F&A])
- Casson Homes Incorporated
- Cerebral Palsy Association of Western Australia
- Chamber of Commerce and Industry Western Australia
- Churches of Christ Federal Aborigines Board Incorporated
- Churches of Christ Homes & Community Service Incorporated
- City of Bayswater Aged Persons Homes Incorporated
- Civilian Maimed and Limbless Association of Western Australia Incorporated
- Corrigin District Hospital Board
- Council of Official Visitors
- CraigCare
- Cronin, David (F&A)
- Daily, Lou (Mental Health Division)

- Debowski, John Wilson Lodge (F&A)
- Devenish Lodge
- Disability Services Commission
- Dryandra Frail Aged Hostel
- Education Department of Western Australia
- Geraldton Health Service
- Geriaction (Western Australian Branch)
- Goomalling Districts Frail Aged Lodge Incorporated (Quamby Lodge)
- Health Care Association of Western Australia Incorporated
- Health Consumers Council
- John Wilson Lodge
- Joondalup Health Campus
- Joondalup Health Campus (Mental Health Service)
- Kickett, Marian (Office of Aboriginal Health)
- Kununoppin Districts Health Service
- League of Help for the Elderly Incorporated
- Lincolne Scott
- Lions Eye Institute of Western Australia
- Mackey, Ruth (Private Sector Licensing Unit [PSLU])
- Meath Care Incorporated
- Metropolitan Health Service Board
- Metropolitan Health Service Board (Swan Health Service)
- Minister for Seniors
- Moran Health Care Group
- Mukinbudin Nursing Post
- Nedlands Aged Persons Homes Trust Incorporated

- Niola Private Hospital
- Norman Disney & Young
- Office of Seniors' Interests
- Princess Margaret Hospital for Children
- Private Hospital Association of Western Australia (Submission made on behalf of and with the approval of: Bethesda Hospital, Fremantle Kaleeya Hospital, Gosnells Family Hospital, Hollywood Private Hospital, Mercy Hospital Mt Lawley, Mt Lawley Private Hospital, Niola Private Hospital, Peel Health Campus, Perth Clinic, Perth Surgicentre, Rockingham Family Hospital, South Perth Community Hospital, St John of God Healthcare Bunbury, St John of God Healthcare Geraldton, St John of God Healthcare Murdoch, St John of God Healthcare Subiaco, Undercliffe Hospital, Woodvale Day Surgery
- Quairading District Hospital Board
- Richmond Fellowship of Western Australia Incorporated
- Rocky Bay Incorporated
- Royal Australian Institute of Architects
- Ryan, Noel (F&A)
- Salisbury Home
- Seventh Day Adventist Church
- Shire of Swan Aged Persons Homes Trust Incorporated
- Shire of Waneroo Aged Persons Homes Trust Incorporated
- Silver Chain
- Small Business Development Corporation of Western Australia
- Steens Gray & Kelly Pty Ltd
- Swan Adult Mental Health Centre
- Undercliffe Hospital Complex
- Uniting Church Homes
- Warmun Community (Turkey Creek) Incorporated
- West Pilbara Health Service

- Western Australian Association for Mental Health Incorporated
- Western Australian Rural Directors of Nursing and Health Service Managers Association
- Wilkinson, Ross (Technical Services Unit [TSU])

10. At the same time, the Department and its consultant conducted face to face interviews with a range of respondents, interviews that were designed to follow up and to explore in more detail the substance of written contributions submitted. During this face to face interview process, discussions were held with:

- Andrews, Elizabeth (Lions Eye Institute)
- Bayliss, Denise (Richmond Fellowship)
- Belcher, Wayne (Church of Christ Homes and Community Services Inc)
- Bird, Penny (Cerebral Palsy Association)
- Blyth, Geoff (Chamber of Commerce & Industry WA)
- Bovell, Lillias (Local Government Association of WA)
- Brooks, Christine (Swan Adult Mental Health Centre)
- Brown, David (Cerebral Palsy Association)
- Burns, John (Healthcare Association of WA)
- Collins, Geoff (Amaroo Retirement Village)
- Davies, Trevor (Public Health Division, HDWA)
- Drake, Maxine (Health Consumers' Council of WA)
- Dunn, Pauline (Swan Adult Mental Health Centre)
- Fisher, Lucy (Private Hospitals Association)
- Fletcher, Anne (Silver Chain)
- Flett, Penny (Brightwater Care Group)
- Flynn, Stuart (Council of Official Visitors)
- Glass, Nigel (Civilian Maimed & Limbless Association of WA)
- Harding, Vaughan (Uniting Church Homes)
- Hobley, Adrian (Devenish Lodge)

- Holder, Peter (Brightwater Care Group)
- Kerr, Warren (Hames Sharley)
- Kosky, Michelle (Health Consumers' Council of WA)
- LeCoultre, John (Belswan)
- Lorraine, Peter (Silver Chain)
- Moran, Dianne (Office of Seniors Interests)
- Munroe, David, (Small Business Development Corporation of WA)
- Murray, Wendy (Office of Seniors Interests)
- Palmer, Glyn (Private Hospitals Association)
- Pickworth, Jenny (Legal Services Branch, HDWA)
- Prior, Graham (Forrest Partners)
- Psaila-Savona, Paul (Public Health Division, HDWA)
- Richardson, Pamela (Aged Care WA)
- Ridge, Ken (Baptist Care/WA Baptist Hospital & Homes Trust Inc)
- Scheggia, Wayne (Local Government Association of WA)
- Smith, Christine (Geriaction WA)
- Toms, Barry (John Wilson Lodge)
- Toms, Lyn (John Wilson Lodge)
- Tuxworth, Ian, (Belswan)
- Walsh, Gerry (Rocky Bay Inc)
- Watters, Joy (Rocky Bay Inc)

ORIGINAL RECOMMENDATIONS RECONSIDERED

11. Six of the 38 recommendations in the original discussion paper have previously been reconsidered in the light of the community consultation process, with the outcome of that reconsideration process being detailed in our ***Final Report on the Review of the Licensing of Private Sector Aged Care Facilities in Western Australia*** of 31 March 1999. The remaining recommendations from the original report are now to be re-examined.

General Comments on the Report:

12. Before looking in detail at reaction to and comments offered about each of the recommendations presented in the original Report, it would be useful to record some of the general reaction to the licensing framework presented in that part of the Report which dealt with other than aged care issues.

13. The **Alzheimer's Association Western Australia** supported "the recommendations, as listed in the review".

14. The **Auditor-General** saw the Review as being "wide-ranging" and commended "the Department for undertaking (it) and including a period of public consultation on the report". The Auditor-General also "found it useful to be able to identify the purpose of the licensing function … to be *'a mechanism whereby the community would be assured of receiving health care services that met at least a minimum community standard set by the regulator"*".

15. The **Australian Physiotherapy Association** commented that "the recommendations sound reasonable, equitable and mindful of … financial reality".

16. The **Belswan Group** saw that "the general direction outlined … is appropriate and whilst there needs to be some clarification of some matters there is a considerable basis for progress".

17. **Brightwater** endorsed "all the recommendations", and believed that "the same standards should apply to public and private health care provider organisations". Brightwater similarly supported "the establishment of standards for other facilities, particularly psychiatric hostels".

18. The **Disability Services Commission** provided advice that it had "no objections to any part of the Review conducted into health and other facilities in Western Australia".

19. The **Joondalup Health Campus** confirmed "that (it) and Mayne Nickless are in agreement with the outcomes of the review".

20. The **Metropolitan Health Service Board** endorsed "the gist of the proposal, with some reservations about some individual Recommendations". The Board saw "the principles espoused in the document" as being "relevant and reasonable". The Board believed the recommendations of the report to be "advantageous".

21. The **Metropolitan Health Service Board (Swan Health Service)** strongly supported "those recommendations which refer specifically to or are presently applicable to psychiatric hostels, in particular, the development and documentation of standards required for psychiatric hostels".

22. The **Moran Health Care Group**, on the basis that recommendations 1 to 6 apply to the aged care sector, "support(ed) the overall report".

23. The **Office of Seniors' Interests** commented that "the streamlining of administration and monitoring which will be bought about by the recommendations listed in the report are likely to contribute to reduced duplication and increased efficiency".

24. The **Princess Margaret Hospital for Children** had "no major reservations with regard to the proposed recommendations arising from the Review".

25. The **Royal Australian Institute of Architects** provided advice that it "supports the intent outlined in the report to improve the current methods used to license health facilities; supports the premise that the same standards and licensing arrangements apply to both private and the public sector facilities; believes that it would be preferable if a national set of standards could be developed to apply to health and aged care facilities; supports the establishment of a formally constituted Standards Reference Committee …; strongly commends the role currently undertaken by the HDWA Facilities and Assets Branch personnel in the development of standards and the provision of advice on the application of standards to private and public health and aged care facilities; suggests that if alternative options are to be examined for the development and maintenance of facility standards, that a University-based research group be considered; strongly opposes the restriction on self certification by the architect responsible for the design of individual health care and aged care facilities as it believes that the architect responsible for the project is in a unique position to certify compliance with the relevant codes and standards; welcomes the opportunity to participate in the formulation of innovative staffing strategies including private sector secondments to the proposed Health & Aged Services Licensing Unit".

26. **Silver Chain** acknowledged "the legitimate role the Health Department plays in regulating and maintaining minimum standards in the health care sector" and shared "the desire of the Department to ensure that health care services comply with agreed minimum standards, and that clients' health needs can be met safely and appropriately".

27. The **Small Business Development Corporation of Western Australia** "generally" supported "the licensing recommendations in the Report".

28. The **Swan Adult Mental Health Centre** expressed "support for the recommendations made … with particular reference to licensed psychiatric hostels of which there are seven in the Swan Catchment Area".

29. The **Warmun Community (Turkey Creek) Incorporated** raised "no objections to the recommendations contained in the review", but pointed out

that “additional Government funding will be needed to upgrade and maintain our Walumba Aged Care Facility to meet the obvious increase in standards”.

30. The **West Pilbara Health Service** expressed the view that “the Review findings appear to be a logical step in the direction of risk reduction, quality enhancement and general industry standards reform”.

PSYCHIATRIC HOSTELS

31. In the original Report, Recommendations 7 and 12 to 14 applied specifically and (with the exception of recommendation 7) exclusively to the psychiatric hostel sector. This sector will now be reconsidered.

General Comments on Recommendations 7, 12, 13 and 14:

32. In its submission, the **Alzheimer's Association of Western Australia** supported the recommendations, arguing that "the implementation of changes that will enable an arm's length approach to the regulation of public and private residential-type facilities within a clear set of parameters is to be commended."

33. **Brightwater** similarly endorsed the outcomes of the Review, asserting that "the same standards should apply to public and private health care provider organisations" and supporting "the establishment of standards for … psychiatric hostels."

34. The **Education Department of Western Australia** referred to its 1999 review of "the needs of students with psychiatric conditions" and expressed its interest in participating in any working parties which might "be established to address youth health issues, or examine the services provided for youth".

35. The **Metropolitan Health Service Board (Swan Health Service)** expressed strong support for "those recommendations which refer specifically to or are presently applicable to psychiatric hostels, in particular, the development and documentation of standards required for psychiatric hostels."

36. In her submission, the Honourable the **Minister for Seniors** raised "the emerging issues around the ageing of residents in psychiatric hostels and the lack of nursing care available to these residents other than through Home and Community Care". The Minister went on to draw attention to the need to ensure the availability of nursing homes for elderly sufferers of mental illness, "an increasing group with diverse medical and psychiatric needs".

37. The **Office of Seniors' Interests** supported "the recommendations concerned with the definition, monitoring and administration of psychiatric hostels", arguing that the "recommendations support the improved legislative and administrative delineation of psychiatric hostels and responsibilities for these". The Office expressed a hope that the recommendations "together with more comprehensive monitoring standards as recommended will result in improved services for people in this client group."

38. However, the Office raised a number of specific issues and concerns. It asserted, in terms of the aged care sector, that "there is a dearth of dementia specific care available in Western Australia". The Office expressed a view that "this situation may be improved by the … recommendations which, given the ageing of our population and the high rates of dementia amongst those aged 80 years and over, are timely".

39. On the other hand, the Office believed that insufficient consideration had been given to "the ageing of residents in psychiatric hostels and the lack of nursing

care available to these residents other than through Home and Community Care". The Office expressed some uncertainty as to how "nursing home care for ageing and increasingly frail psychiatric hostel residents will be accommodated".

40. The **Western Australian Association for Mental Health Incorporated** raised two important issues for clarification. Firstly; whether both "private (for profit) and non-government (not for profit) services" are intended to be embraced by the recommendations in the original Report; and, secondly, the apparent failure to "disentangle standards requirements for private psychiatric hostels from those for private hospitals in spite of the fact that the two have been lumped together historically for legislative convenience and in a context in which all psychiatric care was hospital-based and strongly institutionalised".

41. The Association also sought an examination of "the significance of alternative models for psychiatric hostels and other forms of supported accommodation".

Findings and Conclusions

42. The offer by the Education Department of Western Australia to participate in any working parties which might be established to address youth health issues or to examine the services provided for youth is one which we believe, while outside the scope of our examination of the licensing framework applicable to psychiatric hostels, should be noted and addressed by the Mental Health Division. Such a collaborative approach would, in our view, be to the benefit of both the Health and Education Departments.

43. The issues raised by the Honourable the Minister for Seniors concerning the ageing of residents in psychiatric hostels, the lack of nursing care available to these residents other than through Home and Community Care, and the need to ensure the availability of nursing homes for elderly sufferers of mental illness are outside our terms of reference but are ones which, in our view, should be addressed by the Mental Health Division.

44. The concern raised by the Office of Seniors' Interests relating to the dearth of dementia specific care available in Western Australia should also, in our view be addressed by the Mental Health Division.

Original Recommendation 7: Standards for psychiatric hostels, day care facilities, nursing posts

That, as a matter of urgency, the standards required of proprietors, of facilities, and of care in psychiatric hostels, day care facilities, nursing posts and the like be developed and adequately documented.

45. The **Australian Association of Occupational Therapists** strongly supported the recommendation "which related to the development of standards concerning the physical state of the building, public health by-laws and the suitability of proprietors". The Association advocated "that these standards be adequately documented and legislated" and expressed a belief that "compliance to these standards will assist the improvement of not only facilities, but most importantly the care of residents".

46. Based on an assumption that the newly developed standards would be at a higher level than the currently operating informal standards, the Association recommended "that there be a transition period to allow hostels a reasonable timeframe to comply with the new standards" on the grounds that "it would be unfortunate if a consequence of a poorly planned and unrealistic implementation of new standards resulted in homelessness of the current residents of hostels".

47. Turning to the content of any newly-developed standards, the Association supported the inclusion of "a component which incorporates assessment … whereby the principles of continuous improvement need to be applied (in order to) … assist in benchmarking and the development of outcome measures". In addition, the Association called for standards to "address quality of life issues for residents in hostels which would include the availability of single room accommodation in hostels and the provision of appropriate life skills and activities programs in the hostels".

48. The **Australian Nursing Federation (Western Australia)** supported the recommendation on the basis that compliance with the new standards would be monitored.

49. The **Council of Official Visitors** supported the recommendation "in principle", but argued that "proprietors of psychiatric hostels must be required to have clear, simple, contracts with residents, as a pre-condition of licensing". The Council also suggested that the standards should ensure that the "licensee and staff must have knowledge of psychiatric illnesses and care, not necessarily formal qualifications" and that "training and background/suitability of staff … be included".

50. The Council offered to participate in the development of standards for psychiatric hostels.

51. **Devenish Lodge**, offered the view that "the development of a set of standards would be welcomed by Hostel proprietors" who "would expect to contribute to the development process". However, the Lodge argued that "if such standards are to be accompanied by 'effective sanctions' … for non-compliance" the Department should "cease the practise of sending patients to non-licensed

hostels and deal only with those that meet the standards, and actively encourage patients towards the licensed facilities".

52. In addressing the matter of nursing posts, the **Health Care Association of Western Australia Incorporated** expressed the view that it "does not support the current licensing model and would want to see changes to ensure a fairer, less prescriptive and intrusive process". The Association asserted that "recent experience is that the licensing process for nursing posts is progressively becoming more onerous and increasingly prescriptive as it expands its role into assessment of physical infrastructure, work practices, and policy and procedure". In the Association's view, "the annual visits of licensing staff to the various nursing posts and their investigative approach has also made life difficult for nurse practitioners".

53. The Association suggested that there should be put in place "an agreed definition of when a nursing service falls within the definition of a nursing post for the purposes of licensing", that such services should be recognised "as primarily community health services", and that " there is little benefit applying hospital infrastructure standards to these services other than compliance with basic occupational safety and health standards". **Silver Chain** expressed concerns in identical terms.

54. The **Health Consumers Council** strongly supported "the development of standards of care for psychiatric hostels" and argued that this task should be given some priority. The Council expressed the view that the standards for corporate governance should include "a requirement that doctors and other health professionals involved in the ownership of private psychiatric hostels, hospitals or day care facilities and referring patients to these facilities must declare to their patients their financial interest or the relevant financial interests of their families".

55. **John Wilson Lodge** agreed with the recommendation, but on condition that resource implications be adequately addressed.

56. The **Joondalup Health Campus (Mental Health Service)** argued that the proposed new standards "should be global in intention and not just relate to physical premises". The Campus suggested that "minimum standards should incorporate the principles stated in the … National Standards for Mental Health Services".

57. With respect to day surgeries, the **Lions Eye Institute of Western Australia** nominated two national bodies which, according to the Institute, are currently reviewing care in this sector (namely the Australian Day Surgery Council and the Australian Day Surgery Nurses Association). The Institute advised that both have as their objects the development of standards of care and national guidelines for both the private and public sector, and suggested that they would be able to play a role in the development of standards for day surgeries.

58. The **Metropolitan Health Service Board** commented that "the inclusion of standards for Psychiatric Hostels is a much needed requirement" and that "the establishment of published standards should potentially assist in the

improvement of environmental and care standards", a reform which, in the view of the Board, was "long overdue". The Board suggested that the Australian Council on Healthcare Standards be commissioned to assist in the development of standards.

59. **Niola Private Hospital** expressed the view that the Private Hospitals Association of Western Australia should participate in establishing the new standards.

60. The **Private Hospital Association of Western Australia** supported the recommendation, and similarly argued that "the private hospitals industry needs to be represented on any Committee created to establish and change standards". In a later submission, the Association expressed its support for "the notion of classes of day surgery" and argued that much of the groundwork done by NSW could be readily adapted for use in Western Australia.

61. The **Richmond Fellowship of Western Australia Incorporated** recognised the need for the development of new standards, but noted that "ideal standards" for psychiatric hostels, for day surgeries, and for nursing posts will differ markedly. The Fellowship also argued that "any standards should comply with the Disability Services Acts (State and Federal) and the Standards developed as a result of the Acts".

62. **Salisbury Home** accepted the need for standards to be developed, but drew attention to the resource issues facing psychiatric hostel service providers.

63. **Swan Adult Mental Health Centre** strongly supported "the urgent review and development of clearly documented standards required of proprietors, facilities and care of residents of psychiatric hostels". The Centre went on to express "serious concerns regarding the current lack of standards and the very variable quality of facilities and care available to persons with severe chronic mental illnesses who are already severely disadvantaged both by the nature of the illness and the lack of social support". The Centre expressed a view "that the standards for psychiatric hostels should be the same as the Commonwealth Standards for Aged Nursing Homes and Hostels thus eliminating discrimination against the mentally ill in terms of accommodation needs".

64. The **Western Australian Association for Mental Health Incorporated** recommended that "the 'National Standards for Mental Health Services' proposed under the National Mental Health Strategy" should guide the development of standards for accommodation services.

65. The Association questioned "the appropriateness of continuing to include psychiatric hostels with nursing posts and day care facilities for the purpose of developing standards and licensing requirements" and indicated a preference for the avoidance of the development of "two categories of hostels ie. those requiring licences and those that do not".

66. In particular, the Association argued that reform of the licensing framework for psychiatric hostels must take account "of the major mental health reforms under the National Mental Health Plan and Strategy, particularly with regard to the

crucial change from hospital based to community-based supported accommodation options for people with psychiatric disability", and of "the current and emerging options for community based supported accommodation which cannot be adequately addressed merely by a revision of the definition of 'a psychiatric hostel' under the Hospital and Health Services Act 1927".

Findings and Conclusions

67. The process of community consultation and discussion demonstrated overwhelming support for the general thrust and intent of our original recommendation. Some of the views advanced during the consultation process, however, seem to us to represent misreading of the basis and/or intent of our recommendation and, consequently, call for some clarification. In addition, the process brought to light a number of particularly helpful suggestions that, in our view, warrant incorporation into our revised recommendations.

68. In paragraph 56 of our Report, we stated that:

"In the case of hospital services, standards are clearly established through the Australian Council of Health Standards processes. The standards required of proprietors and of care in aged care facilities, psychiatric hostels, day care facilities, nursing posts and the like are much less adequately documented. Similarly, facility standards so well developed for hospitals are less well developed in the case of aged care facilities and are still under development for psychiatric hostels."

69. As we explained in paragraph 55, the licensing process is predicated on:

"identification of:

- *an acceptable standard of proprietor (person, or corporate entity);*
- *an acceptable standard of health care;*
- *an acceptable standard of facility to underpin the level of health care,*

with assessment and certification of a proponent proposal or service as meeting those standards".

70. Our recommendation was intended to lead to the development of separate standards covering proprietors, facilities and care for psychiatric hostels, for day surgeries, and for nursing posts, and to ensure that these three sets of standards reflect the roles and responsibilities of each of these three very different services.

71. By way of further clarification of issues raised during the consultation, we stress that we see no valid distinction in terms of the licensing framework between psychiatric hostels which are classified as "private (for profit)" and those which are "non-Government (not for profit)", or between public and private sector institutions. Our recommendations are intended to apply to all psychiatric hostels irrespective of into which of the above-mentioned categories they fall.

72. Similarly, while we recognised in our Discussion Paper that the licensing framework currently applied to psychiatric hostels, day surgeries and nursing posts derived from the licensing framework applied to the private hospital sector, we believe strongly that the development of new, contemporary standards against which psychiatric hostels, day surgeries and nursing posts are to be licensed in future must take account of the fact that there has been a fundamental shift away from hospital-based, institutionalised care, particularly in the case of psychiatric care. The new standards to be developed must embrace this paradigm shift and must reflect the nature and purpose of contemporary psychiatric hostels, day surgeries and nursing posts.

73. Flowing from the community consultation process, we believe and have recommended that the development of new standards for psychiatric hostels, for day surgeries, and for nursing posts should be undertaken in a particular contemporary, consultative context.

Recommendations

Recommendation 7: Standards for psychiatric hostels, day surgeries, nursing posts

7. (a) That, as a matter of urgency, the standards required of proprietors, of facilities, and of care for psychiatric hostels, for day surgeries, and for nursing posts be developed and adequately documented.

7. (b) That the definitions of day surgeries and nursing posts contained in the *Hospitals and Health Services Act 1927* be revised in consultation with health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a day surgery or nursing post requiring licence.

7. (c) That relevant recommendations apply to all psychiatric hostels, irrespective of whether they are classified as private (for profit) non-Government (not for profit), public sector, or private sector institutions.

7. (d) That the development of new, contemporary standards against which psychiatric hostels, day surgeries, and nursing posts are to be licensed in future take account of the fundamental shift away from hospital-based, institutionalised care, particularly in the case of psychiatric care, and that the new standards to be developed embrace this paradigm shift and reflect the nature and purpose of contemporary psychiatric hostels, day surgeries, and nursing posts.

7. (e) That separate standards covering proprietors, facilities and care be developed for psychiatric hostels, for day surgeries, and for nursing posts, and that these three sets of standards reflect the roles and responsibilities of each of these three very separate services.

7. (f) That in implementation of the new standards for psychiatric hostels, for day surgeries, and for nursing posts, a reasonable transition

period be agreed to allow hostels, day surgeries, and nursing posts an appropriate timeframe within which to comply with the new standards, and that the conditional licensing framework referred to elsewhere in this report be utilised in order to foster the progress of psychiatric hostels, of day surgeries, and of nursing posts towards their newly defined standards.

7. (g) That once the new standards and licensing framework for psychiatric hostels are in place, the Department and Government Health agencies refer clients only to licensed hostels, actively discouraging clients away from unlicensed premises.

7. (h) That the new standards to be developed for psychiatric hostels incorporate the principles set out in the National Standards for Mental Health Services under the National Mental Health Strategy.

7. (i) That the new standards for psychiatric hostels encompass psychiatric/psychological treatment centres and crisis/respite/interim care centres which provide accommodation and care, as well as psychiatric hostels.

7. (j) That the offer by the Education Department of Western Australia to participate in any working parties which might be established to address youth health issues or to examine the services provided for youth be noted and addressed by the Mental Health Division.

7. (k) That the ageing of residents in psychiatric hostels, the availability of nursing care to residents in psychiatric hostels, and the need to ensure the availability of nursing homes for elderly sufferers of mental illness be addressed by the Mental Health Division.

7. (l) That the Mental Health Division address the availability of dementia-specific care available in Western Australia.

7. (m) That, in establishing the necessary processes for the development of new standards for psychiatric hostels, for day surgeries, and for nursing posts, the Department take into account wherever possible the suggestions and advice offered during the public consultation process and summarised above, especially:

(i) the offer by the Council of Official Visitors to participate in the development of standards for psychiatric hostels;

(ii) the nomination of the Australian Day Surgery Council and the Australian Day Surgery Nurses Association to participate in the development of standards for day surgeries;

(iii) the suggestion that the Australian Council on Healthcare Standards be commissioned to assist in the development of standards for psychiatric hostels, for day surgeries, and for nursing posts;

(iv) the request that the Private Hospitals Association of Western Australia participate in establishing new standards, especially for private hospitals;

(v) the suggestion that standards for psychiatric hostels, for day surgeries, and for nursing posts comply with the Disability Services Acts (Western Australia and Commonwealth) and with the standards developed as a result of those Acts;

(vi) the proposal that the work done in NSW relating to classes of day surgery be examined with a view to adapting it for use in Western Australia.

Original Recommendation 12: Definition of psychiatric hostels

That the definition of a psychiatric hostel contained in the Hospitals and Health Services Act 1927 *be revised in consultation with mental health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a psychiatric hostel requiring licence.*

74. The **Australian Association of Occupational Therapists** expressed the view that "the definition of what constituted a hostel was too broad in that the minimum number of three unrelated residents could result in group homes, women's refuges and even community-based supported accommodation being categorised as a hostel". In the Association's view, "a multi-disciplinary committee including consumers, carers and NGOs could provide significant assistance in the formulation of a less ambiguous definition of a hostel".

75. The **Australian Nursing Federation (Western Australia)** supported the recommendation, but argued that the nursing profession should be among the groups consulted during the process.

76. **Baptist Care** also supported the recommendation, offering the view that a "four-bed emergency/crisis/respite facility receiving no subsidies is not a psychiatric hostel".

77. The **Council of Official Visitors** supported the recommendation, and sought involvement in the consultation process.

78. The **Health Consumers Council** argued that "consumers must be involved in discussions about what does and does non constitute a psychiatric hostel requiring a licence". The Council argued that "involvement of consumers with appropriate knowledge of residential care is critical to the success of appropriate classification licensing and regulation".

79. The **Joondalup Health Campus (Mental Health Service)** saw merit in extending the definition of 'psychiatric hostels' "to include comment on the skill base of workers employed within these settings".

80. The **Metropolitan Health Service Board** believed that "the definition of psychiatric hostels including the ability to review and monitor financial viability, proprietor appropriateness and integrity is absolutely essential" and suggested that "this function should be performed by the Mental Health Division".

81. The **Richmond Fellowship of Western Australia Incorporated** asserted that the re-definition was "particularly urgent in the case of our agency and a number of others". The Fellowship explained that "whilst most of our sites are currently licensed, it is felt that they do not constitute a psychiatric hostel".

82. The **Swan Adult Mental Health Centre** considered that the "definition of what constitutes a psychiatric hostel should be re-examined as a matter of urgent priority". The Centre asserted that "in the Perth metropolitan area there are a number of unlicensed boarding houses which offer accommodation to persons

with severe chronic mental illnesses who meet the criteria for admission to a licensed hostel. These persons are very vulnerable and prone to exploitation which can very easily happen where there are no standards and no accountability to any licensing body".

Findings and Conclusions

83. The community consultation process endorsed our original recommendation, and gave rise to a number of useful contributions which could, and should be utilised by the department in implementing the recommendation.

Recommendations

Recommendation 12: Definition of psychiatric hostels

12. That the definition of a psychiatric hostel contained in the *Hospitals and Health Services Act 1927* be revised by the Mental Health Division in consultation with mental health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a psychiatric hostel requiring licence.

Original Recommendation 13: Role of Chief Psychiatrist

That, in determining whether or not to grant a licence with respect to a psychiatric hostel, the Commissioner of Health take into account not only the recommendations of the HDWA unit responsible for licensing matters, but also the conclusions and recommendations contained in a written report required to be submitted by the Chief Psychiatrist, and that this requirement be included in future legislative amendment.

84. The **Australian Association of Occupational Therapists** suggested that "a multi-disciplinary team would be a more appropriate body to make a judgment about the granting of a psychiatric hostel licence rather than being the sole responsibility of the Chief Psychiatrist".

85. The **Australian Nursing Federation (Western Australia)** supported the recommendation, but asked that "criteria to guide the Chief Psychiatrist" be developed.

86. The **Council of Official Visitors** did not support the recommendation, arguing that "this additional input should be independent of the Health Department of WA and should be provided by the Council of Official Visitors".

Findings and Conclusions

87. Our original recommendation 13 was generally supported during the public consultation process.

88. However, two alternative views were put forward. The first was to transfer the proposed role of the Chief Psychiatrist in the licensing process to of a multi-disciplinary team, and the second was to transfer the proposed role of the Chief Psychiatrist in the licensing process to the Council of Official Visitors.

89. We are not persuaded to either of the alternatives put forward.

90. The role of Chief Psychiatrist is pivotal to the development and maintenance of mental health services in Western Australia. It seems to us therefore that that pivotal role should be recognised by formally including the Chief Psychiatrist in the licensing process relating to psychiatric hostels.

91. That is not to say, of course, that in forming conclusions and recommendations to be put to the licensing authority as part of the psychiatric hostel licensing process, the Chief Psychiatrist could not utilise input from a range of appropriate allied disciplines or from the Council of Official Visitors. In fact, in our view, to do so would be both sensible and appropriate.

Recommendations

Recommendation 13: Role of Chief Psychiatrist

13. That, in determining whether or not to grant a licence with respect to a psychiatric hostel, the Commissioner of Health take into account not only the recommendations of the HDWA unit responsible for licensing matters, but also the conclusions and recommendations contained in a written report required to be submitted by the Chief Psychiatrist (utilising input from a range of appropriate allied disciplines and from the Council of Official Visitors), and that this requirement be included in future legislative amendment.

Original Recommendation 14: Transfer of certain functions to Mental Health Division

That all functions currently undertaken by the PSLU and related units within the Finance and Resource Management Division with respect to the administration, payment, monitoring and recording of subsidy payable to psychiatric hostels be transferred immediately to the Mental Health Division.

92. The **Australian Association of Occupational Therapists** supported a proposition that the Mental Health Division "undertake and oversee the licensing of psychiatric hostels", while the **Private Hospital Association of Western Australia** saw this recommendation as meaning that "the licensing of psychiatric hostels, not private psychiatric hospitals, would be transferred to the Mental Health Division".

93. The **Richmond Fellowship of Western Australia Incorporated** supported the recommendation, but called for a review of "the way in which bed subsidies are calculated". The Fellowship argued that bed subsidy assessment "is based on medical, health and hygiene aspects", with "issues of acuteness of illness and the level of one-to-one support to assist in … rehabilitation … not really considered".

94. **Swan Adult Mental Health Centre** expressed similar concerns, and argued that there was a "need for the present subsidy system for residents in licensed hostels to be examined". The Centre commented that the "fact that hostel owners receive a higher subsidy for more dependent residents provides an incentive for accepting and retaining those residents who require more physical care and may be more appropriately placed in a nursing home, as well as encouraging dependency in other residents". The Centre suggested that "the provision of a set subsidy with no variation for level of care and dependency may help to discourage residents becoming more dependent and less functional".

Findings and Conclusions

95. The original recommendation was based on the important principle of separating clearly the statutory licensing function from the subsidy payment function with respect to psychiatric hostels. While this principle was generally endorsed during the public consultation process, two matters were raised which require comment.

96. Firstly, there seems to have been a misapprehension on the part of some respondents that the original recommendation entailed the transfer to the Mental Health Division not only of the subsidy payment function and responsibility, but also of the psychiatric hostel licensing function. Such a conclusion is a misreading of our original recommendation.

97. We originally recommended, and maintain the view, that the statutory licensing function within the department should remain within a single, specialised body, but that that body should not at the same time be required to involve itself in

day to day program management involving those sectors for which it has responsibility to uphold the integrity of the licensing framework.

98. Secondly, some respondents raised issues relating to the method of calculation of subsidies for psychiatric hostels, and suggested changes to current policy with respect thereto. Such a discussion, being quite outside our terms of reference, is one which could well be entered into between the mental health division and the psychiatric hostel sector.

Recommendations

Recommendation 14: Transfer of certain functions to Mental Health Division

14. (a) That all functions currently undertaken by the PSLU and related units within the Finance and Resource Management Division with respect to the administration, payment, monitoring and recording of subsidy payable to psychiatric hostels be transferred immediately to the Mental Health Division.

14. (b) That issues relating to the method of calculation of subsidies for psychiatric hostels and suggested changes to current policy with respect thereto be discussed between the Mental Health Division and the psychiatric hostel sector.

LICENCES

99. In the original Report, Recommendations 8 to 11 referred to elements of the licence. These recommendations will now be reconsidered.

Original Recommendation 8: Duration of licences

That, depending upon the quality of each facility and the care provided, and upon the level to which it complies with the relevant published standards, the duration of each licence granted vary so that one-year, two-year or three-year licences are granted, and that, pending any necessary amendments to State legislation to give effect to this recommendation, the Commissioner of Health grant automatic annual renewal of each licence issued throughout the currency of the relevant approved licence period.

Original Recommendation 9: Date of renewal of licences

That each licence granted become subject to renewal upon the relevant anniversary of its initial granting, and that appropriate records and data-bases be developed and maintained by HDWA to ensure adequate advance notification to licence-holders to enable them and the Department to undertake all steps necessary to facilitate re-licensing prior to the expiry of a licence.

Original Recommendation 10: Conditional Licences

That relevant legislation be amended to enable the granting by the Commissioner of Health of conditional licences where a particular facility does not completely meet the required published standards, but where the level of non-compliance is not sufficient to warrant outright refusal to grant a licence (in the case of new facility applications) or withdrawal of licence (in the case of applications for re-licensing).

Original Recommendation 11: Duration and scope of Conditional Licence

That the legislation provide that conditional licences have a maximum duration of one year (during which remedial work required to enable the facility completely to meet the required published standards must be completed), that a conditional licence may be renewed as a conditional licence if remedial work is required, and that the conditional licence specify the particular deficiencies required to be corrected.

100. **John Wilson Lodge** commented that "there may be circumstances where conditional licences should be granted for periods longer than 12 months and the Department should have this flexibility".

101. **Norman Disney & Young**, in addressing recommendation 8, argued that "automatic annual renewal of licence, even as a temporary measure, without ensuring an acceptable standard of facility to achieve the appropriate Health outcome should not be contemplated".

102. The **Private Hospital Association of Western Australia** supported "the recommendation for varying periods of licence" and suggested that "for hospitals accredited with ISO/ACHS a 3 year period of licence would be appropriate".

Findings and Conclusions

103. These recommendations were generally supported by respondents during the public consultation process.

104. The view expressed that conditional licences should be able to be issued for periods in excess of one year is one which we do not support. The reason for our original recommendation was to ensure that, at regular and defined periods, the conditional licence arrangement be reviewed to ensure that satisfactory progress was being made to ameliorate non-complying elements. Of course, our original recommendation also made available the option of renewing a conditional licence, but only where the terms of the original conditional licence had been adhered to.

105. Nor do we support the proposition that automatic annual renewal of licences within the one-year, two-year, or three-year duration determined would in any way detract from the achievement of acceptable facility standards. Our suggestion of automaticity of renewal was intended to be a temporary measure to bridge the time between acceptance of our recommendations and the necessary amendments to the current legislation.

106. It seems quite appropriate to us that, where the condition of the facility warranted the recommended granting of a two or three year licence, the automatic annual renewal of that licence during the two or three year period determined would be perfectly consistent with the underlying aims and intentions of the licensing process.

107. However we do see some merit in the view expressed that for hospitals accredited with ISO/ACHS a three-year period of licence would be appropriate.

Recommendations

Recommendation 8: Duration of licences

8. (a) That, depending upon the quality of each facility and the care provided, and upon the level to which it complies with the relevant published standards, the duration of each licence granted vary so that one-year, two-year or three-year licences are granted, and that, pending any necessary amendments to State legislation to give effect to this recommendation, the Commissioner of Health grant automatic annual renewal of each licence issued throughout the currency of the relevant approved licence period.

8. (b) That, subject to their compliance with other requirements of the licensing framework, a three-year period of licence normally be granted to hospitals accredited with ISO/ACHS.

Recommendation 9: Date of renewal of licences

9. That each licence granted become subject to renewal upon the relevant anniversary of its initial granting, and that appropriate records and data-bases be developed and maintained by HDWA to ensure adequate advance notification to licence-holders to enable them and the Department to undertake all steps necessary to facilitate re-licensing prior to the expiry of a licence.

Recommendation 10: Conditional Licences

10. That relevant legislation be amended to enable the granting by the Commissioner of Health of conditional licences where a particular facility does not completely meet the required published standards, but where the level of non-compliance is not sufficient to warrant outright refusal to grant a licence (in the case of new facility applications) or withdrawal of licence (in the case of applications for re-licensing).

Recommendation 11: Duration and scope of Conditional Licence

11. That the legislation provide that conditional licences have a maximum duration of one year (during which remedial work required to enable the facility completely to meet the required published standards must be completed), that a conditional licence may be renewed as a conditional licence if remedial work is required, and that the conditional licence specify the particular deficiencies required to be corrected.

ASSESSMENTS REQUIRED

108. In the original Report, Recommendations 15 to 18 referred to assessment of the financial viability, appropriateness, and public esteem of the prospective licensee and client satisfaction with the service provided. These recommendations will now be reconsidered.

Original Recommendation 15: Financial viability of the proprietor

That future applicants for new licences (in every case) and that applicants for renewal of licences (at least every six years) be required to submit with their application a clear authorisation to enable HDWA, at the applicant's expense, to commission Dun and Bradstreet (or a similar company of repute) to prepare and submit to the Commissioner a report on the sufficiency of the material and financial resources available to the applicant to comply with the requirements of this Act.

Original Recommendation 16: Proprietor appropriateness

That the authorisation enable Dun and Bradstreet (or a similar company of repute), at the applicant's expense, to attest to the fact that the applicant has attained the age of 18 years, and (by reference to criminal and police records) to offer a view on whether the applicant is a person of good character and repute and a fit and proper person to conduct a private health care facility.

Original Recommendation 17: Industry and community esteem

That the report submitted by Dun and Bradstreet (or a similar company of repute), at the applicant's expense, include in relation to the applicant, written references provided by members of the community, health care professionals, and representatives of the industry into which the new applicant desires entry or in which the renewal applicant desires to remain.

Original Recommendation 18: Patient/resident/carer/staff consultation

That, in relation to applications for licence renewal, each application be required to provide evidence that the views of patients and/or residents and/or carers and/or family members and/or staff have been sought in relation to the standard of care received and service offered.

109. The **Australian Nursing Federation (Western Australia)**, addressing the financial viability and propriety of applicants, argued that reports to the Commissioner should canvass the applicants' "compliance with industrial award conditions and their history in the industry in other states of Australia". The Federation suggested that "it is not unknown for proprietors to leave one state bankrupt and set up business in the next".

110. The Federation did not support the minimum age of 18 years for applicants, but believed that "inadequate life and business experience can be assumed at that age".

111. In the case of applicants in the psychiatric hostel sector, the **Council of Official Visitors** suggested that, in relation to recommendation 18, it prepare "the submissions based on the collation of its regular reports routinely gathered over an extended period of time".

112. **Devenish Lodge** argued strongly against each of these recommendations, regarding them as "a waste of money and time", "not … necessary", "ridiculous" and already provided for under the current system.

113. The **Health Consumers Council** maintained, in relation to recommendation 16, that "if a health professional such as a doctor or nurse is an applicant for a new licence, a check be made with the appropriate Registration Board as to any issues that the Board may be aware of regarding the applicant". Referring to recommendation 18, the Council also expressed the view that "standards of consumer/resident consultation should be established" to ensure real consultation with consumers/patients.

114. **John Wilson Lodge** supported recommendations 15 and 16 in the case of new applicants for licences, but disagreed in the case of licence renewal "unless the applicant is under some form of receivership". In relation to recommendation 17, the Lodge did not support the approach adopted in the original Report on the grounds that "it may not always be possible for new applicants to provide reference from the industry". Turning to recommendation 18, the Lodge advanced the view that "the views of all stake holders are continually canvassed on an informal basis, this being the nature of the interaction". For that reason, the Lodge did not agree that "evidence of this interaction (should) be required to be submitted as part of the licence renewal process".

115. The **Joondalup Health Campus**, referring to recommendation 15, suggested that "if the applicant/operator is able to provide the necessary information ie. credit ratings/corporate governance etc, … they be given the opportunity to do so directly and not via an external appraiser at their own cost".

116. **Joondalup Health Campus (Mental Health Service)** pointed out, in relation to recommendation 15, that "the requirement to provide commercially sensitive information into the public arena could impinge upon the maintenance of the integrity of such information and is invasive without sufficient argument of established need". Turning to recommendation 16, the Service argued that "not only should there be due scrutiny of proprietors, but this should by statutory power be extended to employees of the proprietor". The Service went on to suggest that "this scrutiny should be subject to annual review of continued appropriateness".

117. Regarding recommendation 17, the Service suggested that "any screening process should include supportive evidence". However, as the Service pointed out, "any requirement for industry support for an application should include cognisance of Trade Practices legislation" directed to prevent measures which "could disadvantage newcomers into the marketplace". The Service also suggested that, in respect of recommendation 18, "Standards espoused in the *National Standards for Mental Health Services* address this issue comprehensively".

118. Niola Private Hospital argued that recommendation 16 should apply only "for persons or bodies seeking a licence for the first time", that recommendation 17 should not apply to public hospitals, and that recommendation 18 is "a quality issue, not a licensing issue" with "good organisations … doing this already".

119. The **Private Hospital Association of Western Australia** strongly opposed recommendation 15 "on the grounds that it creates an unnecessary cost impost on both the Health Department of WA and proprietors". To support its view, the Association argued that existing mechanisms (such as Corporations Law) cover financial viability, while for publicly listed private health care groups the Stock Exchange imposes stringent reporting requirements. In addition, the Association asserted that, by endorsing the financial viability of a proprietor, the Department might find itself subject to legal claim lodged in the event of loss by persons who may have relied upon such an endorsement. The Association further argued that, "if a proprietor is in financial difficulty, it is that proprietor's responsibility to seek alliances, raise further equity or loan money, sell the facility, or close down". The proprietor is, according to the Association, well aware that failure to fund licensing requirements not only puts the licence at risk but would lead to a situation where medical practitioners would be likely to withdraw their work from such a facility.

120. The Association expressed its support for recommendation 16 only "in the case of a new applicant or change of proprietor", while it did not support recommendation 17 in the case of private hospitals, asserting that "private hospital business would founder in the absence of community esteem". The Association expressed concern that "information obtained through such a process could be used inappropriately" and believed that "community esteem is not relevant to the running of a hospital and therefore should not be a licensing issue".

121. Similarly, the Association argued that recommendation 18 was "too prescriptive and not appropriate for private hospitals". The Association suggested that ACHS or ISO accreditation, which requires hospitals to seek patient satisfaction information, would be an appropriate alternative.

122. The **Richmond Fellowship of Western Australia Incorporated**, addressing recommendation 15, asserted that, in the case of not-for profit agencies who are largely funded by Government, "these costs may have an adverse effect" inasmuch as funding is not automatically indexed to compensate for increases in administrative costs. The Fellowship argued that "further costs … imposed by Government … will only reduce the level of service provision or increase costs to residents".

123. On the other hand, while recognising the possible cost impact, the Fellowship sees recommendation 16 as being "a positive recommendation for residents' quality of care". The Fellowship did however point out that in not-for-profit organisations, "the executive officer is the licensee and that executive officers change more frequently" than do licensees of for-profit psychiatric hostels.

124. **Salisbury Home** expressed "grave reservations" about recommendation 15. The Home argued that "it would be far more appropriate for each hostel owner

to obtain a simple letter from their business accountants stating that they are solvent". The Home regarded recommendation 16 as "a load of nonsense", arguing that "perfectly adequate measures are taken to ensure that all staff employed in licensed hostels are suitable persons under the existing arrangements". The Home had similar feelings towards recommendation 18, arguing that the hostels are sufficiently open to official visitation to preclude the necessity for consultation with patients/residents/carers/staff.

125. The **Undercliffe Hospital Complex** strongly opposed recommendation 15, arguing that "it not only places a cost on both the health provider and HDWA but also sets HDWA up as the arbitrator of financial viability with no stated objective measures proposed". The Complex argued that "it is not the role of HDWA to be a financial judge, there are existing laws which provide for this" and asserted that "this recommendation gives the impression of a Department set up to control a sector rather than monitor it".

126. The Complex supported recommendation 16 for new applicants only, but rejected recommendation 17. In relation to recommendation 18, the Complex argued that , since "ACHS accreditation already provides for patient satisfaction surveys and the like", such a recommendation was not necessary.

Findings and Conclusions

127. This group of recommendations attracted significant comment during the public consultation process.

128. A number of respondents raised objections to recommendations 15 and/or 16.

129. The grounds of the objections varied:

- a minimum age of 18 years was too low, and could lead to proprietors with inadequate life and business experience;
- the provision of commercially sensitive information is invasive;
- the provision of information on financial viability creates an unnecessary cost impost on proprietors;
- already existing mechanisms (such as corporations law, stock exchange reports and company accountants) would provide guarantees of financial viability, rather than the specially prepared report recommended;
- any endorsement by the department of the financial viability of a proprietor on the basis of the reporting mechanism recommended could leave the department liable to legal claims lodged in the event of loss by persons who may have relied upon such an endorsement;
- the recommendation is unnecessary on the grounds that, if a proprietor finds enters into a period of financial difficulty, it is that proprietor's responsibility to deal with the financial problem or to close their premises.

130. On the other hand, a number of respondents not only supported recommendations 15 and/or 16, but expressed the view that the recommendations should go further.

131. It was suggested that:

- the appropriate registration board be consulted to determine whether or not there were issues regarding applicants of which the board might be aware;

- in relation to recommendation 16, the appropriateness check should extend not only to proprietors but also to employees of the proprietor;

- in the case of not-for-profit organisations, the Executive Officer rather than the proprietor association should be the subject of the appropriateness scrutiny.

132. Finally, many respondents argued that the financial viability and appropriateness scrutiny should apply only to applications for new licences or at a time of change of ownership, and that these scrutinies should not be required for applicants for renewal of existing licences.

133. In assessing the contributions made during the consultation process, it is important to bear in mind that the current licensing framework, detailed in the *Hospitals and Health Services Act 1927*, already requires, in Section 26B sub-section (2) that the Commissioner shall be satisfied about a number of matters, including the age, character and repute, financial viability, and understanding of the relevant duties and obligations of anybody who desires to obtain a licence.

134. The sub-section reads as follows:

> *(2) Subject to this Act, a person not being a member of a firm or a body corporate who desires to obtain a licence to conduct a private hospital shall satisfy the Commissioner -*
>
> *(a) that he or she has attained the age of 18 years;*
>
> *(b) that he or she is a person of good character and repute and a fit and proper person to conduct a private hospital;*
>
> *(c) that he or she has sufficient material and financial resources available to him or her to comply with the requirements of this Act; and*
>
> *(d) that he or she understands fully the duties and obligations imposed on him or her in relation to the conduct of a private hospital under this Act and otherwise. ...*

135. What is proposed by our four recommendations is not therefore any new set of requirements imposed upon the industry, but a mechanism whereby the existing requirements of the current Act can better be measured and more certainly implemented.

136. The requirements of the current Act are, in our view, perfectly defensible.

137. They require a licence holder to have reached the age of majority, to be a person of good character and repute, to be a fit and proper person to conduct a facility, to have possession of sufficient material and financial resources to comply with the Act, and to understand fully the duties and obligations imposed in relation to the conduct of that facility.

138. Given that the licensing framework was originally applied and continues to be applied in order to ensure the provision of appropriate levels of care to persons in licensed health and health related facilities, and to provide protection to persons who by virtue of their admission to health and health related facilities are deemed to be vulnerable, it would in our view be singularly inappropriate for those assurances and protections to be wound back or to be discarded.

139. At the same time, we recognised in our earlier report that compliance with these provisions of the *Hospitals and Health Services Act 1927* had been somewhat inconsistent and, on many occasions, far from rigorous. It was for this reason, that we recommended the adoption of a standard, more formalised approach to appropriateness and viability assessments.

140. While we recognise that the methodology that we have recommended will have some cost impact on new applicants for licences, we also believe that the utilisation of this formalised and standardised approach will provide a degree of certainty to applicants, will ensure that appropriateness and viability scrutinies are undertaken in a consistent and professional way, and will provide the Commissioner with comparable assistance against which the Commissioner can make the necessary licensing decisions.

141. We are, therefore, disinclined to make substantial variations to our original recommendations in relation to applications for new licences.

142. Nonetheless, we are persuaded by the representations made that, a licence having been granted following satisfactory outcomes to the viability and appropriateness scrutinies, there is no need for these scrutinies to be repeated for licence renewal purposes. The only time the scrutiny should be repeated is, in our view, when a licensed premises undergoes a change of ownership.

143. Recommendations 17 and 18 were more widely supported, although a number of suggestions were made by way of refinements to those recommendations.

144. It was suggested that:

- the outcomes of recommendation 18 could be improved in the case of psychiatric hostels if the Council of Official Visitors were to be requested to provide reports based on the Council's own experience and knowledge;

- standards should be promulgated to ensure real consultation with consumers and patients;

- the National Standards for Mental Health Services address this issue comprehensively; and

- ACHS or ISO accreditation, which requires hospitals to seek patient satisfaction information, would be an appropriate alternative to recommendation 18 in the case of the private hospital sector.

145. While a number of the refinements suggested have been included by us in our revised recommendations, others relate more appropriately to implementation mechanisms. We commend them to the department and suggest that, in the course of implementation of our recommendations, they be further considered.

Recommendations

Recommendation 15: Financial viability of the proprietor

15. That future applicants for new licences (in every case) and that applicants for renewal of licences (after a change of ownership) be required to submit with their application a clear authorisation to enable HDWA, at the applicant's expense, to commission Dun and Bradstreet (or a similar company of repute) to prepare and submit to the Commissioner a report on the sufficiency of the material and financial resources available to the applicant to comply with the requirements of this Act.

Recommendation 16: Proprietor appropriateness

16. That the authorisation enable Dun and Bradstreet (or a similar company of repute), at the applicant's expense, to attest to the fact that the applicant has attained the age of 18 years, and (by reference to criminal and police records) to offer a view on whether the applicant is a person of good character and repute and a fit and proper person to conduct a private health care facility.

Recommendation 17: Industry and community esteem

17. That the report submitted by Dun and Bradstreet (or a similar company of repute), at the applicant's expense, include in relation to the applicant, written references provided by members of the community, health care professionals, and representatives of the industry into which the new applicant desires entry or in which the renewal applicant desires to remain, except that, in the case of private hospitals, ACHS or ISO accreditation be deemed to provide full compliance with this requirement.

Recommendation 18: Patient/resident/carer/staff consultation

18. That, in relation to applications for licence renewal, each application be required to provide evidence that the views of patients and/or residents and/or carers and/or family members and/or staff have been sought in relation to the standard of care received and service offered,

except that, in the case of private hospitals, ACHS or ISO accreditation be deemed to provide full compliance with this requirement.

LEGISLATIVE CHANGES

146. In the original Report, Recommendation 19 referred to legislative amendments required to implement the licensing framework proposed. This recommendation will now be reconsidered.

Original Recommendation 19: Legislative Amendments

That the various legislative enactments governing licensing be revised and amended to support the recommendations made in this Report, and (inter alia) to address the following issues:

- *clarification of the definitions of the types of services requiring licensing: hospitals, aged care facilities, day surgeries, nursing posts, psychiatric hostels etc.;*
- *introduction of differential licence periods to reflect varying standards of facilities and service;*
- *formalisation of conditional licensing as an improvement mechanism;*
- *making more explicit the option of revocation of licence for non-compliance with licence conditions;*
- *removal of the "pro forma" nature of licence renewal;*
- *entrenchment and definition of standards as a benchmark in licensing;*
- *inclusion of discretionary elements to enable the legislation to cope with structural/cultural change (eg. "aging-in-place" in aged hostels);*
- *application of meaningful penalties for non-compliance.*

147. The **Private Hospital Association of Western Australia** supported this proposition, arguing that "legislative changes need to be made to define day surgeries and to correct the existing anomaly which results in some prime function day surgeries not requiring a licence". The Association further suggested that "definition of both Day Surgeries and Approved Procedure Facilities (as proposed in the *Health Legislation Amendment Bill No 4 1998)* … be included in the Act" and that "a new classification structure for Day Surgeries be established".

Findings and Conclusions

148. This recommendation was overwhelmingly supported during the public consultation process.

149. One consistent representation made to us was that, in the process of clarifying the definitions of the types of services requiring licensing, special attention be paid to day surgeries and nursing posts to ensure that the new definition to be

contained in the amended legislation adequately and appropriately defines those facilities which require a licence and excludes those which do not.

150. In formulating these new definitions, we believe that it would be both appropriate and beneficial for there to be the widest possible consultation with the affected industry.

Recommendations

Recommendation 19: Legislative Amendments

19. That the various legislative enactments governing licensing be revised and amended to support the recommendations made in this Report, and (inter alia) to address the following issues:

- **clarification of the definitions of the types of services requiring licensing: hospitals, aged care facilities, day surgeries, nursing posts, psychiatric hostels etc.;**
- **introduction of differential licence periods to reflect varying standards of facilities and service;**
- **formalisation of conditional licensing as an improvement mechanism;**
- **making more explicit the option of revocation of licence for non-compliance with licence conditions;**
- **removal of the "pro forma" nature of licence renewal;**
- **entrenchment and definition of standards as a benchmark in licensing;**
- **inclusion of discretionary elements to enable the legislation to cope with structural/cultural change (eg. "aging-in-place" in aged hostels);**
- **application of meaningful penalties for non-compliance.**

CERTIFICATION AND ACCREDITATION

151. In the original Report, Recommendations 20, 21 and 34 referred certification of services and accreditation of certifiers. These recommendations will now be reconsidered.

Original Recommendation 20: Allocation of risk and cost

That a better balance be struck between public sector licensing and private sector service provision with a more appropriate allocation and acceptance of risk and cost, and that this balance be achieved by adopting a framework for licensing (except in the aged care area) which requires:

- *future applicants for new licences (in every case) and applicants for renewal of licences (at least every six years) to be required to submit with their application for a licence a Compliance Certificate submitted under affidavit by an architect or engineer or building surveyor (the Accredited Certifier) of the applicant's choice;*

- *the Accredited Certifier to be professionally registered in Western Australia (with the professional registration number identified on the certificate);*

- *the Accredited Certifier to be accredited by HDWA (with the accreditation number identified on the certificate);*

- *the Accredited Certifier to be the holder of appropriate professional indemnity insurance (with the company and policy number identified on the certificate);*

- *the Accredited Certifier not to be the architect, builder or any other person consulting to or contracting to the works (with a statement to this effect to be explicitly made on the certificate);*

- *the Accredited Certifier may be privately employed, be employed by a local government authority or be employed in the State public service;*

- *the Accredited Certifier not to be or to have been involved in any aspect of the design or documentation of the building (with a statement to this effect to be explicitly made on the certificate);*

- *the Accredited Certifier not to have a direct or indirect financial interest in the building or in any body associated with the building (with a statement to this effect to be explicitly made on the certificate);*

- *the Accredited Certifier not to be employed by any person or body associated with any aspect of the building, except only for their employment as Accredited Certifier (with a statement to this effect to be explicitly made on the certificate).*

- *the Compliance Certificate to assert that the Accredited Certifier has read and understood the officially published standards relevant to the facility for which a licence or licence renewal is sought;*

- *the certificate to confirm either:*

  - *that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility; or*

  - *that the facility for which the licence or licence renewal is sought does not fully meets the officially published standards relevant to the facility, in which case the certificate is to specify in precise terms those elements of the officially published standards relevant to the facility which are not met and provide a program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.*

Original Recommendation 21: Assessment of certificate and grant of licence

That, on the basis of the certificate submitted, HDWA assess the application and

- *where the certificate confirms that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility, considers whether or not to grant a full licence for the relevant period; or*

- *where the certificate confirms that the facility for which the licence or licence renewal is sought does not fully meet the officially published standards relevant to the facility, considers whether or not to grant a conditional licence for the relevant period, taking into account the submitted program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.*

Original Recommendation 34: Accreditation

That any professionally registered architect, engineer or building surveyor be entitled to seek accreditation from the Commissioner of Health as an Accredited Certifier, and that the process of managing the accreditation process not be managed by the HDWA licensing area.

152. **Devenish Lodge** argued that recommendation 20 entails a substantial cost impost, and that "private psychiatric hostels do not have sufficient funding to meet this".

153. **John Wilson Lodge** did not support recommendations 20 and 21, seeing them as imposing "very substantial cost imposition onto the private sector". The Lodge proposed an alternative, namely for "the Health Department to out source this function to an appropriate professional if it is considered that cost savings can be achieved".

154. In addressing recommendation 20, **Lincolne Scott** argued that "it is not possible for a single practitioner to certify a health facility of any size or complexity from their own personal knowledge or experience" but that "the Accredited Certifier will rely on confirmation of elements of the facility from either the design team, independent consultants or other accredited certifier (as currently happens with certification to the BCA)".

155. Lincolne Scott went on to assert that "the involvement of independent professionals is seen as crucial to maintain the integrity of the system, controlling of risk and assisting the maintenance of the public and the private hospital systems" and suggested that "if the proposed system is to be truly independent then the position of sub-certifiers needs to be considered". Lincolne Scott recommended that "certification be controlled by HDWA as at present with applicants charged a fee for services", arguing that "the current system allows a group of experienced professionals to achieve an overall best result".

156. On the question of accreditation, Lincolne Scott suggested that "the accreditation and regulation of Health Professionals will require a substantial input which may not be appropriate to the size of the health sector".

157. Addressing recommendation 20, **Norman Disney & Young** asserted that "if Accredited Certification is required by private sector individuals, then the cost of this service will escalate dramatically". Norman Disney & Young also foresaw that "accreditation of certifiers will have its own political difficulties". In the view of Norman Disney & Young, "the current risk management of the licensing process by HDWA personnel involvement seems to have been effective", and as such should not be changed.

158. In relation to recommendation 34, Norman Disney & Young asserted that "this recommendation will bury the Commissioner of Health in the issue of certifying accreditors with all the attendant political problems" and that the recommendation "will require significant resources to administer".

159. In supporting recommendation 20, the **Private Hospital Association of Western Australia** made the point that "standards are frequently being amended, often within 2-5 years of a new facility being built". Under these circumstances, the Association believed that it remained "unclear whether … a facility must continually undertake works in order to meet new standards and that these upgrades must be in place at the time of re-licensing". In the Association's view, while it accepts that standards change over time, minimum mandatory standards should be established with a reasonable timeframe for new facilities to comply with the new standards.

160. The **Richmond Fellowship of Western Australia Incorporated** supported recommendation 20 with the reservation that the likely additional costs to be incurred might lead to higher fees payable by residents.

161. The **Royal Australian Institute of Architects** strongly opposed "the restriction on self certification by the architect responsible for the design of individual health care and aged care facilities as it believes that the architect responsible

for the project is in a unique position to certify compliance with the relevant codes and standards". In the Institute's view, "architects expert in this field regard it as a part of their responsibilities to ensure that the final building meets all the relevant standards, guidelines and codes". Such a view is, according to the Institute, "supported by the Professional Indemnity Insurance held by architectural practices".

162. In presenting its argument for self-certification, the Institute asserts that recommendation 20 "seeks to duplicate" architectural involvement in each project, and argues that "it is an expensive impost to require the owner or operator of the facility to employ two architects to perform the same task". Furthermore, according to the Institute, "the exclusion of the architect responsible for the facility excludes the independent professional who knows most about the particular building".

163. In the Institute's view, "no third party certifier can ever vouch for all the aspects to the same degree of detail as the architect who has inspected the building throughout the construction process" and therefore the Institute "strongly recommends that self-certification be permitted in these new arrangements".

164. On the question of accreditation (recommendation 33), the Institute supported the recommendation and offered to assist "by organising a training course to ensure that architects have the necessary knowledge and skills to apply to become Accredited Certifiers", and offered also "to manage the accreditation process if this is required".

165. **Steens Gray & Kelly Pty Ltd** "foresee some difficulties" in relation to recommendation 20, in particular with respect to the proposal for independent Accredited Certifiers. While, in the view of Steens, "every effort is being made to keep the accrediting professional at arms length from the licensee" (an approach which Steens see as "admirable and desirable"), it expressed a concern "that the number of professionals suitably qualified and prepared to undertake this work are few in number". In addition, Steens sees "the fact that large private hospital groups commission many of these professionals from time to time to undertake large commissions" as making certification work "onerous, perhaps undesirable and a possible conflict of past or future interest for the professional". As a possible solution, Steens proposed "selection from a panel by random number or other means, not selection by the applicant".

166. In addition, Steens argued that certification "responsibility would be onerous and could only be successfully carried out using detailed criteria, access to medical professionals and some programmed feedback from those managing or reviewing the facility after the accreditation".

Findings and Conclusions

167. These recommendations were generally supported during the public consultation, with some significant input received, particularly from professional associations and firms.

168. While one of the intents of the original recommendations (namely, to keep the accrediting professional at arms length from the licensee) was appreciated by respondents, a contrary argument, put most cogently by the Royal Australian Institute of Architects, was that the architect responsible for the project is in a unique position to certify compliance with the relevant codes and standards.

169. According to the Institute, the principal shortcomings of third party certification as against self-certification were the duplication of professional involvement, and hence the additional financial impost involved, and the exclusion from the certification process of an independent professional who knows most about the particular building subject to licensing. The association best expressed its position in commenting that "no third party certifier can ever vouch for all the aspects to the same degree of detail as the architect who has inspected the building throughout the construction process".

170. In addition, the point was made that, in many cases, certification of the integrity of the systems involved may well involve the application of the professional skills of more than one certifier, ie. that more complex certification would require both architectural and engineering input.

171. We believe that these are all legitimate and sustainable criticisms of our earlier approach and that they can be sustained on the basis of cost reduction, risk management, applicability of professional indemnity insurance, and application of relevant professional skills to the certification process.

172. We have therefore amended our original recommendations accordingly, and have, in those recommendations, withdrawn our recommended requirement for third party certification, allowing instead self-certification by one or more relevant professionals.

Recommendations

Recommendation 20: Facility Standards

20. (a) That a better balance be struck between public sector licensing and private sector service provision with a more appropriate allocation and acceptance of risk and cost, and that this balance be achieved by adopting a framework for licensing (except in the aged care area) which requires:

- **future applicants for new licences (in every case) and applicants for renewal of licences (when, at intervals of not less than seven years, they are required so to do by the Commissioner) to be required to submit with their application for a licence a Compliance Certificate submitted under affidavit by an architect and/or an engineer (the Accredited Certifier) of the applicant's choice;**

- **the Accredited Certifier to be professionally registered in Western Australia (with the professional registration number identified on the certificate);**

- **the Accredited Certifier to be accredited by HDWA (with the accreditation number identified on the certificate);**

- **the Accredited Certifier to be the holder of appropriate professional indemnity insurance (with the company and policy number identified on the certificate);**

- **the Accredited Certifier not to have a direct or indirect financial interest in the building or in any body associated with the building (with a statement to this effect to be explicitly made on the certificate);**

- **the Compliance Certificate to assert that the Accredited Certifier has read and understood the officially published standards relevant to the facility for which a licence or licence renewal is sought;**

- **the certificate to confirm either:**

  - **that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility; or**

  - **that the facility for which the licence or licence renewal is sought does not fully meets the officially published standards relevant to the facility, in which case the certificate is to specify in precise terms those elements of the officially published standards relevant to the facility which are not met and provide a program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.**

20. (b) That the Royal Australian Institute of Architects be invited to organise training courses to ensure that prospective Accredited Certifiers have the necessary knowledge and skills.

<u>Recommendation 21: Assessment of certificate and grant of licence</u>

21. That, on the basis of the certificate submitted, HDWA assess the application and

- **where the certificate confirms that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility, considers whether or not to grant a full licence for the relevant period; or**

- **where the certificate confirms that the facility for which the licence or licence renewal is sought does not fully meet the officially published standards relevant to the facility, considers whether or not to grant a conditional licence for the relevant**

period, taking into account the submitted program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.

Recommendation 34: Accreditation

34 (a) That any professionally registered architect or engineer be entitled to seek accreditation from the Commissioner of Health as an Accredited Certifier.

34 (b) That accreditation with the Department consist simply of lodging with the accreditation authority details of name, contact details, professional registration number, and professional registration expiry date, together with such other information as the Department might, from time to time, require.

34 (c) That the process of managing the accreditation process not be managed by the HDWA licensing area, but that the Royal Australian Institute of Architects be invited to manage the accreditation process on behalf of the Department.

EXECUTIVE DIRECTOR PUBLIC HEALTH

173. In the original Report, Recommendation 22 referred to the role of the Executive Director Public Health in relation to local government authorities. This recommendation will now be reconsidered.

Original Recommendation 22: Role of Executive Director Public Health

That the Executive Director Public Health become more involved with the licensing process through on-going discussion and consultation with local government authorities and, as a last resort, by using his/her powers under the Health Act 1911 to make orders binding the local authority to act to ensure that health inspectors undertake regular inspections of licensed health and aged care institutions in Western Australia.

Findings and Conclusions

174. This recommendation was generally supported during the public consultation process, and was the subject of no adverse criticism or alternative suggestion.

Recommendations

Recommendation 22: Role of Executive Director Public Health

22. That the Executive Director Public Health become more involved with the licensing process through on-going discussion and consultation with local government authorities and, as a last resort, by using his/her powers under the Health Act 1911 to make orders binding the local authority to act to ensure that health inspectors undertake regular inspections of licensed health and aged care institutions in Western Australia.

STANDARDS

175. In the original Report, Recommendations 23 to 25 referred to the formulation and content of standards, and to the process for developing standards. These recommendations will now be reconsidered.

Original Recommendation 23: Formulation of Standards

That HDWA adopt as a principle the formulation of a three-tiered approach to the setting of standards for licensed health care facilities involving:

- *formal adoption of Building Code of Australia and/or Australian Standards Association standards (where available, and as amended from time to time);*

- *incorporation of Western Australian local government and statutory requirements (including fire and public health regulations, local authority building codes etc.); and*

- *augmentation of the above standards by the preparation and promulgation by HDWA of additional requirements only as strictly required to meet specific and otherwise unmet Western Australian and Departmental needs.*

Original Recommendation 24: Content of Standards

That HDWA standards for each type of licensed care fully address requirements against which assessments can be made of the:

- *fitness and propriety of the applicant, including the sufficiency of the material and financial resources available to the applicant in terms of legislative requirements;*

- *suitability of the proposed premises for the designated purpose; and*

- *arrangements proposed for the satisfactory maintenance of appropriate clinical standards, and for the management, equipment and staffing of the facility.*

Original Recommendation 25: Process for developing Standards

That HDWA adopt the following formal process for the formulation, publication and revision of Standards:

- *Draft Standards, in accordance with the provisions of Recommendations 23 and 24, and draft revisions to existing Standards to be prepared by HDWA;*

- *the Draft Standards and draft revisions to be released and widely circulated for a period of 60 days during which industry and public comment, reaction and input can be obtained;*

- *industry and public comment, reaction and input received to be assessed and considered within 30 days by a formally constituted Standards Reference Committee representative of the Department, the relevant industry group, consumers and health care professionals;*

- *amended Standards and revisions to be prepared and endorsed by the Standards Reference Committee for submission to the Commissioner of Health;*

- *Standards and Revised Standards to come into effect only upon their formal authorisation by the Commissioner of Health and their publication by him.*

176. The **Australian Nursing Federation (Western Australia)** suggested that standards should specifically address "the suitability of the premises from an occupational health and safety perspective and … clinical standards, equipment and staffing".

177. The **Council of Official Visitors** argued that the Standards Reference Committee for psychiatric hostels include a representative from the Council.

178. **Devenish Lodge** asserted that "private psychiatric hostels are very poorly funded" and that "any move towards the development, adoption and enforcement of standards must take this into consideration". In particular, the Lodge argued that "the delivery of health care to a level similar to that required of aged care facilities will only be possible with similar levels of funding".

179. **John Wilson Lodge** argued that "the three tiered approach to the setting of standards … does not take into account funding issues, the ability of a hostel to comply with updated standards and the level of care and ability to provide an acceptable service to its clients". According to the Lodge, "there will be no discretion or flexibility where various building codes are the basis of the standard to be applied".

180. The Lodge asserted that "the recommendation will require hostels to comply with the current standard regardless of when the premises was constructed" rather than being "required to comply with … the codes at the time of construction".

181. **Joondalup Health Campus (Mental Health Service)** suggested that the "formulation of standards applicable to the private sector should reflect at the least equivalent public sector services". The Service went on to argue that "these standards should provide for the inclusion of service outcome measures incorporating where appropriate benchmarked clinical indicators". In support of this position, the Service asserted that "national mental health strategies have for some time been drifting towards the initiation of outcomes standards to assist in the evaluation of different types of services. Any move towards the establishment of clinical or service outcome standards should be praised and extended across the public (sector) and not restricted in their application to the private sector".

182. Turning to recommendation 25, the Service argued that "draft standards should be formulated with … industry/consumer/public representation and not exclusively by the HDWA". In general, the Service held the view that "the creation of standards for the establishment and maintenance of services measured against accepted outcomes should make the process of assessment/compliance simpler".

183. **Lincolne Scott** expressed the view that "the current standards largely meet the proposed requirements", arguing that "most areas of dissension with the guidelines has occurred in the nursing home area and has to some degree been brought about by the changing nature of the nursing homes and the blurring of the definitional boundaries between nursing homes and hospitals". Lincolne Scott asserted that, "in many cases the nursing home standards have been developed from the hospital standard and their appropriateness needs to be questioned by those within the system to ensure that the standards are appropriate".

184. The **Metropolitan Health Service Board** argued that that the public consultation period should be increased to 180 days, with the time available for the Standards Reference Committee to assess public input being increased to 90 days.

185. **Niola Private Hospital** suggested that the Private Hospital Association of Western Australia should be a standing member of relevant Standards Reference Committees, and that the public consultation period should be increased to 120 days.

186. **Norman Disney & Young** commented, in relation to recommendation 25, that "the process proposed will politicise the process and lead to the usual publicity of any adverse elements or methods", while "the current arrangement has worked and been accepted by the industry".

187. The **Private Hospital Association of Western Australia** suggested that the Standards Reference Committee should have, as its role, to review new standards, to decide which are appropriate for adoption in the health care industry, and to conduct an appeal process enabling proprietors to lodge appeals regarding the appropriateness of the standard to their particular facility or the conclusions of the Accredited Certifier. The Association further argued that the Standards Reference Committee should be representative of the entire industry and include a nominated representative from the Private Hospitals Association of Western Australia.

188. The Association also recommended that the public consultation period for standards should be extended to 120 days.

189. In relation to the proposed content of standards, the Association expressed the view "that a review of licensing could perhaps provide an opportunity to assess some of the duplication which occurs between the licensing process and the ACHS/ISO Accreditation process". The Association went on to assert that "a number of areas such as medical records, quality improvement programs, staff development … are extensively covered by ACHS" and argued that "there may

be merit (and cost saving for the PSLU) in reviewing the inspection guidelines in tandem with the ACHS requirements and removing some of the overlap".

190. The **Richmond Fellowship of Western Australia Incorporated** supported recommendation 24, but drew attention to the need for "the individuality of the service provided" to be taken into account. The Fellowship advanced by way of example the case of nursing homes and facilities for ageing or physically disabled people which "will need certain floor surfaces, grab rails etc" which "may not be the case with young non-physically disabled people". The Fellowship stressed the "need to balance quality of care, living in a 'normal' environment and duty of care".

191. The **Royal Australian Institute of Architects** strongly recommended that the Department "support a national approach to standards for health facilities and aged care facilities". The Institute supported the process outlined in recommendation 25 for the development of standards and offered "to be represented on the Standards Reference Committee to be established as part of this process".

Findings and Conclusions

192. These recommendations were almost universally supported during the public consultation process, although a number of refinements and suggestions were made which are worthy of inclusion.

193. In the first place, a number of respondents commented that the period available for public comment, reaction and input (originally set at 60 days) and the period made available for the Standards Reference Committees to assess and consider that public comment, reaction and input (originally set at 30 days) were too restrictive and too limited.

194. We are persuaded on basis of the arguments presented that the process would be enhanced without being unduly protracted if the periods set were 120 days and 60 days respectively.

195. We are similarly persuaded that the revision of the various standards which will follow adoption of our recommendations will provide a excellent opportunity to assess and eliminate some of the duplication and overlap which apparently occurs between the licensing process and the ACHS/ISO accreditation process, particularly in areas such as medical records, quality improvement programs, staff development etc.

196. Many other suggestions were made which fall more into the category of implementation issues than issues that go to the heart of the recommendation. These include appropriate membership of the Standards Reference Committees, and empowering the Standards Reference Committees to hear appeals relating to the appropriateness of the standard to their particular facility or the conclusions or actions of the Accredited Certifier or of the Licensing Unit.

197. We commend these suggestions to the Department for consideration during the implementation phase.

Recommendations

Recommendation 23: Formulation of Standards

23. That HDWA adopt as a principle the formulation of a three-tiered approach to the setting of standards for licensed health care facilities involving:

- **formal adoption of Building Code of Australia and/or Australian Standards Association standards (where available, and as amended from time to time);**
- **incorporation of Western Australian local government and statutory requirements (including fire and public health regulations, local authority building codes etc.); and**
- **augmentation of the above standards by the preparation and promulgation by HDWA of additional requirements only as strictly required to meet specific and otherwise unmet Western Australian and Departmental needs.**

Recommendation 24: Content of Standards

24. (a) That HDWA standards for each type of licensed care fully address requirements against which assessments can be made of the:

- **fitness and propriety of the applicant, including the sufficiency of the material and financial resources available to the applicant in terms of legislative requirements;**
- **suitability of the proposed premises for the designated purpose; and**
- **arrangements proposed for the satisfactory maintenance of appropriate clinical standards, and for the management, equipment and staffing of the facility.**

24. (a) That the revision of standards lead to the assessment and elimination of as much as possible of the duplication and overlap between the licensing process and the ACHS/ISO accreditation process, particularly in areas such as medical records, quality improvement programs, staff development etc.

Recommendation 25: Process for developing Standards

25. (a) That HDWA adopt the following formal process for the formulation, publication and revision of Standards:

- **Draft Standards, in accordance with the provisions of Recommendations 23 and 24, and draft revisions to existing Standards to be prepared by HDWA;**

- **the Draft Standards and draft revisions to be released and widely circulated for a period of 120 days during which industry and public comment, reaction and input can be obtained;**

- **industry and public comment, reaction and input received to be assessed and considered within 60 days by a formally constituted Standards Reference Committee representative of the Department, the relevant industry group, consumers and health care professionals;**

- **amended Standards and revisions to be prepared and endorsed by the Standards Reference Committee for submission to the Commissioner of Health;**

- **Standards and Revised Standards to come into effect only upon their formal authorisation by the Commissioner of Health and their publication by him.**

25. (b) That a Standards Reference Committee be established for each of the Aged Care, Hospital, Psychiatric Hostel, Day Surgery and Nursing Post area, and that, in determining membership of each Committee, the Department note:

- **the request by the Council of Official Visitors for representation on the Committee covering psychiatric hostels;**

- **the request by the Private Hospital Association of Western Australia for representation on the Committee covering hospitals;**

- **the offer of the Royal Australian Institute of Architects to be represented on appropriate Standards Reference Committees.**

25. (c) That each Standards Reference Committee be empowered to hear appeals relating to the appropriateness of the standard to services within its particular area or the conclusions or actions of an Accredited Certifier or of the Licensing Unit.

APPLICATION TO PUBLIC SECTOR

198. In the original Report, Recommendations 26 and 27 referred to the application of the proposed licensing framework to the public sector. These recommendations will now be reconsidered.

Original Recommendation 26: Application of Standards and licensing to public sector

> *That public sector health and aged care services be subject to the same standards and licensing arrangements and processes as apply to similar private sector services, and, in the case of services other than aged care services, that:*
>
> - *where a public sector facility is assessed as fully meeting the relevant Standard, a licence be granted for an appropriate duration;*
>
> - *where a public sector facility is assessed as not fully meeting the relevant Standard, a conditional licence be granted for an appropriate duration, with the licence being conditional upon agreement between HDWA and the licensee with respect to the adherence by the licensee to a program of corrective action to address the deficiencies identified in the Compliance Certificate provided by the accredited certifier.*

Original Recommendation 27: Budget restriction on public sector facilities holding conditional licence

> *That, where a public sector service is granted a conditional licence for an appropriate duration, that service have imposed upon it a budget restriction to the effect that an identified portion of each annual budget appropriation to that service be by way of a "tied-for-purpose" component, with the purpose being specified as action required to remedy over an agreed period the deficiencies identified in the Compliance Certificate provided by the accredited certifier.*

199. The **Metropolitan Health Service Board** saw the proposal as a "move toward equity by requiring public and private sector facilities to meet the same standards" and expressed the view that it agreed with the principle. Nonetheless, the Board expressed reservations about these recommendations. The Board asserted that "when the private sector performance matches that of the public sector, when they are the provider of last resort, when public hospitals transfer their most serious cases to their private sector equivalents, we will know that both sectors should be subjected to the same licensing requirements".

200. **Steens Gray & Kelly Pty Ltd** supported this recommendation, but saw "considerable difficulties" to be overcome in its implementation arising from the fact that, in rural Western Australia, "the devolution of responsibility to the region has drained remote areas of engineering expertise" so making "risk management and awareness of liabilities difficult". Steens believed "that to take remote area facilities up to the private sector standards and then manage them at that level will be very difficult and costly" but confessed that "no immediate solution comes to mind".

Findings and Conclusions

201. With some reservations, these recommendations received the support of most respondents during the public consultation process.

Recommendations

Recommendation 26: Application of Standards and licensing to public sector

26. That public sector health and aged care services be subject to the same standards and licensing arrangements and processes as apply to similar private sector services, and, in the case of services other than aged care services, that:

- **where a public sector facility is assessed as fully meeting the relevant Standard, a licence be granted for an appropriate duration;**

- **where a public sector facility is assessed as not fully meeting the relevant Standard, a conditional licence be granted for an appropriate duration, with the licence being conditional upon agreement between HDWA and the licensee with respect to the adherence by the licensee to a program of corrective action to address the deficiencies identified in the Compliance Certificate provided by the accredited certifier.**

Recommendation 27: Budget restriction on public sector facilities holding conditional licence

27. That, where a public sector service is granted a conditional licence for an appropriate duration, that service have imposed upon it a budget restriction to the effect that an identified portion of each annual budget appropriation to that service be by way of a "tied-for-purpose" component, with the purpose being specified as action required to remedy over an agreed period the deficiencies identified in the Compliance Certificate provided by the accredited certifier.

OTHER OPTIONS

202. In the original Report, Recommendations 28 to 30 and 32 referred to alternative approaches to the proposed new licensing framework. These recommendations will now be reconsidered.

Original Recommendation 28: Complete deregulation not a viable option

That complete deregulation of private health care provision by the removal of any legislative or regulatory requirement for State licensing be deemed an inappropriate response.

Original Recommendation 29: Supplementation of resources for existing activity not a viable option

That full supplementation of resources for existing activity be deemed an inappropriate response.

Original Recommendation 30: Full cost recovery not a viable option

That full cost recovery for existing activity be deemed an inappropriate response.

Original Recommendation 32: Contracting out and employee buy-out not viable options

That contracting out the current in-house processes and/or pursuit of a potential employee buy-out of current in-house activity be deemed inappropriate responses.

Findings and Conclusions

203. These recommendations were almost universally supported during the public consultation process.

Recommendations

Recommendation 28: Complete deregulation not a viable option

28. That complete deregulation of private health care provision by the removal of any legislative or regulatory requirement for State licensing be deemed an inappropriate response.

Recommendation 29: Supplementation of resources for existing activity not a viable option

29. That full supplementation of resources for existing activity be deemed an inappropriate response.

Recommendation 30: Full cost recovery not a viable option

30. That full cost recovery for existing activity be deemed an inappropriate response.

Recommendation 32: Contracting out and employee buy-out not viable options

32. That contracting out the current in-house processes and/or pursuit of a potential employee buy-out of current in-house activity be deemed inappropriate responses.

ADMINISTRATIVE CHARGE

204. In the original Report, Recommendation 31 referred to a proposed administration charge. This recommendation will now be reconsidered.

Original Recommendation 31: Administration Charge required

That there be implemented in the context of the adoption of our other recommendations the setting by regulation of an Administration Charge or fee of around $100 to be paid at the time any application for a new licence or for the renewal of an existing licence is submitted

205. The **Metropolitan Health Service Board** suggested that the Administration Charge be "somehow indexed to inflation", so "enabling … automatic escalation … to counter the effects of inflation".

Findings and Conclusions

206. While this recommendation was universally supported during the public consultation process, a suggestion was made (with which we concur) that the administration charge be indexed to inflation so enabling automatic escalation to counter the effects of inflation.

Recommendations

Recommendation 31: Administration Charge required

31. That there be implemented in the context of the adoption of our other recommendations the setting by regulation of an Administration Charge or fee of around $100 to be paid at the time any application for a new licence or for the renewal of an existing licence is submitted, and that the Administration Charge be indexed to inflation.

INSPECTIONS AND SANCTIONS

207. In the original Report, Recommendations 33 and 35 referred to random inspections and sanctions for non-compliance. These recommendations will now be reconsidered.

Original Recommendation 33: Random inspection program

> *That State licensing activity, based on professional certification, be supported by an on-going program of random inspection designed to ensure maximum reasonable coverage of the facilities and services licensed.*

Original Recommendation 35: Sanctions

> *That the relevant legislation be amended to ensure that the Western Australian licensing framework is supplemented with effective sanctions by way of withdrawal of licence or the imposition of an appropriate penalty for non-compliance with established standards, including specific sanctions, both remedial and punitive, against breaches of duty of care by Accredited Certifiers.*

208. The **Australian Association of Occupational Therapists** supported random inspections, seeing them as "ensuring (as part of an accreditation process) … continuous improvement".

209. **John Wilson Lodge** supported recommendation 35, advancing the view that "sanctions should apply where there has been wilful and continuous non-compliance with established standards". The Lodge argued that written notice of alleged non-compliance should be given before sanctions are considered.

210. The Lodge also drew attention to the practice of referring clients to unlicensed premises, asserting that "sanctions will apply to licensed hostels in the event that standards are not met while Health Department staff refer clients to unlicensed hostels … outside … the licensing system … which generally provide a much lower standard of accommodation with … minimum … or no personal care".

211. Addressing recommendation 33, the **Metropolitan Health Service Board** agreed that "the ability to randomly inspect would also assist in improving standards".

212. The **Private Hospital Association of Western Australia** supported recommendation 33, but suggested that "if access to either documentation or particular departmental staff are required, then a reasonable period of notice (48 hours) would be appreciated".

213. In discussing recommendation 33, the **Richmond Fellowship of Western Australia Incorporated** argued that, "whilst inspections can be seen a necessary measure of the standard of care being given, consideration of the residents must be" assured. The Fellowship drew attention to "inspections being intrusive" and "not … tolerated … in private rental accommodation".

214. **Steens Gray & Kelly Pty Ltd** suggested, in relation to recommendation 33, that "inspections by personnel outside the accreditation process would have merit" in providing for "review of the accreditors" and could feed back into standard setting and policy development.

Findings and Conclusions

215. These recommendations were generally supported throughout the public consultation process, with some suggested improvements which we have adopted.

Recommendations

Recommendation 33: Random inspection program

33. That State licensing activity, based on professional certification, be supported by an on-going program of random but regular inspection designed to ensure maximum reasonable coverage of the facilities and services licensed, and to ensure that standards are adhered to.

Recommendation 35: Sanctions

35. That the relevant legislation be amended to ensure that the Western Australian licensing framework is supplemented with effective sanctions by way of withdrawal of licence or the imposition of an appropriate penalty for non-compliance with established standards, including:

- **specific penalties, both remedial and punitive, against breaches of duty of care by Accredited Certifiers;**

- **specific and significant daily penalties for operating unlicensed premises or for operating in breach of licence conditions.**

ADMINISTRATIVE ARRANGEMENTS

216. In the original Report, Recommendations 36 to 38 referred to the administrative arrangements proposed for the Department to manage the new framework. These recommendations will now be reconsidered.

Original Recommendation 36: Establishment of a Health and Aged Services Licensing Unit

> *That the PSLU, the F&A Branch and the TSU be abolished, and that there be established within the Finance and Resource Management Division of HDWA a Health and Aged Services Licensing Unit with a Standards Section of around five (5) personnel for development of formal standards on proprietors, services and facilities, and a License Administration Section of some four (4) personnel.*

Original Recommendation 37: Staffing the Health and Aged Services Licensing Unit

> *That all positions in the new Unit be filled after advertising within HDWA with careful attention being paid to the selection of the most appropriate person to manage the Unit, and that innovative staffing practices be adopted, including staffing some positions in the new Unit by way of short-term secondment from other parts of the state health system and from the private sector.*

Original Recommendation 38: Shared or Common Services Agency

> *That F&A Branch/TSU functions and staff not drawn into the new Health and Aged Services Licensing Unit should be considered for incorporation into the proposed shared services division or agency currently under consideration within HDWA.*

217. The **Corrigin District Hospital Board** expressed concern with "proposals … which recommended the abolishment of those Health Department internal divisions relating to Facilities and Assets, and Technical Services". The Board conveyed its "experience that these people have been of great benefit, especially in rural areas, when it comes down to guiding us, and developing strategies, to improve our resource levels" and expressed the view that "the knowledge they have of our assets and work flow patterns and standards will not be readily replaced".

218. The **Health Care Association of Western Australia Incorporated** made the point that "for rural and remote Health Care Units, the TSU provides a broad range of technical expertise encompassing such areas as fire and safety, sterilising services, medical imaging and relief personnel … and advice on training programmes where required". In the view of the Association, "without this assistance, many rural and remote Health Care Units would find it difficult to progress these technical issues" since the "expertise is not readily available in many rural areas".

219. The **Kununoppin Districts Health Service** stressed that "country areas have only limited expertise at their disposal, and consequently for specialised

technical advice and assistance they rely utterly on the Health Department". For this reason, the Service strongly opposed recommendation 36. This view was also expressed in identical terms by the **Mukinbudin Nursing Post**. The **Quairading District Hospital Board** conveyed its opposition to this recommendation for the same reasons, as did the **West Pilbara Health Service**.

220. The **Royal Australian Institute of Architects** commented that "over the years, an excellent source of knowledge and information has been developed in the HDWA Facilities & Assets Branch". The Institute expressed concern that that "the health care industry in WA may loose the considerable expertise built up in these field by the Health Department". The Institute believed that it is "essential that the knowledge and expertise built up over many years in HDWA is retained" and suggested that, "it may be viable to transfer this group (ie the Facilities and Assets Branch and the Technical Services Unit)to the Hospital Planning and Design Research Group currently under consideration for establishment at Curtin University".

221. The **Western Australian Rural Directors of Nursing and Health Service Managers Association** expressed "great concern" with respect to recommendation 36, arguing that "the expertise contained within this unit will be lost to the rural and remote sector if the unit is abolished".

Findings and Conclusions

222. While the recommendations relating to the establishment and staffing of a Health and Aged Services Licensing Unit were supported during the public consultation process, serious reservations and concerns were expressed, principally by the non-metropolitan health sector and by the Royal Australian Institute of Architects relating to the proposal in the original recommendations to abolish the Facilities and Assets Branch and the Technical Services Unit.

223. It was put to us, and we concede the strength of the argument, that the Facilities and Assets Branch and the Technical Services Unit provide a broad range of technical expertise encompassing such areas as fire and safety, sterilising services, medical imaging etc, and that it would be undesirable for the health sector in Western Australia to lose the considerable expertise built up in these fields.

224. We accept, therefore, that whether this expertise and these specialist skills are retained within the department or within a possible shared or common services agency, they should be retained within the health system so that they continue to be made available to all sectors of that system, particularly in rural and non-metropolitan Western Australia.

225. We have therefore amended our original recommendations to take account of these legitimate concerns and appropriate representations.

Recommendations

Recommendation 36: Establishment of a Health and Aged Services Licensing Unit

36. That there be established within the Finance and Resource Management Division of HDWA a Health and Aged Services Licensing Unit with an appropriately staffed Standards Section for development of formal standards on proprietors, services and facilities, and an appropriately staffed License Administration Section.

Recommendation 37: Staffing the Health and Aged Services Licensing Unit

37. That all positions in the new Unit be filled after advertising within HDWA with careful attention being paid to the selection of the most appropriate person to manage the Unit, and that innovative staffing practices be adopted, including staffing some positions in the new Unit by way of short-term secondment from other parts of the state health system and from the private sector.

Recommendation 38: Shared or Common Services Agency

38. That F&A Branch/TSU functions and staff not drawn into the new Health and Aged Services Licensing Unit be considered for incorporation into the proposed shared services division or agency currently under consideration within HDWA.

REVISED RECOMMENDATIONS

226. We therefore recommend that Recommendations 7 to 38 in the original Report be replaced by the following Recommendations:

Standards for psychiatric hostels, day surgeries, nursing posts

7. (a) That, as a matter of urgency, the standards required of proprietors, of facilities, and of care for psychiatric hostels, for day surgeries, and for nursing posts be developed and adequately documented.

7. (b) That the definitions of day surgeries and nursing posts contained in the *Hospitals and Health Services Act 1927* be revised in consultation with health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a day surgery or nursing post requiring licence.

7. (c) That relevant recommendations apply to all psychiatric hostels, irrespective of whether they are classified as private (for profit) non-Government (not for profit), public sector, or private sector institutions.

7. (d) That the development of new, contemporary standards against which psychiatric hostels, day surgeries, and nursing posts are to be licensed in future take account of the fundamental shift away from hospital-based, institutionalised care, particularly in the case of psychiatric care, and that the new standards to be developed embrace this paradigm shift and reflect the nature and purpose of contemporary psychiatric hostels, day surgeries, and nursing posts.

7. (e) That separate standards covering proprietors, facilities and care be developed for psychiatric hostels, for day surgeries, and for nursing posts, and that these three sets of standards reflect the roles and responsibilities of each of these three very separate services.

7. (f) That in implementation of the new standards for psychiatric hostels, for day surgeries, and for nursing posts, a reasonable transition period be agreed to allow hostels, day surgeries, and nursing posts an appropriate timeframe within which to comply with the new standards, and that the conditional licensing framework referred to elsewhere in this report be utilised in order to foster the progress of psychiatric hostels, of day surgeries, and of nursing posts towards their newly defined standards.

7. (g) That once the new standards and licensing framework for psychiatric hostels are in place, the Department and Government Health agencies refer clients only to licensed hostels, actively discouraging clients away from unlicensed premises.

7. (h) That the new standards to be developed for psychiatric hostels incorporate the principles set out in the National Standards for Mental Health Services under the National Mental Health Strategy.

7. (i) **That the new standards for psychiatric hostels encompass psychiatric/psychological treatment centres and crisis/respite/interim care centres which provide accommodation and care, as well as psychiatric hostels.**

7. (j) **That the offer by the Education Department of Western Australia to participate in any working parties which might be established to address youth health issues or to examine the services provided for youth be noted and addressed by the Mental Health Division.**

7. (k) **That the ageing of residents in psychiatric hostels, the availability of nursing care to residents in psychiatric hostels, and the need to ensure the availability of nursing homes for elderly sufferers of mental illness be addressed by the Mental Health Division.**

7. (l) **That the Mental Health Division address the availability of dementia-specific care available in Western Australia.**

7. (m) **That, in establishing the necessary processes for the development of new standards for psychiatric hostels, for day surgeries, and for nursing posts, the Department take into account wherever possible the suggestions and advice offered during the public consultation process and summarised above, especially:**

(i) **the offer by the Council of Official Visitors to participate in the development of standards for psychiatric hostels;**

(ii) **the nomination of the Australian Day Surgery Council and the Australian Day Surgery Nurses Association to participate in the development of standards for day surgeries;**

(iii) **the suggestion that the Australian Council on Healthcare Standards be commissioned to assist in the development of standards for psychiatric hostels, for day surgeries, and for nursing posts;**

(iv) **the request that the Private Hospitals Association of Western Australia participate in establishing new standards, especially for private hospitals;**

(vii) **the suggestion that standards for psychiatric hostels, for day surgeries, and for nursing posts comply with the Disability Services Acts (Western Australia and Commonwealth) and with the standards developed as a result of those Acts;**

(viii) **the proposal that the work done in NSW relating to classes of day surgery be examined with a view to adapting it for use in Western Australia.**

Duration of licences

8. (a) That, depending upon the quality of each facility and the care provided, and upon the level to which it complies with the relevant published standards, the duration of each licence granted vary so that one-year, two-year or three-year licences are granted, and that, pending any necessary amendments to State legislation to give effect to this recommendation, the Commissioner of Health grant automatic annual renewal of each licence issued throughout the currency of the relevant approved licence period.

8. (b) That, subject to their compliance with other requirements of the licensing framework, a three-year period of licence normally be granted to hospitals accredited with ISO/ACHS.

Date of renewal of licences

9. That each licence granted become subject to renewal upon the relevant anniversary of its initial granting, and that appropriate records and data-bases be developed and maintained by HDWA to ensure adequate advance notification to licence-holders to enable them and the Department to undertake all steps necessary to facilitate re-licensing prior to the expiry of a licence.

Conditional Licences

10. That relevant legislation be amended to enable the granting by the Commissioner of Health of conditional licences where a particular facility does not completely meet the required published standards, but where the level of non-compliance is not sufficient to warrant outright refusal to grant a licence (in the case of new facility applications) or withdrawal of licence (in the case of applications for re-licensing).

Duration and scope of Conditional Licence

11. That the legislation provide that conditional licences have a maximum duration of one year (during which remedial work required to enable the facility completely to meet the required published standards must be completed), that a conditional licence may be renewed as a conditional licence if remedial work is required, and that the conditional licence specify the particular deficiencies required to be corrected.

Definition of psychiatric hostels

12. That the definition of a psychiatric hostel contained in the *Hospitals and Health Services Act 1927* be revised by the Mental Health Division in consultation with mental health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a psychiatric hostel requiring licence.

Role of Chief Psychiatrist

13. That, in determining whether or not to grant a licence with respect to a psychiatric hostel, the Commissioner of Health take into account not only the recommendations of the HDWA unit responsible for licensing matters, but also the conclusions and recommendations contained in a written report required to be submitted by the Chief Psychiatrist (utilising input from a range of appropriate allied disciplines and from the Council of Official Visitors), and that this requirement be included in future legislative amendment.

Transfer of certain functions to Mental Health Division

14. (a) That all functions currently undertaken by the PSLU and related units within the Finance and Resource Management Division with respect to the administration, payment, monitoring and recording of subsidy payable to psychiatric hostels be transferred immediately to the Mental Health Division.

14. (b) That issues relating to the method of calculation of subsidies for psychiatric hostels and suggested changes to current policy with respect thereto be discussed between the Mental Health Division and the psychiatric hostel sector.

Financial viability of the proprietor

15. That future applicants for new licences (in every case) and that applicants for renewal of licences (after a change of ownership) be required to submit with their application a clear authorisation to enable HDWA, at the applicant's expense, to commission Dun and Bradstreet (or a similar company of repute) to prepare and submit to the Commissioner a report on the sufficiency of the material and financial resources available to the applicant to comply with the requirements of this Act.

Proprietor appropriateness

16. That the authorisation enable Dun and Bradstreet (or a similar company of repute), at the applicant's expense, to attest to the fact that the applicant has attained the age of 18 years, and (by reference to criminal and police records) to offer a view on whether the applicant is a person of good character and repute and a fit and proper person to conduct a private health care facility.

Industry and community esteem

17. That the report submitted by Dun and Bradstreet (or a similar company of repute), at the applicant's expense, include in relation to the applicant, written references provided by members of the community, health care professionals, and representatives of the industry into which the new applicant desires entry or in which the renewal applicant desires to remain,

except that, in the case of private hospitals, ACHS or ISO accreditation be deemed to provide full compliance with this requirement.

Patient/resident/carer/staff consultation

18. That, in relation to applications for licence renewal, each application be required to provide evidence that the views of patients and/or residents and/or carers and/or family members and/or staff have been sought in relation to the standard of care received and service offered, except that, in the case of private hospitals, ACHS or ISO accreditation be deemed to provide full compliance with this requirement.

Legislative Amendments

19. That the various legislative enactments governing licensing be revised and amended to support the recommendations made in this Report, and (inter alia) to address the following issues:

- **clarification of the definitions of the types of services requiring licensing: hospitals, aged care facilities, day surgeries, nursing posts, psychiatric hostels etc.;**
- **introduction of differential licence periods to reflect varying standards of facilities and service;**
- **formalisation of conditional licensing as an improvement mechanism;**
- **making more explicit the option of revocation of licence for non-compliance with licence conditions;**
- **removal of the "pro forma" nature of licence renewal;**
- **entrenchment and definition of standards as a benchmark in licensing;**
- **inclusion of discretionary elements to enable the legislation to cope with structural/cultural change (eg. "aging-in-place" in aged hostels);**
- **application of meaningful penalties for non-compliance.**

Facility Standards

20. (a) That a better balance be struck between public sector licensing and private sector service provision with a more appropriate allocation and acceptance of risk and cost, and that this balance be achieved by adopting a framework for licensing (except in the aged care area) which requires:

- **future applicants for new licences (in every case) and applicants for renewal of licences (when, at intervals of not less than seven years, they are required so to do by the Commissioner) to be required to**

submit with their application for a licence a Compliance Certificate submitted under affidavit by an architect and/or an engineer (the Accredited Certifier) of the applicant's choice;

- **the Accredited Certifier to be professionally registered in Western Australia (with the professional registration number identified on the certificate);**

- **the Accredited Certifier to be accredited by HDWA (with the accreditation number identified on the certificate);**

- **the Accredited Certifier to be the holder of appropriate professional indemnity insurance (with the company and policy number identified on the certificate);**

- **the Accredited Certifier not to have a direct or indirect financial interest in the building or in any body associated with the building (with a statement to this effect to be explicitly made on the certificate);**

- **the Compliance Certificate to assert that the Accredited Certifier has read and understood the officially published standards relevant to the facility for which a licence or licence renewal is sought;**

- **the certificate to confirm either:**

  - **that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility; or**

  - **that the facility for which the licence or licence renewal is sought does not fully meets the officially published standards relevant to the facility, in which case the certificate is to specify in precise terms those elements of the officially published standards relevant to the facility which are not met and provide a program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.**

20. (b) That the Royal Australian Institute of Architects be invited to organise training courses to ensure that prospective Accredited Certifiers have the necessary knowledge and skills.

<u>Assessment of certificate and grant of licence</u>

21. That, on the basis of the certificate submitted, HDWA assess the application and

- **where the certificate confirms that the facility for which the licence or licence renewal is sought fully meets the officially published standards**

relevant to the facility, considers whether or not to grant a full licence for the relevant period; or

- **where the certificate confirms that the facility for which the licence or licence renewal is sought does not fully meet the officially published standards relevant to the facility, considers whether or not to grant a conditional licence for the relevant period, taking into account the submitted program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.**

Role of Executive Director Public Health

22. That the Executive Director Public Health become more involved with the licensing process through on-going discussion and consultation with local government authorities and, as a last resort, by using his/her powers under the Health Act 1911 to make orders binding the local authority to act to ensure that health inspectors undertake regular inspections of licensed health and aged care institutions in Western Australia.

Formulation of Standards

23. That HDWA adopt as a principle the formulation of a three-tiered approach to the setting of standards for licensed health care facilities involving:

- **formal adoption of Building Code of Australia and/or Australian Standards Association standards (where available, and as amended from time to time);**

- **incorporation of Western Australian local government and statutory requirements (including fire and public health regulations, local authority building codes etc.); and**

- **augmentation of the above standards by the preparation and promulgation by HDWA of additional requirements only as strictly required to meet specific and otherwise unmet Western Australian and Departmental needs.**

Content of Standards

24. (a) That HDWA standards for each type of licensed care fully address requirements against which assessments can be made of the:

- **fitness and propriety of the applicant, including the sufficiency of the material and financial resources available to the applicant in terms of legislative requirements;**

- **suitability of the proposed premises for the designated purpose; and**

- **arrangements proposed for the satisfactory maintenance of appropriate clinical standards, and for the management, equipment and staffing of the facility.**

24. (a) That the revision of standards lead to the assessment and elimination of as much as possible of the duplication and overlap between the licensing process and the ACHS/ISO accreditation process, particularly in areas such as medical records, quality improvement programs, staff development etc.

<u>Process for developing Standards</u>

25. (a) That HDWA adopt the following formal process for the formulation, publication and revision of Standards:

- **Draft Standards, in accordance with the provisions of Recommendations 23 and 24, and draft revisions to existing Standards to be prepared by HDWA;**

- **the Draft Standards and draft revisions to be released and widely circulated for a period of 120 days during which industry and public comment, reaction and input can be obtained;**

- **industry and public comment, reaction and input received to be assessed and considered within 60 days by a formally constituted Standards Reference Committee representative of the Department, the relevant industry group, consumers and health care professionals;**

- **amended Standards and revisions to be prepared and endorsed by the Standards Reference Committee for submission to the Commissioner of Health;**

- **Standards and Revised Standards to come into effect only upon their formal authorisation by the Commissioner of Health and their publication by him.**

25. (b) That a Standards Reference Committee be established for each of the Aged Care, Hospital, Psychiatric Hostel, Day Surgery and Nursing Post area, and that, in determining membership of each Committee, the Department note:

- **the request by the Council of Official Visitors for representation on the Committee covering psychiatric hostels;**

- **the request by the Private Hospital Association of Western Australia for representation on the Committee covering hospitals;**

- **the offer of the Royal Australian Institute of Architects to be represented on appropriate Standards Reference Committees.**

25. (c) That each Standards Reference Committee be empowered to hear appeals relating to the appropriateness of the standard to services within its particular area or the conclusions or actions of an Accredited Certifier or of the Licensing Unit.

Application of Standards and licensing to public sector

26. That public sector health and aged care services be subject to the same standards and licensing arrangements and processes as apply to similar private sector services, and, in the case of services other than aged care services, that:

- **where a public sector facility is assessed as fully meeting the relevant Standard, a licence be granted for an appropriate duration;**

- **where a public sector facility is assessed as not fully meeting the relevant Standard, a conditional licence be granted for an appropriate duration, with the licence being conditional upon agreement between HDWA and the licensee with respect to the adherence by the licensee to a program of corrective action to address the deficiencies identified in the Compliance Certificate provided by the accredited certifier.**

Budget restriction on public sector facilities holding conditional licence

27. That, where a public sector service is granted a conditional licence for an appropriate duration, that service have imposed upon it a budget restriction to the effect that an identified portion of each annual budget appropriation to that service be by way of a "tied-for-purpose" component, with the purpose being specified as action required to remedy over an agreed period the deficiencies identified in the Compliance Certificate provided by the accredited certifier.

Complete deregulation not a viable option

28. That complete deregulation of private health care provision by the removal of any legislative or regulatory requirement for State licensing be deemed an inappropriate response.

Supplementation of resources for existing activity not a viable option

29. That full supplementation of resources for existing activity be deemed an inappropriate response.

Full cost recovery not a viable option

30. That full cost recovery for existing activity be deemed an inappropriate response.

Administration Charge required

31. That there be implemented in the context of the adoption of our other recommendations the setting by regulation of an Administration Charge or fee of around $100 to be paid at the time any application for a new licence or for the renewal of an existing licence is submitted, and that the Administration Charge be indexed to inflation.

Contracting out and employee buy-out not viable options

32. That contracting out the current in-house processes and/or pursuit of a potential employee buy-out of current in-house activity be deemed inappropriate responses.

Random inspection program

33. That State licensing activity, based on professional certification, be supported by an on-going program of random but regular inspection designed to ensure maximum reasonable coverage of the facilities and services licensed, and to ensure that standards are adhered to.

Accreditation

34 (a) That any professionally registered architect or engineer be entitled to seek accreditation from the Commissioner of Health as an Accredited Certifier.

34 (b) That accreditation with the Department consist simply of lodging with the accreditation authority details of name, contact details, professional registration number, and professional registration expiry date, together with such other information as the Department might, from time to time, require.

34 (c) That the process of managing the accreditation process not be managed by the HDWA licensing area, but that the Royal Australian Institute of Architects be invited to manage the accreditation process on behalf of the Department.

Sanctions

35. That the relevant legislation be amended to ensure that the Western Australian licensing framework is supplemented with effective sanctions by way of withdrawal of licence or the imposition of an appropriate penalty for non-compliance with established standards, including:

- **specific penalties, both remedial and punitive, against breaches of duty of care by Accredited Certifiers;**
- **specific and significant daily penalties for operating unlicensed premises or for operating in breach of licence conditions.**

Establishment of a Health and Aged Services Licensing Unit

36. That there be established within the Finance and Resource Management Division of HDWA a Health and Aged Services Licensing Unit with an appropriately staffed Standards Section for development of formal standards on proprietors, services and facilities, and an appropriately staffed License Administration Section.

Staffing the Health and Aged Services Licensing Unit

37. That all positions in the new Unit be filled after advertising within HDWA with careful attention being paid to the selection of the most appropriate person to manage the Unit, and that innovative staffing practices be adopted, including staffing some positions in the new Unit by way of short-term secondment from other parts of the state health system and from the private sector.

Shared or Common Services Agency

38. That Facilities and Assets Branch and Technical Services Unit functions and staff not drawn into the new Health and Aged Services Licensing Unit be considered for incorporation into the proposed shared services division or agency currently under consideration within HDWA.