Transcript

Department of Health and Aged Care

Quarterly Financial Report (QFR) Webinar:

Updates and Q&A

**Presented by:**

**moderator:**

Jessica Evans

Assistant Secretary, Structural Adjustment Strategy

**Panellists:**

Peter Edwards   
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Nicki Phelan  
Director, Financial Monitoring and Analysis

Grant Corderoy  
Senior Partner, StewartBrown

Joshua Maldon  
Assistant Secretary, Choice and Transparency

[*Opening visual of slide with text saying ‘Ageing and Aged Care’, ‘Australian Government with Crest (logo)’, ‘Department of Health and Aged Care’, ‘Quarterly Financial Report (QFR) Webinar:’, ‘Updates and Q&A’, ‘Department of Health and Aged Care’, ‘Please note that this webinar will be recorded’, ‘health.gov.au/aged-care-reforms’*]

[The visuals during this webinar are of each speaker presenting in turn via video with reference to the content of a PowerPoint presentation being played on screen, with Auslan interpreter signing on screen]

**Jessica Evans:**

Hi everyone and welcome to today’s webinar on financial reporting. I can see a number of people are still joining but I will kick off the session as there is a lot to cover today.

Firstly I’d like to acknowledge the traditional owners of the lands on which we meet. For me it is the Ngunnawal people. And I’d like to pay my respects to Elders past, present and emerging. I’d also like to extend that acknowledgment and respect to any Aboriginal and Torres Strait Islander people on the call with us today.

My name is Jessica Evans and I’m the Assistant Secretary of the Structural Adjustment Strategy Branch in the Department of Health. I’m joined today by colleagues from both the Aged Care Quality and Safety Commission as well as the Department. I have Peter Edwards who’s the Executive Director of Financial and Prudential Regulation from the Aged Care Quality and Safety Commission, I have Nicky Phelan, the Director of the Financial Monitoring and Engagement Program within the Department, and Joshua Maldon, the Assistant Secretary of the Choice and Transparency Branch. I’d also like to welcome Grant Corderoy from StewartBrown. Grant is senior partner in StewartBrown and will be taking us through the technical detail on the completion of both the labour costs and hours worked which is a component of the Quarterly Financial Report.

Today’s webinar is primarily focused on the new Quarterly Financial Report and we’re aiming to give practical information to providers on how they can go about completing the QFR. We’re also going to try and address a lot of the questions that came in after our last webinar to try and help make the reporting process as easy as possible. I’ll also give some high level comments on changes that are being made to this year’s Annual Report as well as some other transparency requirements around the publication of the General Purpose Financial Reports.

If you have any questions throughout please submit them to the Q&A which you should have down on the right hand side of your screen, a little question mark or a Q&A function. I’ll put those to the panel as we speak and try and get through as many as we can. The webinar is also being recorded and will be made available on the forms administration website and I’d also like to point out that the website currently contains frequently asked questions that were submitted at the last webinar. I think there are about 30 pages to that covering all sorts of topics. So I encourage you to take a look at that when completing or thinking about the QFR.

If we could go to the next slide.

Sorry. We’ll move to the next one.

So the Quarterly Financial Report is a new requirement and the template for the report was shared with the sector in May this year following several months of consultation. The form itself is now available on the forms administration website and it includes four parts. It includes viability and prudential compliance questions, a quarterly financial statement, a report on labour costs and hours and a food and nutrition report. And we’ll go through each of these topics in detail today.

One question that we have received quite commonly over the last few months is which providers need to complete which sections of the Quarterly Financial Report. So before I go on the viability and prudential questions will apply to residential and home care providers and there are specific questions for each provider type. This will not include CHSP, Government, MPS or NATSIFAC providers. The section on quarterly financial statements apply to all approved providers. If your organisation only provides residential or home care you need to complete the section of the quarterly financial statement that applies to the services you deliver.

If your organisation delivers multiple types of care you’ll need to complete the sections of the quarterly financial statement that are relevant to your organisation. So that would be across community, retirement, home care or residential care. If your service only delivers CHSP you do not need to complete the report of the quarterly financial statement.

The section on labour costs and hours, all residential and home care providers must complete this section at a facility level. CHSP, MPS and NATSIFAC providers do not need to complete this section for the first report. In relation to food and nutrition this is residential providers only and this includes MPS and NATSIFAC.

The other question we receive a lot of the time is who needs to sign off on this report. So the report needs to be signed by a Director or a member of the provider’s governing body but it does not need to be audited. Next slide please.

So the purpose of the QFR is a range of things. It’s about financial oversight and access to more timely information. It will help with choice and transparency as much of the information will be reported through star ratings. It will help with policy development and funding decisions and will also help with the monitoring of prudential and quality standards. Next slide.

The first quarterly report will be due on the 4th of November 2022 and then each quarter after that with the timeframes shown on the screen. There is an extended timeframe to allow for the Christmas reporting period. And I’d just like to note that timeframes particularly for the first quarter, although and every quarter after that, are critical for star ratings as it will use information submitted in relation to care minutes which will be published as part of star ratings. And any provider that doesn’t submit a Quarterly Financial Report on time will not be able to then have its star ratings published.

Before getting into the QFR I’ll just really quickly touch on the changes to the Annual Financial Report. For residential aged care providers the changes to this year’s ACFR which is due on the 31st of October will be minor and they will be made to align both the ACFR with the QFR. Sorry about all of the acronyms. In particular this will be about making the annual report capture hours worked rather than paid hours to be consistent with the quarterly report. We’ll also seek additional information on the care that is delivered by agency staff by employee type which is also consistent with the quarterly report.

For home care providers there are more significant changes being made to the annual report and this is being discussed with home care providers at various webinars over the last six months. Broadly home care providers will need to submit an approved provider income statement, balance sheet and cashflow statement which is consistent with what residential aged care providers currently report. There will be a consolidated parent entity segment report for home care and home care providers will also report on direct care and contracted services, labour costs and hours and labour costs and hours delivered for care management and administration.

Next slide.

So both the QFR and the ACFR will be reported through the forms administration page which providers will be familiar with. Information is already on the website including the template for both forms, definitions and frequently asked questions. We expect the portal for the QFR will open on 1 October but we will email all providers once the form is open and we will have Helpdesk arrangements in place. Forms administration will assist with the reporting of the QFR and the ACFR but if there are technical questions or accounting type questions on the completion of the labour costs and hours StewartBrown will be providing that function and we’ll have contact details available at the end of this presentation. Next slide.

So the key changes – and I’ve received this question a few times. No. Sorry. I covered that. They are the changes that are being made for the ACFR, for both residential and home care. So I just covered that earlier. Next slide.

And again.

Excellent. So finally before we go into the detail of the QFR you will have heard at previous webinars that the Government is also introducing a requirement for providers to publish their general purpose financial report on their website or if they don’t have a website on a website that is publicly accessible. The first report will be due five months after the approved provider’s financial year and for the majority of providers this will be November and it will give the provider one month to publish its report after the ACFR is due.

So that is it for me. I’ll take questions, general questions at the end of the presentation. I would just like to hand to Peter Edwards from the Commission. At our last webinar we received a few questions on how the report will be used in terms of compliance and what actions will be taken by the Commission so I’ve asked Peter to come and address this with everyone directly. Peter over to you.

[*Visual of slide with text saying ‘Aged Care Quality and Safety Commission’, ‘Quarterly Financial Reporting’, ‘How we will use information lodged’, ‘How we will support compliance with the reporting obligation’, ‘Peter Edwards’, ‘Executive Director – Finance & Prudential Regulation’, ‘Aged Care Quality & Safety Commission’*]

**Peter Edwards:**

Thank you. Thanks Jess. And look thanks for the opportunity to come along and speak on behalf of the Commission. I’ll just briefly cover off on two things. What our interest in the quarterly reporting is, but also how we will be working to support compliance. So we’ll just move to the next slide.

So at the beginning of 2020 the Commission became responsible for the prudential compliance function when that function transferred across to the Commission from the Department. Over the next 12 months we will also take on a slightly greater role in monitoring some elements of financial viability given the risks that poses to accessibility, continuity of care and some elements of quality of care.

So for us the quarterly reporting is quite important because regular and timely data is important in supporting the analytics that we undertake. We use the analytics to help us to effectively target those providers at greatest risk of potential non-compliance or where there may be emerging viability problems that may have the potential to cause quality and safety issues.

So for us that targeting is important because the earlier we can intervene the more options there usually are to support providers to avoid non-compliance as well as more options to move back into compliance. So prevention for us is always better than cure.

Probably the last thing I’d say on this slide is that better targeting also minimises the regulatory burden imposed on lower risk providers because we can see where the risks lay and focus on those providers that are at the greatest risk leaving other providers that have lower risks not necessarily having to be targeted by us.

So I’ll just move to the next slide. I’ll just speak briefly about our approach to compliance in this space. So as I mentioned getting this data is important to the Commission for the protection of consumers. We know that the preparation and lodgment process may be more challenging for some of you than others. That said we will need to actively monitor compliance with the lodgment timeframes as quarterly nature of the reporting brings with it the risk of periods starting to collapse into each other if that process is not appropriately managed. So we will be initially using informal procedures to remind and then caution providers about consequence of not lodging within the set timeframes however if that’s not effective in getting required action within a reasonable period we will need to escalate fairly quickly to form procedures to drive compliance where that’s necessary. Obviously our preference is that you’ll keep the reporting obligations and associated timeframes at front of mind. That way we can all save ourselves time and effort, us following up and you being followed up.

So I think that’s all I’ve really got to say because I’m just very conscious there’s a lot to get through today and I’m sure you’ll want to engage and have some questions perhaps at the end regarding my bit. So back to you Jess.

**Jessica Evans:**

Thank you so much Peter. I think the questions that have come through actually do relate to how to publish or report on care minutes. So probably not one for you. There is a really quick question here Peter which is around given there’s no kind of care minute target for allied health – and I think it was in relation to a comment you made around monitoring the care minutes delivered by registered nurses, enrolled nurses and personal care workers, which I think is different as this person says. Allied health don’t have the care target. But I think your general message around kind of prudential quality and how the reports will be used still stands.

**Peter Edwards:**

Yeah. That’s correct.

**Jessica Evans:**

Excellent. Okay. Thanks Peter. I’m going to move through to Nicki Phelan who will talk through the first section of the reporting requirements which is what we’re referring to as the viability and prudential questions. Thanks Nicki.

[*Visual of slide with text saying ‘Part 1’, ‘Viability Questions (Residential and Homecare)’, ‘Purpose and context’, ‘Q&A’, ‘Nicki Phelan’, ‘Director’, ‘Market and Workforce Division, Aged Care Group’*]

**Nicki Phelan:**

Thank you Jess and thanks for the opportunity to speak to you all today. As Jess mentioned my name is Nicky Phelan and I’m the Director of the Financial Monitoring and Analysis Section within the Structural Adjustment Operations Branch and I’m delighted to be able to walk you through the next few worksheets in the Quarterly Financial Report which relate to viability.

Next slide please. So the purpose of the information that’s collected through the viability worksheet is to really help us identify providers that might be facing financial stress or to identify providers that could be facing emerging risks due to their business activities which could later lead to financial stress. The early identification of emerging risks enables the Department to proactively engage with providers and we like to work with them collaboratively and we help to support them to develop options that might be of benefit in addressing some of the financial risks that providers could face.

In terms of the questions that need to be answered there are three worksheets and you’re seeing the first worksheet on screen now. Providers with residential aged care services need to complete just this first worksheet based on their residential operations. There are 13 short questions that just require a yes or no answer. There are ten focus areas and they include questions on solvency, financial performance, liquidity levels, occupancy levels, RADs, the sale or purchase of a facility, business improvement advice, governance and management and recruitment and retention of staff as well as capital works.

If you answer yes to any of the questions there’s a column on the right hand side and we would appreciate any additional information that can be provided. These comments help us to understand whether you’re facing emerging risk or if the response is a normal and expected part of your business operations. In answering yes to some of these questions it does not mean that your organisation is necessarily facing financial risk.

Once the questions have been populated for the first quarter your responses will be saved and this means that you only need to make changes to your initial responses when your situation changes.

Next slide please.

The next two worksheets are to be completed by providers with home care operations. In the second worksheet which is on screen now there are ten short questions that require a yes or no answer and they’re across eight focus areas. The focus areas include questions on solvency, financial performance results, liquidity levels, the number of home care recipients, whether you’re planning to sell or purchase services, business improvement advice, governance and management as well as the recruitment and retention of staff.

If you answer yes to any of these questions we’d appreciate further information that can be put in the response column on the right hand side of the form. These additional comments again help us to understand whether your home care operations are potentially facing financial stress or if the response noted is a normal part and expected part of your business operations.

Next slide please.

There’s a second worksheet that needs to be completed by providers who deliver home care services and it focuses on the business structures that are used in delivering those operations.

Providers delivering home care packages are asked to identify the type of structures that are used to deliver these services to consumers and the percentage of those services that are provided through this type of structure. This information will help the Department to better understand the type of business structures that are used in delivering home care services to consumers.

Again once the questions have been populated for the first quarter your responses will be saved and this means that you only need to make changes to the initial responses provided when there’s a change in your circumstances.

Next slide please.

And I’m just looking to see if there’s any questions.

**Jessica Evans:**

Nicki, no. The questions that have come through all still appear to be about the calculation of labour costs and hours. So thank you for going through. And I know you’re on the line so if people do have questions about any of what you presented you’ll be here and we can go back to that. But otherwise I will keep moving through and go to Grant to talk about the Quarterly Financial Statement. Thank you.

[*Visual of slide with text saying ‘Part 2’, ‘Quarterly Financial Statements’, ‘Purpose and context’, ‘Q&A’, ‘Grant Corderoy’, ‘Senior Partner’, ‘StewartBrown’*]

**Grant Corderoy:**

Thank you Jessica and welcome everyone. Look obviously there’s a lot more work involved for some providers in doing this and we’ll certainly work our way through with you and through the Department in our technical section. For all questions that are specific to a provider or could need some working through please avail yourself of the opportunity of using the technical section, and we’re there to help work through.

So if we look at the next slide this first part of it on the next slide refers to the Quarterly Financial Statements which is at the approved provider level. So in the Aged Care Financial Report that’s at the parent entity level. This is just at the approved provider. So if you’re an organisation who has six approved providers as an example, each one for a different residential home, you’d be filling this out for each of the approved providers. And again it’s very consistent with what you do in your managed reporting or in your year end segment reporting. So effectively following the principles of AASB but doesn’t have to be entirely.

So again when we’re looking at it the residential segment should tie up with what’s in your detailed residential notes which we’ll come to in your income and expenditure statement. Similarly for home care if you’re also providing home care or for a home care specific provider it should tie up from both an income and expenditure point of view particularly with what’s in your home care individual income expenditure statements.

Community really includes anything except for home care packages. So in other words it includes CHSP, disability services, children’s services, and retirement is your independent living units, those sort of services, affordable housing, that are effectively under state-based tenancy type laws. And you can see that things like cash and cash in bank and equity you don’t need to disclose. Now of course accounting is not an exact science so where there’s got to be an allocation what we’re suggesting you use, what is reasonable and supportable, and keep a rationale of how you’ve done it. So for example we might get a particular facility that co‑exists as an independent living unit and a residential aged care and make an allocation for example on the property plant and equipment, the building cost or even the land cost based on the usage of that particular site. But again just use what’s reasonable and supportable. So have an allocation base. It might be based on the area occupied, it might be based on the number of residents, depending what you feel is an acceptable basis for doing it.

If we go to the next slide thanks.

And the next slide’s looking at the income and expenditure part. And again the format of this is fairly similar to your general purpose financial report where you have your income, your operating income and in a sense your non-operating income which can include impairment re-evaluations, reversals of impairments, fair value gains, other income, and then your expenses in the major categories going forward. So again same methodology almost exactly as in the Aged Care Financial Report.

Now the areas that talk about external lines of credit and fee ratios, this is more to assist both the Department and the Quality Commission that you heard from Peter where they’ll want to be doing a review. But again it’s not big brother looking down. It’s sort of saying if they’re feeling that the sector is going in a particular way or a provider might be having certain issues, it allows for an early discussion between the Department or the Quality Commission and the provider. So it’s actually really for the provider’s benefit but it’s also for the benefit to assess how is the sector going, what is the overall liquidity ratio of the sector, what is the capital adequacy, and what lines of credit are required. So it really helps us get an understanding of some of these financial fundamentals which are very important when we’re looking for the assessment of how the sector is going as well as individual providers.

Now if we could go to the next slide thanks and this is just a summary slide. I guess important and what I would point to on this particular slide is where it says why are we doing this. And I say it’s very much to support policy development considerations. Policy needs to be based on accurate figures, on accurate assessment of what’s going on. And in the past this has been very difficult. Now the Quarterly Financial Reports and the Aged Care Financial Reports allow the Department, the Quality Commission and importantly from 1 July next year the Independent Hospital and Aged Care Pricing Authority, to have significant information so they can design policy, review policy and of course in the Pricing Authority to see what the price, what the subsidy should be and recommend what the subsidy should be in all areas of providing care. So this is really of fundamental importance and a major contributor to that sort of information.

So again when we’re doing the reporting, the quarterly reporting or the annual reporting, consider what is reasonable and the basis for your particular home, the individual home or home care package, and what do you think is supportable and reasonable for the policymakers to get information that’s representative of how your organisation is performing. And I think if you ask those fundamental questions then we can get down to some of the more reasons for what’s happening from thereon.

So just before we go to the next slide are there any questions at this stage Jess?

**Jessica Evans:**

Yes there are Grant. Thank you for checking in. There are actually a couple in relation to residential aged care providers that are co-located and whether or not the financial information can be combined and submitted together or do they need to estimate a cost split. So that’s one. The other one is about facilities that co-locate and operate on the same site. So do you have some advice on that one for us or would you like us to take that question?

**Grant Corderoy:**

No. I have some advice. Again we’ll be touching on this when we look at the individual homes, but when you have a separate NAPS ID you have to report on that NAPS ID. So in other words you don’t combine them. You might be running it in a sense as a combined facility but you need to report it on a separate NAPS ID because when we’re looking at the funding and the basis of the funding or if there’s a viability assessment they’d have to do it based on the NAPS ID. So unfortunately where you have a combined home and you’ve got two NAPS IDs then we need to separate it and you need to again make it supportable how you’re allocating between one NAPS ID and the other NAPS ID.

**Jessica Evans:**

Thanks Grant. The other question is on how to allocate accounts payable out across this reporting statement?

**Grant Corderoy:**

Yeah. Look this is a good question and also could come down to your leave entitlements, that of your payroll system. I think you just have to use a basis that you think is correct. So in accounts payable I’d be looking at what are your total expenses and how much portion of the expenses relate to – putting payroll to one side, what are your expenses that would go through accounts payable, and then how many allocated to residential, coded to residential, how many go to home care, how many go to community services. So in other words I’d use the allocation based on the expenses that go through accounts payable. Similarly for payroll with leave entitlements, a similar basis. How much of the leave entitlements relate to employees who are coded to residential care or home care? So I’d be using that as the allocation. And again just leave a rationale. You don’t have to submit the rationale but in your workings for the quarterly reporting and the annual reporting leave a rationale of how you’ve come to that calculation that’s supportable. But again it will be based on what you feel is the right figure for your particular organisation.

**Jessica Evans:**

Excellent. And I think Grant there are other questions but I would say they again relate mostly to care minutes which you are likely to cover in the next section. So I’ll hold those over.

**Jessica Evans:**

All right. Thank you. So if we can go two slides hence.

*[Visual of slide with text saying ‘Part 3’, ‘Care Labour Costs and Hours’, ‘(Residential and Homecare)’, ‘’Purpose and context’, ‘Q&A’, ‘Grant Corderoy’, ‘Senior Partner’, ‘StewartBrown’]*

I think the next one after this.

Right. So this is now getting down to I guess the detail of going on. Now again I just sort of say to people the reason that we need to get this information is so that both the Independent Pricing Authority as well as the Department as well as the Quality Commission can really ascertain what are the costs of care, how care is being delivered and where the hours and the minutes are in the care. So that’s the basis for doing it. It does obviously move into your star rating to see what care you’re having and your transparency. And transparency is a very important area for I guess the public and the providers to be working together to improve the understanding of how care is delivered. And that’s the basic rationale.

So when we go down to this section – and this section is similar again to the expanded Aged Care Financial Report. Now I might add that providers that are in the StewartBrown survey, this section will automatically be part of the survey and will come across into the Quarterly Financial Report. We’re attempting as far as possible, the Department and ourselves, to minimise additional costs of doing it. So rather than duplicating it we’ll be able to make it automatic. But as a general view you can see the top is your labour costs. Now your labour costs are effectively the full costs of employing a staff member at the staff member level. So in other words it includes their normal pay, any overtime pay, their leave loadings, RDOs, sick type pay, any of those areas, penalties, your shift penalties and allowances, superannuation of course, and any fringe benefits that you pay on their behalf, and termination pay. So it’s the cost of employing at the staff level and therefore it includes the general costs of employment which are payroll tax, workers’ compensation premiums, staff training, which aren’t specifically to an employee. And so that’s a fairly normal way of doing it but most providers would be doing that anyway and as part of their general purpose financial reports. But this is obviously giving more detail in that area.

Now of course care management is the facility manager and there will be examples under registered nurses, enrolled nurses and personal care workers where there’s going to be an allocation where they might be performing direct care services and other services that aren’t related to direct care. So care manager is a good example. When they’re performing services which could be specific to providing of care which could include care plans and the like that’s very much where they’ve reallocated to care management and to registered nurses. But if they’re providing care like rostering and facility management and those areas that aren’t specifically related even though they are related to the overall provision of care, but specifically related to a resident’s care, then obviously they can’t be included in that category. Similarly for a home model where you might get a personal care worker who also performs catering as far as the delivery of food and the servicing of food. You’ve got to look at an allocation of what’s their normal hours’ time that they spend percentage wise performing one function or the other.

Now again when we look at agency costs – and this is going to have to be a little bit of a change for both allied health and agency – I think the definition of agency will be clearly if they’re not on the payroll. So for example you might have a contractor, a personal contractor who’s got an ABN, and if they’re paid on the payroll, keep them as labour costs. But if they’re a person that you pay through the accounts payable system or any of your other approved suppliers, agency suppliers through your accounts payable system, then obviously they come under the area of agency costs. So we need to now work with our specific agents to get the dissection of both the dollars by registered nurses, enrolled nurses and personal care workers and allied health, as well as the hours or minutes that they’re working. So that will require some more work to be done with your providers and I think it’s a matter of saying to those providers that this is the basis that funding decisions can be made and operational decisions can be made so it’s very much that they’ll have to abide by that sort of area.

Now the last line there is an interesting one called contract labour management entity staff costs. So this is those providers who may have a separate entity be it related or unrelated that provides staffing services. In other words they pay a management fee for those services. Now if that’s the case and they’ve got direct care dollars and hours included in there it’s really important that you allocate that portion to the very segments. For example if you had no dollars, or in fact no minutes, and you put it all under the bottom line item that would really distort your minutes and really distort your dollars. So you’ll have to in a sense allocate from your management service fees, allocate it individually to those other line items and then the balance when you’re paying from other staff costs, that could be care management or they could be lifestyle or something unrelated, then you’ll obviously leave the balance there. If we go to the next slide thank you.

So the next slide when we’re looking here is now getting down to the labour hours and some of the really key questions. Now again approach it by saying what is representative of your own home, residential home – and you might have many homes in the organisation but of each home – and what do you feel is representative for the Quality Commission, the Independent Pricing Authority, the Department to be able to see how aggregate homes are going, which is very important when we’re looking at the funding coming forward.

So the very first critical one is we’ve got to look at staff hours worked as distinct from staff hours paid. So for example what’s the difference is that staff hours paid will include when I’m on leave, be it sick leave or annual leave or long service leave or an RDO. It might be staff training. Staff hours worked I guess is an easy way of saying when the staff has an interface with the residents. In other words they’re working on the floor in an aged care home and they could be working for the direct care delivery not necessarily in the same room as each resident but they’re there to interface with the resident. So it’s where they’re physically I guess at a facility.

So the easiest way to get the staff hours worked if you can is from the roster because the roster should identify what hours have been worked under what category is being worked. If you can’t get it from the roster the payroll system is a secondary way of doing it or you might want to cross check. And the payroll system again is very good in the sense that it will give you the hours but make certain that you exclude the non-worked hours, in other words the paid hours that relate to your days off, RDOs or annual leave etcetera. Those hours are not to be included. Now of course overtime hours if they’re worked on the shift are absolutely to be included. So that’s the big area to be clear, be distinctive between hours worked and hours paid. And we need to know what the hours worked are when we’re looking at our staffing hours and staffing minutes.

Now the shift is always going to be an interesting one. Why is the shift being put into the Quarterly Financial Report? This is to see (a) what the coverage of registered nurses are by a shift and (b) in relation to the 24/7 RN hours that’s going to be coming in effectively from 1 July next year. And again there may be some exemptions to that but we need to look at that on a case by case. So what the shift is, we need to get an idea of what’s your normal shift that an RN is working. Remember the shift is only in relation to your registered nurse. So what shifts are they working. Now it could be a morning, an afternoon, an evening shift. You’re going to have examples where they might cross over shifts. So again use your methodology. Be consistent with it. If they cross over shifts you might say it’s the main shift that they’re working on. Let’s say they were working from 11:00am to 6:00pm as an example. That might be a crossover. So what’s the main shift that they’re working on? Or if it is an actual that they’re working on half morning and half afternoon then allocate it that way. But the result still would be looking at what is the main shift that they’re working on when you’re looking at the allocation of the shifts, and again see that it looked reasonable when you’ve completed it, it looked reasonable to the coverage of RNs that you’d expect in your particular home. I think that’s an important one.

And similarly you need to do exactly the same rationale for your agency staff and that’s going to be very important, that we’re treating from a point of view of your hours and minutes – we treat agency as well as your direct staff that you’re employing as being allocation of aggregate of those is what goes into the minutes. So it’s going to be a little bit of an understanding how it goes but I think it’s very important that we get the correct hours and minutes and very important that we get the allocation of the shifts for your registered nurses.

Now just before we go on there are there any questions Jess that particularly relate to this?

**Jessica Evans:**

Yeah. There’s a few that were on the labour expenses and there’s a few of labour costs. So I’m going to go through the ones that I think you’ve touched on but might just want to clarify. I would also say to people that as I’m watching these questions come through the frequently asked questions document that we have on the forms administration website does answer the majority of these questions. So I really do suggest that people have a look at that as they are working these things going forward.

But Grant, so for you, we’ve got:

*Q: How should average hourly rates and pay be calculated?*

**Grant Corderoy:**

Right. So we’re coming up to that slide but I’ll look at that now. The average hourly rate is your average base rate. So for example with a registered nurse you might have different classifications and I would just base it on what’s your average base rate. So the hourly rate is purely using the figure $32 an hour. You might be paying your registered nurses $29 an hour up to $36 an hour. What do you feel is the weighting of that is your average base rate that you’re paying a registered nurse, your average base rate that you’re paying an enrolled nurse, and the average base rate that you’re paying a personal care worker. Now again that’s an important calculation because it allows a sense check. It allows us to sense check your costs and your minutes because when we’re looking at everything from doing the subsidy we want to understand what are the rates of pay, the average rates of pay, how many hours have they been working or how many minutes are they working, and build this in to the fairly complicated matrix that’s going to come up which comes up to the subsidy level. But base it on your base rate and your average rate of that particular classification of staff knowing you might have several rates within that classification but you’ll have to weight it to get the right base rate for each one.

And again just leave a rationale of how you do it so if there are any questions or yourself, you’re wanting to do it the next quarter or the quarter after, you know exactly what your rationale was for getting that average rate.

**Jessica Evans:**

Thank you. There’s a few around:

*Q: Where should care management be reflected?*

I think you’ve also touched on that but you might want to draw that out in labour hours and expenses again.

**Grant Corderoy:**

So care management is one of these grey areas and probably a fairly significant one. There’s obviously the care manager could well be a registered nurse in many cases but could be an enrolled nurse or performing personal care work type functions depending on the size of the home. And again I think the simplest definition is when they’re doing work that’s associated with the direct care services of a resident which should be allocated to the direct care labour, the direct care minutes.

Where they’re doing work that’s relating to the facility as a whole – which could be staff rostering, it could be other issues relating to staff, areas that you’re dealing with staff as a collective, your facility management. It might be dealing with compliance within your organisation and other areas – that is care management. So I think the simplest way of saying it is how much of that role are they doing that’s going to directly benefit an individual resident? So if you’re doing a care plan or you’re discussing their health with them or discussing with a parent over a particular resident, I think that would be a more general acceptance of what goes under direct care delivery. When you’re doing management roles that affect a group of people in a facility or a wing if you’re just involved in the wing of a facility then that should be just care management and not direct care hours.

**Jessica Evans:**

Thanks Grant. And just a couple on the 24/7, the morning shift, afternoon shift and overnight shift.

*Q: If a shift goes across morning and afternoon where should the hours be reflected? All morning, all afternoon or a split between each?*

**Grant Corderoy:**

Yes. And again if we put in an example of the normal shift hours, say 7 o’clock to 3 o’clock, not all homes work by that. But I think most homes do work on a morning, afternoon, evening shift type basis. So as I said I think the preference would be from my point of view is where is the majority of their time spent, the morning and afternoon, depending where you classified morning, afternoon, evening, come from. You will have some workers who cross over shifts or indeed have a more regular overtime situation. And again you’d either allocate those workers if they’re significantly in both shifts that I’ve allocated, but if there’s only 10% related to one shift and 90% of their time is on a morning and 10% the afternoon, my inclination would be just to treat that person as a morning shift. But if it’s a fairly equal weighting between the two then you’d need to allocate them based on the time that they’ve got there.

**Jessica Evans:**

*Q: In terms of non-worked hours, if a staff member spends say 10% of their time providing direct care, how should their leave hours be reported in the non-worked hours category?*

**Grant Corderoy:**

Right. So non-worked hours is an interesting one. In the case of the care minutes or whether you [0:47:32] care hours, if you’re picking up the figure from the roster, then you won’t have non‑worked hours because you’re only picking up the actual hours on the floor. If you’re picking it up from payroll when the non-worked hours in the sense of the balance – so for example if I was being paid this week for 22 hours of which 16 hours I was working, physically working, and six hours was annual leave, then the six hours of annual leave would be my non-worked hours as far as the annual leave and the 16 hours that I was working would be allocated to whatever my star category was. Now that’s from the payroll system but when you’re looking at your hours from a roster, generally speaking most rosters don’t include if anyone’s not there or on leave or other things. So the non-worked hours is in a sense a reconciling item if you’re reconciling back to your payroll system and it just includes those hours and dollars where they’re not physically in a sense interfacing with a resident is what I want to say, but actually on the floor of an aged care home.

**Jessica Evans:**

Thanks Grant. Okay. I would suggest you keep moving through the presentation. I think a lot of the other questions go to some of the detail that you’re about to go into.

**Grant Corderoy:**

Okay. Thank you. So if we can go to the next slide thanks, which really covers a little bit of what we’ve talked about, the non-worked hours. Again not so much – sorry the slide before.

The slide before. Yeah. So that covers the average hourly rate which you’ve talked about again using your base rate. I do want to quickly talk about your occupancy, your bed days. Your occupied bed days I look as being your available bed days. So for example if you’ve got an 80 bed home but if only 70 beds are available for a resident occupying at any point in time then you put your available bed days is 70 by the number of days in the quarter. So it is not your approved places. It’s how many beds are available. So you might have less beds available for your approved places because you might be going through refurbishment. You might have closed a wing at the moment when you haven’t had staffing, you’ve got staffing issues. So some homes have actually closed certain beds so they’ve only got the number of beds commensurate to what their staffing is available.

So it’s very much ask the question again how many beds are available in the quarter for a resident to be in that room or that bed. And so that’s your available days. The occupied bed days ratio percentage will come from the basis of that. And the direct care minutes. I think we’ve covered the direct care minutes. That calculation is done in your Quarterly Financial Report but it does serve as a self-check yourself to see if the minutes are quite out of line with what you would expect it to be.

So if we go to the next slide and this is really just an information slide. This is sort of the standard sort of chart of accounts that we see in the standard that we often advise providers to be putting in. Now you see the line that says RN – Wages. So basically it’s picking up how you might allocate rather than having one general entry count for wages. You might split it up between wages, superannuation going to a different general entry count, your leave entitlement movements go to a different one, agency. Now that line wages can’t be used to allocate your average rates of pay because that wages will include things like your other entitlements and movements that are in that line. So you might consider looking at that one but it might not necessarily include overtime rates, penalty rates and leave pay. So sometimes you might take four weeks leave. The payment will be paid to that account 510.1 and the account 510.15 will be the movement in my leave provision. So in other words if I use the account 510.1 to calculate my average rate of pay I’d actually be including my actual paid leave or termination in it. So while that chart’s quite good and reflective for your normal accounting it mightn’t be the count that you’d be using to use your average rates of pay. I’ll be going to your payroll and see what your base rates are for each category. Now if we go to the next slide.

These are just some very quick tips, quality assurance tips. I won’t go through them. But I think the biggest tip to see that you’re preparing it right and it looks right is calculate your minutes. So what we’re saying firstly is we like to break things down. And it’s shown on here to per resident per day or per bed day if we want to call it. So let’s have a look what your average funding is, at your total revenue, at this stage actual revenue, divided by your occupied bed days to give you a dollars per bed per day, and then use that as the basis when you’re comparing it to your rates for your paid rates for RNs, ENs and ANs and also your minutes. So in other words it’s a good way particularly when you can compare with all your facilities. So we think that’s a very good quality assurance before you move on. Next slide please.

And this is just I guess some words about the care minutes. So remember the care minutes are mandatory from 1 October 2023 and providers will need to have registered nurses on site from 1 July 2023 24/7. Now a question that has been asked through the portal is why are we getting these minutes now if they’re not actually due until 1 October 2023? It’s going to be very important from a trend analysis point of view, is that when the Pricing Authority starts to look at some of the costs that are coming through and the minutes that are coming through they want to see what the trends are.

Now remember that we’ve completed the Aged Care Financial Report for financial year ’21 which included the care hours which can be converted to minutes, and we’re also completing it for FY ’22 so there’s going to be a trend already emerging. So for example if you see a significant difference in your hours or minutes from FY ’21 Aged Care Financial Report to your Quarterly Financial Report that you’re submitting or your Aged Care Financial Report, that’s a question that you need to ask yourselves why because it’s likely to be a flag for the Quality Commission or the Department or the Pricing Authority to say what’s the reason for that difference. So you want to make certain that your trend is consistent and understanding. And again gathering this data to get a trend is how when we’re looking at the future subsidy to be paid we need to understand that so we can put in all the ingredients including wage increases, including inflation and the cost of providing care is going to be very important going forward. So this slide just gives a bit more detail to what I was talking about under the care minutes. If we can just go to the next slide thanks.

And the next slide is again regarding the reporting. Why are we getting to this level? Well our first port of call is the Royal Commission. The Royal Commission, one of its very strong recommendations was to have an RN on site at all times, they move from 16 hours to 24 hours coverage at all times, and to have the direct care minutes shown for what they call direct care, RNs, ENs and PCWs, and to understand how it works and that there is sufficient coverage. And the AN-ACC funding that’s coming up in October, the first tranche has included an additional amount to cover providers moving their care minutes up to the level they need, the average being 200 minutes, but obviously the actual minutes will be depending on the acuity within each of your homes and each of your residents. But this is going to be very important. So this is why the shift work is important to get for the 24/7 but also the accuracy of the care minutes.

So I said before see what’s reasonable and supportable in your home and then think is this reasonable and supportable so that the Department, the Quality Commission and IHPA can make proper decisions. Because this is the thing that we’ve all argued in the sector for many years. We want to make certain that the subsidy providing care is commensurate with the cost of providing the care and ensuring that if we need to provide more care then that’s what appropriately is funded under the subsidy arrangements. If we just go to the next slide thanks.

So this is just a very quick worked example. It’s really around again the allocation. So this is an example around the allocating of a care manager and how that care manager – how much time will they be spending in a sense with interaction with a resident that it benefits the resident from a care perspective. And I think that’s the golden rule. Now interaction again can be looking into their care plans, can be speaking to their family, they’ll be talking to staff about a particular resident. There are many ways that you interact. But it’s looking at the interaction that you’re having with a resident. And if the care manager is doing that for 10% of their time or 30% of their time or 70% of their time that’s how you allocate it. But again – always caution – make certain that you’ve got the rationale for it and it’s supportable. And if you’ve got the rationale and it’s supportable there’s no issues at all. But that’s what’s going to be important going forward. So if we can just go to the next slide thanks.

And these are just again tips on the 24/7 RN. This is an area – as I said we’ve introduced this concept of asking for the morning, afternoon and evening shifts. So we want to understand exactly what they are and very important that it’s not just for your direct employees who are RNs but also very important for your agency staff. And again check those hours to the roster. A really good check is just get a roster for a fortnight or if you can get the rosters accumulated for your three monthly and check the total number of hours as per the roster by category agrees with what you’re putting in your Quarterly Financial Report. Or you just get one or two normal rosters and multiply it out but just see if they agree. I think the self-checking is really important from your own operational point of view as well as it is important from your reporting point of view. Now if you could go to the next slide thank you.

And these are just further considerations when you’re completing your Quarterly Financial Report. Again a lot of the reporting should be similar to what you should be including in your normal management, your normal operations. This is important from a roster point of view, which is significantly important as we know comparing your roster to your subsidy. So that’s what I’d call normal management reporting and operation reporting. We’re just now putting it in a more formalised sense when we’re reporting back to the Department and the Quality Commission in this sense. So again treat it on that basis.

Now I make a comment about the non-worked hours which of course refers to staff training or times that they’re not working in a particular shift on the floor. And again that’s more the balance but again it’s good to know because we want to see how much of the staff time, because staff training of course is significantly important when we’re looking at the quality of care and career paths and ensuring that we’re providing good consistent care. So it’s not insignificant. And we need to understand from a policy point of view is there enough funding for that? How’s the funding working for that? How much staff training is being used? So there are real benefits in reporting in this way. And the co-located facilities, I did touch on that before for the question that Jess said. Again you need to provide the information for each NAPS ID. So if you’ve got a combined home that’s got two NAPS ID then you’re going to have to provide the information for each NAPS ID and make a proper allocation between the two based on reasonableness, based on the supportable view, how it works.

Now if we just go to the next slide thank you. And again agency staff. And again the Department really need to understand the impact of agency staff. What we have seen, probably the single biggest issue in aged care at the moment, is staffing and getting staff. So the agency staff has been a big impost on providers because they’re having to use more agency staff maybe than they’ve historically had to use to be able to get staff on the floor working to meet the residents’ needs. Obviously overtime has been another impact. So we need to understand what is the impact of agency staff and how does this then come into the overall cost of providing care. And that’s why the allocation of staff is really important.

And similarly for allied health. Now allied health is again a very strong part of the care delivery for a resident. I don’t think anyone would suggest otherwise. Now it doesn’t include it in the minutes of care but it’s important that we need how much allied health is being provided and the hours of allied health and the cost of allied health again for the Pricing Authority to be able to determine how much subsidy needs to be paid to perform the allied health and if there needs to be increased allied health what is the cost of it and have the funding for it and how is that going to work. So again this is giving us significant more data and that’s the big thing that we’re getting from the Quarterly Financial Report. It’s not a benchmarking service. It’s not a service of big brother. It’s a service to get information so that we can use it for policy, to understand the levels of funding, and to be able to be much more inclusive and not reactionary when care delivery is going to come in the future. And so getting the split between agency, allied health and other care staff is going to be very important for those sorts of areas.

Next slide if I can, is some very comprehensive definitions. I think like any data collection including our data collection at StewartBrown and the Department’s data collection is a cleansing process and a process to understand is it consistent, is it accurate. And the basis for this is ensuring that we follow fairly strict data definitions. So on the forms administration website there’s a link to the data definitions. I really suggest that not only do you look at it initially but have a look at the definitions every quarter just before you’re doing your return to make certain for not just the quarter that’s just gone but the quarter coming ahead and the quarter after that that you’re following a consistent approach to the data definitions. Now they’re quite detailed. Now again through the Helpdesk we can then get the data to come on and use the technical side of it.

Jess any questions at this point?

**Jessica Evans:**

Thanks Grant. There certainly are. I can see they’ve been assigned and the teams are responding. Just given time Grant I’d suggest you kind of move through to the close and then we’ll go to Josh and if there is time at the end we’ll return to some of the questions that haven’t been answered through the chat.

**Grant Corderoy:**

Yes. Okay. Thank you very much. I think Jess is right. We knew this was going to be a big section. So if we just go to the next slide please.

Maybe the next slide after that.

Home care packages. Now for the home care providers who are just doing home care and not residential that have been listening in, there’s a very similar basis to exactly how we’ve done this. The look and feel of this looks a lot like the data we’re collecting for residential aged care. So again the labour costs includes all the costs of remuneration, all the costs of employing a staff member but excludes payroll tax, workers’ comp premiums, staff training, those sort of costs. We need to get a dissection between agency and brokered which is very important in exactly the same way. Now notice that we’re looking at registered nurses, enrolled nurses, personal care as well as allied health and other staff. This is a bit different to many home care providers doing it but again very important for the Pricing Authority to know what’s the mix of staff that are providing home care services so the subsidy and the funding for home care can be based on that mix of staff. So that’s again the question of why we need to do it and why we need to be looking at that as we go forward. So we need to have that split between agency and brokered. We need to know how much is agency and brokered and how much of course relates to those staffing categories.

Commission, brokerage and franchise fees. These are only applicable if you’ve got a separate franchising arrangement or a different sort of subcontracting arrangement. And again if that’s the case we need to understand what it is. I suggest for those – and there won’t be many of those – they’re ones if you can go to the Helpdesk and then the technical guys will look at it as we go.

And our domestic assistance. Just so you know domestic assistance also comes under personal care. So when you’ve got domestic assistance that’s personal care going forward. So again that’s the look and feel. Now I might just stop there Jess. Are there any questions on that one?

No. So can we go to the next slide thanks?

Okay. So the next slide now moves on to the labour hours expenditure. Again this is on the hours and it’s again on the hours worked. So similar to what I said before for any home care providers who have just joined us. This is not on the paid hours. This is how many hours that that particular employee has been delivering service to a care recipient. And that’s very important as we go on to be looking at it as your hours worked. And the worked hours excludes leave entitlements, hours that don’t relate to direct service delivery. And again this is going to be a little bit of a transition phase for some of the home care providers. And again we and the Department will work with the providers to help in that transition phase.

Any questions Jess in relation to these two slides?

**Jessica Evans:**

Sorry. I realised I was on mute earlier. As I said Grant the questions are continuing to come in. We’re responding as much as possible as we go. But I think if you continue through for perhaps five more minutes and then we’ll go to Josh to speak about the food and nutrition section of the report, if that works for you.

**Grant Corderoy:**

Yep. Perfectly. So many of the home care providers who are also residential care will understand where I’m coming from. This has been particularly for home care providers who are now just having to provide this level of detail and compliance. And as I said there will be some specific questions I’m sure. I think again it’s a matter of understanding why we’re getting this data. And the data is really so we understand what is the mix of staff with the service delivery and what is the cost of providing that service delivery, how many hours they’re providing, so this can then be put in to the matrix to help provide the appropriate funding for clients.

So if we just go to the next slide thanks and this just provides a little bit more definition around it. So direct service delivery care labour costs. Again it’s important as I say for the Department to get accurate information. And the staff costs include all remuneration, superannuation and other costs but exclude payroll tax, workers’ compensation premiums, staff training. Agency staff and subcontracted brokered staff, again we need to know how much you’re employing directly or how many you’re using through a broker or subcontractor. So the same issues we’ve had before. And particularly as we had through the pandemic there had to be additional agency staff costs. So when we see a trend is this a trend that’s now going to continue because of staff shortages or taking time to get staff or this will reduce as we hopefully recover from the full impacts of the pandemic? And again we recommend and the Department recommends opening a dialogue with your agency providers, suppliers, to sort of see how we can increase supporting arrangements and how you can track those going forward.

And other direct service delivery staff. Again make certain the representations that you’re putting in are applicable to their staffing categories. So we just don’t want to have direct care hours or understated because we’ve got other direct care staff that we’re not including in those categories. There’s a line called other and this is where they’re not a RN or an EN or a personal care type worker or personal care assistant. This is for other staff that are doing direct care services and I think that’s really important. And to focus again on the paid hours and the worked hours. Paid hours is for your dollars. Worked hours is when we’re looking at how many hours they’ve worked performing a care service delivery for a care recipient.

If we go to the next slide thanks and it’s just looking at again the data definitions. Similar to before they’re found on the forms administration website. Please read them. Please go to the Helpdesk or the Department technical area for any that you want clarification on. There are quite a number of the definitions. They’re quite detailed. It’s important to be consistent and accurate. But we’re there and the Department of course are very much there to assist providers. This is not going to the principal when you come to the Department. This is going to get assistance and going to get a technical view. And often you’ll create a question that is not only relevant but needs to cause consideration to how we treat a particular item going forward. And I think that’s the great benefit of having that communication going forward.

So Jess I think that’s it from me if I can wrap that up.

**Jessica Evans:**

Yes. Perfect Grant. And thank you for those kind of closing comments. I’ll go to Josh to talk through the final part of the Quarterly Financial Report and if there is any time remaining Grant I’ll come back to you on some of the questions. Otherwise we will complete them through frequently asked questions out of this session. Thanks Grant.

I’ll hand over to you Josh.

[*Visual of slide with text saying ‘Part 4’, ‘Food and Nutrition Reporting’, ‘Purpose, context and requirements’, ‘Q&A’, ‘Josh Maldon’, ‘Assistant Secretary’, ‘Choice and Transparency Branch, Aged Care Group’*]

**Joshua Maldon:**

Thank you. Thanks for the introduction. You guys are doing really well. An hour and 14 minutes deep and we’ve gone through some pretty heavy content stuff. But I think Jess has saved the best for last so you guys are in luck.

So I’m the Assistant Secretary of the Choice and Transparency Branch. So I’ve got the responsibility for food and nutrition including reporting under the Quarterly Financial Report. So the Australian Government is committed to improving food and nutrition delivered to older people in aged care and you’ll be aware that more broadly it stated its clear agenda to improve aged care service delivery by strengthening accountability and transparency.

So for food and nutrition it’s taking a really multifaceted approach to achieving this. So there’s increased funding in residential aged care including the additional $10 per resident per day. We’ve got a dedicated food and nutrition standard which we expect to be undertaking public consultation as part of the urgent review of standards later this year. We’ve got consumer experience interviews where we’ll ask 20% of residents nationally ‘Do you like the food here?’ and publish those results on the new star ratings in December 2022.

And importantly in meeting that increased accountability we’re looking at building capability by working with the Aged Care Quality and Safety Commission and the Maggie Beer Foundation across a range of sector education initiatives. And that’s in addition to the strengthening of food and nutrition reporting which I’m about to talk to you about today.

So why is food and nutrition reporting important? Your reporting is critical to enable us to understand what good looks like within the context of food and nutrition and the dining experience. Your reporting will enable us to better understand the relationships between important input measures such as expenditure, food and service delivery models including where these are outsourced, staffing such as chefs, cooks, allied health effort and costs. And we’ll be comparing these outcome measures including regulation, quality indicators and consumer experience to see what story it’s telling us. That deeper understanding will give us the opportunity to better understand in detail what the meal time expectations are for older Australians in aged care and what the actual ability of service providers is to deliver quality care and services.

So today our focus is going to be on the food and nutrition reporting requirements to make sure you’re all comfortable with what you need to do when it’s time to submit your Quarterly Financial Report. We may have time for questions at the end. I’m not 100% sure. But if we don’t certainly happy for you to email those through and we will get to them.

So importantly since we last spoke there have been some changes. So these changes have been made based on feedback and Government’s explicit commitment to strengthen reporting and transparency. So if we go to the next slide and we’ll do a quick recap. So since 1 July 2021 there’s been a new basic daily fee supplement of $10 per resident per day provided to support aged care providers to deliver better care and services with a focus on food and nutrition. So to be eligible for the basic daily fee supplement service providers entered into an agreement with the Department. As part of this agreement providers were required to report on elements of food and nutrition expenditure. The BDF will continue, as we call it, until the 30th of September 2022 after which from the 1st of October it will be rolled into the AN-ACC funding for all residential services. While MPS and NATSIFAC are funded using different mechanisms all these services too will receive the BDF funding.

So given all these services will be receiving the funding all services will now be required to report on food and nutrition through a component in the Quarterly Financial Report. When you commence reporting in the Quarterly Financial Report it will differ depending on if you currently receive the BDF or not. So for services currently receiving the BDF you’ll report through the QFR for this current reporting period which is quarter one. So July to September due on the 4th of November. For services not currently receiving the BDF you will report through the QFR from next quarter, so quarter two, October to December due the 13th of February.

So I want to clarify two key points for you. So by October 2022 food and nutrition reporting will be mandatory for all residential services, NATSIFAC and MPS services, reflecting the Government’s commitment to greater transparency of provider expenditure of food in aged care. Unlike the BDF reporting all the food and nutrition reporting questions in the QFR will now be mandatory. Previously a number were voluntary and that was in order to provide some parts of the sector that needed it with more time to transition to the new requirements. So I’m going to be going through the reporting requirements with you this afternoon in order to make the transition to reporting in the QFR as seamless as possible.

So as already mentioned there have been some changes in the reporting fields and I’ll highlight these explicitly as I go along just to make sure we avoid any confusion.

So if we jump to the next slide please.

The first section in the food and nutrition report asks for costs related to resident expenses which are broken down into oral nutritional supplements, not including enteral or tube feeds, and oral health living expenses. So these kind of expenses could include toothpaste, toothbrushes, floss, denture cleaning solutions, reminder systems and other items for good oral health. So it doesn’t include labour but for this section you do need to provide quarter totals for spending on these items.

The next section asks for costs related to allied health expenses and allied health hours which are categorised into either dietetic care or speech pathology which are further broken down into employee or consultant agency labour costs for each. For expenses you would include salaries and superannuation paid to employees and contract or invoice costs for contractors. For hours you would include labour hours worked which does not include leave or training. So please note one of the things we’ve updated is the definitions for speech pathology and these fields now only relate to expenses and hours involved with food and nutrition and dining experience. Expenses and hours relating to things such as communication are collected elsewhere.

So there’s detailed definitions for each Quarterly Financial Reporting field which are available for you to review on the Department’s website. I strongly advise you to use these as a guide while you are completing the reporting to ensure accuracy.

The next few sections are specific to reporting of catering and there have been some changes since the last webinar. So if we can jump to the next slide there.

So we’re going to be asking you to indicate how the majority of your main meals are prepared by selecting your primary food preparation model from the options of cook fresh, cook chill or cook freeze. So this will give us a better understanding to the food models that are being used as an input and how these relate to outcomes. It will also help guide the Aged Care Quality and Safety Commission to identify where residents may be at nutritional risks.

So if we jump to the next slide. The most significant change from the basic daily fee in the previous webinar is to the catering categories and their names. What we want to do is make it easier and more logical for services to identify their catering types which is why we’ve simplified the catering names and included whether the catering is done on or off site. The two main catering types are now internal and contract catering and these are split by whether the cooking is done on or offsite.

So what do we mean by internal catering? So internal catering on site, this relates to instances where meal preparation is done on site by the organisation. Internal catering off site is where there’s a central kitchen for multiple facilities where food is prepared off site by the approved provider with an internal arrangement between the aged care service and the approved provider. Internal catering transport and delivery costs is the delivery or transport costs related to internal catering, for example the delivery of fresh ingredients. So for both types of internal catering we want the food costs split by whether the food is fresh or not and hours reported for cooks and chefs, food service and food management. And I’ll go more into those requirements in just a minute.

So next if we jump to the next slide we have contract catering. So contract catering on site where food is prepared on site by an external provider, contract catering off site which used to be third party external kitchen where the cost of the entire contract for food is prepared off site by an external provider. We’ve removed the field ‘Other’ as we felt the data we received from this field was not going to be useful and it was just another field to complete. We’ve included the field ‘Total cost of contract’ as a clearer way for you to provide us your contract cost while also splitting the food cost by fresh and other. We understand that contract cost will include labour and potentially delivery and we expect that. We do not expect the values entered in food and ingredients to equal the contract cost.

So if we jump to the next slide please.

So let’s talk a little bit more about the split of food ingredients and staff hours. So we’ve incorporated into the Quarterly Financial Report the food and cooking ingredient costs which will need to be separated by whether these are fresh or not. Delineation is simply identified by the GST classification. Using the GST classification ensures consistent reporting between services and given it is in common use in purchasing arrangements this split is intended to avoid confusion. We understand that this is a new requirement for contract catering off site and information will need to be obtained from your contractor which could be difficult initially. And I can assure you that’s something that we’ve taken into account through this approach.

However we do strongly believe that the data we’ll receive from this additional reporting is crucial to inform both older Australians looking at aged care and policy and ultimately leading to the improvement of resident nutritional outcomes which is the goal that we both share. So therefore from quarter three six months into the reporting we expect to be seeing data which will accurately help us discern the make up of food served for older Australians in residential aged care. That is the proportion of food which is fresh and that which is processed or pre-prepared for all catering types.

Final reporting requirements are on staff hours. So if we jump to the next slide. The first field requires the hours for cooks and chefs which covers labour paid hours in total for the quarter. The second field relates to the hours for food and food service management which covers labour paid hours for food service and food management staff in total for that quarter. So again more detailed information is available for what to include in those fields within the definitions on the Department’s Quarterly Financial Report website link.

So next slide please. Why are we asking these questions about fresh food, food preparation and hours? Look the research demonstrates that freshly prepared food is generally more nutritious and also more flavourful so it’s got a higher chance of being consumed particularly in the residential care cohort of frail elderly where taste sensations may be muted or changed. Food which isn’t consumed simply cannot be used to help the nutritional intake of a person so food has to be delicious as well as nutritious. It needs to be cooked, prepared and served by someone and this is where the collection of hours comes into play. Greater scrutiny will be applied to services using minimal fresh ingredients and using food preparation methods other than cook fresh which we’ll be checking how they relate to ensure positive nutritional outcomes.

In addition we’ve also heard from older Australians that they want to be informed about the use of fresh and pre-prepared or processed food in residential aged care when selecting a residential aged care service. So subject to Government decisions it is possible that in future this information may be published.

So that brings me to the end of the reporting field but I want to highlight a few additional points for you that you may find helpful for completing the reporting. So labour hours are reported with the catering type and it no longer matters if they’re employees or agency staff, just whether they work on or off site. By streamlining the catering categories we’ve made the reporting of hours easier. You can enter your catering under as many categories as fits in your catering model. So for example if you cook breakfast, lunch and snacks on site but get dinner delivered via an external contract you’ll be filling in both internal catering on site and contract catering off site. So you can see that in the highlighted fields on the screen. I think it was on the previous slide though.

As per the BDF, the basic daily fee, food service and food management hours does not include time spent on personal care minutes. That is recorded elsewhere. So for those of you with multiple services the reporting is streamlined so that you can complete the reporting for all services together in one report. While submissions still need to be made for each service being able to complete them all in one place will make it easier for larger providers to report through all their services.

So the Department’s just released explanatory notes to assist with completion of food and nutrition reporting via the Quarterly Financial Report and these notes contain detailed information for each section of reporting as well as frequently asked questions which we’ll continue to add to even as I can see your questions rolling in today. We’ll be able to also highlight some service scenarios so you can see how reporting fits into those fields. These notes now replace the basic daily fee notes on the Department’s website.

So look thanks for listening. And it brings me to the end of my presentation. I hope you’ve found it informative. I think we’re fast running out of time so you’re probably best emailing those to nutritioninagedcare@health.gov.au and we’ll get a response to you as soon as we can. Thanks Jess.

**Jessica Evans:**

Thank you so much Josh. It was great to have you take us through that. Look with the last one minute I will say thank you for everyone who engaged. Thank you to the presenters. There are a lot of questions that we will be following up on and adding to our frequently asked questions.

[*Visual of slide with text saying ‘Part 5’, ‘Other Issues and Next Steps’, ‘Latest Quarterly Financial Report, Definitions, Guides and Frequently Asked Questions are located at https://health.formsadministration.com.au/dss.nsf/DSSForms.xsp’, ‘Providers will submit the first QFR using Forms Administration’s data collection portal. Providers will receive notification emails when the portal is open’, ‘A helpdesk run by Forms Administration will be available to assist with the completion and lodgement of QFR. Providers can call the helpdesk on (02) 4403 0640 or email enquiries to health@formsadministration.com.au’, ‘In the meantime, please email your questions to the FFBCONSULTATION@health.gov.au inbox’*]

As I said a lot of these questions are already available on the website that is up on the screen so formsadministration.com.au on the forms section so please take a look at those in the first instance. As I said a lot of these questions are now very specific to particular provider types so again use the Helpdesk functions and we will notify through the newsletters once frequently asked questions have been updated.

So thank you to everyone and apologies we didn’t get through all of the questions.

[*Closing visual of slide with text saying ‘Ageing and Aged Care’, ‘Australian Government with Crest (logo)’, ‘Department of Health and Aged Care’, ‘Thank you’, ‘For more information, please contact the Department of Health and Aged Care’, ‘health.gov.au/aged-care-reforms’*]

[End of Transcript]