www.audit.act.gov.au

ACT AUDITOR–GENERAL'S

PERFORMANCE AUDIT REPORT

Specialist assessment services for dementia and cognitive decline

Report No. 5 / 2025

The ACT Audit Office acknowledges the Ngunnawal people as the traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region.

The ACT Audit Office acknowledges and respects their continuing culture and the contribution they make to the life of this city and this region.

Contact for this report

General enquiries about this report should be directed to:

Email: actauditorgeneral@act.gov.au

Phone: (02) 6207 0833

Postal address: ACT Audit Office, GPO Box 158, Canberra ACT 2601.

Freedom of Information

Freedom of information requests can be made by emailing: actauditorgeneral@act.gov.au

Accessibility

The ACT Audit Office is committed to making its information accessible to as many people as possible. If you would like to receive this publication in an alternative format, please telephone the Office on (02) 6207 0833.

If you are deaf, or have a hearing or speech impairment, please telephone the National Relay Service on 13 36 77.

If English is not your first language and you require a translating and interpreting service, please telephone Access Canberra on 13 22 81.

ISSN: 2204-700X (Print) ISSN: 2204-7018 (Online)

Produced for the Office of the ACT Legislative Assembly by the ACT Audit Office.

Information about the ACT Audit Office and an electronic version of this annual report can be found on the website www.audit.act.gov.au.

Audit Team

Laura Thomas

Aidan Carroll

Dr Nathan D'Cunha (Associate Professor, University of Canberra)

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

PA 24/12

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Speaker

I am pleased to forward to you a Performance Audit Report titled 'Specialist assessment services for dementia and cognitive decline' for tabling in the Legislative Assembly pursuant to Subsection 17(5) of the *Auditor-General Act 1996*.

The audit has been conducted in accordance with the requirements of the *Auditor-General Act 1996* and relevant professional standards including *ASAE 3500 – Performance Engagements*.

Yours sincerely

Michael Harris
Auditor-General
10 September 2025

Contents

Summary

Dementia is a progressive, irreversible neurocognitive disorder characterised by the Diagnostic Statistical Manual of Mental Disorders (DSM 5) as:

> An acquired deficit in cognitive function impairing attention, planning, inhibition, learning, memory, language, visual perception, spatial skills, social skills or other cognitive functions.

Canberra Health Services (CHS) operates a range of services for people with dementia. Three services provide specialist assessment services for dementia and cognitive decline:

- General Geriatric Clinic (GGC);
- Memory Assessment Service (MAS); and
- Rapid Assessment of the Deteriorating Aged at Risk (RADAR) service.

Specialist assessment services for dementia and cognitive decline are a key contact point of specialised advice within the health care system, which can:

- provide support and care for people with dementia and their care partners;
- facilitate primary access to treatment;
- act as pathways to referral for further support; and
- provide a source of authoritative advice for general practitioners.

The objective of the audit was to assess the effectiveness of CHS' specialist assessment services for dementia and cognitive decline.

Conclusions

Planning and oversight of service delivery

Planning for the delivery of specialist assessment services from the General Geriatric Clinic (GGC), Memory Assessment Service (MAS) and Rapid Assessment of Deteriorating Aged at Risk (RADAR) service can be improved.

The services operate within the Geriatric Medicine Unit (GMU) within the Rehabilitation, Aged and Community Services (RACS) Division of CHS. While the RACS Division has identified key deliverables and actions in annual divisional business plans, it has not clearly articulated which initiatives, deliverables or performance measures that the GGC, MAS or RADAR service were responsible for. Nor does the GMU have a documented work plan that identifies planned deliverables, targets or performance measures relevant for the GMU and the GGC, MAS or RADAR service.

Strategic planning for the delivery of specialist assessment services for dementia and cognitive decline, and dementia services more generally, is expected to be improved by the Health and Community Services Directorate's development of the first ACT-specific, evidence-based framework for care for people with behavioural and psychological symptoms of dementia (BPSD).

Referral management

The delivery of specialist assessment services can be improved by the development of clear, documented referral acceptance eligibility criteria and a prioritisation framework for the delivery of services. While aspects of these are addressed through a service-specific *RADAR Model of Care*, there is no similar document for the GGC or MAS.

CHS has a limited understanding of referral patterns to the GGC, MAS and RADAR service, and does not actively monitor or report on referral sources. CHS similarly has a poor understanding of the timeliness of its assessment and diagnosis services and has been unable to identify and report on wait times between referral and initial appointments due to limitations of the Digital Health Record (DHR). Not monitoring referral patterns to the services, or accurately knowing wait times for the services, has significant implications for service planning and service delivery and CHS' ability to demonstrate it is meeting the community's needs.

Communicating a diagnosis of dementia

The communication of a diagnosis of dementia (or Mild Cognitive Impairment) can be improved by the development and implementation of a policy or standard operating procedure(s) to guide the timely sharing of written explanations of results and next steps with clients. At present there is variability in how this is done by clinicians across the services. Delays in sending appointment records to referring medical practitioners were identified, which may pose a risk to clients receiving timely and appropriate care.

The development of a policy, that includes expected timeframes for clinicians to communicate diagnoses, and guidance on other critical post-diagnosis information such as next steps and available supports, would provide clarity on how and when this information should be shared with referring medical practitioners, clients and their care partner(s).

Post-diagnosis support, advice and care

The delivery of services by the GGC, MAS and RADAR service can be improved by developing and maintaining a repository of information that clinicians can access and provide directly to clients and care partners following a diagnosis of dementia or Mild Cognitive Impairment. The absence of such information increases the risk that clients and their care partner(s) do not access appropriate support services post-diagnosis.

While the RADAR service is involved in client care planning post-diagnosis support by providing direct referrals and actively assisting clients to access additional supports in the community, the GGC and MAS often rely on the client's referring medical practitioner or the client themselves to make referrals to additional supports after their diagnosis.

Across the services there are underdeveloped relationships with, and support pathways to, key support services in the ACT including Dementia Australia, community care services and legal and financial counselling. These services are critical to providing clients and their care partner(s) with comprehensive and consistent support options.

Information collection and management

CHS does not effectively collect and manage information on the delivery of services by the GGC, MAS and RADAR service, to identify and report on the effectiveness of service delivery or whether there are opportunities for improvement.

A lack of standard operating procedures for inputting information into the Digital Health Record (DHR), and an absence of data collection policies, limits the services' ability to collect consistent data that can be used for monitoring and reporting purposes. The GGC, MAS and RADAR service are unable to effectively monitor performance data relating to referral rates and sources, wait times or staff workload and are unable to effectively monitor and report on performance.

Key findings

Planning and oversight of service delivery

Paragraph

Planning for service delivery

In December 2024, the Australian Government published the *National Dementia Action Plan 2024–2034* (National Dementia Action Plan). In accordance with the National Dementia Action Plan, the Health and Community Services Directorate is currently developing the first ACT-specific, evidenced-based framework for care for people with behavioural and psychological symptoms of dementia (BPSD). This framework is expected to be released in 2025 and will inform health services planning for people experiencing extreme BPSD. There was no documented overarching strategy that described how the Territory would implement *National Framework for Action on Dementia 2006-2010* or *National Framework for Action on Dementia 2015-2019* priorities for action and there is otherwise no ACT-specific Action Plan to guide dementia care in the Territory. 2.17

The RACS Division has identified key deliverables and actions in annual divisional business plans. Both the *2022-2023 RACS Divisional Business Plan* and *2023-2024 RACS Divisional Business Plan* aligned deliverables with the strategic priorities described in the CHS Strategic Plan and CHS Corporate Plan. Both documents include 2.28

high-level information that describes the planned deliverables for the division and how the division will measure its performance. Neither business plan clearly articulated which initiatives, deliverables or performance measures that the GGC, MAS or RADAR service were responsible for contributing to.

2.32 According to the CHS Planning Framework, each individual unit, area, or team is required to complete a unit work plan that should align with the divisional business plan. The GGC, MAS and RADAR service are part of the GMU, within the RACS Division. The GMU does not have a documented work plan that identifies planned deliverables, targets or performance measures relevant for the GMU and the services that it provides to the community.

2.40 The CHS Planning Framework describes a model of care as a document that 'outlines the way health services are delivered'. In March 2024, a *RADAR Model of Care* was approved, which clearly describes the services to be provided by the RADAR service and relevant goals and targets and performance measures. The GGC and MAS have not developed models of care.

Performance oversight

2.47 The *Performance Reporting and Monitoring Framework 2022-2024* identifies performance reporting, monitoring and management roles and responsibilities of front-line clinical team members, managers and senior clinicians. Some staff in the RACS Division carry out multi-faceted roles where functions alternate between the front-line clinical staff, managers, senior clinicians and executive responsibilities. This means there is a risk that staff do not understand their responsibilities as they pertain to performance reporting, monitoring and management.

2.52 RACS managers, senior clinicians and the executive rely on information shared at the RACS Executive Committee and Quality and Safety Committee to guide their performance reporting and monitoring activities. However, the inconsistent use of data entry fields and an inability to access required reports from the DHR means that neither committee has access to reporting that accurately reflects the performance of the GGC, MAS or RADAR service. This compromises the ability of managers, senior clinicians and the executive to identify trends, issues, discrepancies, gaps, root cause of variances or opportunities for performance improvement.

2.60 The RACS Executive Committee is responsible for 'providing leadership, direction and management' for the RACS Division. It meets monthly. Between January 2022 and November 2024, the RACS Executive Committee met 28 times out of a possible 34 (82 percent). At each of the meetings, an update from the GMU was provided. The RADAR service was discussed at several meetings in the context of workload concerns and provision of advice in relation to ongoing recruitment of a nurse practitioner, but the GGC and MAS were not specifically discussed.

2.66 The RACS Quality and Safety Committee is responsible for '[overseeing] the management and implementation of quality and safety' for the RACS Division. The committee is primarily focused on monitoring data and information that CHS is required to collect under the National Safety and Quality Health Service Standards

and considers a range of clinical quality and safety matters. The committee has had a limited role in overseeing the performance reporting and monitoring of the GGC, MAS and RADAR service.

Referral management

Referral acceptance and client intake

National Service Guidelines Standard 3.1 states services should have clear guidelines for accepting referrals. The *CHS Medical Specialist Outpatient Referral Acceptance (Adults and Children) Policy* also requires all outpatient services within CHS to have clear, documented referral acceptance eligibility criteria that identify both reasons for referral and suitable conditions for referral. *Outpatient Referral Acceptance Guidelines* have not been developed for the GGC, MAS or RADAR service. The RADAR service has, however, included relevant information in a *RADAR Model of Care*. The absence of documented referral acceptance eligibility criteria for the GGC and MAS increases the risk of inconsistent referrals or acceptance of inappropriate referrals to these services. 3.13

National Service Guidelines Standard 3.2 requires services to accept referrals from multiple sources including General Practitioners (GPs), clinical specialists and other health professionals, as well as self-referrals. The GGC, MAS and RADAR service accept referrals from GPs, clinical specialists and other health professionals, but do not accept self-referrals. While referral from a GP is preferred, allowing self-referral aligns with a person-centred approach and provides an additional option for clients to access services. 3.28

Although the DHR collects data on referring medical professionals, the RACS Division does not actively monitor or report on referral sources for the GGC, MAS or RADAR service. This impedes CHS' ability to determine whether services are meeting the needs of clients across the Territory or identify sources of inadequate referrals and provide targeted education to improve their quality. 3.31

There are two primary sources of information for medical practitioners with regards to referral criteria and the information that should be included in a client referral: the Geriatric Medicine Referrals page on the ACT and Southern New South Wales (SNSW) HealthPathways portal; and the CHS public website. The service-specific criteria published on the Geriatric Outpatient Referrals HealthPathways page for the MAS is incorrect, increasing the risk that medical practitioners may not refer clients under 65 for cognitive assessment. This may delay specialist assessment, diagnosis and support, including application for funding through the National Disability Insurance Scheme (NDIS), for which eligibility ceases after 65. Some of the standard referral information published on HealthPathways is not as detailed as the information required by National Service Guidelines Standard 3.4, which increases the risk of inadequate information being included in client referrals. 3.44

The CHS website contains publicly accessible information about the GGC, MAS and RADAR service, including individual webpages for each service. Each webpage includes a link to the HealthPathways portal that medical practitioners can access if 3.49

they require more detailed referral information. Medical practitioners must be registered users of the HealthPathways portal to access this information. The Capital Health Network estimates that only one quarter of primary care clinicians in the ACT are registered users.

Clinicians interviewed for the purpose of the audit reported receiving incomplete referrals and client questionnaires prior to their initial appointment with a client. Analysis of a selection of referrals between 2022 and 2024 for the GGC, MAS and RADAR service shows that key information can be omitted from external referrals including family history, investigatory results (e.g. cognitive screening and imaging) and the client's hearing and vision status. Clinical specialists can be more confident assessing clients when they have these details at the initial assessment, potentially allowing the client to receive treatment and support more quickly through an accurate diagnosis in the initial appointment. 3.53

Referral prioritisation

National Service Guidelines Standard 3.5 encourages services to prioritise the referrals they receive to optimise case flow. The *RADAR Model of Care* includes a prioritisation framework in accordance with the requirements of the standard. The GGC and MAS have not developed a similar prioritisation framework. This increases the risk of excessive wait times for clients requiring care and the risk that people and care partners who may benefit from timely assessment and diagnosis do not receive early intervention and access to services and supports. There is also a risk that those without dementia, but with Mild Cognitive Impairment, may not receive timely advice that could help delay or avoid dementia. 3.65

Triaging referrals based on client characteristics and condition can improve patient outcomes by minimising wait times for those requiring care urgently. The RADAR service is responsible for triaging and prioritising patients for all three services. RADAR service clinicians conduct daily triage and prioritisation of all GGC, MAS and RADAR service referrals. The *RADAR Model of Care* establishes clear triage categories, including for high priority clients. The GGC and MAS services do not have documented prioritisation categories. 3.66

Access to information and support for clients

Access to data on the timeliness of assessment and diagnosis can allow for more informed clinical interventions to help manage symptoms of dementia before the condition progresses. CHS has historically collected data on the timeliness of assessment and diagnosis, including wait time data. CHS advised that, since the implementation of the DHR, the accuracy of the data is unverifiable and therefore unreliable. Not having accurate data on the timelines of the delivery of services, including wait times, has implications for service planning and service delivery. 3.72

National Service Guidelines Standard 4.1 identifies the written information that services should provide to clients prior to their appointment. For GGC and MAS appointments, CHS administration staff send an appointment letter to clients to advise of each scheduled appointment. However, the correspondence does not 3.80

conform with the requirements of the standard, because it does not include information on the type and purpose of the assessment, wait times, assessment cost and duration or the names of staff members who the client will see at the appointment. The RADAR service does not provide clients with written information prior to their appointment. CHS advised this was because clinicians attend clients in their home within a matter of days or weeks.

The wait between receiving a referral and seeing a clinical specialist can be difficult for the client, their care partner(s) or family. National Service Guidelines Standard 4.2 recommends that services support clients and care partners during the wait time for an initial assessment, if required. CHS does not routinely offer clients waiting for GGC and MAS initial appointments counselling or support for themselves or their care partner(s) but would consider attending the client's home to address concerns should they express distress with respect to the expected wait time. The RADAR service acts as an interim support for clients with urgent needs while they wait for an appointment with the GGC and MAS, but this is only provided if the client, or their care partner(s), self identifies as needing additional support. 3.86

Communicating a diagnosis of dementia

Client management post-diagnosis

National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible to ensure the client can begin treatment and seek further support. None of the appointment records reviewed for the purpose of the audit explicitly identified the date a client was diagnosed with dementia or Mild Cognitive Impairment, and it was not possible to reliably determine the time elapsed between receipt of referral and diagnosis and the beginning of treatment and support. 4.15

The GGC, MAS and RADAR service refer clients to neuropsychologists from the RACS Psychology and Counselling Service for supplementary neuropsychological investigations. The RACS Psychology and Counselling Service estimated that, as of November 2024 there were approximately 12 clients on its waiting list, and two of those clients were under the age of 60. The estimated wait time for this service as of November 2024 was nine months. The long wait time for this service impacts the timeliness of treatment and support. 4.16

National Service Guidelines Standard 10.1 strongly recommends services provide clients with an easy-to-understand written explanation of results and next steps if the diagnosis is uncertain as well as a layperson's summary of test results. Providing these documents has several benefits, including allowing the client and their care partner(s) to remember complex information, receive continuity of care and advocate for further testing. The GGC, MAS and RADAR service have not developed or implemented a policy or standard operating procedures to guide the sharing of written explanations of results and next steps with clients, or a laypersons summary of a client's test result reports. This has resulted in varied practices among specialists. 4.21

National Service Guidelines Standard 10.1 strongly recommends clinicians use the preferred terms of 'dementia' and 'Mild Cognitive Impairment' when communicating a diagnosis. Five out of six specialists consulted for the purpose of the audit reported using these terms, while the sixth specialist also reported using the term 'moderate cognitive impairment'. A review of 140 appointment records for the purpose of the audit shows that 93 involved a diagnosis of 'dementia' or 'Mild Cognitive Impairment'. Of those 93 appointment records, 82 (88 percent) used the terms 'dementia', 'Mild Cognitive Impairment' or 'Alzheimer's disease', which are considered appropriate. Other terms that were used included 'moderate cognitive decline', 'neurocognitive disorder' or 'cognitive impairment'. 4.26

National Service Guidelines Standard 10.1 strongly recommends that appointments during which the diagnosis is communicated should be long enough for the client to process the information and ask questions. The GGC and MAS allocate 30-minute appointments with a nurse prior to a one-hour appointment with a medical specialist. Due to the mobile nature of the RADAR service, there are no set time limits for an appointment. The current length of appointments is in accordance with the Medicare Benefits Schedule that provides for medical services that are subsidised by the Australian Government. 4.30

National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible to ensure the client can begin treatment and seek further support. After a client attends an appointment with the GGC, MAS or RADAR service, medical specialists send written communication to the client's referring medical practitioner to document the outcomes of the appointment. Analysis of the time elapsed between client appointments, and the date written communication was sent to referring medical practitioners identified record-keeping inconsistencies and some significant delays. Of the 140 appointment records reviewed for the purpose of the audit, only 66 included written communication with a sent date: 70 percent were sent within ten days of the appointment, 14 percent were sent up to 25 days after the appointment and 16 percent were sent more than 77 days after the appointment. Delays to the provision of written communication to referring medical practitioners may pose a risk to clients receiving timely and appropriate care. 4.40

National Service Guidelines Standard 11.1 strongly recommends assessing clinicians ask the client if, and with whom, the outcome of their assessment should be shared. As the services have not developed procedures to guide post-diagnostic communication with clients or care partner(s), there is no defined standard practice. A lack of standard processes for information sharing and obtaining informed consent increases the risk of not adhering to the client's preferences during disclosure and may violate individual preferences, autonomy and confidentiality. 4.50

National Service Guidelines Standard 11.1 strongly recommends that where a client does not have the capacity to decide whether to receive their diagnosis, the decision of their proxy decision maker (known as a Person Responsible in most states) should be respected and further discussed over time. A review of appointment records for the purpose of the audit showed that medical specialists regularly provide 4.54

information related to Advanced Care Planning, including enduring power of attorney arrangements, with clients.

Post-diagnosis support, advice and care

Post-diagnosis support

According to the National Service Guidelines, a post-feedback follow-up session provides an opportunity to monitor the client and update their care plan or treatment based on changing client requirements. Because the RADAR service is a responsive and short-term service designed to manage urgent cases, follow-up sessions may be provided to support care planning and monitoring when clinically indicated. However typically, feedback and follow-up sessions are provided by the GGC, MAS or other community services within CHS such as nursing staff or allied health professionals. The GGC and MAS offer a follow-up appointment to discuss the client's diagnosis, but only a maximum of one, and only if the client is required to commence medication. This does not accord with National Service Guidelines Standard 12.1, which stipulates all clients who receive a diagnosis should receive a feedback session and at least two additional follow up sessions. 5.13

National Service Guidelines Standard 12.2 states that the clinical specialist who assessed the client should have a leading role in the initial post-diagnostic process. Of 48 GGC appointment records that were reviewed, 46 (96 percent) clients were seen by the same clinical specialist who conducted the initial appointment for their follow up appointment. Of 22 MAS appointment records, 19 (86 percent) clients were seen by the same clinical specialist who conducted their initial appointment for their follow up appointment. It was not possible to reliably assess whether RADAR service clients see the same clinical specialist across appointments because most appointment records did not include specific clinician names, and some RADAR service clients also attend follow-up appointments through other services. 5.22

National Service Guidelines Standard 12.3 strongly recommends that services ensure timely scheduling of feedback sessions and that a feedback session is conducted as soon as possible after the final diagnostic assessment, ideally within four weeks of the initial assessment. The audit was unable to determine the wait time between initial and feedback appointments for the GGC, MAS and RADAR service because wait time data in the DHR dataset provided by CHS was unreliable. 5.26

National Service Guidelines Standard 12.4 states the feedback session during which the diagnosis is communicated should be attended by all relevant parties including a support person and/or allied health professionals. Analysis of the selected appointment records indicated a support person or care partner attended 99 appointments (70 percent) across the GGC, MAS and RADAR service. No allied health professionals attended an initial, feedback or follow-up appointment for the GGC or MAS. The RADAR service often conducts appointments with a clinical specialist and a nurse, occasionally supplemented by a social worker or occupational therapist. 5.34

Care planning

National Service Guidelines Standard 13.1 strongly recommends that the client, their care partner and all assessing clinicians (e.g. medical practitioner, neuropsychologist) be actively involved in the client's care planning. The involvement of GGC and MAS clinicians in care planning is minimal and most care planning is undertaken by the client's GP and community-based support services. Inconsistent involvement in care planning and the siloed approach of other services involved in client care is a risk to clients receiving coordinated care. The RADAR service operates as a traditional multidisciplinary team and may involve a clinical specialist, social worker and registered nurse in care planning as required. The RADAR service includes clients and care partners in care planning where the client or care partner has capacity to participate. 5.56

National Service Guidelines Standard 13.1 strongly recommends that clients with Mild Cognitive Impairment or early signs of dementia are provided with personalised risk reduction information along with their GP or other referring medical practitioner. The audit examined the 33 appointment records to determine whether the clinical specialist provided them with personalised risk reduction information. Across all services, clinical specialists provided risk reduction information to 70 percent of clients that had a diagnosis of Mild Cognitive Impairment. 5.59

National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should provide support and advice to clients they did not initially assess and diagnose. A review of the selected appointment records identified that all three services provide support and advice to clients they did not initially assess or diagnose. 5.63

National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should assure the client and their care partner(s) that further advice and assistance can be sought after the discharge. There are currently no formalised pathways for clients to seek further advice or assistance from CHS services beyond referral by the client's GP or the clinical specialist who originally conducted the assessment. 5.68

National Service Guidelines Standard 13.2 strongly recommends that services have active relationships with relevant support services to refer as appropriate (e.g. support groups for carers). Clinical specialists from the GGC and MAS advised that they refer clients to Dementia Australia, Dementia Support Australia and the SPICE Program, while the *RADAR Model of Care* includes a list of internal and external stakeholders with which the service seeks to foster and maintain a relationship including My Aged Care, Community Nursing, Fitness to Drive, Dementia Australia and Dementia Support Australia. On occasion, representatives from Dementia Australia and other external organisations have spoken at CHS staff meetings. 5.82

The National Service Guidelines Standard 13.2 recommends services offer follow-up phone calls to assist the client with the care plan implementation. The GGC, MAS and RADAR service do not have a telephone appointment policy and a review of DHR 5.86

data indicated that only six telephone and two video follow-up appointments occurred between 2022 and 2024. The minimal use of video follow-up appointments reduces client access to clinical specialist appointments where clients who may be experiencing cognitive impairment cannot attend a physical location.

National Service Guidelines Standard 13.3 strongly recommends that, where appropriate, directly after the diagnosis, clients are provided with advice, information and support regarding various issues. Analysis of the selected appointment records identified that clinical specialists recorded providing advice, information and supports in relation to most of the issues identified in the standard, although it was not possible to confirm whether this was provided to the referring GP only, or directly to clients and care partners as well. CHS has not developed or maintained a repository of information and supports that clinicians can access and provide directly to clients and care partners. Although clinicians use their specialist expertise to decide what advice, information and supports may be relevant to each individual client, CHS could better support clinicians in this decision making by providing printable information sheets and templates with pre-filled information options in relation to the issues identified in the standard. 5.92

National Service Guidelines Standard 13.4 states that if a service is unable to provide more detailed post-diagnostic support (e.g. due to lack of resources), it should refer clients to relevant, available and timely services with dementia expertise. A review of the selected client appointment records found that all three services did not regularly recommend clients to the support services described in National Service Guidelines Standard 13.4. CHS advised that 'in practice, referral back to the General Practitioner is made, who plays a central role in coordinating further referrals to supports based on individual patient needs'. No service referred to group-based programs focused on well-being or evidence-based cognitive interventions. The GGC, MAS and RADAR service do not meet the requirements of this standard. 5.106

National Service Guidelines Standard 13.5 strongly recommends that services connect clients with key support services where appropriate including driving assessment services, Dementia Australia, community care services and legal and financial counselling services. Analysis of the appointment records indicated low rates of referral to these services and the way in which clinicians recorded referrals to services was inconsistent. CHS has not developed or maintained a repository of information, resources or available support services that may assist them to easily identify potential support options. Although clinicians use their specialist expertise to decide what services may be relevant to each individual client, CHS could better support clinicians in this decision-making by providing them with easier access to this information. 5.113

Information collection and management

Client health information

Referrals to the GGC, MAS and RADAR service are sent to the RACS Administration Team to action. The information included in each referral is manually entered into the DHR by the RACS Administration Team. The information that is collected through 6.9

the referral process is not standardised and information provided by GPs varies. There are no standard operating procedures to guide the recording of referral information in the DHR, which increases the risk of errors and inconsistences.

Throughout a client's journey, nursing, specialist and allied health professionals collect and record clinical information in the DHR. The information that is collected aims to provide an accurate and holistic view of the client that can inform appropriate treatment or next steps for the client. DHR functionality allows for users to enter clinical information on an as required basis and there are no mandatory fields. This can present a challenge for nursing, specialist and allied health staff as accessing client information may require them to navigate a multitude of fields in the DHR. The Health and Community Services Directorate is in the process of developing an education package to support outpatient DHR users. Nonetheless, it remains the responsibility of individual business units to establish standard operating procedures and policies to guide appropriate data collection in the DHR. 6.17

Client feedback

The CHS Consumer Feedback and Engagement Team (CFET) is responsible for collecting and managing feedback across CHS services. The CFM Procedure requires all feedback to be provided to the CFET so that it can be recorded in the RiskMan feedback module and managed centrally. Although this is a requirement of the CFM Procedure, CHS is not able to identify with certainty whether this occurs in practice. 6.27

A total of 1,298 feedback records were entered into the RiskMan feedback module between January 2022 and June 2024 and allocated to the RACS Division. The feedback records consisted of 654 compliments (50.4 percent), 587 complaints (45.2 percent) and 57 comments (4.4 percent). At the time of the audit, the RiskMan feedback did not allow for complaints to be allocated to, and recognised by, specific business units or services. It was therefore not possible to identify feedback that related specifically to the GGC, MAS or RADAR service. CHS advised the issue has been fixed and future data will be available for business units and services. 6.31

When recording feedback in the RiskMan feedback module, the CFET provides a brief description of the feedback in a summary field, which is limited to 250 characters. Information in the summary field of the RiskMan feedback module varies significantly, with some entries containing a few words and others providing more detail. The variation and inconsistency in the detail of the summary field may impact results that are produced when a search of the database is performed. 6.36

The CFM Procedure includes workflow diagrams to guide the process for collecting and managing client feedback. The workflow diagrams clearly articulate the required actions, roles and responsibilities that staff should follow when managing and responding to feedback. They provide reasonable guidance to staff and support consistent feedback management. The CFM Procedure does not define what role(s) or levels within the organisation are responsible for managing and responding to feedback, nor has the RACS Division developed any policy or procedural guidance to this effect. This increases the risk that feedback is managed inconsistently or inappropriately. 6.47

A review of 11 feedback records between January 2022 and June 2024 that were specific to the GGC, MAS and RADAR service shows that all of the feedback records were managed according to the established workflow. The feedback records included the original feedback, advice from the CFET where required and a record of the outcome. 6.54

According to the established workflow, all complaints should be addressed by contacting clients by phone or in writing. The review of the selected feedback records showed that nine out of ten clients or carer partner(s) that had made a complaint had been contacted. One complaint that was received related to the appropriateness of treatment from a clinical specialist. The CFET recommended that the clinical specialist contact the complainant directly to resolve the issue. The clinical specialist acted on this advice and contacted the complainant to discuss the complaint. Due to the nature of the complaint, it would have been better for the complaint to have been addressed and resolved by an Executive Level Officer. 6.55

Use of data to report on and improve service delivery

Prior to the implementation of the DHR, CHS used the ACT Patient Administration System (ACTPAS) to manage central patient information. Outpatient services had access to data and reporting capability for services including referral data, workload, client hours and hospital readmission data. This information could be used to provide an indication of service performance. The RADAR service sourced data and reported on key information to governance forums with a focus on using the data to improve service delivery. For example, a *RADAR Overview Report* provided to the RACS Executive in August 2022 documented key RADAR service activity data that was used to highlight an increase in workload for the RADAR service and the potential need for additional staff. The GGC or MAS have not produced a similar report. 6.61

Due to DHR reporting constraints for outpatient service data, primarily due to inconsistencies in how services record information in the DHR, trends, issues, discrepancies, gaps and root cause of variances are not routinely identified and reported on. This means that the GGC, MAS and RADAR service are unable to effectively monitor performance data relating to referral rates and sources, wait times or staff workload and are unable to effectively monitor and report on performance to: 6.65

- assess whether services are meeting the needs of the community; or
- identify mitigation strategies to rectify performance issues.

The RACS Quality and Safety Committee regularly reviews consumer feedback data including: number of compliments, complaints and comments received; number of complaints resolved within the CHS target of 35 days; percentage of patient survey results that rated the services provided as ‘very good’ or ‘good’; and top three compliment and complaint themes. Complaint themes relating to conduct, information/communication/education and access were consistently highlighted in reports between August 2022 and February 2024 (18 reports in total). There was no 6.75

further description for each theme. There is no evidence that the RACS Quality and Safety Committee discussed the cause of the themes being consistently raised.

In December 2022, the RADAR service conducted a *Geriatric patients readmitted within 28 days with RADAR involvement: clinical and social characteristics* clinical audit. The findings were used to identify potential service improvements for the RADAR service. There has not been a follow-up audit to determine whether the findings from this audit have improved the services provided by the RADAR service. Audits have not been conducted in relation to the GGC or MAS and there are currently no plans in place to evaluate these services. 6.81

Recommendations

Recommendation 1	Geriatrics Medicine Unit planning and reporting

CHS should ensure that the Geriatric Medicine Unit (GMU):

a) develops an annual unit work plan, in accordance with the requirements of the *CHS Planning for Exceptional Care: Planning Framework 2021-2024*, that aligns with and supports RACS divisional business plans; and

b) as part of this process, and in accordance with the requirements of the *Performance Reporting and Monitoring Framework 2022-2024*, identify appropriate mechanisms for monitoring and reporting on performance against established performance measures.

Recommendation 2	Tracking of referral sources

CHS should develop its information management and processing capabilities to monitor and report on sources of referral to the GGC, MAS and RADAR service.

Recommendation 3	Information on the HealthPathways portal

CHS should liaise with the Capital Health Network to review and update the service-specific referral criteria that is published on the HealthPathways Portal for the GGC, MAS and RADAR service.

Recommendation 4	Wait time data

CHS and the Health and Community Services Directorate should collaborate to develop source system capabilities to monitor and report on wait time data for the GGC, MAS and RADAR service.

Recommendation 5 **Pre-appointment client letters**

CHS should review and improve information provided in pre-appointment client letters for the GGC, MAS and RADAR service.

Recommendation 6 **Repository of information, resources and available supports**

CHS should develop and maintain a repository of information, resources and available supports that clinicians can easily access and provide to clients and care partners following a diagnosis of dementia or Mild Cognitive Impairment where appropriate.

Recommendation 7 **Models of care**

CHS should develop and implement models of care for the GGC and MAS, and update the *RADAR Model of Care* as required, to reflect:

a) referral acceptance eligibility criteria in accordance with the requirements of the *CHS Medical Specialist Outpatient Referral Acceptance (Adults and Children) Policy*;

b) a framework for prioritising accepted referrals;

c) a formal process and protocols for managing and supporting clients and care partner(s) in distress whilst waiting for an appointment;

d) minimum standards for communicating diagnoses, test results and next steps;

e) protocols for the provision of a post-feedback follow up session and additional follow-up sessions, where it is identified by clinicians as required;

f) defined risk reduction information that is to be provided to clients diagnosed with early stages of dementia or Mild Cognitive Impairment; and

g) a common approach for the delivery of risk reduction information across CHS' specialist assessment services for dementia and cognitive decline.

Recommendation 8 **Collection of referral and clinical information**

CHS should develop:

a) a standard operating procedure(s) for the collection and storage of referral information in the DHR relating to the GGC, MAS and RADAR service; and

b) guidelines that specify minimum requirements, including the fields that should be used, to support the consistent collection of clinical information in the DHR.

Recommendation 9 Consumer Feedback Management Policy

CHS should review and update the *Consumer Feedback Management Policy* to:

a) clearly define roles and responsibilities for responding to feedback; and

b) establish a process to confirm whether business units have appropriately addressed feedback.

Agencies' response

In accordance with subsection 18(2) of the *Auditor-General Act 1996*, Canberra Health Services was provided with a draft proposed report for comment. In accordance with subsection 18(3) of the *Auditor-General Act 1996* the Health and Community Services Directorate (formerly the ACT Health Directorate) was also provided with a *draft proposed report* for comment.

All comments in response to the draft proposed report were considered and changes were reflected in a *first final proposed report*. Canberra Health Services and the Health and Community Services Directorate were provided with the *first final proposed report* for comment.

All comments in response to the first final proposed report were considered and changes were reflected in a *second final proposed report*. Canberra Health Services and the Health and Community Services Directorate were provided with the *second final proposed report* for comment.

All comments in response to the second final proposed report were considered and changes were reflected in a *final report*. As part of the final proposed report process, agencies were invited to provide comments for inclusion in the *final report* in the Summary chapter. The following comments were provided for inclusion in the Summary chapter.

Canberra Health Services

Canberra Health Services (CHS) acknowledges the importance of independent performance audits in supporting transparency, accountability and the continuous quality improvement of services.

CHS welcomed the opportunity to participate in this review and to reflect on the delivery of specialist assessment services for dementia and cognitive decline across the General Geriatrics Clinic (GGC), Memory Assessment Service (MAS), and Rapid Assessment of the Deteriorating Aged at Risk (RADAR) Service.

CHS notes that the audit assessed these services against the Memory and Cognition Guidelines: National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia (2021), developed by the Australian Dementia Network. While these guidelines are

respected and provide an aspirational model for multidisciplinary clinics, they have not been adopted or implemented by CHS and do not reflect the design or intent of the current operating model of the three services. This difference has been highlighted in the conclusions of the report.

CHS acknowledges the professionalism and clinical expertise of the teams working across GGC, MAS, and RADAR. These services are led by experienced geriatricians, nurse practitioners, registered nurses, and allied health professionals who apply sound clinical judgement and autonomy in accordance with national standards and guidance of the relevant specialty colleges and professional associations. These teams provide high quality clinical care to the Canberran community.

CHS is committed to considering the recommendations from the audit as part of its broader commitment to continuous clinical service improvement. The opportunity provided by external audit to identify ways to improve the quality, accessibility, and responsiveness of specialist assessment services is welcomed by CHS.

1 Introduction

Dementia in the ACT

1.1 Dementia is a progressive, irreversible neurocognitive disorder (NCD) characterised by the Diagnostic Statistical Manual of Mental Disorders (DSM 5) as:

> An acquired deficit in cognitive function impairing attention, planning, inhibition, learning, memory, language, visual perception, spatial skills, social skills or other cognitive functions.

1.2 Dementia's prevalence is increasing as Australia's population ages. Dementia Australia estimates that as of 2025, 6,100 people were living with dementia in the Australian Capital Territory (ACT). This is predicted to increase to 12,300 (an increase of 102 percent) by 2054.[1]

1.3 In 2024, approximately 430 people in the ACT were living with Younger Onset Dementia, which is when onset of dementia symptoms occurs in people under 65 years. This is predicted to increase to 650 (a 51 percent increase) by 2054.[2]

Dementia's impact

1.4 The symptoms of dementia can profoundly impact the daily life of those who experience them. Individuals living with dementia may undergo psychological, cognitive and sensory changes including memory loss, changes in planning or problem-solving skills, trouble doing everyday tasks, changes in mood or personality, apathy, poor judgement and lack of insight, problems with speaking and writing and confusion about time and place.[3]

1.5 Care partners, including family, can also be impacted by a diagnosis. In 2018, the most common reason for primary carers of people with dementia to take on their caring role was because it was a family responsibility.[4] People living with dementia often require comprehensive support with everyday living, sometimes reducing the care partner's ability to participate in other activities, including paid employment. As of 2019, 66 percent of

[1] Dementia Australia (2025) *Dementia facts and figures*, Dementia Australia website, accessed 19 March 2025.

[2] Dementia Australia (2024) *2024-2054 Dementia Prevalence Data Estimates and Projections – All forms of dementia*, Dementia Australia website, accessed 19 March 2025.

[3] Healthdirect (2024) *Dementia – an overview*, Healthdirect website, accessed 19 March 2025.

[4] Australian Institute of Health and Welfare (AIHW) (2024) *Dementia in Australia – Carers of people with dementia*, AIHW website, accessed 19 March 2025.

people aged 30 to 84 and 33 percent over 85 with dementia in the ACT were living in the community, as opposed to residential aged care.[5]

1.6 Common complications associated with dementia, including falls and urinary tract infections, may require hospitalisation. In 2022-23, there were 26,300 people hospitalised in Australia due to dementia, totalling 407,100 bed days.[6]

1.7 When hospitalised, people with dementia are at higher risk for adverse events and preventable complications including falls, pressure injuries, infection and death. In 2020-21, dementia accounted for $3.7 billion of total direct health and aged care system expenditure in Australia.[7] Some reports estimate this cost is much higher.

Specialist assessment services for dementia and cognitive decline

1.8 Specialist assessment services for dementia and cognitive decline assess and treat clients with dementia and cognitive decline. Australian Clinical Guidelines advise medical practitioners who suspect cognitive impairment to refer clients to a specialist assessment service for dementia and cognitive decline for a comprehensive assessment and diagnosis.[8]

1.9 Specialist assessment services for dementia and cognitive decline are a key contact point of specialised advice within the health care system. They can:

- provide support and care for people with dementia and their care partners;
- facilitate access to treatment;
- act as pathways to referral for further support; and
- provide a source of authoritative advice for general practitioners.

[5] AIHW (2023) *Geographical variation in health service use by people living with dementia –Demographics*, AIHW website, accessed 19 March 2025.

[6] AIHW (2024) *Dementia in Australia – Hospitalisations due to dementia*, AIHW website, accessed 19 March 2025.

[7] AIHW (2024) *Dementia in Australia – Health and aged care expenditure on dementia*, AIHW website, accessed 19 March 2025.

[8] NHMRC (2016) *Clinical Practice Guidelines and Principles of Care for People with Dementia*, NHMRC website, accessed 19 March 2025.

1.10 Timely access to specialist assessment services for dementia and cognitive decline has potential benefits for those diagnosed, their care partners and families including:

> … receiving treatments that may potentially slow functional decline, providing opportunities to make decisions about the future and enabling participation in clinical trials and other research.[9]

Territory roles and responsibilities

Canberra Health Services

1.11 CHS operates a range of services relevant to people with dementia and cognitive decline. These services include assessment services, inpatient wards, outpatient clinics and support services.

1.12 Services may be specifically targeted towards people exhibiting signs of dementia or cognitive decline or they may offer a broader range of support and intervention of which care for dementia and cognitive decline is a part. A description of CHS services relevant to people with dementia and cognitive decline is provided in Table 1-1.

Table 1-1 CHS services relevant to people with dementia and cognitive decline

Service	Description
Advanced Care Planning	Provides assistance to complete Statement of Choices, Power of Attorney and Health Direction documents.
Aged Care Assessment Team (ACAT)	Provides assessments to help frail older people access support.
Clinical Psychology Service	Outpatient clinic at the University of Canberra Hospital. Provides therapies, techniques and strategies for people recovering from a recent brain injury or illness and older people with cognitive difficulties.
General Geriatric Clinic (GGC)	Outpatient clinic at the University of Canberra Hospital. Refer to Table 1-2 for a more detailed description.
Memory Assessment Service (MAS)	Outpatient clinic at the University of Canberra Hospital. Refer to Table 1-2 for a more detailed description.
Geriatric Acute Wards	Inpatient wards 11a and 11b at Canberra Hospital. Provides acute inpatient services to older people including those living with dementia.
Geriatric Rapid Acute Care Evaluation (GRACE)	Mobile community service based at North Canberra Hospital for residents living in Residential Aged Care Facilities. Develops assessments and care plans in partnership with primary care providers, aged care facility staff and emergency health services.

[9] Pavkovic S, Goldberg LR, Alty JE and Abela M (2023) 'Enhancing post-diagnostic care in in Australian memory clinics: Health professionals' insights into current practices, barriers and facilitators, and desirable support', *Dementia*, 23(1):109-131.

Service	Description
Rapid Assessment of the Deteriorating Aged at Risk (RADAR)	Mobile team of doctors, nurses and allied health workers, based at the University of Canberra Hospital and Canberra Hospital. Visits clients in their home to conduct physical and cognitive assessments and conducts 'hot clinics' at Canberra Hospital. Refer to Table 1-2 for a more detailed description.
Residential Aged Care Liaison Nurse	Assists Canberra Hospital or University of Canberra Hospital patients moving into a Residential Aged Care facility.

Source: Audit Office based on *The Integrated Atlas of Dementia Care in the Australian Capital Territory*.

Specialist assessment services for dementia and cognitive decline

1.13 Specialist assessment services for dementia and cognitive decline are provided by three CHS services, primarily located at the University of Canberra Hospital:

- General Geriatric Clinic (GGC);
- Memory Assessment Service (MAS); and
- Rapid Assessment of the Deteriorating Aged at Risk (RADAR) service.

1.14 Specialist assessment services for dementia and cognitive decline are part of the overall service offerings of the three CHS services. A 2024 study published by the University of Canberra showed that at least half of all clients of all three services had dementia.[10] A description of each of the three CHS services is shown in Table 1-2.

Table 1-2 GGC, MAS and RADAR service descriptions

Service	Description of service
GGC	A geriatrician-led service that offers comprehensive geriatric assessments for people over the age of 65, or 45 years and older for Aboriginal and Torres Strait Island peoples with multiple and complex medical issues. These may include, but are not limited to: – older people at risk of falls; – those who need to use multiple medications; – those with memory decline; and – osteoporosis.
MAS[1]	A geriatrician-led service that provides early diagnosis, treatment, advice and referral services for people under the age of 70 who may be suffering with early memory changes or possible dementia.
RADAR service	A multidisciplinary team of doctors, nurses and allied health professionals that visit people aged over 65, or 45 years and over for Aboriginal and Torres Strait Islander people, in their home to conduct physical and mental assessments. It provides various geriatric services including: – physical and mental/memory assessments;

[10] Tabatabaei-Jafari H et. al (2024) 'The Integrated Atlas of Dementia Care in the Australian Capital Territory: A Collective Case Study of Local Service Provision', *Health Services Insights,* (17):3. See 'Supplementary Material – Supplementary Table 1' for list of services.

Service	Description of service
	– falls assessments; – medication review; – pain review; – collection of bloods, urine and stool samples and swabs; – home environment assessment; – recommendations for home modification and equipment; – increasing services at home if able/needed; – organising direct admission to hospital if needed; and – contacting general practitioners.

Source: Audit Office, based on CHS documentation.

Note 1: CHS advised that 'the Memory Assessment Service (MAS) is for people under the age of 70 years. In practice, MAS has occasionally accepted referrals originally directed to the General Geriatric Clinic during periods of high demand. Geriatricians have also referred some patients aged 70-80 years to MAS when a more detailed review of a dementia diagnosis was required'.

1.15 The GGC, MAS and RADAR service are part of the Geriatric Medicine Unit (GMU) within the Rehabilitation, Aged and Community Services (RACS) Division of CHS.

1.16 The Full Time Equivalent (FTE) allocation for each service as at November 2024 is shown in Table 1-3.

Table 1-3 GGC, MAS and RADAR service full-time equivalent (FTE) (November 2024)

Service	Role	FTE Allocation	Notes
GGC	Geriatrician	0.5	7 Geriatricians provide services in the GGC, with one working across both the GGC and MAS.
MAS	Geriatrician	0.5	4 Geriatricians provide services in the MAS, with one working across both the GGC and MAS.
RADAR service	Geriatrician	1.0	-
	Registrar	1.0	-
	Resident Medical Officer	1.0	-
	Registered Nurses	3.0	-
	Allied Health Professionals	1.0	Includes Occupational Therapist and Social Worker.

Source: Audit Office, based on CHS documentation.

1.17 In response to the first final proposed report, CHS advised that the FTE allocation for the RADAR service Allied Health Professionals has increased since audit fieldwork. The FTE for RADAR service Allied Health Professionals as at August 2025 is shown in Table 1-4.

Table 1-4 RADAR service Allied Health Professional FTE (August 2025)

Allied Health Professional	FTE Allocation	Notes
Nutritionist	0.2	Previously not funded, but service was provided.
Occupational Therapist	1.0	Previously funded at 0.5 FTE, increased from February 2025.
Physiotherapist	1.0	Previously not funded, funded February 2025.
Social Worker	1.0	Previously funded at 0.5 FTE, increased from January 2025.

Source: Audit Office, based on CHS advice.

Health and Community Services Directorate

1.18 The Health and Community Services Directorate (formerly the ACT Health Directorate) is responsible for setting policy and planning the delivery of health services in the ACT. This function includes managing demand for and supply of health services, leading health workforce and clinical strategies and undertaking infrastructure programs.

Audit objective and scope

Audit objective

1.19 The objective of the audit was to assess the effectiveness of Canberra Health Services' (CHS) specialist assessment services for dementia and cognitive decline.

Audit scope

1.20 The audit focused on the activities of CHS to plan for and manage services that provide specialist assessments for dementia and cognitive decline.

In-scope services

1.21 The services that were in-scope for the audit were the:

- General Geriatric Clinic (GGC);
- Memory Assessment Service (MAS); and
- Rapid Assessment for Deteriorating Aged at Risk (RADAR) service.

Planning and management of services

1.22 The audit considered CHS' activities to plan for, and manage, the intake of clients referred to the services including:

- service referral and pre-appointment plans and processes; and
- the definition and communication of service roles and responsibilities.

Client support and communication

1.23 The audit considered CHS' activities for post-assessment support and communication with clients, care partners and/or family including:

- plans and processes for post-assessment support, advice and care; and
- communication processes with referring entities, clients and care partner(s).

Monitoring, evaluation and reporting

1.24 The audit considered CHS' activities to monitor, evaluate and report on service delivery, including the use of service delivery data to inform performance improvement.

1.25 In considering the use of service delivery data and its use to inform performance improvement, the audit considered:

- processes and procedures for collecting and managing information to assist in the planning for, and management of, client care;
- monitoring and reporting of performance; and
- the use of evaluation and reporting processes to inform care and support arrangements for clients, care partner(s) and/or families.

Out of scope

1.26 The audit did not review or assess the accuracy of clinical assessments and decisions.

1.27 The audit did not consider services that do not primarily perform specialist assessments for dementia and cognitive decline. Out of scope services that may assist people living with dementia in the ACT include:

- the Geriatric Rapid Acute Care Evaluation (GRACE);
- the Aged Care Assessment Team (ACAT);
- the Older Persons Mental Health Community Teams (OPMHCT);
- the Clinical Psychology Service; and
- private practices.

Audit criteria, approach and method

Audit criteria

1.28 To form a conclusion against the objective, the following criteria were used:

- Do the services have effective plans and processes to manage timely intake of referred clients?
  - Do service referral plans and processes align with principles identified in the National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia 2021 (the National Service Guidelines)?
  - Do service pre-appointment practices align with principles identified in the National Service Guidelines?
  - Are service roles sufficiently defined and communicated to facilitate appropriate referrals?
- Do the services facilitate effective post-assessment support, advice and care for clients and/or care partner(s)?
  - Do services have documented plans and processes for post-assessment support, advice and care?
  - Do service plans and processes for post-assessment support, advice and care align with principles identified in the National Service Guidelines?
  - Does service post-assessment follow-up with clients and/or care partner(s) align with principles identified in the National Service Guidelines?
- Do the services communicate effectively with clients and/or care partner(s)?
  - Do services communicate in accordance with principles identified in the National Service Guidelines?
  - Are resources available for effective communication?
- Do the services use service delivery data and information effectively?
  - Does service information collection and management align with the CHS Performance Reporting and Monitoring Framework?
  - Does service monitoring align with the CHS Performance Reporting and Monitoring Framework?
  - Does service evaluation and reporting align with the CHS Performance Reporting and Monitoring Framework?

National Service Guidelines

1.29 The Audit Office assessed each service against national standards set out in the Australia Dementia Network (ADNeT) *Memory and Cognition Clinic Guidelines: National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia* (National Service Guidelines). The audit assessed each in-scope service (GGC, MAS and RADAR service) against the version of the Guidelines published in 2021.

Relevance of the National Service Guidelines

1.30 The National Service Guidelines were developed to establish recommended national service standards for Australian Memory and Cognition Clinics. Memory and Cognition Clinics are defined by the National Service Guidelines as:

> … a multidisciplinary, specialist assessment service for dementia and cognitive decline. The multidisciplinary team may either be employed within the clinic or engaged via established and timely referral networks.[11]

1.31 The Audit Office noted the similarity between the specialist assessment services for dementia and cognitive decline offered by the GGC, MAS and RADAR service and the services offered by Memory and Cognition Clinics (as defined in the National Service Guidelines) and has therefore used the National Service Guidelines as a source of better practice by which to assess the delivery of services. The Audit Office notes, however, that CHS has not explicitly adopted the National Service Guidelines for use by the GGC, MAS or RADAR service.

1.32 Although the National Service Guidelines have not been adopted or endorsed by CHS, the Audit Office considers that they represent better practice and provide appropriate guidance for the elements of the GGC, MAS and RADAR service that offer specialist assessment services for dementia and cognitive decline.

Application of the National Service Guidelines

1.33 The National Service Guidelines identify Standards for the delivery of services. Standards are categorised according to the strength of their recommended application. A definition of each recommendation level and a definition of each is shown in Table 1-5.

Table 1-5 National Service Guidelines recommendation levels and definitions

Level	Definition
Strong Recommendation (SR)	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.

[11] Australian Dementia Network (2021) *Memory and Cognition Clinic Guidelines: National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia*, page 8.

Level	Definition
	They achieved the highest level of agreement (>70% of responses were within the "high agreement" rating on the Likert scale) during the Delphi Process. It is expected that all Memory and Cognition Clinics would be able to meet these recommendations, independent of their location and financial resources.
Recommendation (R)	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic. These recommendations achieved a moderate to high level of agreement (>70% of responses were between "medium" and "high agreement" ratings on the Likert Scale). It is expected that most Memory and Cognition Clinics would be able to meet these recommendations if sufficient resources were available.
Practice Point (PP)	These recommendations represent mostly aspirational criteria. They might not apply to each clinic or might be currently unfeasible given the highly variable staffing and financial resources of Australian Clinics.

Source: Audit Office, based on the *Memory and Cognition Clinic Guidelines: National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia.*

1.34 The National Service Guidelines recognise that it is unrealistic to expect services to meet every standard.

1.35 The Audit Office based the audit criteria on selected aspects of the National Service Guidelines Standards that align with the audit scope. Standards that were not used for the purpose of the audit relate to clinical assessments and decisions, which are outside the scope of this audit. The audit focuses only on administrative functions, and not clinical judgment, when assessing the effectiveness of in-scope services.

1.36 Chapters 3 to 5 of the report consider the performance of the GGC, MAS and RADAR service against National Service Guidelines Standards. The audit provides an assessment of whether each service is meeting the requirements of each standard either fully, partially or not at all. Table 1-6 shows the description of each assessment category.

Table 1-6 Performance keys and descriptions

Key	Category description
✓	Meets National Service Guidelines Standard.
✗	Does not meet National Service Guidelines Standard.
●	Partially meets National Service Guidelines Standard.
N/A	National Service Guidelines Standard requirement is not applicable to this service

Source: Audit Office.

Audit approach and method

1.37 The audit was conducted in accordance with *ASAE 3500 – Performance Engagements.* The audit adopted the policy and practice statements outlined in the Audit Office's *Performance Audit Methods and Practices* (PAMPr) which is designed to comply with the requirements of the *Auditor-General Act 1996* and *ASAE 3500 – Performance Engagements.*

1.38 The Audit Office complied with the independence and other relevant ethical requirements related to assurance engagements in the conduct of this audit.

1.39 The audit approach and method consisted of:

- interviews with key CHS staff, non-government organisations and private sector practitioners;
- identifying, reviewing and analysing relevant information provided by CHS including policies, procedures and financial records;
- analysing Digital Health Record (DHR) activity data and selected appointment records for the in-scope services; and
- performing an interjurisdictional review of specialist assessment services for dementia and cognitive decline and associated academic literature.

Analysis conducted

1.40 The Audit Office analysed the following data and information as specific to the GGC, MAS and RADAR service:

- activity data sourced from the DHR;
- appointment records for appointments that occurred between November 2022 and September 2024;
- referral records that were received between May 2022 and May 2024;
- interviews with CHS medical practitioners; and
- feedback records sourced from the RiskMan feedback module for feedback that was received between January 2022 and June 2024.

DHR activity data

1.41 The Audit Office reviewed activity data sourced from the DHR for all three services from November 2022 to September 2024. The data contained basic records of:

- 1,906 GGC and MAS appointments; and
- 2,194 RADAR service appointments.

1.42 The activity data included the date of the appointment, appointment provider, patient identification number associated with the appointment and whether the appointment was a new consultation or follow up consultation.

1.43 CHS reported that wait times included in the dataset are unverifiable and unreliable. Therefore, the Audit Office did not use them for the purpose of the audit.

Appointment records

1.44 The Audit Office reviewed 140 appointment records specific to specialist assessment services for dementia and cognitive decline provided by the GGC, MAS and RADAR services between 2022 and 2024.

1.45 The appointment records contained written information about client history, discussions with clients and care partners surrounding care and support, test results, recommendations to the referring medical practitioner and plans for follow up. A breakdown of the appointment records by specialist and year is shown in Table 1-7.

Table 1-7 Breakdown of appointment records by specialist

Service	Specialist	Number of appointment records provided
General Geriatric Clinic (66 records)	Geriatrician 1	15
	Geriatrician 2	15
	Geriatrician 3	10
	Geriatrician 4	11
	Geriatrician 5	15
Memory Assessment Service (45 records)	Geriatrician 1	15
	Geriatrician 2	15
	Geriatrician 3	15
RADAR (29 records)	Geriatrician 1	3
	Geriatrician 2	5
	Geriatrician accompanied by a registered nurse and/or allied health	21

Source: Audit Office.

Referral records

1.46 The Audit Office selected and reviewed 45 referral records (15 for each service) that were specific to specialist assessment services for dementia and cognitive decline the GGC, MAS and RADAR service provided between May 2022 and May 2024.

Interviews

1.47 The Audit Office interviewed seven medical specialists from the GGC, MAS and RADAR service. A breakdown of the medical specialists interviewed is shown in Table 1-8.

Table 1-8 Number of medical specialists interviewed

Service	Number of medical specialists interviewed	Number of medical specialists allocated to service
General Geriatric Clinic	3	7
Memory Assessment Service	2	4
RADAR	1	1
Senior Clinician (works across all services)	1	1

Source: Audit Office analysis based on Geriatric Outpatient Clinic Structure.

Feedback records

1.48 The Audit Office selected 11 feedback records that were specific to specialist assessment services for dementia and cognitive decline the GGC, MAS and RADAR service provided between 2022 and 2024. Feedback records included complaints, compliments or comments from clients or care partners and records of how CHS had managed each feedback record. This information was sourced from the RiskMan feedback module that CHS uses to record and track feedback.

Subject matter expertise

1.49 The Audit Office engaged the University of Canberra (UC) to provide subject matter expertise. The consultant who provided subject matter expertise to this audit was Dr Nathan D'Cunha (Associate Professor, UC). Dr Nathan D'Cunha is an ACT Health Research and Innovation Fellow focused on non-pharmacological interventions for people with dementia and their care partners and is involved in several research projects on intergenerational care, allied health in residential aged care, and nutrition and healthy ageing.

2 Planning and oversight of service delivery

2.1 This chapter discusses CHS' planning for the delivery of services provided by the GGC, MAS and RADAR service.

Summary

Conclusions

Planning for the delivery of specialist assessment services from the General Geriatric Clinic (GGC), Memory Assessment Service (MAS) and Rapid Assessment of Deteriorating Aged at Risk (RADAR) service can be improved.

The services operate within the Geriatric Medicine Unit (GMU) within the Rehabilitation, Aged and Community Services (RACS) Division of CHS. While the RACS Division has identified key deliverables and actions in annual divisional business plans, it has not clearly articulated which initiatives, deliverables or performance measures that the GGC, MAS or RADAR service were responsible for. Nor does the GMU have a documented work plan that identifies planned deliverables, targets or performance measures relevant for the GMU and the GGC, MAS or RADAR service.

Strategic planning for the delivery of specialist assessment services for dementia and cognitive decline, and dementia services more generally, is expected to be improved by the Health and Community Services Directorate's development of the first ACT-specific, evidence-based framework for care for people with behavioural and psychological symptoms of dementia (BPSD).

Key findings

Planning for service delivery	Paragraph
In December 2024, the Australian Government published the *National Dementia Action Plan 2024–2034* (National Dementia Action Plan). In accordance with the National Dementia Action Plan, the Health and Community Services Directorate is currently developing the first ACT-specific, evidenced-based framework for care for people with behavioural and psychological symptoms of dementia (BPSD). This framework is expected to be released in 2025 and will inform health services planning for people experiencing extreme BPSD. There was no documented overarching strategy that described how the Territory would implement *National Framework for Action on Dementia 2006-2010* or *National Framework for Action on Dementia 2015-2019* priorities for action and there is otherwise no ACT-specific Action Plan to guide dementia care in the Territory.	2.17

The RACS Division has identified key deliverables and actions in annual divisional business plans. Both the *2022-2023 RACS Divisional Business Plan* and *2023-2024 RACS Divisional Business Plan* aligned deliverables with the strategic priorities described in the CHS Strategic Plan and CHS Corporate Plan. Both documents include high-level information that describes the planned deliverables for the division and how the division will measure its performance. Neither business plan clearly articulated which initiatives, deliverables or performance measures that the GGC, MAS or RADAR service were responsible for contributing to. 2.28

According to the CHS Planning Framework, each individual unit, area, or team is required to complete a unit work plan that should align with the divisional business plan. The GGC, MAS and RADAR service are part of the GMU, within the RACS Division. The GMU does not have a documented work plan that identifies planned deliverables, targets or performance measures relevant for the GMU and the services that it provides to the community. 2.32

The CHS Planning Framework describes a model of care as a document that 'outlines the way health services are delivered'. In March 2024, a *RADAR Model of Care* was approved, which clearly describes the services to be provided by the RADAR service and relevant goals and targets and performance measures. The GGC and MAS have not developed models of care. 2.40

Performance oversight

The *Performance Reporting and Monitoring Framework 2022-2024* identifies performance reporting, monitoring and management roles and responsibilities of front-line clinical team members, managers and senior clinicians. Some staff in the RACS Division carry out multi-faceted roles where functions alternate between the front-line clinical staff, managers, senior clinicians and executive responsibilities. This means there is a risk that staff do not understand their responsibilities as they pertain to performance reporting, monitoring and management. 2.47

RACS managers, senior clinicians and the executive rely on information shared at the RACS Executive Committee and Quality and Safety Committee to guide their performance reporting and monitoring activities. However, the inconsistent use of data entry fields and an inability to access required reports from the DHR means that neither committee has access to reporting that accurately reflects the performance of the GGC, MAS or RADAR service. This compromises the ability of managers, senior clinicians and the executive to identify trends, issues, discrepancies, gaps, root cause of variances or opportunities for performance improvement. 2.52

The RACS Executive Committee is responsible for 'providing leadership, direction and management' for the RACS Division. It meets monthly. Between January 2022 and November 2024, the RACS Executive Committee met 28 times out of a possible 34 (82 percent). At each of the meetings, an update from the GMU was provided. The RADAR service was discussed at several meetings in the context of workload concerns and provision of advice in relation to ongoing recruitment of a nurse practitioner, but the GGC and MAS were not specifically discussed. 2.60

The RACS Quality and Safety Committee is responsible for '[overseeing] the management and implementation of quality and safety' for the RACS Division. The committee is primarily focused on monitoring data and information that CHS is required to collect under the National Safety and Quality Health Service Standards and considers a range of clinical quality and safety matters. The committee has had a limited role in overseeing the performance reporting and monitoring of the GGC, MAS and RADAR service. 2.66

Planning for service delivery

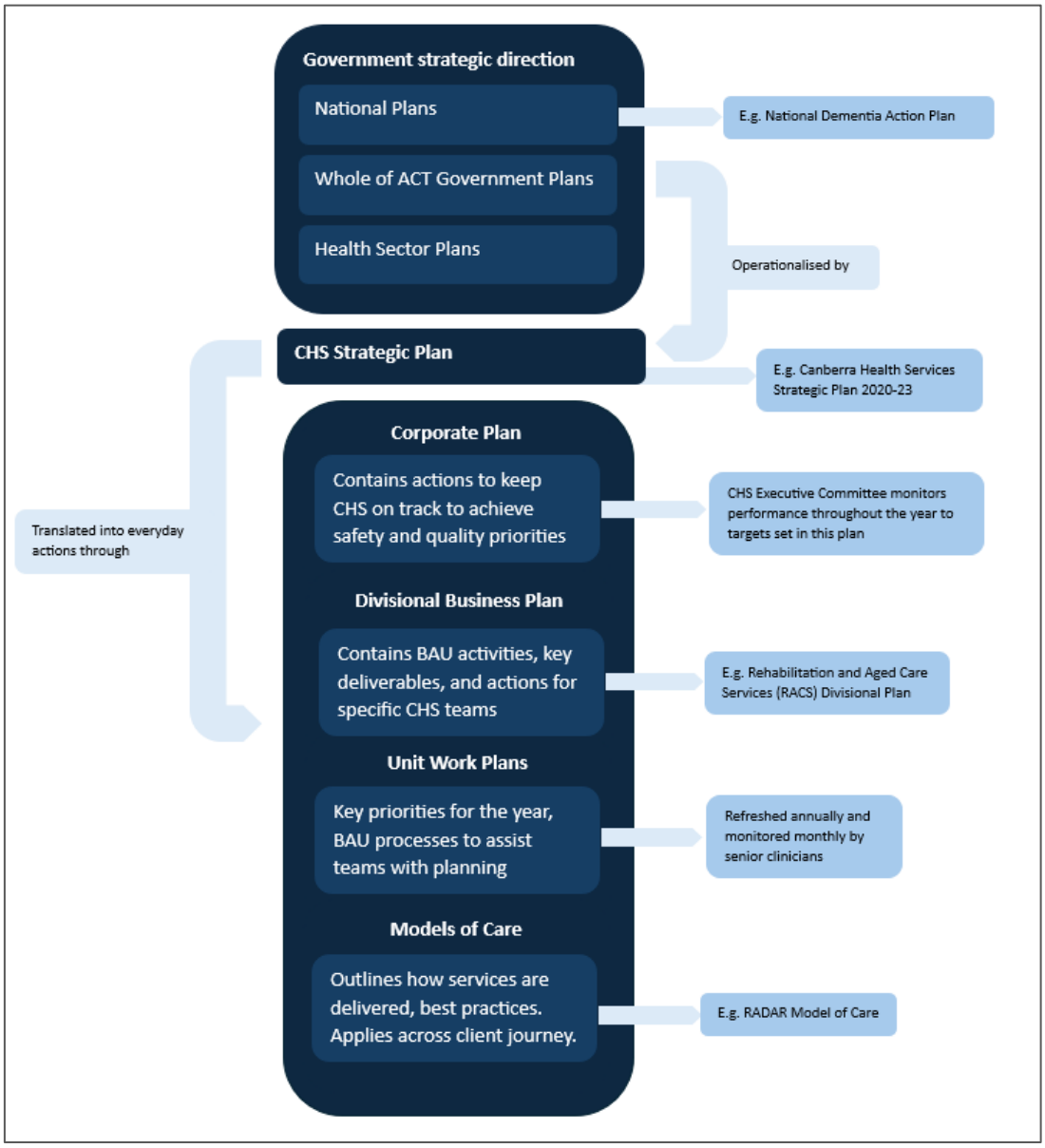
2.2 In May 2022, CHS published the *Canberra Health Services Exceptional Care Framework 2020-2023* (the Exceptional Care Framework). The Exceptional Care Framework describes CHS' approach to service delivery. It is supported by eight supplementary organisation-wide 'foundational frameworks' that focus on governance, consumers, planning, performance, workforce capabilities, improvement and innovation, risk and human resources.

2.3 This chapter considers CHS' planning for the delivery of services provided by the GGC, MAS and RADAR service against two of the eight foundational frameworks:

- the *CHS Planning for Exceptional Care: Planning Framework 2021-2024* (the CHS Planning Framework); and
- the *CHS Measuring Exceptional Care Performance Reporting and Monitoring Framework 2022-24* (the CHS Reporting and Monitoring Framework).

2.4 The CHS Planning Framework describes CHS' approach to strategic and business planning to support the delivery of services. CHS' approach to strategic and business planning is shown in Figure 2-1.

Figure 2-1 CHS approach to strategic and business planning



Source: Audit Office, based on the *Planning for Exceptional Care – Planning Framework 2021-2024.*

2.5 According to the CHS Planning Framework, the strategic direction for dementia care should be:

- informed by national dementia planning; and
- operationalised at the divisional and service levels through divisional business plans, unit work plans and models of care.

National strategic direction for dementia

National Frameworks for Action on Dementia

2.6 The Australian Government has developed and published two national frameworks for action on dementia:

- *National Framework for Action on Dementia 2006–2010*; and
- *National Framework for Action on Dementia 2015-2019*.

2.7 The national frameworks provide strategic direction to states and territories and 'guide the development and implementation of actions, plans and policies to reduce the risk of dementia and improve outcomes for people with dementia and their carers'.

National Framework for Action on Dementia 2006–2010

2.8 In May 2006 the Australian Health Ministers' Conference published the *National Framework for Action on Dementia 2006–2010*. The National Framework stated it:

> … will build on a solid foundation of dementia plans developed by the States and Territories. In the context of these initiatives, the *National Framework for Action on Dementia 2006–2010* looks beyond aged care to consider the health care and support implications of dementia.[12]

2.9 The *National Framework for Action on Dementia 2006–2010* identified five priorities for action that focused on care and support, access and equity, information and education, research and workforce and training.

National Framework for Action on Dementia 2015-2019

2.10 In August 2012, Australian health ministers agreed to designate dementia as the ninth National Health Priority Area. The actions from the *National Framework for Action on Dementia 2006-2010* were used as a foundation for the *National Framework for Action on Dementia 2015-2019*.

2.11 The National Framework for Action on Dementia 2015-2019 identified its purpose was to:

> … guide the development and implementation of actions, plans and policies to reduce the risk of dementia and improve outcomes for people with dementia and their carers.

2.12 The former ACT Health Directorate undertook various supporting activities for the priorities for action described in the *National Framework for Action on Dementia 2006-2010* and *National Framework for Action on Dementia 2015-2019.* However, the former ACT Health Directorate was unable to provide evidence of operational plans or policies specific to

[12] Australian Health Ministers' Conference (2006), *National Framework for Action on Dementia 2006-2010*, accessed 19 March 2025.

dementia and cognitive decline that were developed and implemented during this period, or an overarching strategy that described how the priorities for action were to be implemented for the Territory.

National Dementia Action Plan 2024–2034

2.13 In December 2024, the Australian Government published the *National Dementia Action Plan 2024–2034* (National Dementia Action Plan). The Action Plan was endorsed by health ministers across Australia, including the ACT Minister for Health on behalf of the Territory.

2.14 The Action Plan 'sets out a plan for continuing to improve the lives and care of people living with dementia in Australia over the next 10 years' and states that its implementation will be supported by:

> **Collective Priority Frameworks** – that will set out priorities that governments will focus on for the first 3 years of the Action Plan. It is anticipated there would be 3 collective priority frameworks spanning the life of the Action Plan.
>
> **Monitoring and data improvement** – Data will be collected and analysed over the life of the Action Plan to help measure progress and achievements against activities over time.
>
> **Reporting** – There will be annual reporting on the difference being made under the Action Plan, looking at both changes in the measures of progress and at activities delivered. A comprehensive mid-point review will also be conducted.
>
> **Governance** – Clear governance arrangements will underpin implementation of the Action Plan to drive implementation, oversee monitoring and reporting and to keep governments accountable and on track.[13]

2.15 The National Dementia Action Plan sets out eight actions. *Action 4 - Improve dementia diagnosis and post diagnostic care and support* is particularly relevant to the GGC, MAS and RADAR service. Action 4 is shown in Figure 2-2.

[13] Australian Government Department of Health and Aged Care (DHAC) *National Dementia Action Plan 2024-2034*, DHAC website, accessed 19 March 2025.

Figure 2-2 Action 4 of the *National Dementia Action Plan 2024–2034*

Action 4: **Improve dementia diagnosis and post diagnostic care and support**

Outcome statement for people living with dementia

I can recognise the signs of dementia and understand where to go if I have concerns. I can access health professionals who are willing and able to assess my symptoms and provide a timely diagnosis. I am linked with information and supports to assist me, my carer and my family immediately following a dementia diagnosis.

How are we going to make a difference?

1. Review and update clinical practice guidelines and principles of care for people living with dementia every 3 to 5 years.
2. Review how the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) support effective dementia diagnosis and ongoing management every 3 to 5 years.
3. Clarify pathways for dementia screening, assessment and diagnosis across the country, including identification of best practice.
4. Increase the capacity and reach of memory clinics and review the funding model.
5. Embed memory clinics in targeted Aboriginal Controlled Community Health Organisations (ACCHOs) and Aboriginal Controlled Community Organisations (ACCOs) to support improved access, diagnosis and care for First Nations people.
6. Develop and promote culturally appropriate cognitive assessment tools in partnership with diverse communities and experts, and support training for clinicians to use these tools.
7. Improve support, care coordination and planning for people living with dementia and their carers following a dementia diagnosis, including models for First Nations, CALD and other diverse communities.
8. Improve diagnostic and post-diagnostic services and supports for groups facing additional barriers to care, such as people living with younger onset dementia and children living with dementia and their families.
9. Improve and embed supports for people living with dementia in disability support services.

Need for change	Finding out about dementia early is essential. Support from health, aged care, and disability services should help people living with dementia to enjoy their lives as much as possible.
Where do we want to be in 10 years?	Dementia signs are recognised, and people are diagnosed as early as possible, helping them to slow the progression, maximise their abilities and plan for the future. People are provided with information and connected to coordinated supports immediately following their dementia diagnosis.
How will we know if we have made a difference?	1. Improved national consistency in services offered across memory clinics for assessment and post-diagnostic care and support. 2. Increased number of people being assessed for dementia in memory clinics. 3. Increased number of First Nations people seen and supported through memory clinics, including through clinics embedded in ACCHOs and ACCOs. 4. Increased number of people with signs and symptoms of dementia who are seen by a specialist within three months of receiving a referral. 5. Reduction in the average time taken for people to receive a diagnosis of dementia from the onset of first symptoms. 6. Increased number of people living with dementia with a chronic disease management plan in place with their GP. 7. Increased number of people living with dementia and their carers reporting a positive experience of diagnostic and post-diagnostic care. 8. More people living with younger onset dementia and children with dementia are accessing and satisfied with diagnostic and post-diagnostic services and supports, including through disability services.

Source: *National Dementia Action Plan 2024–2034*, page 40.

2.16 In accordance with the National Dementia Action Plan, the Health and Community Services Directorate is currently developing the first ACT-specific, evidenced-based framework for care for people with behavioural and psychological symptoms of dementia (BPSD). This framework is expected to be published in 2025 and will inform health services planning for people experiencing extreme BPSD. There is otherwise no ACT-specific Action Plan to guide dementia care in the Territory.

2.17 In December 2024, the Australian Government published the *National Dementia Action Plan 2024–2034* (National Dementia Action Plan). In accordance with the National Dementia Action Plan, the Health and Community Services Directorate is currently developing the first ACT-specific, evidenced-based framework for care for people with behavioural and psychological symptoms of dementia (BPSD). This framework is expected to be released in 2025 and will inform health services planning for people experiencing extreme BPSD. There was no documented overarching strategy that described how the Territory would implement *National Framework for Action on Dementia 2006-2010* or *National Framework for Action on Dementia 2015-2019* priorities for action and there is otherwise no ACT-specific Action Plan to guide dementia care in the Territory.

CHS organisational planning

2.18 According to the CHS Planning Framework, CHS is expected to operationalise the government's strategic direction through organisation-wide, divisional and business unit plans. Organisation-wide strategic planning is apparent through the CHS Strategic Plan and CHS Corporate Plan. Divisional strategic planning is documented in divisional business plans, unit work plans and models of care.

CHS Strategic Plan

2.19 CHS strategic plans define CHS' purpose and vision, identify intended achievements over a defined period and outline relevant accountability indicators. The *CHS Strategic Plan 2020-2023* (the CHS Strategic Plan) identified a series of strategic priorities, based on national, whole-of-government and sector-level planning. Although a revised CHS Strategic Plan was published in August 2024, the audit refers to the *CHS Strategic Plan 2020-2023* as it guided CHS' activities between 2020 and 2024.

2.20 The CHS Strategic Plan identified four strategic priorities. The strategic priorities are expected to guide planning for all service delivery, including the services provided by the GGC, MAS and RADAR service. A summary of the strategic priorities is shown in Figure 2-3.

Figure 2-3 CHS strategic priorities (2020 to 2023)

Source: CHS Strategic Plan 2020-2023, page 5.

CHS Corporate Plan

2.21 CHS corporate plans are the mechanism by which activities established through CHS Strategic Plan strategic priorities are directed. They also serve as a Quality Improvement Plan to support CHS in achieving planned safety and quality priorities. CHS corporate plans are endorsed by the CHS Executive Committee.

July 2022 to June 2023

The *CHS Corporate Plan July 2022 – June 2023* included an initiative that targeted improvements to CHS' delivery of outpatient services, which was particularly relevant to the services provided by the GGC, MAS and RADAR service. Details of the initiative, and its supporting deliverable and performance measure, are shown in Table 2-1.

Table 2-1 Timely care and patient flow initiative (CHS Corporate Plan 2022-23)

Strategic Priority	Initiative	Deliverable	Performance measure
Personal health services	Timely care and patient flow	We will ensure our community is accessing the right care, at the right time, in the right place, with the right clinician	By June 2023, we will increase the % of initial medical specialist outpatient appointments to 35% of all appointments

Source: Audit Office based on the *CHS Corporate Plan July 2022 – June 2023*.

2.22 CHS' *Annual Report 2022-2023* did not report on whether CHS had achieved the performance measure.

July 2023 to June 2024

2.23 The *CHS Corporate Plan July 2023 – June 2024* included the same initiative, but with a revised performance measure. The performance measure was revised to:

> By 30 June 2024, we will publicly report our Outpatient wait times, by Specialty, to provide visibility and transparency to our community, and inform improvement targets.

2.24 CHS' *Annual Report 2023-2024* did not report on whether CHS had achieved the performance measure.

Rehabilitation, Aged and Community Services (RACS) Division Business Plan

2.25 Divisional business plans are an important mechanism for facilitating business units' planning for, and performance monitoring of, services to the community. According to the CHS Planning Framework, annual divisional business plans 'take the actions from the annual Corporate Plan and identify which CHS teams are going to do what'. Divisional business plans should connect corporate plan actions and team activities.

2.26 Both the *2022-2023 RACS Divisional Business Plan* and *2023-2024 RACS Divisional Business Plan* aligned deliverables with the strategic priorities described in the CHS Strategic Plan and CHS Corporate Plan. Both documents included high-level information that described the planned deliverables for the division and how the division will measure its performance.

2.27 Neither business plan clearly articulated the initiatives, deliverables or performance measures that were relevant to the GGC, MAS or RADAR service.

2.28 The RACS Division has identified key deliverables and actions in annual divisional business plans. Both the *2022-2023 RACS Divisional Business Plan* and *2023-2024 RACS Divisional Business Plan* aligned deliverables with the strategic priorities described in the CHS Strategic Plan and CHS Corporate Plan. Both documents include high-level information that describes the planned deliverables for the division and how the division will measure its performance. Neither business plan clearly articulated which initiatives, deliverables or performance measures that the GGC, MAS or RADAR service were responsible for contributing to.

Geriatrics Medicine Unit (GMU) work plan

2.29 According to the CHS Planning Framework, each individual unit, area or team is required to complete a unit work plan that should align with the divisional business plan. The GGC, MAS and RADAR service are part of the GMU, within the RACS Division.

2.30 The CHS Planning Framework specifies that unit work plans should 'articulate key priorities for the year, as well as [business as usual] processes to assist teams with prioritisation and planning' and should be refreshed annually. Performance against the unit work plan should be reviewed every month.

2.31 The GMU does not have a documented work plan. There are no documented planned deliverables, targets or performance measures for the GMU and the services that it provides to the community. There is no assurance that the services provided by the GMU align with the annual divisional business plans or that the GMU has clearly defined outcomes and performance measures by which the performance of services can be assessed.

2.32 According to the CHS Planning Framework, each individual unit, area, or team is required to complete a unit work plan that should align with the divisional business plan. The GGC, MAS and RADAR service are part of the GMU, within the RACS Division. The GMU does not have a documented work plan that identifies planned deliverables, targets or performance measures relevant for the GMU and the services that it provides to the community.

Models of care

2.33 The CHS Planning Framework describes a model of care as a document that:

> … outlines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort. A model of care must be evidence based, apply across the patient journey with all care providers and service partners and linked to the government and CHS strategic direction as articulated in the Strategic Plan.

GGC and MAS

2.34 The GGC and MAS have not developed models of care specific to their services. CHS advised that:

> From a health service perspective, it is worth noting that not all clinical services have documented models of care in place, nor are they expected to, as it is not universally required across all service areas. Rather, we ensure that care delivery follows established best practices and clinical guidelines.

RADAR Model of Care

2.35 In March 2023, the RADAR service developed the *RADAR Model of Care*, which was approved in March 2024. It aims to provide an:

> … evidence-based framework for describing the right care, at the right time, by the right person/team and in the right location across the continuum of care. A clearly defined and articulated MOC helps ensure that all health professionals are 'viewing the same picture', working towards common goals and most importantly evaluating performance on an agreed basis.

2.36 The *RADAR Model of Care* aims to provide information in relation to:

- the principles, benefits and elements of care;
- the basis for how RADAR delivers evidence-based care through integrated clinical practice, education and research;
- patient/client flows (the areas from where patients enter and exit the service) and service coordination;
- the processes and tools used by team members to provide client-centred care; and
- learning and development opportunities for students through clinical placements from a variety of tertiary institutions.

2.37 The *RADAR Model of Care* establishes a series of goals and targets. The goals and targets identified in the *RADAR Model of Care* are shown in Table 2-2.

Table 2-2 *RADAR Model of Care* goals and targets

Description	Target
Patients at high-risk of presentation to hospital stratification will be visited within 72 hrs (i.e., next 3 working days) of receiving referral from GP (Note: identified high/low risk stratification for RADAR patient)	100%
Patients will be visited by medical and nursing staff of receiving referral from GP.	100%
Patients discharged from the wards or ED requiring RADAR follow up will be seen within the timeframe as requested on the referral or as per MDT triage outcomes. Inpatient teams are expected to contact RADAR directly to inform of urgency of review.	100%
Patients will be discharged in 72 hours (e.g., next 3 working days) of decision made to discharge to actual discharge from DHR and internal RADAR database.	80%
Median Length of stay from referral received to referral close date for the period under review. (Exception of guardianship)	-21 days
Patients will have a discharge letter sent to the GP within 72 hrs (next 3 working days) of discharge from RADAR – notes significant delay in transcription service.	80%
Patients who had RADAR home assessment will have a feedback letter at discharge from the RADAR service	100%

Source: *RADAR Model of Care*, pages 26 and 27.

2.38 The *RADAR Model of Care* also identifies four key performance measures, which are shown in Table 2-3.

Table 2-3 *RADAR Model of Care* key performance measures

Description
Response time from referral to first intervention measured in days.
Number of RADAR patients representing to hospital per month and reasons for readmission.

Description
Patient/carers compliment and complaints.
Adverse events.

Source: RADAR Model of Care, page 27.

2.39 The *RADAR Model of Care* is a comprehensive document that clearly describes the functions of the RADAR service and relevant goals and targets and performance measures. The goals and targets and performance measures provide an opportunity for the RADAR service to monitor its performance.

2.40 The CHS Planning Framework describes a model of care as a document that 'outlines the way health services are delivered'. In March 2024, a *RADAR Model of Care* was approved, which clearly describes the services to be provided by the RADAR service and relevant goals and targets and performance measures. The GGC and MAS have not developed models of care.

Performance oversight

CHS Performance Reporting and Monitoring Framework 2022-2024

2.41 The *Performance Reporting and Monitoring Framework 2022-2024* (the Reporting and Monitoring Framework) provides guidance for the monitoring and reporting of performance. The purpose of the Framework was to provide:

> ... a clear understanding of how we report, monitor and manage performance across and at all levels of the organisation. It provides the Framework to ensure there is stewardship, oversight, transparency and shared accountabilities for internal and external performance reporting and monitoring.

2.42 The Reporting and Monitoring Framework also served as a guide for articulating:

> … what we measure, how we measure, and who needs to monitor each aspect of performance to support us to deliver exceptional health care that is safe, effective, personal, accessible, connected, and well-led.

Roles and responsibilities

2.43 The Reporting and Monitoring Framework acknowledges that for consumers and carers to feel confident in the care that they receive, it is important that:

- data is used to improve the quality of care received;
- data and performance can be reviewed by consumers and carers where appropriate; and

- feedback on opportunities for improvement can be provided.

2.44 The roles and responsibilities of front-line clinical team members, managers and senior clinicians as they relate to reporting, monitoring and management of performance are shown in Table 2-4.

Table 2-4 Performance reporting and monitoring roles and responsibilities

Role	Responsibility
Front-line clinical team members	• participate in regular monitoring activities, including audit; • report clinical or staff incidents when they occur; • understand the process of data collection, monitoring, reporting and how it relates to my role; and • work as part of a team to actively improve services in response to what the data tells us.
Managers and senior clinicians	• ensure all staff understand the importance of data collection and analysis and its role at CHS; • work with the executive to set targets for performance, ensure data integrity and appropriateness of measures; • work with Finance and Business Intelligence partners to understand the information provided; • identify and report on trends, issues, discrepancies, gaps and root cause of variances; • identify opportunities for improvement in performance and implement actions to address key issues identified; and • ensure information and data is reviewed, analysed, and key information is reported up to the next level in the organisation.
Executives	• review, endorse, and implement the Performance Reporting and Monitoring Framework; • receive and review reports aligned to key areas of our care, our people, our infrastructure and technology and our performance; • provide feedback, questioning and guidance on areas of focus; • ensure data integrity, appropriateness of data measures and reporting accurately reflects performance; • set targets for performance, identify and action opportunities for improvement from data reports; • set measures for committee review and ensure reporting to governance committees is accurate, appropriate and analysed; • ensure information and data is reviewed, analysed and key information reported up to next level in organisation; and • implement accountability for performance across the organisation.

Source: Audit Office, adapted from the *Performance Reporting and Monitoring Framework 2022-2024.*

2.45 The Reporting and Monitoring Framework does not define positions associated with each role. This gives rise to a risk of staff not understanding their responsibilities for performance reporting and monitoring under the Framework.

2.46 Some staff in the RACS Division carry out roles that are multi-faceted, for which functions alternate between front-line clinical staff, managers, senior clinicians and the executive. For example, there are front-line clinical team members who also have a role as a manager. Similarly, the Clinical Director, Geriatric Medicine, carries out the role of front-line clinical team member, manager, senior clinician and the executive.

2.47 The *Performance Reporting and Monitoring Framework 2022-2024* identifies performance reporting, monitoring and management roles and responsibilities of front-line clinical team members, managers and senior clinicians. Some staff in the RACS Division carry out multi-faceted roles where functions alternate between the front-line clinical staff, managers, senior clinicians and executive responsibilities. This means there is a risk that staff do not understand their responsibilities as they pertain to performance reporting, monitoring and management.

RACS front-line clinical team members

2.48 Discussions with front-line clinical team members that work across the GGC, MAS and RADAR service indicated a consistent understanding of the importance of data collection and how it relates to their role as defined in the *Performance Reporting and Monitoring Framework 2022-2024.*

2.49 Front-line clinical team members working in the GGC, MAS and RADAR service noted that they do not have an explicit role in improving services in response to data because they either do not have access to the required reports in the DHR, or the available reports do not meet their needs. One front-line clinical team member also advised that they did not know how to access data and reporting in the DHR.

RACS managers, senior clinicians and RACS executive

2.50 Discussions with staff representing the roles of managers, senior clinicians and RACS executive indicated that they primarily rely on the information shared at the RACS executive Committee and Quality and Safety Committee to guide their performance reporting and monitoring activities.

2.51 However, the inconsistent use of data entry fields and an inability to access required reports from the DHR means that neither committee has access to reporting that accurately reflects the performance of the GGC, MAS or RADAR service. This compromises the ability of managers, senior clinicians and the executive to identify trends, issues, discrepancies, gaps, the root cause of variances or opportunities for performance improvement.

2.52 RACS managers, senior clinicians and the executive rely on information shared at the RACS Executive Committee and Quality and Safety Committee to guide their performance reporting and monitoring activities. However, the inconsistent use of data entry fields and an inability to access required reports from the DHR means that neither committee has access to reporting that accurately reflects the performance of the GGC, MAS or RADAR service. This compromises the ability of managers, senior clinicians and the executive to identify trends, issues, discrepancies, gaps, root cause of variances or opportunities for performance improvement.

RACS governance oversight

2.53 The Clinical Director, Director of Nursing and Director of Allied Health participate in two RACS Division governance forums established to provide oversight of services provided by the RACS Division:

- RACS Executive Committee: and
- RACS Quality and Safety Committee.

RACS Executive Committee

2.54 The RACS Executive Committee is:

> … responsible for providing leadership, direction and management for the Division of RACS. It is the peak decision-making body for the Division.
>
> The RACS executive addresses all dimensions of organisational performance through its Terms of Reference and associated activities.

2.55 The functions of the RACS Executive Committee include:

- promoting the development of an effective executive team for the RACS Division;
- managing the business of the RACS Division;
- responding to, and providing direction for, emerging issues including key organisation-wide issues;
- disseminating appropriate information from the network and hospital executive committees, e.g. the Canberra Hospital Operation Committee; and
- progressing operational tasks related to the core activities of the RACS Division according to organisational and divisional business plans, as well as reviewing and responding to any emerging activity data.

2.56 The RACS Executive Committee is Chaired by the Executive Director, RACS. The committee is made up of 14 members from across the RACS Division. The most recent terms of reference for the RACS Executive Committee were approved by the Executive Director, RACS on 17 December 2024.

2.57 The RACS Executive Committee meets monthly. Between January 2022 and November 2024, the RACS Executive Committee met 28 times out of a possible 34 (82 percent).

2.58 Between January 2022 and November 2024, the RACS Executive Committee was provided with updates in relation to:

- CHS-wide governance forums of relevance to the RACS Executive Committee;
- financial performance;
- services delivered by the RACS Division including nursing, rehabilitation medicine, geriatric medicine, client support services, allied health and oral health services;
- other information on an as-required basis from areas such as operations, Community Health Centres, the NDIS Support Unit, HR Business Partner or the RACS Executive Officer; and
- emerging issues requiring the attention of the RACS Executive Committee.

2.59 At each of the meetings, an update from the GMU was provided to the committee. The RADAR service was discussed at several meetings in the context of workload concerns and provision of advice in relation to ongoing recruitment of a nurse practitioner. The GGC and MAS services were not specifically discussed.

2.60 The RACS Executive Committee is responsible for 'providing leadership, direction and management' for the RACS Division. It meets monthly. Between January 2022 and November 2024, the RACS Executive Committee met 28 times out of a possible 34 (82 percent). At each of the meetings, an update from the GMU was provided. The RADAR service was discussed at several meetings in the context of workload concerns and provision of advice in relation to ongoing recruitment of a nurse practitioner, but the GGC and MAS were not specifically discussed.

RACS Quality and Safety Committee

2.61 The role of the RACS Quality and Safety Committee is to provide a forum that will:

> Oversee the management and implementation of quality and safety for the Division of RACS and
>
> Ensure that quality and safety information is made available to inform both clinical and administrative decision making.

2.62 The RACS Quality and Safety Committee terms of reference advise that the committee reports to both the Executive Director, RACS and the Chief Operating Officer, CHS. The Executive Director, RACS is also the Chair of the committee. This arrangement does not align with governance better practice and increases the risk of inadequate oversight of the committee. The committee is made up of 17 members and meets on the second Monday of each month.

2.63 Between May 2022 and November 2024, the committee met a total of 20 times out of a possible 30 (66 percent). A review of meeting minutes from the meetings shows that the committee is primarily focused on monitoring data and information that CHS is required to collect under the National Safety and Quality Health Service Standards and considers a range of clinical quality and safety matters.

2.64 The National Safety and Quality Health Service Standards are developed by the Australian Commission on Safety and Quality in Health Care and provide a nationally consistent statement of the level of care consumers can expect from health service organisations. All public and private hospitals, day procedure services and public dental practices are required to be accredited to the National Safety and Quality Health Service Standards.

2.65 The committee did not specifically discuss the GGC or MAS during this period. According to the meeting minutes, the committee discussed the RADAR service twice, in the context of sharing consumer stories with the committee.

2.66 The RACS Quality and Safety Committee is responsible for '[overseeing] the management and implementation of quality and safety' for the RACS Division. The committee is primarily focused on monitoring data and information that CHS is required to collect under the National Safety and Quality Health Service Standards and considers a range of clinical quality and safety matters. The committee has had a limited role in overseeing the performance reporting and monitoring of the GGC, MAS and RADAR service.

Recommendation 1 Geriatrics Medicine Unit planning and reporting

CHS should ensure that the Geriatric Medicine Unit (GMU):

a) develops an annual unit work plan, in accordance with the requirements of the *CHS Planning for Exceptional Care: Planning Framework 2021-2024*, that aligns with and supports RACS divisional business plans; and

b) as part of this process, and in accordance with the requirements of the *Performance Reporting and Monitoring Framework 2022-2024*, identify appropriate mechanisms for monitoring and reporting on performance against established performance measures.

3 Referral management

3.1 This chapter discusses the performance of the GGC, MAS and RADAR service with respect to National Service Guidelines Standards relevant to the management of referrals. The relevant standards are shown in Table 3-1.

Table 3-1 Better practice standards for referral management

Number	Standard
3.1	Memory and Cognition Clinic has clear guidelines for accepting referrals and a framework for prioritising the accepted referrals.
3.2	Referrals to Memory and Cognition Clinic can be accepted from multiple sources.
3.4	To adequately process a referral, Memory and Cognition Clinic ensures that all relevant information is received.
3.5	Memory and Cognition Clinic is encouraged to prioritise the referrals they receive to optimise the case flow.
3.6	Memory and Cognition Clinic ensures timely access to assessment and diagnosis.
4.1	Prior to the assessment, Memory and Cognition Clinic provides written information about the assessment process to their clients.

Source: Audit Office, based on the *National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia.*

Summary

Conclusions

The delivery of specialist assessment services can be improved by the development of clear, documented referral acceptance eligibility criteria and a prioritisation framework for the delivery of services. While aspects of these are addressed through a service-specific *RADAR Model of Care*, there is no similar document for the GGC or MAS.

CHS has a limited understanding of referral patterns to the GGC, MAS and RADAR service, and does not actively monitor or report on referral sources. CHS similarly has a poor understanding of the timeliness of its assessment and diagnosis services and has been unable to identify and report on wait times between referral and initial appointments due to limitations of the Digital Health Record (DHR). Not monitoring referral patterns to the services, or accurately knowing wait times for the services, has significant implications for service planning and service delivery and CHS' ability to demonstrate it is meeting the community's needs.

Key findings

Referral acceptance and client intake

	Paragraph
National Service Guidelines Standard 3.1 states services should have clear guidelines for accepting referrals. The *CHS Medical Specialist Outpatient Referral Acceptance (Adults and Children) Policy* also requires all outpatient services within CHS to have clear, documented referral acceptance eligibility criteria that identify both reasons for referral and suitable conditions for referral. *Outpatient Referral Acceptance Guidelines* have not been developed for the GGC, MAS or RADAR service. The RADAR service has, however, included relevant information in a *RADAR Model of Care*. The absence of documented referral acceptance eligibility criteria for the GGC and MAS increases the risk of inconsistent referrals or acceptance of inappropriate referrals to these services.	3.13
National Service Guidelines Standard 3.2 requires services to accept referrals from multiple sources including General Practitioners (GPs), clinical specialists and other health professionals, as well as self-referrals. The GGC, MAS and RADAR service accept referrals from GPs, clinical specialists and other health professionals, but do not accept self-referrals. While referral from a GP is preferred, allowing self-referral aligns with a person-centred approach and provides an additional option for clients to access services.	3.28
Although the DHR collects data on referring medical professionals, the RACS Division does not actively monitor or report on referral sources for the GGC, MAS or RADAR service. This impedes CHS' ability to determine whether services are meeting the needs of clients across the Territory or identify sources of inadequate referrals and provide targeted education to improve their quality.	3.31
There are two primary sources of information for medical practitioners with regards to referral criteria and the information that should be included in a client referral: the Geriatric Medicine Referrals page on the ACT and Southern New South Wales (SNSW) HealthPathways portal; and the CHS public website. The service-specific criteria published on the Geriatric Outpatient Referrals HealthPathways page for the MAS is incorrect, increasing the risk that medical practitioners may not refer clients under 65 for cognitive assessment. This may delay specialist assessment, diagnosis and support, including application for funding through the National Disability Insurance Scheme (NDIS), for which eligibility ceases after 65. Some of the standard referral information published on HealthPathways is not as detailed as the information required by National Service Guidelines Standard 3.4, which increases the risk of inadequate information being included in client referrals.	3.44
The CHS website contains publicly accessible information about the GGC, MAS and RADAR service, including individual webpages for each service. Each webpage includes a link to the HealthPathways portal that medical practitioners can access if they require more detailed referral information. Medical practitioners must be registered users of the HealthPathways portal to access this information. The Capital Health Network estimates that only one quarter of primary care clinicians in the ACT are registered users.	3.49

Clinicians interviewed for the purpose of the audit reported receiving incomplete referrals and client questionnaires prior to their initial appointment with a client. Analysis of a selection of referrals between 2022 and 2024 for the GGC, MAS and RADAR service shows that key information can be omitted from external referrals including family history, investigatory results (e.g. cognitive screening and imaging) and the client's hearing and vision status. Clinical specialists can be more confident assessing clients when they have these details at the initial assessment, potentially allowing the client to receive treatment and support more quickly through an accurate diagnosis in the initial appointment. 3.53

Referral prioritisation

National Service Guidelines Standard 3.5 encourages services to prioritise the referrals they receive to optimise case flow. The *RADAR Model of Care* includes a prioritisation framework in accordance with the requirements of the standard. The GGC and MAS have not developed a similar prioritisation framework. This increases the risk of excessive wait times for clients requiring care and the risk that people and care partners who may benefit from timely assessment and diagnosis do not receive early intervention and access to services and supports. There is also a risk that those without dementia, but with Mild Cognitive Impairment, may not receive timely advice that could help delay or avoid dementia. 3.65

Triaging referrals based on client characteristics and condition can improve patient outcomes by minimising wait times for those requiring care urgently. The RADAR service is responsible for triaging and prioritising patients for all three services. RADAR service clinicians conduct daily triage and prioritisation of all GGC, MAS and RADAR service referrals. The *RADAR Model of Care* establishes clear triage categories, including for high priority clients. The GGC and MAS services do not have documented prioritisation categories. 3.66

Access to information and support for clients

Access to data on the timeliness of assessment and diagnosis can allow for more informed clinical interventions to help manage symptoms of dementia before the condition progresses. CHS has historically collected data on the timeliness of assessment and diagnosis, including wait time data. CHS advised that, since the implementation of the DHR, the accuracy of the data is unverifiable and therefore unreliable. Not having accurate data on the timelines of the delivery of services, including wait times, has implications for service planning and service delivery. 3.72

National Service Guidelines Standard 4.1 identifies the written information that services should provide to clients prior to their appointment. For GGC and MAS appointments, CHS administration staff send an appointment letter to clients to advise of each scheduled appointment. However, the correspondence does not conform with the requirements of the standard, because it does not include information on the type and purpose of the assessment, wait times, assessment cost and duration or the names of staff members who the client will see at the appointment. The RADAR service does not provide clients with written information 3.80

prior to their appointment. CHS advised this was because clinicians attend clients in their home within a matter of days or weeks.

The wait between receiving a referral and seeing a clinical specialist can be difficult for the client, their care partner(s) or family. National Service Guidelines Standard 4.2 recommends that services support clients and care partners during the wait time for an initial assessment, if required. CHS does not routinely offer clients waiting for GGC and MAS initial appointments counselling or support for themselves or their care partner(s) but would consider attending the client's home to address concerns should they express distress with respect to the expected wait time. The RADAR service acts as an interim support for clients with urgent needs while they wait for an appointment with the GGC and MAS, but this is only provided if the client, or their care partner(s), self identifies as needing additional support. 3.86

Referral acceptance and client intake

3.2 The GGC, MAS and RADAR service can receive referrals from:

- private medical practitioners external to CHS; and
- internal CHS services such as hospital wards and the Emergency Department.

Guidelines and frameworks for accepting and prioritising referrals

3.3 National Service Guidelines Standard 3.1 recommends that services have clear guidelines for accepting referrals and a framework for prioritising referrals that have been accepted.

3.4 A summary of GGC, MAS and RADAR service performance against National Service Guidelines Standard 3.1 is shown in Table 3-2.

Table 3-2 Summary of performance against National Service Guidelines Standard 3.1

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinics have:	**Level**	**GGC**	**MAS**	**RADAR service**
Clear guidelines for accepting referrals and a framework for prioritising accepted referrals.	R	●	●	✓

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.

Level definitions	
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.

Source: Audit Office analysis.

Guidelines for accepting referrals

3.5 Documented guidelines for the acceptance of referrals support:

- timely client access to appropriate services; and
- a common understanding among staff about client eligibility and service functions.

CHS outpatient referral acceptance policy

3.6 The *CHS Medical Specialist Outpatient Referral Acceptance (Adults and Children) Policy* (Referral Acceptance Policy) requires all outpatient services within CHS to have:

> … clear, documented referral acceptance eligibility criteria that will include both reasons for referral and suitable conditions for referral.

3.7 The purpose of the Referral Acceptance Policy is to '… manage demand and establish realistic expectations for referrers and consumers.'

3.8 According to the Referral Acceptance Policy, the Clinical Director and Divisional Executive Director must approve *Outpatient Referral Acceptance Guidelines* for each service. *Outpatient Referral Acceptance Guidelines* should allow for four categories to guide the prioritisation of clients.

3.9 *Outpatient Referral Acceptance Guidelines* for each service should be circulated to, and used by, the CHS Central Health Intake (CHI) team, the CHS General Practitioner Liaison Service and the ACT and SNSW Health Pathways (Capital Health Network) to facilitate a consistent understanding of referral acceptance criteria for each service.

3.10 *Outpatient Referral Acceptance Guidelines* have not been developed for the GGC, MAS or RADAR service. The RADAR service has, however, included the required information in the *RADAR Model of Care*. There is no similar document for the GGC or MAS.

3.11 Section 7 of the *RADAR Model of Care* provides details of referral pathways and client eligibility criteria for the RADAR service. The criteria that must be met for clients to be referred to the RADAR service are that:

- The person is aged 65 years or over and 45 years or over for Aboriginal or Torres Strait Islander.
- The person has suffered a decline in function/ability, which the referring doctor anticipates will result in a likely hospital admission within the next two weeks.
- The person is being discharged home from the care of a General Medicine or Geriatric Staff Specialist from an ACT Public Health Facility (UCH/TCH).
- The person does not require immediate hospital admission for an acute illness.

- There is a high likelihood that the person will be able to stay in their usual place of residence whilst the clinical reason for their deterioration is managed.

3.12 Section 7 of the *RADAR Model of Care* also details processes for external and internal referrals and referral criteria flowcharts for referrals from medical practitioners, the Emergency Department and inpatient units. Flowcharts contain information specific to each scenario including service aims, appropriate person for referral, method of referral, role of the RADAR service team and exclusion criteria. Each scenario flowchart identifies:

- the aims of the RADAR service;
- criteria to guide appropriate referral to the RADAR service;
- exclusion criteria;
- team member roles within the RADAR service;
- the role of the RADAR service; and
- methods of referral.

3.13 National Service Guidelines Standard 3.1 states services should have clear guidelines for accepting referrals. The *CHS Medical Specialist Outpatient Referral Acceptance (Adults and Children) Policy* also requires all outpatient services within CHS to have clear, documented referral acceptance eligibility criteria that identify both reasons for referral and suitable conditions for referral. *Outpatient Referral Acceptance Guidelines* have not been developed for the GGC, MAS or RADAR service. The RADAR service has, however, included relevant information in a *RADAR Model of Care*. The absence of documented referral acceptance eligibility criteria for the GGC and MAS increases the risk of inconsistent referrals or acceptance of inappropriate referrals to these services.

3.14 Recommendation 7 is intended to address this finding.

Framework for prioritising referrals

3.15 Prioritisation and triage processes are discussed from paragraph 3.54.

Accepting referrals from multiple sources

3.16 People who require specialist assessment services for dementia and cognitive decline may present to the health system in a variety of ways. More referral opportunities increase access to specialist assessment, diagnosis, treatment and support. To address issues such as stigma and delayed recognition of symptoms, services should network effectively with other health and social care system components to receive referrals from a range of services.

3.17 National Service Guidelines Standard 3.2 states:

> Referrals to Memory and Cognition Clinics can be accepted from multiple sources.
>
> - GP or medical specialist – Preferred referral source [Strongly recommended]
> - Self-referrals – The GP's endorsement of the self-referral or general involvement of the GP should be encouraged to ensure ongoing support after the Memory and Cognition Clinic assessment [Recommended]
> - Other health professionals – This may include, but is not limited to, nurse practitioners, allied health and the Aged Care Assessment Team (ACAT) [Recommended]

3.18 A summary of the GGC, MAS and RADAR service performance against National Service Guidelines Standard 3.2 is shown in Table 3-3.

Table 3-3 Summary of performance against National Service Guidelines Standard 3.2

National Service Guidelines Standard requirement		**Meeting National Service Guidelines Standard?**		
Referrals to Memory and Cognition Clinic can be accepted from multiple sources:	**Level**	**GGC**	**MAS**	**RADAR service**
GP or a medical specialist.	SR	✓	✓	✓
Self-referrals.	R	✗	✗	✗
Other health professionals.	R	✓	✓	✓

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.

Source: Audit Office analysis.

Referral sources

3.19 All services accept referrals from General Practitioners (GPs), clinical specialists and other health professionals in accordance with National Service Guidelines Standard 3.2. However, no service accepts self-referrals, which the standard recommends.

3.20 While referral from a GP is preferred, allowing self-referral aligns with a person-centred approach and provides an additional option for clients to access services.

GGC and MAS referral sources

3.21 The services provided by CHS' geriatric outpatient services are described in the *Geriatric Outpatient Services Description*. The Description also includes general information on referral sources for the GGC and MAS.

3.22 The *Geriatric Outpatient Services Description* provides the following information on referral sources for CHS' geriatric outpatient services:

> … referrals to these services are received from General practitioners and other clinicians within the hospital…
>
> … referral by General Practitioner/another clinician.

3.23 The publicly available webpages for the GGC and MAS reinforce that clients can only access the service through referral from a GP or clinical specialist.

3.24 The GGC and MAS also receive referrals from the RADAR service. Analysis of appointment records for the GGC and MAS show that RADAR service clinicians often refer directly to these services for follow up appointments.

RADAR service referral sources

3.25 The RADAR service relies upon the *RADAR Model of Care* to guide the services that are delivered to clients. The *RADAR Model of Care* does not contain a clear list of referral sources, but does state that:

> RADAR is a rapid response program to support older persons in the community when they are becoming unwell, and their own General Practitioner (GP) requires assistance with medical management. RADAR also assists with timely and effective transition to the home of clients being discharged from inpatient wards (Geriatric and General Medicine) and the emergency department (ED) who may require geriatric support in addition to the care provided by their general practitioner (GP).
>
> In exceptional circumstances, a referral may be accepted from other sources such as senior health care professional (HCP) working in primary health care.

3.26 The CHS website provides publicly available information in relation to the RADAR service:

> If you are in hospital, the medical team in the Emergency Department or in the wards can refer you to our service when you're discharged. Otherwise, you will need a referral from your general practitioner or community health professional.

3.27 In response to the draft proposed report CHS advised that there were risks with allowing a person to self-refer to the service:

> This approach could significantly increase demand and impact service capacity. Referral from a General Practitioner is preferred and represents established practice. It also ensures continuity of care, with the GP remaining a key part of the patient's healthcare team.

3.28 National Service Guidelines Standard 3.2 requires services to accept referrals from multiple sources including General Practitioners (GPs), clinical specialists and other health professionals, as well as self-referrals. The GGC, MAS and RADAR service accept referrals from GPs, clinical specialists and other health professionals, but do not accept self-referrals. While referral from a GP is preferred, allowing self-referral aligns with a person-centred approach and provides an additional option for clients to access services.

CHS understanding of referral sources

3.29 The GGC, MAS and RADAR service are the primary public health services undertaking specialist cognitive assessments for dementia and cognitive decline in the ACT. It is important that CHS understands referral trends so that the services are better able to meet the needs of the community.

3.30 Although the DHR collects data on referring medical professionals, the RACS Division does not actively monitor or report on referral sources for the GGC, MAS or RADAR service. Without a clear understanding of referral patterns, including which health professionals refer to services and from where, CHS is not able to:

- determine whether services are meeting the needs of clients across the Territory; or
- identify sources of inadequate referrals and provide targeted education to improve the quality of these referrals.

3.31 Although the DHR collects data on referring medical professionals, the RACS Division does not actively monitor or report on referral sources for the GGC, MAS or RADAR service. This impedes CHS' ability to determine whether services are meeting the needs of clients across the Territory or identify sources of inadequate referrals and provide targeted education to improve their quality.

Recommendation 2 Tracking of referral sources

CHS should develop its information management and processing capabilities to monitor and report on sources of referral to the GGC, MAS and RADAR service.

Collecting referral information

3.32 Services must collect information prior to an appointment with a client to ensure the attending clinical specialist has sufficient personal and medical information to make the best use of the limited appointment time. Complete information may help the clinical specialist make a confident assessment in the client's first appointment and remove the need to wait for a second appointment to receive a diagnosis and begin treatment.

3.33 National Service Guidelines Standard 3.4 states:

> To adequately process a referral, Memory and Cognition Clinic ensures that all relevant information is received, including:
>
> - Demographic information [Strongly recommended]
> - Client's preferred spoken language, language abilities, and the need for an interpreter [Strongly recommended]
> - Main symptoms [Strongly recommended]
> - Progression of symptoms (e.g., rapid decline, no decline noticed) [Strongly recommended]
> - Medical and psychiatric history [Strongly recommended]
> - A list of current medications [Strongly recommended]
> - Family history [Recommended]
> - Presence of behavioural and/or psychological symptoms [Recommended]
> - Blood test results [Recommended]
> - Imaging results [Recommended]
> - Reports by other specialists or previous investigations [Recommended]
> - Information about safety concerns for the client or family/carer [Recommended]
> - Results of cognitive screening [Practice Point]
> - Information regarding the clients support network [Practice Point]
> - Hearing status [Practice Point]
> - Vision [Practice Point]

3.34 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 3.4 is summarised in Table 3-4.

Table 3-4 Summary of performance against National Service Guidelines Standard 3.4

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
To adequately process a referral, Memory and Cognition Clinic ensures that all relevant information is received, including:	**Level**	**GGC**	**MAS**	**RADAR service**
Demographic information.	SR	✓	✓	✓
Preferred spoken language, language abilities, need for interpreter.	SR	✓	✓	✓
Main symptoms.	SR	✓	✓	✓
Progression of symptoms.	SR	✓	✓	✓
Medical and psychiatric history.	SR	✓	✓	✓
List of current medications.	SR	✓	✓	✓
Family history.	R	✓	✓	✓
Presence of behavioural and/or psychological symptoms.	R	✓	✓	✓
Blood test results.	R	✗	✗	✗
Imaging results.	R	✗	✗	✗
Reports by other specialists or previous investigations.	R	✓	✓	✓
Information about safety concerns for the client or family/carer.	R	✓	✓	✓
Results of cognitive screening.	PP	✗	✗	✗
Information regarding the client's support network.	PP	✓	✓	✓
Hearing status.	PP	✗	✗	✗

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
To adequately process a referral, Memory and Cognition Clinic ensures that all relevant information is received, including:	**Level**	**GGC**	**MAS**	**RADAR service**
Vision.	PP	✗	✗	✗

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.
PP	These recommendations represent mostly aspirational criteria.

Source: Audit Office analysis.

Referral criteria and information provided to medical practitioners

3.35 There are two primary sources of information for medical practitioners with regards to referral criteria for the GGC, MAS and RADAR service and the information that should be included in a client referral:

- the *Geriatric Medicine Referrals* webpage on the ACT and Southern New South Wales (SNSW) HealthPathways clinical and referral information portal; and
- the CHS website.

ACT and SNSW HealthPathways

3.36 ACT and SNSW HealthPathways (the HealthPathways portal) is a clinical and referral information portal managed by the Capital Health Network (CHN). It provides localised health information for clinicians to make referral decisions or seek further information from clinical specialists. The portal is not available to the public.

3.37 GPs, clinical specialists and allied health professionals can register to use the HealthPathways portal. The Capital Health Network estimates that only one quarter of primary care clinicians in the ACT are registered users.

3.38 The content published on the portal is maintained by the Capital Health Network in partnership with ACT Health, CORDINARE (Southeastern NSW Primary Health Networks) and the SNSW Local Health District. Content specific to the GGC, MAS and RADAR service is

produced by the Capital Health Network in consultation with CHS. This is facilitated through regular contact with manager-level RACS Division clinicians that provide subject matter expertise to guide the accuracy and suitability of content.

3.39 Service-specific criteria, referral options and guidance on information that should be included in referrals to each service is published in the HealthPathways portal for the GGC, MAS and RADAR service.

3.40 Information for the GGC and MAS is combined on the CHS Geriatric Outpatient Referrals section of the HealthPathways Portal. The service-specific criteria for these services are published as follows:

- Aged at least 65 years old.
- Aboriginal and/or Torres Strait Islander aged at least 45 years old.
- New and follow up appointments.
- Patient is required to have a diagnosed medical condition.

3.41 The service-specific criteria are incorrect for the MAS. According to publicly available information, the MAS provides services to clients under the age of 70, thereby including those under the age of 65. This is a discrepancy in information that increases the risk that medical practitioners may not refer clients under 65 for cognitive assessment. If not referred, younger people with symptoms of dementia may experience delayed specialist assessment, diagnosis and support, including funding through the National Disability Insurance Scheme (NDIS), for which eligibility ceases after 65.

3.42 Standard and service-specific information required for a referral is published on the Geriatrics Outpatient Medicine Referrals page of the HealthPathways portal for the GGC, MAS and RADAR service. The information required for a referral, including patient, clinic and practitioner details, as well as clinical details, aligns with the recommended referral information included in National Service Guidelines Standard 3.4.

3.43 However, some of the standard referral information published on the HealthPathways portal is not as detailed as that required by National Service Guidelines Standard 3.4. For example, although the HealthPathways portal requests copies of ‘results of relevant investigations’, it does not specifically request blood test, imaging or cognitive screening results. Similarly, although the HealthPathways portal requests that medical practitioners provide information in relation to ‘other important factors such as social factors and other services involved’ it does not specifically request family history. This increases the risk of inadequate information being included in referrals to the GGC, MAS and RADAR service.

3.44 There are two primary sources of information for medical practitioners with regards to referral criteria and the information that should be included in a client referral: the Geriatric Medicine Referrals page on the ACT and Southern New South Wales (SNSW) HealthPathways portal; and the CHS public website. The service-specific criteria published on the Geriatric Outpatient Referrals HealthPathways page for the MAS is incorrect, increasing the risk that medical practitioners may not refer clients under 65 for cognitive assessment. This may delay specialist assessment, diagnosis and support, including application for funding through the National Disability Insurance Scheme (NDIS), for which eligibility ceases after 65. Some of the standard referral information published on HealthPathways is not as detailed as the information required by National Service Guidelines Standard 3.4, which increases the risk of inadequate information being included in client referrals.

Recommendation 3 Information on the HealthPathways portal

CHS should liaise with the Capital Health Network to review and update the service-specific referral criteria that is published on the HealthPathways Portal for the GGC, MAS and RADAR service.

CHS website

3.45 The CHS website contains publicly accessible information about the GGC, MAS and RADAR service. This includes an individual webpage for each service that contains an 'information for referrers' panel and dedicated phone numbers that can be used to contact CHS for further information.

3.46 Each panel includes a link to the HealthPathways portal that medical practitioners can access if more detailed referral information is required. Medical practitioners must be registered users of the HealthPathways portal to access this information.

3.47 On 1 February 2025, CHS published territory-wide referral criteria that aims to assist medical practitioners make appropriate referrals to specialist clinics. It provides an extensive list of minimum information that should be included in a referral. The CHS website advises that eReferrals that do not meet the prescribed criteria will be returned to medical practitioners for updating and resubmission. In relation to communication and support that medical practitioners have received surrounding this change, CHS advised that:

> All medical practitioners that refer to CHS have received communication to refer to the website for further information. This has been done through GP Liaison Unit, via email or via response to manual referrals received after 1 February 2025.

3.48 In response to the draft proposed report, CHS advised that 'eReferrals are the most secure and reliable method for submitting referrals' and that:

> When referrals are received outside the eReferral system, our Central Health Intake (CHI) team contacts the referrer to provide support and education on the appropriate process.
>
> Referrers are provided with registration links, and CHS is committed to ensuring that timely and accurate referrals are directed to the appropriate services via CHI.

3.49 The CHS website contains publicly accessible information about the GGC, MAS and RADAR service, including individual webpages for each service. Each webpage includes a link to the HealthPathways portal that medical practitioners can access if they require more detailed referral information. Medical practitioners must be registered users of the HealthPathways portal to access this information. The Capital Health Network estimates that only one quarter of primary care clinicians in the ACT are registered users.

Referral information provided to CHS

3.50 The Audit Office analysed a selection of 45 referrals (15 for each service) received between 2022 and 2024 against each element prescribed in National Service Guidelines Standard 3.4. The result of this analysis is shown in Table 3-5.

Table 3-5 Percentage of referrals that included Standard 3.4 prescribed elements

National Service Guidelines Standard	Level	GGC	MAS	RADAR service
Demographic Information.	SR	100%	100%	87%
Client's preferred spoken language, language abilities and need for an interpreter.	SR	60%	67%	40%
Main symptoms.	SR	67%	100%	93%
Progression of symptoms.	SR	27%	53%	40%
Medical and psychiatric history.	SR	100%	93%	87%
A list of current medications.	SR	100%	87%	67%
Family history.	R	7%	47%	7%
Presence of behavioural and/or psychological symptoms*	R	13%	60%	47%
Blood test results.	R	33%	80%	33%
Imaging results.	R	7%	20%	13%
Reports by other specialists or previous investigations.	R	27%	67%	27%

National Service Guidelines Standard	Level	GGC	MAS	RADAR service
Information about safety concerns for the client or family/carer.	R	7%	20%	53%
Results of cognitive screening.	PP	33%	27%	7%
Information regarding the client's support network.	PP	60%	60%	73%
Hearing status.	PP	7%	7%	0%
Vision.	PP	7%	0%	0%

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.
PP	These recommendations represent mostly aspirational criteria.

Source: Audit Office analysis, based on analysis of 45 referrals from 2022 to 2024.
*This would likely only be included if there are changed behaviours present.

3.51 Of the strongly recommended standards, only 'progression of symptoms' was lacking across the referrals. This was due to the way the referring medical practitioner described symptoms at a point in time, often with minimal background.

3.52 Notably, all the services received little information about family history. Receiving information about family history is relevant to assess the appropriateness of the referral and to determine prioritisation. Investigation and testing results were also often omitted from the referral, meaning clinical specialists sometimes lacked key information prior to the client's initial appointment. Referrers rarely provided the client's hearing and vision status, which could impact the diagnostic process when they attend their specialist appointment. Knowledge of a client's memory and vision status helps provide person-centred care by identifying and responding to the person's needs.

3.53 Clinicians interviewed for the purpose of the audit reported receiving incomplete referrals and client questionnaires prior to their initial appointment with a client. Analysis of a selection of referrals between 2022 and 2024 for the GGC, MAS and RADAR service shows that key information can be omitted from external referrals including family history, investigatory results (e.g. cognitive screening and imaging) and the client's hearing and vision status. Clinical specialists can be more confident assessing clients when they have these details at the initial assessment, potentially allowing the client to receive treatment and support more quickly through an accurate diagnosis in the initial appointment.

Referral prioritisation

Prioritising referrals to optimise case flow

3.54 A prioritisation framework, which is supported by clear prioritisation criteria, can assist services to provide appointments in a consistent and equitable manner. A prioritisation framework allows for a structured, transparent and equitable approach to decision-making when making decisions about referrals. It can facilitate the prioritisation of limited resources for clients that most urgently require care and effectively manage increasing demand to promote timely assessment and diagnosis.

3.55 National Service Guidelines Standard 3.5 states:

> Memory and Cognition Clinics are encouraged to prioritise the referrals they receive to optimise case flow. Under the following circumstances, a referral is regarded as "high priority":
>
> - Safety concerns in the current living situation (for client or family/carer).
> - Suspected self-neglect or abuse.
> - Clients who care for others (e.g., parents of young children, carers of a person with a disability, etc.).
> - Rapid cognitive decline.
> - Significant carer burden and stress.
> - Other safety concerns (e.g. driving, depression symptoms).
> - Clients with a suspected diagnosis of young onset dementia.

3.56 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 3.5 is summarised in Table 3-6.

Table 3-6 Summary of performance against National Service Guidelines Standard 3.5

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic is encouraged to prioritise the referrals they receive to optimise the case flow. Under prescribed circumstances a referral is regarded as **'**high priority**'.**	**Level**	**GGC**	**MAS**	**RADAR service**
Safety concerns in the current living situation (for client or family/carer).	SR	✗	✗	✓

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic is encouraged to prioritise the referrals they receive to optimise the case flow. Under prescribed circumstances a referral is regarded as **'high priority'.**	**Level**	**GGC**	**MAS**	**RADAR service**
Suspected self-neglect or abuse.	SR	✗	✗	●
Clients who care for others (e.g., parents of young children, carers of a person with disability, etc).	SR	✗	✗	●
Rapid cognitive decline.	SR	✗	✗	✓
Significant carer burden and stress.	SR	✗	✗	●
Other safety concerns (e.g., driving, depression symptoms).	SR	✗	✗	●
Clients with a suspected diagnosis of young onset dementia.	SR	✗	✗	●

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.

Source: Audit Office analysis.

Prioritisation

3.57 The RADAR service is responsible for triaging and prioritising patients for all three services. RADAR service clinicians conduct daily triage and prioritisation of all GGC, MAS and RADAR service referrals.

RADAR service prioritisation framework

3.58 Section 8 of the *RADAR Model of Care* outlines the patient triage process for the RADAR service. The patient triage procedure states:

> If patient is at high risk for presentation to hospital according to various variables, a home assessment is organised within 72 hours (i.e., next three working days).
>
> In the instance of an external referral is received on a Friday afternoon, the GP is contacted to discuss the referral and to ascertain the condition and safety of the patient over the weekend if appropriate the patient will then be assessed on the Monday.
>
> If it is deemed that patient will not be safe over the weekend or that the patient's condition will deteriorate significantly then it will be recommended that the patient be sent to the emergency department.

3.59 The *RADAR Model of Care* provides detailed triage criteria for high, moderate and low priority clients and further defines the timeframes for each category based on client acuity.

3.60 According to the *RADAR Model of Care* clients are considered high-priority and should be visited within 72 hours if there is:

> … a high risk of re-admission, or admission to hospital with two or more of the following risk factors:
>
> - Discharged against medical advice.
> - Lives alone.
> - Recurrent falls.
> - Cognitive Impairment/Dementia.
> - Impaired physical functioning (ie personal/practical ADLs).

3.61 The triage category does not explicitly include some of the key elements required by National Service Guidelines Standard 3.5 including 'suspected self-neglect or abuse', 'clients who care for others' or 'significant carer burden and stress'. However, many of the high priority categories do closely resemble those recommended by the standard.

GGC and MAS prioritisation

3.62 Neither the GGC nor MAS service have a documented prioritisation framework. In the absence of a prioritisation framework for the GGC and MAS, CHS advised that:

> A clinician at triage looks at the information provided by the GP and decides on the best possible service for a patient. It is important to keep the criteria open due to the general nature of the clinics. Prioritisation is one of the purposes of triage.

3.63 By not having a documented prioritisation framework, or similar guidance in a model of care, there is a risk of excessive wait times for clients requiring care and that people and care partners who may benefit from timely assessment and diagnosis do not receive early

intervention and access to services and supports. There is also a risk that those without dementia, but with Mild Cognitive Impairment, may not receive timely advice that could help delay or avoid dementia.

3.64 In response to the draft proposed report, CHS advised that:

> Triage is a core function of the RADAR team and is undertaken as part of standard clinical practice by experienced clinicians applying their clinical judgment… patients referred are captured in the referral criteria that apply to RADAR. And so, any patient identified as being in an unsafe environment, experiencing carer stress or rapid decline (for example) would be captured, utilising the expertise and clinical judgement of the team reviewing the referrals, and managed appropriately utilising the resources of the 3 services as indicated.

3.65 National Service Guidelines Standard 3.5 encourages services to prioritise the referrals they receive to optimise case flow. The *RADAR Model of Care* includes a prioritisation framework in accordance with the requirements of the standard. The GGC and MAS have not developed a similar prioritisation framework. This increases the risk of excessive wait times for clients requiring care and the risk that people and care partners who may benefit from timely assessment and diagnosis do not receive early intervention and access to services and supports. There is also a risk that those without dementia, but with Mild Cognitive Impairment, may not receive timely advice that could help delay or avoid dementia.

3.66 Triaging referrals based on client characteristics and condition can improve patient outcomes by minimising wait times for those requiring care urgently. The RADAR service is responsible for triaging and prioritising patients for all three services. RADAR service clinicians conduct daily triage and prioritisation of all GGC, MAS and RADAR service referrals. The *RADAR Model of Care* establishes clear triage categories, including for high priority clients. The GGC and MAS services do not have documented prioritisation categories.

Access to information and support for clients

Timely access to assessment and diagnosis

3.67 Timely access to assessment and diagnosis allows for clinical interventions to help manage symptoms of dementia before the condition progresses. Medication, lifestyle changes and therapies may slow dementia's progression. Timely intervention through specialist cognitive assessment can also reduce stress on care partners by providing access to legal and financial planning, respite and other support including My Aged Care or the National Disability Insurance Scheme (NDIS).

3.68 National Service Guidelines Standard 3.6 states:

> Memory and Cognition Clinic ensures timely access to assessment and diagnosis:
>
> - For **high priority** clients, Memory and Cognition Clinic provides an initial appointment within 30 days of referral, ideally within 14 days of referral.
> - For **routine priority** clients Memory and Cognition Clinic provides initial appointment within 90 days of referral (strongly recommended), within 60 days of referral (recommended), Ideally within 45 days of referral.

3.69 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 3.6 could not be assessed because of a lack of accurate and reliable information.

3.70 CHS advised that, since the implementation of DHR, the accuracy of data on the timeliness of assessment and diagnosis is unverifiable and therefore unreliable. This has significant implications for service planning including an inability to:

- judge system capacity in real time. Wait times could increase substantially and services may be unaware and unable to respond; and
- determine and advocate for budgetary and resourcing requirements. CHS could use data on the timeliness of assessment and diagnosis to demonstrate its resource needs. The need for this data will become increasingly pertinent as the ACT's population ages and the prevalence of dementia increases.

3.71 Without this information, it is not possible for CHS to accurately identify and report on key performance metrics, including whether high priority clients are provided with an initial appointment within 30 days of referral or whether routine priority clients are provided with an initial appointment within 90 days of referral.

3.72 Access to data on the timeliness of assessment and diagnosis can allow for more informed clinical interventions to help manage symptoms of dementia before the condition progresses. CHS has historically collected data on the timeliness of assessment and diagnosis, including wait time data. CHS advised that, since the implementation of the DHR, the accuracy of the data is unverifiable and therefore unreliable. Not having accurate data on the timelines of the delivery of services, including wait times, has implications for service planning and service delivery.

Recommendation 4 Wait time data

CHS and the Health and Community Services Directorate should collaborate to develop source system capabilities to monitor and report on wait time data for the GGC, MAS and RADAR service.

Providing written information to clients

3.73 Being well-prepared for an appointment can reduce client anxiety and enhance their experience. Preparation is particularly important given those using the GGC, MAS or RADAR service may experience cognitive impairment, making it more difficult to navigate everyday tasks, like finding the service's location or understanding what to bring to their appointment.

3.74 National Service Guidelines Standard 4.1 states:

> Prior to the assessment, Memory and Cognition Clinic provides written information about the assessment process to their clients. This information includes:
>
> - Types and purpose of assessment
> - Waiting times – if a booking has not been made, the Memory and Cognition Clinic staff should provide approximate waiting times to the clients with a brief explanation of potential delays. Staff members should emphasise to the clients that waiting times depend on a variety of factors, and, thus, can vary from the suggested ones
> - Assessment costs and duration
> - General information relevant to the appointment – this includes information about:
>   - The names of staff members the client will see on the day
>   - Location and parking or public transport access (e.g. a map)
>   - What to bring for the appointment (especially glasses, hearing aids, and medication).

3.75 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 4.1 is summarised in Table 3-7.

Table 3-7 Summary of performance against National Service Guidelines Standard 4.1

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Prior to the assessment, Memory and Cognition Clinic provides written information about the assessment process to their clients. This information includes:	**Level**	**GGC**	**MAS**	**RADAR service**
Types and purpose of assessment.	SR	✗	✗	N/A
Waiting times.	SR	✗	✗	N/A
Assessment costs and duration.	SR	✗	✗	N/A

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Prior to the assessment, Memory and Cognition Clinic provides written information about the assessment process to their clients. This information includes:	**Level**	**GGC**	**MAS**	**RADAR service**
General information relevant to the appointment such as names of staff members the client will see at appointment, location and parking or public transport access (e.g. a map), What to bring for the appointment (especially glasses, hearing aids, and medication).	SR	●	●	N/A

Assessment outcome key	
✕	Does not meet National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.
N/A	National Service Guidelines Standard requirement is not applicable to this service.
Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.

Source: Audit Office analysis.

Written information provided to clients about the assessment process

GGC and MAS

3.76 GGC and MAS appointments are scheduled by the RACS administration team, which is based at the University of Canberra Hospital. The RACS administration team also sends written information to clients to advise them of their scheduled appointment, via an appointment letter.

3.77 The appointment letter does not conform with the requirements of National Service Guidelines Standard 4.1. It does not include information on the type and purpose of the assessment, wait times, assessment cost and duration or the names of staff members who the client will see at the appointment.

3.78 The appointment letter includes a phone number for the RACS administration team, which allows clients to ask questions prior to their appointment. The administration team also calls clients to remind them of their appointment. CHS clinical staff recognised that the content of the pre-appointment letter required improvement as they could not be certain it was meeting the needs of clients and care partners. Staff also advised of an expectation

for a revised pre-appointment letter, which would incorporate clinician and nurse input to leverage their expertise and experience.

RADAR service

3.79 The RADAR service does not provide clients with written information prior to their appointment. CHS advised this was because clinicians attend clients in their home within a matter of days or weeks. RADAR service clinicians contact clients over the phone prior to their appointment. In doing so, clinicians explain the service and conduct a pre home visit questionnaire which includes questions about the client's home and any safety concerns that the RADAR service clinicians may need to be aware of.

3.80 National Service Guidelines Standard 4.1 identifies the written information that services should provide to clients prior to their appointment. For GGC and MAS appointments, CHS administration staff send an appointment letter to clients to advise of each scheduled appointment. However, the correspondence does not conform with the requirements of the standard, because it does not include information on the type and purpose of the assessment, wait times, assessment cost and duration or the names of staff members who the client will see at the appointment. The RADAR service does not provide clients with written information prior to their appointment. CHS advised this was because clinicians attend clients in their home within a matter of days or weeks.

Recommendation 5 Pre-appointment client letters

CHS should review and improve information provided in pre-appointment client letters for the GGC, MAS and RADAR service.

Supporting clients and care partners prior to an initial assessment

3.81 The wait between receiving a referral and seeing a clinical specialist can be difficult for the client and their care partner(s). It is important clients and care partners have access to adequate support while they wait, should they desire it.

3.82 National Service Guidelines 4.2 states:

> Memory and Cognition Clinic supports clients and care partners during the wait time for an initial assessment, if required.
>
> - Memory and Cognition Clinic can provide a referral to an experienced counsellor in case the client or care partner expresses distress during the waiting time for the initial assessment and requires support.

3.83 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 4.2 is summarised in Table 3-8.

Table 3-8 Summary of performance against National Service Guidelines Standard 4.2

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic supports clients and care partners during the wait time for an initial assessment, if required.	**Level**	**GGC**	**MAS**	**RADAR service**
Memory and Cognition Clinic can provide a referral to an experienced counsellor in case the client or care partner expresses distress during the waiting time for the initial assessment and requires support.	SR	●	●	N/A

Assessment outcome key	
●	Partially meets National Service Guidelines Standard requirements.
N/A	National Service Guidelines Standard requirement is not applicable to this service.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.

Source: Audit Office analysis.

Supports for clients and care partner(s) during the wait time for an initial assessment

3.84 CHS does not routinely offer clients waiting for GGC and MAS initial appointments counselling or support for themselves or their care partner(s). However, CHS advised that if the client, care partner or client's medical practitioner expresses distress with respect to the wait time for an initial appointment with the GGC, MAS or RADAR service, it will consider attending their home to address concerns.

3.85 The RADAR service triage team seeks to see urgent clients within two weeks. This works as a mechanism for supporting clients with urgent needs while they wait for a more comprehensive assessment at the GGC and MAS.

3.86 The wait between receiving a referral and seeing a clinical specialist can be difficult for the client, their care partner(s) or family. National Service Guidelines Standard 4.2 recommends that services support clients and care partners during the wait time for an initial assessment, if required. CHS does not routinely offer clients waiting for GGC and MAS initial appointments counselling or support for themselves or their care partner(s) but would consider attending the client's home to address concerns should they express distress with respect to the expected wait time. The RADAR service acts as an interim support for clients with urgent needs while they wait for an appointment with the GGC and MAS, but this is only provided if the client, or their care partner(s), self identifies as needing additional support.

3.87 Recommendation 7 is intended to address this finding.

4 Communicating a diagnosis of dementia

4.1 This chapter discusses the performance of the GGC, MAS and RADAR service with respect to National Service Guidelines Standards relevant to communicating a diagnosis of dementia. The relevant standards are shown in Table 4-1.

Table 4-1 Better practice standards for client management post-diagnosis

Number	Standard
10.1	Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathic, and easily understandable manner.
11.1	Memory and Cognition Clinic ensures that the client's wishes regarding the confidentiality of their diagnosis are respected.

Source: Audit Office, based on the *National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia.*

Summary

Conclusions

The communication of a diagnosis of dementia (or Mild Cognitive Impairment) can be improved by the development and implementation of a policy or standard operating procedure(s) to guide the timely sharing of written explanations of results and next steps with clients. At present there is variability in how this is done by clinicians across the services. Delays in sending appointment records to referring medical practitioners were identified, which may pose a risk to clients receiving timely and appropriate care.

The development of a policy, that includes expected timeframes for clinicians to communicate diagnoses, and guidance on other critical post-diagnosis information such as next steps and available supports, would provide clarity on how and when this information should be shared with referring medical practitioners, clients and their care partner(s).

Key findings

Client management post-diagnosis

	Paragraph
National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible to ensure the client can begin treatment and seek further support. None of the appointment records reviewed for the purpose of the audit explicitly identified the date a client was diagnosed with dementia or Mild Cognitive Impairment, and it was not possible to reliably determine the time elapsed between receipt of referral and diagnosis and the beginning of treatment and support.	4.15

The GGC, MAS and RADAR service refer clients to neuropsychologists from the RACS Psychology and Counselling Service for supplementary neuropsychological investigations. The RACS Psychology and Counselling Service estimated that, as of November 2024 there were approximately 12 clients on its waiting list, and two of those clients were under the age of 60. The estimated wait time for this service as of November 2024 was nine months. The long wait time for this service impacts the timeliness of treatment and support. 4.16

National Service Guidelines Standard 10.1 strongly recommends services provide clients with an easy-to-understand written explanation of results and next steps if the diagnosis is uncertain as well as a layperson's summary of test results. Providing these documents has several benefits, including allowing the client and their care partner(s) to remember complex information, receive continuity of care and advocate for further testing. The GGC, MAS and RADAR service have not developed or implemented a policy or standard operating procedures to guide the sharing of written explanations of results and next steps with clients, or a laypersons summary of a client's test result reports. This has resulted in varied practices among specialists. 4.21

National Service Guidelines Standard 10.1 strongly recommends clinicians use the preferred terms of 'dementia' and 'Mild Cognitive Impairment' when communicating a diagnosis. Five out of six specialists consulted for the purpose of the audit reported using these terms, while the sixth specialist also reported using the term 'moderate cognitive impairment'. A review of 140 appointment records for the purpose of the audit shows that 93 involved a diagnosis of 'dementia' or 'Mild Cognitive Impairment'. Of those 93 appointment records, 82 (88 percent) used the terms 'dementia', 'Mild Cognitive Impairment' or 'Alzheimer's disease', which are considered appropriate. Other terms that were used included 'moderate cognitive decline', 'neurocognitive disorder' or 'cognitive impairment'. 4.26

National Service Guidelines Standard 10.1 strongly recommends that appointments during which the diagnosis is communicated should be long enough for the client to process the information and ask questions. The GGC and MAS allocate 30-minute appointments with a nurse prior to a one-hour appointment with a medical specialist. Due to the mobile nature of the RADAR service, there are no set time limits for an appointment. The current length of appointments is in accordance with the Medicare Benefits Schedule that provides for medical services that are subsidised by the Australian Government. 4.30

National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible to ensure the client can begin treatment and seek further support. After a client attends an appointment with the GGC, MAS or RADAR service, medical specialists send written communication to the client's referring medical practitioner to document the outcomes of the appointment. Analysis of the time elapsed between client appointments, and the date written communication was sent to referring medical practitioners identified record-keeping inconsistencies and some significant delays. Of the 140 appointment records reviewed for the purpose of the audit, only 66 included written communication with a sent date: 70 percent were sent within ten days of the appointment, 14 percent were sent up to 25 days after the appointment 4.40

and 16 percent were sent more than 77 days after the appointment. Delays to the provision of written communication to referring medical practitioners may pose a risk to clients receiving timely and appropriate care.

National Service Guidelines Standard 11.1 strongly recommends assessing clinicians ask the client if, and with whom, the outcome of their assessment should be shared. As the services have not developed procedures to guide post-diagnostic communication with clients or care partner(s), there is no defined standard practice. A lack of standard processes for information sharing and obtaining informed consent increases the risk of not adhering to the client's preferences during disclosure and may violate individual preferences, autonomy and confidentiality. 4.50

National Service Guidelines Standard 11.1 strongly recommends that where a client does not have the capacity to decide whether to receive their diagnosis, the decision of their proxy decision maker (known as a Person Responsible in most states) should be respected and further discussed over time. A review of appointment records for the purpose of the audit showed that medical specialists regularly provide information related to Advanced Care Planning, including enduring power of attorney arrangements, with clients. 4.54

Client management post-diagnosis

4.2 Effective client management post-diagnosis facilitates:

- empathetic and confidential care;
- condition monitoring by appropriate medical practitioners with specialist expertise; and
- productive care planning and provision of services and supports.

4.3 Services should have plans and processes to guide post-diagnostic support, advice and care provided to clients. Established processes allow for consistent and personalised care that can be adapted to individual needs and preferences, while also facilitating access to support and education.

Communicating a diagnosis

4.4 The way clinicians communicate can impact the experience of the person receiving a dementia diagnosis and their care partner. Empathetic and clear communication allows clients and their care partner to understand the diagnosis and adapt to changing circumstances during what is generally an emotional and confusing time. Helping people understand the diagnosis is crucial as it empowers them to participate in care decisions and plan for the future.

4.5 National Service Guidelines Standard 10.1 states:

> Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathetic, and easily understandable manner.
>
> - Memory and Cognition Clinic clinicians inform the client of the diagnosis as soon as all investigations are completed – Dementia Lived Experience Experts especially stressed the importance of providing the information in both verbal and written forms.
> - When communicating the diagnosis, the preferred terms are "dementia" and "Mild Cognitive Impairment" – Stakeholders involved in the Delphi process preferred the use of these terms, as opposed to the DSM-5 "major and minor cognitive disorder". If known, communicating the dementia sub-type is encouraged.
> - If the diagnosis of dementia is uncertain, clients are given an easy-to-understand written explanation of the results and next steps.
> - Memory and Cognition Clinic offers a lay person summary of the client's test result reports.
> - The appointment during which the diagnosis is communicated is long enough for the client to process the information and ask questions – the length and format of the appointment(s) should be determined based on the clinical judgement and may vary according to the client's preference. Clinicians should consider providing an opportunity for a break with the appointment or providing an additional appointment to continue discussing the diagnosis where required, especially if the client seems confused or distressed.

4.6 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 10.1 is summarised in Table 4-2.

Table 4-2 Summary of performance against National Service Guidelines Standard 10.1

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathic, and easily understandable manner.	**Level**	**GGC**	**MAS**	**RADAR service**
Memory and Cognition Clinic clinicians inform the client of the diagnosis as soon as all the investigations are completed.	SR	●	●	●
When communicating the diagnosis, the preferred terms are "dementia" and "Mild Cognitive Impairment".	SR	●	●	●

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathic, and easily understandable manner.	**Level**	**GGC**	**MAS**	**RADAR service**
If the diagnosis of dementia is uncertain, clients are given an easy-to-understand written explanation of the results and the next steps.	SR	●	●	●
Memory and Cognition Clinic offers a lay person summary of the client's test result reports.	SR	●	●	●
The appointment during which the diagnosis is communicated is long enough for the client to process the information and ask questions.	SR	✓	✓	✓

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.
Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.

Source: Audit Office analysis.

Communicating a diagnosis with clients

4.7 National Service Guidelines Standard 10.1 strongly recommends clinicians inform the client of the diagnosis as soon as they complete all investigations. It also notes that 'Dementia Lived Experience Experts especially stressed the importance of providing the information in both verbal and written forms'.

4.8 The GGC, MAS or RADAR service have not developed or implemented policies or procedures to guide post-diagnostic communication with clients or their care partners. In the absence of policies and procedures, clinicians communicate post-diagnosis information based on their clinical training, individual judgment and historical practices.

4.9 Such an approach can be problematic when clinicians have contrasting approaches to communicating and providing a diagnosis. Contrasting approaches can lead to inconsistent care, diagnostic delay, delayed access to interventions and contribute to confusion and anxiety for clients and their care partner. This could occur if a client of the GGC, MAS or RADAR service presents to hospital and is subsequently treated by another clinician.

Timely verbal diagnosis communication with clients

4.10 National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible. This is critical to supporting the client and their family to begin to understand the condition, make decisions about future care and receive treatment and further support.

4.11 None of the appointment records reviewed for the purpose of the audit explicitly identified the date a client was diagnosed with dementia or Mild Cognitive Impairment. Therefore, it was not possible to reliably determine the time elapsed between receipt of referral and diagnosis for clients diagnosed with dementia or Mild Cognitive Impairment.

4.12 The GGC, MAS and RADAR service refer clients to neuropsychologists from the RACS Psychology and Counselling Service for supplementary neuropsychological investigations. Of 66 GGC, 45 MAS and 29 RADAR service appointment records examined for the purpose of the audit, two, ten and three clients respectively were referred to neuropsychologists from the RACS Psychology and Counselling Service for further testing.

4.13 The RACS Psychology and Counselling Service advised that, as of November 2024, it was resourced by a total of 2.55 Full Time Equivalent (FTE) resources including:

- Graduate resource – 1 FTE;
- Neuropsychologist – 0.85 FTE; and
- Neuropsychologist – 0.7 FTE.

4.14 The RACS Psychology and Counselling Service estimated that, as of November 2024, there were approximately 12 clients on its waiting list, and two of those clients were under the age of 60. Although clients are prioritised and triaged, the estimated wait time for this service was nine months. The RACS Psychology and Counselling Service asserted that it had insufficient staff to meet demand. The long wait time taken to see clients can lead to delays in communicating a definitive dementia diagnosis.

4.15 National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible to ensure the client can begin treatment and seek further support. None of the appointment records reviewed for the purpose of the audit explicitly identified the date a client was diagnosed with dementia or Mild Cognitive Impairment, and it was not possible to reliably determine the time elapsed between receipt of referral and diagnosis and the beginning of treatment and support.

4.16 The GGC, MAS and RADAR service refer clients to neuropsychologists from the RACS Psychology and Counselling Service for supplementary neuropsychological investigations. The RACS Psychology and Counselling Service estimated that, as of November 2024 there were approximately 12 clients on its waiting list, and two of those clients were under the

age of 60. The estimated wait time for this service as of November 2024 was nine months. The long wait time for this service impacts the timeliness of treatment and support.

Timely written communication with clients

4.17 National Service Guidelines Standard 10.1 strongly recommends services provide clients with an easy-to-understand written explanation of results and next steps. Providing these documents helps the client and their care partner to:

- remember complex information;
- receive continuity of care;
- advocate for further testing;
- acquire a second opinion; and
- understand and action specialist recommendations.

4.18 The GGC, MAS and RADAR service have not developed or implemented a policy or standard operating procedures to guide the sharing of written explanations of results and next steps with clients, or a layperson's summary of a client's test result reports.

4.19 The audit considered whether service specialists provide the client with a written explanation of results and next steps or a layperson's summary of test results. Five of seven specialists consulted for the purpose of the audit reported providing:

- a simplified summary of the appointment to the client, including recommendations and next steps (two specialists);
- the appointment record in its entirety (one specialist); and
- written information only on request (two specialists).

4.20 Other CHS services have implemented standard practices for sharing written information and test results with clients. For example, neuropsychologists from the RACS Psychology and Counselling Service provide clients with simplified written feedback explaining their referral, capacity, driving capabilities and memory strategies after their appointment.

4.21 National Service Guidelines Standard 10.1 strongly recommends services provide clients with an easy-to-understand written explanation of results and next steps if the diagnosis is uncertain as well as a layperson's summary of test results. Providing these documents has several benefits, including allowing the client and their care partner(s) to remember complex information, receive continuity of care and advocate for further testing. The GGC, MAS and RADAR service have not developed or implemented a policy or standard operating procedures to guide the sharing of written explanations of results and next steps with clients, or a laypersons summary of a client's test result reports. This has resulted in varied practices among specialists.

4.22 Recommendation 7 is intended to address this finding.

Use of preferred terms when communication with clients

4.23 National Service Guidelines Standard 10.1 strongly recommends clinicians use the preferred terms of 'dementia' and 'Mild Cognitive Impairment' when communicating a diagnosis. These were identified as the preferred terms by expert clinicians and individuals with lived experience of dementia during the development of the standards. Using the preferred terms and communicating in a gradual and individualised approach provides clarity and can allow people to access appropriate treatments, support services and information.

4.24 The Audit Office interviewed seven medical specialists for the purpose of the audit and asked six which terms they use when communicating a diagnosis to clients, carer partners and family members. Five reported using the terms 'dementia' and 'Mild Cognitive Impairment' exclusively with clients and one reported using the terms 'dementia' and 'moderate cognitive impairment' as some clients and care partner may be offended when the preferred term of 'dementia' is used. If a specialist does not use the preferred terms when communicating a diagnosis to clients and care partners, responsibility for using these terms is transferred to the referring medical practitioners.

4.25 A review of 140 appointment records for the purpose of the audit shows that 93 involved a diagnosis of 'dementia' or 'Mild Cognitive Impairment'. Of those 93 appointment records, 82 (88 percent) used the terms 'dementia', 'Mild Cognitive Impairment' or 'Alzheimer's disease', which are considered appropriate. Of the remaining 11 appointment records, five used the terms 'moderate cognitive decline', 'neurocognitive disorder' or 'cognitive impairment' and the remaining six contained no clear indication of the terminology used in the appointment.

4.26 National Service Guidelines Standard 10.1 strongly recommends clinicians use the preferred terms of 'dementia' and 'Mild Cognitive Impairment' when communicating a diagnosis. Five out of six specialists consulted for the purpose of the audit reported using these terms, while the sixth specialist also reported using the term 'moderate cognitive impairment'. A review of 140 appointment records for the purpose of the audit shows that 93 involved a diagnosis of 'dementia' or 'Mild Cognitive Impairment'. Of those 93 appointment records, 82 (88 percent) used the terms 'dementia', 'Mild Cognitive Impairment' or 'Alzheimer's disease', which are considered appropriate. Other terms that were used included 'moderate cognitive decline', 'neurocognitive disorder' or 'cognitive impairment'.

Appointment length

4.27 National Service Guidelines Standard 10.1 strongly recommends that appointments during which the diagnosis is communicated should be long enough for the client to process the information and ask questions.

4.28 The GGC and MAS allocate 30-minute appointments with a nurse prior to a one-hour appointment with a medical specialist. Due to the mobile nature of the RADAR service, there are no set time limits for an appointment. The current length of appointments is in accordance with the Medicare Benefits Schedule that provides for medical services that are subsidised by the Australian Government.

4.29 Of the seven medical specialists interviewed for the purpose of the audit, five were asked whether appointments were long enough to provide a diagnosis and discuss next steps with a client. Four specialists advised appointments were long enough and one advised they were long enough most of the time. There is no evidence of any client complaints about appointment length in CHS Consumer Feedback data.

4.30 National Service Guidelines Standard 10.1 strongly recommends that appointments during which the diagnosis is communicated should be long enough for the client to process the information and ask questions. The GGC and MAS allocate 30-minute appointments with a nurse prior to a one-hour appointment with a medical specialist. Due to the mobile nature of the RADAR service, there are no set time limits for an appointment. The current length of appointments is in accordance with the Medicare Benefits Schedule that provides for medical services that are subsidised by the Australian Government.

Communicating with referring medical practitioners

4.31 Clear and consistent communication to referring medical practitioners ensures clients, care partner(s) and family receive important information and understand appointment outcomes including test results, care planning and specific recommendations for pharmacological and non-pharmacological management and support services. Communication should be sent promptly to facilitate appropriate continuity of care.

Verbal communication with referring medical practitioners

4.32 The GGC, MAS and RADAR service do not communicate verbally with referring medical practitioners unless they require further information to attend to a client appropriately. Referring medical practitioners may contact the service, if necessary, by contacting the Canberra Hospital switchboard and requesting to speak to the relevant medical practitioner to discuss a client. However, this is not common practice.

Quality of written communication to referring medical practitioners

4.33 After a client attends an appointment with the service, medical specialists send an appointment record to the client's referring medical practitioner. The purpose of the appointment record is to document the outcomes of the appointment.

4.34 The content and detail contained in the appointment records reviewed for the purpose of the audit varied significantly. Appointment records that were considered to be of high-quality generally included the following information:

- a summary of the client's medical history;
- a list of current medications;
- the clients personal and social history;
- symptoms and behaviours (including family or care partner observations where available);
- testing results (e.g. cognitive or blood) and the specialist's interpretation;
- provisional diagnosis or diagnosis;
- recommendations to the client and care partner or family in attendance (e.g. supports, practical lifestyle changes); and
- recommendations to the referrer on next steps including further testing required, treatment, medication management and a timeframe for follow up with the specialist.

4.35 Appointment records that were considered to be of low-quality generally included the information outlined above, except for:

- a summary of the client's medical history;
- the client's personal and social history; and
- detailed recommendations to the client and care partner or family in attendance.

Timeliness of written communication to referring medical practitioners

4.36 Since the implementation of the DHR in November 2022, written communication has been sent to medical practitioners via the DHR. Analysis of the time elapsed between client appointments and the date written communication was sent to referring medical practitioners identified record-keeping inconsistencies and some significant delays.

4.37 Of the 140 appointment records reviewed for the purpose of the audit, it was not possible to determine how long it took for CHS to send written communication for 74 (53 percent) of these records because the sent date was not recorded in the DHR.

4.38 Of the 66 appointment records that included written communication with a sent date:

- 46 (70 percent) were sent within ten days of the appointment;
- 9 (14 percent) were sent between ten to 25 days of the appointment; and
- 11 (16 percent) were sent more than 77 days after the appointment, with three taking over 200 days to be sent.

4.39 Delays to the provision of written communication to referring medical practitioners may pose a risk to clients receiving timely and appropriate care. In the absence of timely written communication, referring medical practitioners are not able to action the specialist's recommendation and may miss key information about their client's condition. Delays may also lead to fragmentation in care and impede client and care partner awareness and access to post-diagnostic care and support in the community. When a diagnosis is not clear, delays can also contribute to anxiety and confusion while waiting for clarification about diagnosis and management.

4.40 National Service Guidelines Standard 10.1 strongly recommends clinicians communicate a diagnosis as soon and as accurately as possible to ensure the client can begin treatment and seek further support. After a client attends an appointment with the GGC, MAS or RADAR service, medical specialists send written communication to the client's referring medical practitioner to document the outcomes of the appointment. Analysis of the time elapsed between client appointments, and the date written communication was sent to referring medical practitioners identified record-keeping inconsistencies and some significant delays. Of the 140 appointment records reviewed for the purpose of the audit, only 66 included written communication with a sent date: 70 percent were sent within ten days of the appointment, 14 percent were sent up to 25 days after the appointment and 16 percent were sent more than 77 days after the appointment. Delays to the provision of written communication to referring medical practitioners may pose a risk to clients receiving timely and appropriate care.

Respecting client wishes regarding confidentiality of a diagnosis

4.41 Dementia is a condition fraught with complications due to its progressive nature and associated symptoms, which often render the person diagnosed less able to care for themselves and manage their affairs over time. Medical practitioners represent one of the first steps in a person's journey with dementia and therefore play a critical role in respecting the wishes of their clients, preserving dignity and confidentiality and considering consent to plan for future changes in client capacity.

4.42 National Service Guidelines Standard 11.1 states:

> Memory and Cognition Clinic ensures that the client's wishes regarding the confidentiality of their diagnosis is respected.
>
> - The assessing clinician confirms if the client wishes to know the diagnosis.
> - If a client does not wish to know the diagnosis, the medical practitioner and other Memory and Cognition Clinic staff respect that wish as much as possible.
> - The assessing clinician asks the client if and with whom the outcome of the assessments should be shared.

- If the client does not have the capacity to decide whether to receive their diagnosis, the decision of their proxy decision-maker should be respected and further discussed over time.

4.43 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 11.1 is summarised in Table 4-3.

Table 4-3 Summary of performance against National Service Guidelines Standard 11.1

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathic, and easily understandable manner.	**Level**	**GGC**	**MAS**	**RADAR service**
The assessing clinician confirms if the client wishes to know the diagnosis.	SR	●	●	●
If a client does not wish to know the diagnosis, the medical practitioner and other Memory and Cognition Clinic staff respect that wish as much as possible.	SR	●	●	●
The assessing clinician asks the client if and with whom the outcome of the assessments should be shared.	SR	●	●	●
If the client does not have the capacity to decide whether to receive their diagnosis, the decision of their proxy decision-maker should be respected and further discussed over time.	SR	●	●	●

Assessment outcome key	
●	Partially meets National Service Guidelines Standard requirements.
Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.

Source: Audit Office analysis.

Consideration of client preferences

4.44 National Service Guidelines Standard 11.1 strongly recommends that assessing clinicians confirm if the client wishes to know the diagnosis. This is important as it respects the fundamental principle of personal autonomy. Clinicians should inform clients about the benefits of learning their diagnosis, and the potential for this knowledge to benefit their

quality of life and access to support and services. Taking this approach can also serve to reduce stigma.

4.45 Similarly, National Service Guidelines Standard 11.1 strongly recommends that if a client does not want to know the diagnosis, medical practitioners and other staff should respect that wish as much as possible. When a client does not want to know the diagnosis, clinicians should also aim to provide education to reduce the stigma of the diagnosis and outline the benefits of knowing the diagnosis to ensure that the client receives the required support. If a person does not wish to know their diagnosis, clinical judgement should be used to determine if the client's care partner(s) or family should be informed after consideration of autonomy, capacity, confidentiality, and risk and safety.

4.46 Of the seven medical specialists interviewed for the purpose of the audit, one reported that it was very uncommon for a client to decline information about their diagnosis, and one reported they had never experienced this type of request. None of the seven specialists ask the client whether they want to know their diagnosis or not, or who they want the outcome of their cognitive testing shared with. The appointment records reviewed for the purpose of the audit did not identify any evidence that clinicians provide education to reduce the stigma of a diagnosis when a client does not want to know the diagnosis. It is possible that this is because, as suggested by specialists, it is rare that clients or care partner(s) choose not to know the diagnosis.

Sharing outcomes of client assessments

4.47 National Service Guidelines Standard 11.1 strongly recommends that assessing clinicians ask the client if, and with whom, the outcome of their assessment should be shared. Identifying those who will be informed of a diagnosis in advance promotes client autonomy, respects individual preferences, ensures family members have a shared understanding of what will be shared and with whom and can facilitate continuity of care and access to support services.

4.48 As the services have not developed procedures to guide post-diagnostic communication with clients or care partners, there is no defined standard practice for requesting whether and with whom the client would like to share the outcome of their assessments. A lack of standard processes for information sharing and obtaining informed consent increases the risk of not adhering to the client's preferences during disclosure and may violate individual preferences, autonomy and confidentiality. Similarly, failure to obtain consent related to disclosures to family members or a healthcare provider could compromise future care.

4.49 There was no evidence that specialists asked clients who they want to share information about their diagnosis and care within the appointment records reviewed for the purpose of the audit.

4.50 National Service Guidelines Standard 11.1 strongly recommends assessing clinicians ask the client if, and with whom, the outcome of their assessment should be shared. As the services have not developed procedures to guide post-diagnostic communication with clients or care partner(s), there is no defined standard practice. A lack of standard processes for information sharing and obtaining informed consent increases the risk of not adhering to the client's preferences during disclosure and may violate individual preferences, autonomy and confidentiality.

Proxy decision-makers

4.51 National Service Guidelines Standard 11.1 strongly recommends that where a client does not have the capacity to decide whether to receive their diagnosis, the decision of their proxy decision-maker (known as a Person Responsible in most jurisdictions) should be respected and further discussed over time. As dementia is a progressive disease, and a client's decision-making capacity may change over time, it is crucial that the decision of a proxy decision-maker regarding disclosure of diagnosis be respected, as a dementia diagnosis may have significant implications for health and future planning. The proxy decision-maker is often affected by this diagnosis and is likely to be familiar with the preferences of the client and can act as an advocate for their future care. Timely diagnosis is essential for decision-making, accessing appropriate support and future planning.

4.52 CHS provides clients with an Advanced Care Planning service that aims to provide clients with 'a series of steps you can take to help you plan for your future health care. It helps people who care for you to understand your wishes if you can no longer express them'. The Advanced Care Planning service assists medical practitioners, family members and care partners to be aware of client wishes and choices if they lose legal capacity to make decisions.

4.53 A review of appointment records for the purpose of the audit showed that medical specialists regularly provide information related to Advanced Care Planning, including enduring power of attorney arrangements. Advanced Care Planning was the top item reportedly discussed with clients of the GGC, MAS and RADAR service, making up 30 percent of all support recommendations provided across the records that were reviewed.

4.54 National Service Guidelines Standard 11.1 strongly recommends that where a client does not have the capacity to decide whether to receive their diagnosis, the decision of their proxy decision maker (known as a Person Responsible in most states) should be respected and further discussed over time. A review of appointment records for the purpose of the audit showed that medical specialists regularly provide information related to Advanced Care Planning, including enduring power of attorney arrangements, with clients.

5 Post-diagnosis support, advice and care

5.1 This chapter discusses the performance of the GGC, MAS and RADAR service with respect to National Service Guidelines Standards relevant to post-diagnosis support, advice and care. The relevant standards are shown in Table 5-1.

Table 5-1 Better practice standards for post-diagnosis support, advice and care

Number	Standard
12.1	Following the completion of all assessments and diagnosis formulation, Memory and Cognition Clinic organises the feedback and post-feedback follow-up sessions.
12.2	The clinical specialist who assessed the client has a leading role in the initial post-diagnostic process (i.e., feedback session and care plan development).
12.3	Memory and Cognition Clinic ensures timely scheduling of the feedback session(s).
12.4	The feedback session during which the diagnosis is communicated should be attended by all relevant parties. This includes the assessing clinicians and the client and may also include [various prescribed roles].
12.5	Memory and Cognition Clinic offers follow-up sessions to evaluate the client's progression and care plan implementation.
13.1	Memory and Cognition Clinic ensures that the client receives all relevant information post-diagnosis and assists with developing the care plan.
13.2	Memory and Cognition Clinic facilitates the care plan implementation.
13.3	Where appropriate, directly after the diagnosis, Memory and Cognition Clinic provides advice, information, and support regarding [various prescribed issues].
13.4	If Memory and Cognition Clinic is unable to provide more detailed post-diagnostic support (e.g., due to a lack of resources), it refers clients to relevant, available, and timely services with dementia expertise.
13.5	Where appropriate, Memory and Cognition Clinic connects clients to [various prescribed] services, after the diagnosis is communicated.

Source: Audit Office, based on the *National Service Guidelines for Specialised Dementia and Cognitive Decline Assessment Services in Australia.*

Summary

Conclusions

The delivery of services by the GGC, MAS and RADAR service can be improved by developing and maintaining a repository of information that clinicians can access and provide directly to clients and care partners following a diagnosis of dementia or Mild Cognitive Impairment. The absence of such information increases the risk that clients and their care partner(s) do not access appropriate support services post-diagnosis.

While the RADAR service is involved in client care planning post-diagnosis support by providing direct referrals and actively assisting clients to access additional supports in the community, the GGC and MAS often rely on the client's referring medical practitioner or the client themselves to make referrals to additional supports after their diagnosis.

Across the services there are underdeveloped relationships with, and support pathways to, key support services in the ACT including Dementia Australia, community care services and legal and financial counselling. These services are critical to providing clients and their care partner(s) with comprehensive and consistent support options.

Key findings

Post-diagnosis support

	Paragraph
According to the National Service Guidelines, a post-feedback follow-up session provides an opportunity to monitor the client and update their care plan or treatment based on changing client requirements. Because the RADAR service is a responsive and short-term service designed to manage urgent cases, follow-up sessions may be provided to support care planning and monitoring when clinically indicated. However typically, feedback and follow-up sessions are provided by the GGC, MAS or other community services within CHS such as nursing staff or allied health professionals. The GGC and MAS offer a follow-up appointment to discuss the client's diagnosis, but only a maximum of one, and only if the client is required to commence medication. This does not accord with National Service Guidelines Standard 12.1, which stipulates all clients who receive a diagnosis should receive a feedback session and at least two additional follow up sessions.	5.13
National Service Guidelines Standard 12.2 states that the clinical specialist who assessed the client should have a leading role in the initial post-diagnostic process. Of 48 GGC appointment records that were reviewed, 46 (96 percent) clients were seen by the same clinical specialist who conducted the initial appointment for their follow up appointment. Of 22 MAS appointment records, 19 (86 percent) clients were seen by the same clinical specialist who conducted their initial appointment for their follow up appointment. It was not possible to reliably assess whether RADAR service clients see the same clinical specialist across appointments because most appointment records did not include specific clinician names, and some RADAR service clients also attend follow-up appointments through other services.	5.22
National Service Guidelines Standard 12.3 strongly recommends that services ensure timely scheduling of feedback sessions and that a feedback session is conducted as soon as possible after the final diagnostic assessment, ideally within four weeks of the initial assessment. The audit was unable to determine the wait time between initial and feedback appointments for the GGC, MAS and RADAR service because wait time data in the DHR dataset provided by CHS was unreliable.	5.26
National Service Guidelines Standard 12.4 states the feedback session during which the diagnosis is communicated should be attended by all relevant parties including a	5.34

support person and/or allied health professionals. Analysis of the selected appointment records indicated a support person or care partner attended 99 appointments (70 percent) across the GGC, MAS and RADAR service. No allied health professionals attended an initial, feedback or follow-up appointment for the GGC or MAS. The RADAR service often conducts appointments with a clinical specialist and a nurse, occasionally supplemented by a social worker or occupational therapist.

Care planning

National Service Guidelines Standard 13.1 strongly recommends that the client, their care partner and all assessing clinicians (e.g. medical practitioner, neuropsychologist) be actively involved in the client's care planning. The involvement of GGC and MAS clinicians in care planning is minimal and most care planning is undertaken by the client's GP and community-based support services. Inconsistent involvement in care planning and the siloed approach of other services involved in client care is a risk to clients receiving coordinated care. The RADAR service operates as a traditional multidisciplinary team and may involve a clinical specialist, social worker and registered nurse in care planning as required. The RADAR service includes clients and care partners in care planning where the client or care partner has capacity to participate. 5.56

National Service Guidelines Standard 13.1 strongly recommends that clients with Mild Cognitive Impairment or early signs of dementia are provided with personalised risk reduction information along with their GP or other referring medical practitioner. The audit examined the 33 appointment records to determine whether the clinical specialist provided them with personalised risk reduction information. Across all services, clinical specialists provided risk reduction information to 70 percent of clients that had a diagnosis of Mild Cognitive Impairment. 5.59

National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should provide support and advice to clients they did not initially assess and diagnose. A review of the selected appointment records identified that all three services provide support and advice to clients they did not initially assess or diagnose. 5.63

National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should assure the client and their care partner(s) that further advice and assistance can be sought after the discharge. There are currently no formalised pathways for clients to seek further advice or assistance from CHS services beyond referral by the client's GP or the clinical specialist who originally conducted the assessment. 5.68

National Service Guidelines Standard 13.2 strongly recommends that services have active relationships with relevant support services to refer as appropriate (e.g. support groups for carers). Clinical specialists from the GGC and MAS advised that they refer clients to Dementia Australia, Dementia Support Australia and the SPICE Program, while the *RADAR Model of Care* includes a list of internal and external stakeholders with which the service seeks to foster and maintain a relationship including My Aged Care, Community Nursing, Fitness to Drive, Dementia Australia 5.82

and Dementia Support Australia. On occasion, representatives from Dementia Australia and other external organisations have spoken at CHS staff meetings.

The National Service Guidelines Standard 13.2 recommends services offer follow-up phone calls to assist the client with the care plan implementation. The GGC, MAS and RADAR service do not have a telephone appointment policy and a review of DHR data indicated that only six telephone and two video follow-up appointments occurred between 2022 and 2024. The minimal use of video follow-up appointments reduces client access to clinical specialist appointments where clients who may be experiencing cognitive impairment cannot attend a physical location. 5.86

National Service Guidelines Standard 13.3 strongly recommends that, where appropriate, directly after the diagnosis, clients are provided with advice, information and support regarding various issues. Analysis of the selected appointment records identified that clinical specialists recorded providing advice, information and supports in relation to most of the issues identified in the standard, although it was not possible to confirm whether this was provided to the referring GP only, or directly to clients and care partners as well. CHS has not developed or maintained a repository of information and supports that clinicians can access and provide directly to clients and care partners. Although clinicians use their specialist expertise to decide what advice, information and supports may be relevant to each individual client, CHS could better support clinicians in this decision making by providing printable information sheets and templates with pre-filled information options in relation to the issues identified in the standard. 5.92

National Service Guidelines Standard 13.4 states that if a service is unable to provide more detailed post-diagnostic support (e.g. due to lack of resources), it should refer clients to relevant, available and timely services with dementia expertise. A review of the selected client appointment records found that all three services did not regularly recommend clients to the support services described in National Service Guidelines Standard 13.4. CHS advised that 'in practice, referral back to the General Practitioner is made, who plays a central role in coordinating further referrals to supports based on individual patient needs'. No service referred to group-based programs focused on well-being or evidence-based cognitive interventions. The GGC, MAS and RADAR service do not meet the requirements of this standard. 5.106

National Service Guidelines Standard 13.5 strongly recommends that services connect clients with key support services where appropriate including driving assessment services, Dementia Australia, community care services and legal and financial counselling services. Analysis of the appointment records indicated low rates of referral to these services and the way in which clinicians recorded referrals to services was inconsistent. CHS has not developed or maintained a repository of information, resources or available support services that may assist them to easily identify potential support options. Although clinicians use their specialist expertise to decide what services may be relevant to each individual client, CHS could better support clinicians in this decision-making by providing them with easier access to this information. 5.113

Post-diagnosis support

Providing feedback and post-feedback follow up sessions

5.2 The National Service Guidelines define a feedback session as 'the appointment during which the diagnosis is communicated to the person who had been assessed at the Memory and Cognition Clinic, and the first discussion of post-diagnostic care planning takes place'. Feedback sessions provide the foundation for ongoing care and support for the client. They allow clients and care partners to ask questions to gain a better understanding of the condition and the future direction of care and allow clinicians to provide valuable information and resources that can help manage symptoms and the progression of dementia.

5.3 According to the National Service Guidelines, a post-feedback follow-up session is 'the appointment during which the assessment of the status of the care plan or referral plan occurs'. Follow-up sessions provide the opportunity to monitor the client and update their care plan or treatment based on changing client requirements.

5.4 National Service Guidelines Standard 12.1 states:

> Following the completion of all assessments and diagnosis formulation, Memory and Cognition Clinic organises the feedback and post-feedback follow-up sessions in the following fashion – Recommendations for the follow-up sessions apply after a diagnosis of dementia or MCI classification is established and may apply for clients with subjective cognitive complaints, if required (e.g., monitoring risk factors):
>
> - A separate feedback session to communicate or discuss the diagnosis, start on the care plan, and organise a care coordinator (if available) – In some cases, two shorter feedback sessions may be necessary to allow sufficient time for the client to process the diagnosis.
> - A minimum of one post-feedback follow-up session to assess the status of the care or referral plan's implementation.
> - If necessary, at least one additional follow-up session to provide further support and to monitor and adjust the care plan.

5.5 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 12.1 is summarised in Table 5-2.

Table 5-2 Summary of performance against National Service Guidelines Standard 12.1

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Following the completion of all assessments and diagnosis formulation, Memory and Cognition Clinic organises the feedback and post-feedback follow-up sessions in the following fashion:	**Level**	**GGC**	**MAS**	**RADAR service**
A separate feedback session to communicate or discuss the diagnosis, start on the care plan, and organise a care coordinator (if available).	SR	●	●	●
A minimum of one post-feedback follow-up session to assess the status of the care or referral plan's implementation.	SR	✓	✓	✓
If necessary, at least one additional follow-up session to provide further support and to monitor and adjust the care plan.	R	✗	✗	●

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.

Source: Audit Office analysis.

5.6 The CHS *Geriatric Outpatient Service Description* delineates service objectives for the GGC and MAS including 'appropriate follow up'. This includes at least one initial feedback appointment, and one potential follow-up session based on whether the client commenced medication:

> Follow up feedback meeting that will include client, family and appropriate team members for discussion of treatment options and plan…longer term review may be arranged as clinically indicated…[and] if commenced on medication, follow up review in 3-5 months, then discharged for ongoing care and management to the GP.

5.7 Because the RADAR service is a responsive and short-term service that is designed to manage urgent cases, follow-up sessions may be provided to support care planning and

monitoring when clinically indicated. However, feedback and follow-up sessions are typically provided by the GGC, MAS or other community services within CHS such as nursing staff or allied health professionals.

5.8 Selected appointment records were reviewed for the purpose of the audit to identify whether services offered a feedback appointment and subsequent follow-up session.

5.9 Of the 66 selected GGC appointment records reviewed, clinical specialists committed to an additional appointment in 54 instances (82 percent). The remaining clients were discharged (11 clients) or referred directly to inpatient care due to extreme BPSD (one client). Of the 11 discharged clients:

- four were discharged after their first appointment because the clinical specialist determined they did not have dementia or Mild Cognitive Impairment;
- one received a diagnosis of Mild Cognitive Impairment in their first appointment but did not receive any follow up; and
- six were discharged because the specialist deemed their condition did not require further follow up unless otherwise requested by the referrer.

5.10 Of the 45 selected MAS appointment records reviewed, clinical specialists committed to an additional appointment in 36 instances (80 percent). Of the nine clients discharged from the MAS without an additional appointment:

- one was determined to have normal cognition;
- one client with Mild Cognitive Impairment was discharged and not offered follow-up or support even though they advised the clinician they were a victim of domestic violence;
- two were discharged without follow-up even though they were suspected to have either dementia or Mild Cognitive Impairment; and
- five were discharged because the specialist deemed their condition did not require further follow up unless otherwise requested by the referrer.

5.11 Per the *RADAR Model of Care*, feedback and follow-up appointments for the RADAR service were conducted by other entities; either the GGC and MAS, CHS Palliative Care or other community supports including the CHS Community Nursing Team. Of the 29 selected RADAR service appointment records reviewed, 20 (69 percent) were referred for another appointment with one of these services:

- nine were referred to the GGC or MAS for follow-up;
- nine were referred to other supports for follow-up including the Older Persons Mental Health Team, Dementia Support Australia and Community Nursing; and
- two were referred to the Palliative Care team for follow-up.

5.12 The GGC and MAS offer one follow-up appointment to discuss the client's diagnosis, but only if the client is required to commence medication. This does not align with National Service Guidelines Standard 12.1, which requires all clients who receive a diagnosis to receive a feedback session and at least two additional follow-up sessions.

5.13 According to the National Service Guidelines, a post-feedback follow-up session provides an opportunity to monitor the client and update their care plan or treatment based on changing client requirements. Because the RADAR service is a responsive and short-term service designed to manage urgent cases, follow-up sessions may be provided to support care planning and monitoring when clinically indicated. However typically, feedback and follow-up sessions are provided by the GGC, MAS or other community services within CHS such as nursing staff or allied health professionals. The GGC and MAS offer a follow-up appointment to discuss the client's diagnosis, but only a maximum of one, and only if the client is required to commence medication. This does not accord with National Service Guidelines Standard 12.1, which stipulates all clients who receive a diagnosis should receive a feedback session and at least two additional follow up sessions.

5.14 Recommendation 7 is intended to address this finding.

Maintaining continuity of client care

5.15 Maintaining continuity through assessment to feedback and follow-up sessions is essential to support a positive clinician-client relationship and ensure the client receives appropriate recommendations for further support.

5.16 National Service Guidelines Standard 12.2 states:

> The clinical specialist who assessed the client has a leading role in the initial post-diagnostic process (i.e. feedback session and care plan development).

5.17 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 12.2 is summarised in Table 5-3.

Table 5-3 Summary of performance against National Service Guidelines Standard 12.2

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathic, and easily understandable manner.	**Level**	**GGC**	**MAS**	**RADAR service**
The clinical specialist who assessed the client has a leading role in the initial post-diagnostic process (i.e. feedback session and care plan development).	SR	✓	✓	●

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic clinicians communicate the diagnosis in a timely, empathic, and easily understandable manner.	**Level**	**GGC**	**MAS**	**RADAR service**
Assessment outcome key				
✓	Meets National Service Guidelines Standard requirements.			
●	Partially meets National Service Guidelines Standard requirements.			
Level definitions				
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.			

Source: Audit Office analysis.

GGC and MAS

5.18 The audit considered selected appointment records to determine whether GGC and MAS follow-up appointments are conducted by the same clinical specialist that conducted the initial appointment. Forty-eight GGC appointments and 22 MAS appointments were relevant to this review.[14]

5.19 Analysis of these appointment records identified that:

- 46 (96 percent) of GGC clients were seen by the same clinical specialist who conducted the initial appointment for their follow up appointment; and
- 19 (86 percent) of MAS clients were seen by the same clinical specialist who conducted their initial appointment for their follow up appointment.

5.20 CHS does not have a documented procedure that requires services provide continuity of care by ensuring clients attend an appointment with the same clinical specialist. Nevertheless, administrative staff advised they aim to schedule appointments with the same clinical specialist wherever possible. The reason for any clinical specialist change varies. Clients may ask to switch clinical specialists within the GGC and MAS due to personal preference or may seek a second opinion after their initial appointment. CHS clinicians asserted this was a rare occurrence.

[14] Twenty-seven percent of the selected GGC appointment records and 51 percent of the selected MAS appointment records were either first appointments or appointments conducted prior to the advent of the DHR and therefore could not be cross-referenced in CHS data.

RADAR service

5.21 A review of the selected appointment records identified that it was not possible to reliably assess whether RADAR service appointments are conducted by the same clinical specialist that conducted the initial appointment because:

- most appointment records did not include specific clinician names. CHS advised that 'while the extracted data set provided to the Audit Team may not have included this detail, the names of all treating team members are documented within the patient's DHR clinical record'; and
- some RADAR service clients also attend follow-up appointments through other services. Of 29 RADAR service appointment records selected, eight were referred to the same clinical specialist at the GGC or MAS for follow-up.

5.22 National Service Guidelines Standard 12.2 states that the clinical specialist who assessed the client should have a leading role in the initial post-diagnostic process. Of 48 GGC appointment records that were reviewed, 46 (96 percent) clients were seen by the same clinical specialist who conducted the initial appointment for their follow up appointment. Of 22 MAS appointment records, 19 (86 percent) clients were seen by the same clinical specialist who conducted their initial appointment for their follow up appointment. It was not possible to reliably assess whether RADAR service clients see the same clinical specialist across appointments because most appointment records did not include specific clinician names, and some RADAR service clients also attend follow-up appointments through other services.

Scheduling timely feedback sessions

5.23 The timely scheduling of feedback sessions allows clients, families and care partners to receive a definitive diagnosis. The longer the client waits for the feedback session, the more their condition may progress without a plan, treatment or support in place, which negatively impacts their wellbeing.

5.24 National Service Guidelines Standard 12.3 strongly recommends that:

> Memory and Cognition Clinics ensure timely scheduling of the feedback sessions(s).
>
> - The feedback session is conducted as soon as possible after the final diagnostic assessment – ideally a feedback session is conducted within four weeks of the initial assessment, provided that all assessments have been completed and the results of all investigations are received.

5.25 The audit was unable to determine the wait time between initial and feedback appointments for the GGC, MAS and RADAR service because wait time data in the DHR dataset provided by CHS was unreliable.

5.26 National Service Guidelines Standard 12.3 strongly recommends that services ensure timely scheduling of feedback sessions and that a feedback session is conducted as soon as possible after the final diagnostic assessment, ideally within four weeks of the initial assessment. The audit was unable to determine the wait time between initial and feedback appointments for the GGC, MAS and RADAR service because wait time data in the DHR dataset provided by CHS was unreliable.

Ensuring relevant parties are present during feedback sessions

5.27 A care partner can provide the assessing clinical specialist with essential background into the client's historical behaviour and activities of daily living which can help the clinical specialist in their cognitive assessment. When a client receives their diagnosis, the care partner or family member can provide emotional support, help enact a care or treatment plan and, in some cases, act as enduring power of attorney.

5.28 Allied health professionals may provide support and care to the client when they're diagnosed with dementia. A social worker may work with family members to access counselling, or an occupational therapist can plan home modifications to improve lifestyle and independence without the client having to wait for and attend additional appointments.

5.29 National Service Guidelines Standard 12.4 states:

> The feedback session during which the diagnosis is communicated should be attended by all relevant parties. This includes the assessing clinicians and the client and may also include the following:
>
> - Support person or care partner (with client's consent)
> - Allied health professionals

5.30 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 12.4 is summarised in Table 5-4.

Table 5-4 Summary of performance against National Service Guidelines Standard 12.4

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
The feedback session during which the diagnosis is communicated should be attended by all relevant parties. This includes the assessing clinicians and the client and may also include the following:	**Level**	**GGC**	**MAS**	**RADAR service**
Support person or care partner (with client's consent).	SR	✓	✓	✓

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
The feedback session during which the diagnosis is communicated should be attended by all relevant parties. This includes the assessing clinicians and the client and may also include the following:	**Level**	**GGC**	**MAS**	**RADAR service**
Allied health professionals.	R	✗	✗	✓

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.

Source: Audit Office analysis.

5.31 A review of the selected appointment records indicated that:

- a support person attended 99 appointments with clients (70 percent) including:
  - 23 out of 28 appointments for the RADAR service (82 percent);
  - 27 out of 45 appointments for the MAS (60 percent);
  - 49 out of 66 appointments for the GGC (74 percent);
- no allied health professionals attended an initial, feedback or follow-up appointment for the GGC or MAS; and
- the RADAR service often conducts appointments with a clinical specialist and a nurse, occasionally supplemented by a social worker or occupational therapist.

5.32 Allied health professionals play an important role in providing support for people with dementia and cognitive impairment. Other jurisdictions have recognised this and have subsequently implemented arrangements in which nursing and allied health professionals work alongside specialist clinicians in dementia and cognitive decline clinics.

5.33 In Victoria, Cognitive Dementia & Memory Service (CDAMS) clinics often include neuropsychologists, nurses, occupational therapists and social workers. Allied health professionals or nurses conduct an initial assessment as the 'key worker' and collect essential information before the specialist clinician consultation. The key worker also provides education and advice on post-diagnostic supports in a follow-up appointment after

receiving a diagnosis. The GGC and MAS are currently unable to provide a similar service to clients because they are not resourced as multidisciplinary services.

5.34 National Service Guidelines Standard 12.4 states the feedback session during which the diagnosis is communicated should be attended by all relevant parties including a support person and/or allied health professionals. Analysis of the selected appointment records indicated a support person or care partner attended 99 appointments (70 percent) across the GGC, MAS and RADAR service. No allied health professionals attended an initial, feedback or follow-up appointment for the GGC or MAS. The RADAR service often conducts appointments with a clinical specialist and a nurse, occasionally supplemented by a social worker or occupational therapist.

Evaluating client's progression and care plan implementation

5.35 Clients should have their supports re-evaluated over time. As dementia progresses, symptoms and client and care partner needs change. The clinician that provides the diagnosis, GPs, or community support organisations specialising in dementia are well-placed to provide ongoing support due to their familiarity with the client. Regular assessment and monitoring allow for modification to medications, interventions and referral to support services to address changes in symptoms, behaviour and care partner needs. This is essential as changes in disease progression affect activities of daily living and independence.

5.36 National Service Guidelines Standard 12.5 states:

> Memory and Cognition Clinic offers follow-up sessions to evaluate the client's progression and care plan implementation.
>
> - Memory and Cognition Clinic follows up all clients with a diagnosis of dementia at least once every 12 months and thereafter based on the client's need for review – Follow-ups should be based on the client's needs. Ideally, they are offered within the 12 months after the diagnosis, particularly if the client cannot be followed up and supported by other clinical services. Clinics with limited resources who are unable to offer follow-up sessions for all clients with an established dementia diagnosis, should ensure an appropriate follow-up mechanism by linking the client into appropriate services.
>
> - Memory and Cognition Clinic follows up all clients with a diagnosis of MCI at least once every 12-18 months based on the clinical judgement and thereafter based on the client's need for review.

5.37 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 12.5 are summarised in Table 5-5.

Table 5-5 Summary of performance against National Service Guidelines Standard 12.5

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic offers follow-up sessions to evaluate the client's progression and care plan implementation.	**Level**	**GGC**	**MAS**	**RADAR service**
Memory and Cognition Clinic follows up all clients with a diagnosis of dementia at least once every 12 months and thereafter based on the client's need for review.	R	●	●	●
Memory and Cognition Clinic follows up all clients with a diagnosis of MCI at least once every 12-18 months based on the clinical judgement and thereafter based on the client's need for review.	R	●	●	●
Assessment outcome key				
●	Partially meets National Service Guidelines Standard requirements.			
Level definitions				
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.			

Source: Audit Office analysis.

GGC and MAS

5.38 The CHS *Geriatric Outpatient Services Description* identifies that GGC and MAS clients should receive one standard follow-up meeting and another medication follow-up review if the client commences medication. If the client is not started on medication, both services discharge them after the initial follow-up feedback meeting.

RADAR service

5.39 The target median length of client admission for the RADAR service is 21 days from the day a referral is received to the day the referral is closed. Some clients stay in the service longer and receive multiple visits in one service period, usually due to their inability or unwillingness to attend an in-person clinic or re-referral by their GP.

5.40 After the initial assessment and prescribed follow up appointments, all services rely on the client's GP and other external support organisations to manage ongoing support. This is generally appropriate as it is reflective of the currently available post-diagnostic community-based support and care services funding available for dementia. However, the GGC, MAS and RADAR service have an important role to ensure people with dementia and

their care partner(s) are appropriately educated and informed in their understanding of their diagnosis and treatment, and available supports following receiving a diagnosis.

Care planning

5.41 The National Service Guidelines provide better practice standards for post-diagnosis care planning for clients.

5.42 The Australian Department of Health and Aged Care has produced a Care Planning Checklist tool that describes the benefits of the care planning process:

> Developing a care plan which is person-centred, and outcomes focused is critical to the success of implementing wellness and reablement and achieving high-quality outcomes for clients. Care planning involves working with your client to develop and document the approach to support the client to achieve their goals.

Providing post-diagnosis information

5.43 Australian clinical guidelines recommend the development of a care plan for people diagnosed with dementia and where possible such plans should involve the person with dementia and relevant care partner(s) or family members to identify goals, challenges and current and future care needs and preferences. Multidisciplinary approaches enhance the design and structure of care plans to meet the medical, psychological and social care needs of the person.

5.44 National Service Guidelines Standard 13.1 states:

> Memory and Cognition Clinic ensures the client receives all relevant information post-diagnosis and assists with developing a care plan.
>
> - Memory and Cognition Clinic provides written post-diagnostic support recommendations to the client, the client's GP, the referring medical practitioner (if other than a GP) and the post-diagnostic support service(s), as applicable.
> - The client, their care partner(s), and all assessing clinicians (e.g. medical practitioner, neuropsychologist) are actively involved in the client's care planning.
> - For clients with MCI or early signs of dementia, Memory and Cognition Clinic provides personalised risk reduction information to the client, GP or other referring medical practitioner, if required.
> - Memory and Cognition Clinic provides support and advice to clients they did not initially assess and diagnose.
> - Memory and Cognition Clinic assures the client and their family/care partner(s) that further advice and assistance can be sought after the discharge.

5.45 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 13.1 is summarised in Table 5-6.

Table 5-6 Summary of performance against National Service Guidelines Standard 13.1

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic ensures the client receives all relevant information post-diagnosis and assists with developing a care plan.	**Level**	**GGC**	**MAS**	**RADAR service**
Memory and Cognition Clinic provides written post-diagnostic support recommendations to the client, the client's GP, the referring medical practitioner (if other than a GP) and the post-diagnostic support service(s), as applicable.	SR	●	●	●
The client, their care partner(s), and all assessing clinicians (e.g. medical practitioner, neuropsychologist) are actively involved in the client's care planning.	SR	✗	✗	●
For clients with MCI or early signs of dementia, Memory and Cognition Clinic provides personalised risk reduction information to the client, GP or other referring medical practitioner, if required.	PP	✓	●	✓
Memory and Cognition Clinic provides support and advice to clients they did not initially assess and diagnose.	PP	✓	✓	✓
Memory and Cognition Clinic assures the client and their family/care partner(s) that further advice and assistance can be sought after the discharge.	PP	✗	✗	✗

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.

Level definitions

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic ensures the client receives all relevant information post-diagnosis and assists with developing a care plan.	**Level**	**GGC**	**MAS**	**RADAR service**
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.			
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.			
PP	These recommendations represent mostly aspirational criteria.			

Source: Audit Office analysis.

Post-diagnostic care planning support

5.46 National Service Guidelines Standard 13.1 strongly recommends services provide written post-diagnostic support recommendations to the client, the referring medical practitioner and post-diagnostic support services as applicable.

5.47 Providing written post-diagnostic support recommendations to the client is important because it aids in the provision of:

- clear communication to the client and their care partner(s) of the diagnosis; and
- personalised information relevant to their circumstances in relation to local community-based support and care options.

5.48 After a dementia diagnosis, both written and verbal information that covers the specific type of dementia, its symptoms, progression (where possible) and available treatments in plain, accessible language should be provided.

5.49 Written recommendations are also critical to enable timely access to suitable post-diagnostic supports which could prolong independence and support participation in decision-making and future planning. Written recommendations can allow family members and care partner(s) access to essential support, education and resources that may improve coping. This should include contact details for key support services like Dementia Australia and information about formal support programs such as the NDIS (under 65) or My Aged Care (65 and over). Essential documentation should cover legal planning (enduring power of attorney, guardianship and advanced care planning), home safety guidance and available community support services. For family care partners, specific resources about education, respite care and support services should be provided. All information should be culturally appropriate, translated if necessary and presented progressively to avoid overwhelming the person with dementia.

5.50 As discussed from paragraph 4.33, the GGC, MAS and RADAR service provide written post-diagnostic support recommendations via an appointment record, which is sent to the referring medical practitioner. Analysis of selected appointment records showed of the:

- sixty-six GGC appointments reviewed, 39 (59 percent) received no support recommendation;
- forty-five MAS appointments reviewed, 21 (47 percent) received no support recommendation; and
- twenty-nine RADAR service appointments reviewed, 4 (14 percent) received no support recommendation.

Client, care partner and assessing clinician involvement in care planning

5.51 National Service Guidelines Standard 13.1 strongly recommends that the client, their care partner and all assessing clinicians (e.g. medical practitioner, neuropsychologist) are actively involved in care planning. The inclusion of the assessing clinicians and allied health clinicians in care planning along with the client and their care partner is important to support a comprehensive person-centred approach. It also ensures care recommendations are informed by the relevant team of clinicians for each client.

GGC and MAS

5.52 The role of GGC and MAS clinicians in care planning is minimal. Clinical specialists make recommendations on the client's ongoing care, but most care planning is undertaken by the client's GP and community-based support services.

5.53 Though a clinical specialist may refer a client for occupational therapy or social work, care planning is largely siloed. A client may work with the social worker or occupational therapist individually, outside of their relationship with the assessing clinician. This is also true for neuropsychologists from the RACS Psychology and Counselling Service that may perform an assessment and provide their opinion to the assessing clinical specialist, but they are generally not further involved in planning for the client's care.

5.54 Inconsistent involvement in care planning and the siloed approach of other services involved in client care is a risk to clients receiving coordinated care.

RADAR service

5.55 The RADAR service operates as a traditional multidisciplinary team and may involve a clinical specialist, social worker and registered nurse in client care planning as required. The RADAR service includes clients and care partner in care planning where the client or care partner has capacity to participate.

5.56 National Service Guidelines Standard 13.1 strongly recommends that the client, their care partner and all assessing clinicians (e.g. medical practitioner, neuropsychologist) be actively involved in the client's care planning. The involvement of GGC and MAS clinicians in care planning is minimal and most care planning is undertaken by the client's GP and community-based support services. Inconsistent involvement in care planning and the siloed approach of other services involved in client care is a risk to clients receiving coordinated care. The RADAR service operates as a traditional multidisciplinary team and may involve a clinical specialist, social worker and registered nurse in care planning as required. The RADAR service includes clients and care partners in care planning where the client or care partner has capacity to participate.

Provision of risk reduction information

5.57 National Service Guidelines Standard 13.1 strongly recommends that clinicians provide clients with Mild Cognitive Impairment or early signs of dementia with personalised risk reduction information. It is important that personalised risk reduction information is provided because people with Mild Cognitive Impairment are at greater risk of developing dementia. According to Clinical Practice Guidelines, people with Mild Cognitive Impairment should be followed up by a specialist memory assessment service, nurse practitioner or GP after 6 to 18 months to monitor cognitive changes and other signs or possible dementia.

5.58 Of the selected appointment records reviewed for the purpose of the audit, there were 33 in which the client had a clear diagnosis of Mild Cognitive Impairment, but there was not enough detail to determine whether a client was displaying earlier signs of dementia. Of the 33 records, 17 were from the GGC, 13 from the MAS and three were from the RADAR service. The audit examined the 33 appointment records to determine whether the clinical specialist provided them with personalised risk reduction information. Across all services, clinical specialists provided risk reduction information to 70 percent of clients that had a diagnosis of Mild Cognitive Impairment.

5.59 National Service Guidelines Standard 13.1 strongly recommends that clients with Mild Cognitive Impairment or early signs of dementia are provided with personalised risk reduction information along with their GP or other referring medical practitioner. The audit examined the 33 appointment records to determine whether the clinical specialist provided them with personalised risk reduction information. Across all services, clinical specialists provided risk reduction information to 70 percent of clients that had a diagnosis of Mild Cognitive Impairment.

5.60 Recommendation 7 is intended to address this finding.

Clients not initially assessed or diagnosed by the GGC, MAS or RADAR service

5.61 National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should provide support and advice to clients that they did not initially assess and diagnose. This is important because clients that present with cognitive concerns may affect social or occupational functioning. Further, subjective cognitive complaints may be present prior to measurable decline. Individual support and advice should be provided to ensure appropriate follow up with their GP or the service in the future.

5.62 A review of the selected appointment records identified that all three services provide support and advice to clients they did not initially assess or diagnose. The review identified 13 instances in which a client had received a diagnosis from another source prior to attending their first appointment with the GGC, MAS or RADAR service including:

- four GGC clients;
- four MAS clients; and
- five RADAR service clients.

5.63 National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should provide support and advice to clients they did not initially assess and diagnose. A review of the selected appointment records identified that all three services provide support and advice to clients they did not initially assess or diagnose.

Ongoing assistance after discharge

5.64 National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states the service should assure the client and their care partner(s) that further advice and assistance can be sought after the discharge.

5.65 Providing clients and their care partner(s) with the option of seeking further advice and assistance after discharge is important as the needs of the person will evolve as dementia progresses.

5.66 Unless referred to another health professional (e.g. social worker or speech pathologist) or another service (e.g. the Aged Care Assessment Team or community care), clients are discharged from CHS. After discharge, people with dementia and their care partner(s) can contact the services through the publicly available CHS contact information if further care or support is required. Contact with individual clinicians after discharge varies and while contact information for follow-up may be offered, this is not routine practice. Clients should be provided with a central point of contact to direct any questions or concerns following discharge. This reduces risks associated with changes in staffing or in processes within the service. The development of clear processes and allocation of a key worker (one clinician or allied health professional allocated to each client throughout the process) with information about future care or services when discharged from CHS may minimise risk.

5.67 The CHS Liaison and Navigation Service (LaNS) is a consent-based service that can provide information, coordination and navigation for clients with complex healthcare needs and facilitate opportunities to improve a clients' experience and health outcomes. The client or their care partner(s) were not referred to the LaNS in any of the selected appointments records examined.

5.68 National Service Guidelines Standard 13.1 includes a practice point or aspirational criterion that states services should assure the client and their care partner(s) that further advice and assistance can be sought after the discharge. There are currently no formalised pathways for clients to seek further advice or assistance from CHS services beyond referral by the client's GP or the clinical specialist who originally conducted the assessment.

Facilitating care plan implementation

5.69 It is important that services have active connections with support services to which they refer their clients for ongoing support in care plan implementation. If clinicians don't have adequate knowledge of local supports or active relationships, clients may miss out on opportunities to receive services and support.

5.70 National Service Guidelines Standard 13.2 states:

> Memory and Cognition Clinic facilitates the care plan implementation.
>
> - Memory and Cognition Clinic has active relationships with relevant support services to refer as appropriate (e.g., support group for carers).
> - Memory and Cognition Clinic offers follow-up phone calls to assist the client with care plan implementation.

5.71 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 13.2 is summarised Table 5-7.

Table 5-7 Summary of performance against National Service Guidelines Standard 13.2

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic facilitates the care plan implementation.	**Level**	**GGC**	**MAS**	**RADAR service**
Memory and Cognition Clinic has active relationships with relevant support services to refer as appropriate (e.g. support group for carers).	SR	✗	✗	●

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
Memory and Cognition Clinic facilitates the care plan implementation.	**Level**	**GGC**	**MAS**	**RADAR service**
Memory and Cognition Clinic offers follow-up phone calls to assist the client with care plan implementation.	R	✗	✗	✗

Assessment outcome key	
✗	Does not meet National Service Guidelines Standard requirements.
●	Partially meets National Service Guidelines Standard requirements.
Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.

Source: Audit Office analysis.

Relationships with relevant support services

5.72 National Service Guidelines Standard 13.2 strongly recommends services have active relationships with relevant support services to refer clients as appropriate (e.g. support groups for carers).

5.73 Greater integration of health and social care services is vital to ensuring sustainable and long-term quality provision for people living with dementia and their families. CHS can assist clients and families to receive support after diagnosis by building active relationships with key support services including Dementia Australia, Carers ACT and Dementia Support Australia.

5.74 Building an active relationship can involve meetings and correspondence between clinical specialists and support services, general collaboration in relation to client care and the provision of education to support services provided by the GGC, MAS and RADAR service and vice versa. Being well-connected and having open lines of communication with community-based services can assist with continuity of care and expedite access to counselling, education, peer support programs and support groups.

GGC and MAS

5.75 The CHS *Geriatric Outpatient Description* includes a list of organisations to which clients may be referred from the GGC and MAS including Dementia Australia, Dementia Support Australia and Sustainable Personalised Interventions for Cognition, Care and Engagement (SPICE Program).

5.76 Clinical specialists interviewed for the purpose of the audit advised that they refer clients to Dementia Australia, Dementia Support Australia and the SPICE Program. Analysis of selected appointment records shows that clinical specialists very rarely refer the client to services directly but instead recommend the client's referring medical practitioner refer the client or the client self-refer. Client referrals are discussed further in paragraphs 5.94 to 5.112.

RADAR service

5.77 The *RADAR Model of Care* includes a list of internal and external stakeholders with which the service seeks to foster and maintain a relationship including My Aged Care, Community Nursing, Fitness to Drive, Dementia Australia and Dementia Support Australia. RADAR service clinicians were more likely to make direct referrals to services on behalf of the client either through the clinical specialist themselves or the social worker that the RADAR service has on staff. Client referrals are discussed further in paragraphs 5.94 to 5.112.

Relationship with Dementia Australia

5.78 Dementia Australia is a national organisation funded by the Australian Government, which provides professional support for people with dementia, their families and carers including education, counselling, transportation and assistance applying for government programs like the NDIS and My Aged Care.

5.79 CHS representatives do not meet regularly with Dementia Australia, although Dementia Australia has been invited to speak at CHS staff meetings about the services it offers. This has been a key opportunity to develop knowledge and relationships across the services. No outcomes or actions have been recorded from these meetings.

Relationships with other services

5.80 On occasion, representatives from other external organisations are invited to speak at staff meetings. For these meetings there is no established schedule of speakers and there are no recorded outcomes or actions from these meetings.

5.81 GGC, MAS and RADAR service representatives do not promote or undertake community education about the services that they provide. This is a missed opportunity, as all three services rely on external support organisations for post-diagnostic follow up and support for clients. A more proactive approach could lead to greater staff knowledge of available services in the ACT and better understanding of referral processes.

5.82 National Service Guidelines Standard 13.2 strongly recommends that services have active relationships with relevant support services to refer as appropriate (e.g. support groups for carers). Clinical specialists from the GGC and MAS advised that they refer clients to Dementia Australia, Dementia Support Australia and the SPICE Program, while the *RADAR*

Model of Care includes a list of internal and external stakeholders with which the service seeks to foster and maintain a relationship including My Aged Care, Community Nursing, Fitness to Drive, Dementia Australia and Dementia Support Australia. On occasion, representatives from Dementia Australia and other external organisations have spoken at CHS staff meetings.

Follow-up phone calls to clients

5.83 National Service Guidelines Standard 13.2 recommends that services offer follow-up phone calls to assist the client with care plan implementation. Providing follow up phone calls is beneficial for client care because it helps to identify changing needs, ensures referred services are accessible and suitable and offers an opportunity to address further questions or provide additional information to support the client and their goals.

5.84 The GGC, MAS and RADAR service do not have an active telephone appointment policy. This increases the risk of inconsistent practice. Follow-up phone calls also provide an opportunity to identify if there is psychological distress after receiving a dementia diagnosis.

5.85 A review of DHR appointment data associated with 1,906 GGC and MAS appointments and 2,194 RADAR service appointments indicated that only six telephone and two video follow-up appointments occurred across all services between 2022 and 2024. The minimal use of video follow-up appointments reduces client access to clinical specialist appointments where clients who may be experiencing cognitive impairment cannot attend a physical location.

5.86 The National Service Guidelines Standard 13.2 recommends services offer follow-up phone calls to assist the client with the care plan implementation. The GGC, MAS and RADAR service do not have a telephone appointment policy and a review of DHR data indicated that only six telephone and two video follow-up appointments occurred between 2022 and 2024. The minimal use of video follow-up appointments reduces client access to clinical specialist appointments where clients who may be experiencing cognitive impairment cannot attend a physical location.

Providing advice, information and support about key issues

5.87 Clinicians working in the GGC, MAS and RADAR service are key sources of knowledge for clients, their families, care partner(s) and referring medical practitioners that may not have specialised expertise in dementia post-diagnostic advice.

5.88 National Service Guidelines Standard 13.3 strongly recommends that:

> Where appropriate, directly after the diagnosis, Memory and Cognition Clinic provides advice, information, and support regarding the following issues:
>
> - Education about dementia (e.g. psychoeducation) provided to the client, family and carers.
> - Carer support.
> - Beneficial lifestyle changes.
> - Behaviour management interventions.
> - Risk reduction education.
> - Management of safety concerns.
> - Written personalised strategies to help the client live with dementia day-to-day (e.g. use of calendars, medication boxes and phone reminders.
> - Involvement in research and clinical trials (where appropriate).

5.89 The audit did not consider the appropriateness of clinician decisions to provide clients, or not provide clients, with advice, information and support relating to the issues identified in National Service Guidelines Standard 13.3. This is a matter of clinical judgment, which is informed by a client's presentation, comorbidities, functional status, social circumstances and personal preferences.

5.90 Analysis of the selected appointment records identified that clinical specialists recorded providing advice, information and supports in relation to most of the issues identified in National Service Guidelines Standard 13.3. It was not possible to confirm whether this was provided to the referring GP only, or directly to clients and care partners as well. Written personalised strategies to help the client live day-to-day and involvement in research and clinical trials were not recorded.

5.91 CHS has not developed or maintained a repository of information and supports that clinicians can access and provide directly to clients and care partners. Although clinicians use their specialist expertise to decide what advice, information and supports may be relevant to each individual client, CHS could better support clinicians in this decision making by providing printable information sheets and templates with pre-filled information options in relation to the issues identified in National Service Guidelines Standard 13.3. This approach has been found to be useful in other memory and assessment services as it enables clinicians to quickly select appropriate information for the client based on their clinical judgement and add personalised recommendations where appropriate.

5.92 National Service Guidelines Standard 13.3 strongly recommends that, where appropriate, directly after the diagnosis, clients are provided with advice, information and support

regarding various issues. Analysis of the selected appointment records identified that clinical specialists recorded providing advice, information and supports in relation to most of the issues identified in the standard, although it was not possible to confirm whether this was provided to the referring GP only, or directly to clients and care partners as well. CHS has not developed or maintained a repository of information and supports that clinicians can access and provide directly to clients and care partners. Although clinicians use their specialist expertise to decide what advice, information and supports may be relevant to each individual client, CHS could better support clinicians in this decision making by providing printable information sheets and templates with pre-filled information options in relation to the issues identified in the standard.

5.93 Recommendation 6 is intended to address this finding.

Referring clients to services with dementia expertise

5.94 Reliable referral processes and strong relationships with support services are crucial to providing person-centred care and empowering people to manage their condition as well as possible. The GGC, MAS and RADAR service rely on the referrer and external services to provide post-diagnostic support. These supports are essential to ensure clients have continued support and care after their diagnosis.

5.95 National Service Guidelines Standard 13.4 states:

> If the Memory and Cognition Clinic is unable to provide more detailed post-diagnostic support (e.g. due to lack of resources), it refers client to relevant, available and timely services with dementia expertise. Where appropriate, these services include:
>
> - Provision of psychological support (e.g. management of depression/anxiety)
> - Nursing support – this may include care coordination
> - Occupational therapy
> - Speech and language therapy
> - Group based programs focused on improving well-being (e.g. day centres with leisure activities, Meeting Centre Support Programs, etc.)
> - Dietic advice – provided by a dietician with expertise in dementia, preferably an Accredited Practising Dietician (APD)
> - Exercise programs – Provided by an exercise physiologist or physiotherapist with expertise in dementia
> - Provision of interventions for poor sleep-wake functioning (e.g. cognitive behaviour therapy, sleep hygiene, interventions to treat obstructive sleep apnoea)
> - Home-based multidisciplinary reablement programs

- Evidence-based cognitive interventions (e.g. computerised or memory strategy training) via face-to-face appointments or via Telehealth) – Dementia Lived Experience Experts particularly endorse the option of telehealth, if they cannot get to the service easily.

5.96 The performance of the GGC, MAS and RADAR service against National Service Guidelines Standard 13.4 is summarised in Table 5-8.

Table 5-8 Summary of performance against National Service Guidelines Standard 13.4

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
If the Memory and Cognition Clinic is unable to provide more detailed post-diagnostic support (e.g. due to lack of resources), it refers client to relevant, available and timely services with dementia expertise. Where appropriate, these services include:	**Level**	**GGC**	**MAS**	**RADAR service**
Provision of psychological support (e.g. management of depression/anxiety).	SR	✓	✓	✓
Nursing support – this may include care coordination.	SR	✗	✗	✓
Occupational therapy.	SR	✗	✗	✓
Speech and language therapy.	SR	✓	✗	✗
Group based programs focused on improving well-being (e.g. day centres with leisure activities, Meeting Centre Support Programs, etc).	R	✗	✗	✗
Dietetic advice.	R	✓	✗	✓
Exercise programs.	R	✓	✗	✗
Provision of interventions for poor sleep-wake functioning (e.g. cognitive behaviour therapy, sleep hygiene, interventions to treat obstructive sleep apnoea).	R	✗	✓	✗
Home-based multidisciplinary reablement programs.	R	✓	✗	✓

National Service Guidelines Standard requirement		Meeting National Service Guidelines Standard?		
If the Memory and Cognition Clinic is unable to provide more detailed post-diagnostic support (e.g. due to lack of resources), it refers client to relevant, available and timely services with dementia expertise. Where appropriate, these services include:	**Level**	**GGC**	**MAS**	**RADAR service**
Evidence-based cognitive interventions (e.g. computerised or memory strategy training) via face-to-face appointments or via Telehealth) – Dementia Lived Experience Experts particularly endorse the option of telehealth, if they cannot get to the service easily.	PP	✗	✗	✗

Assessment outcome key	
✓	Meets National Service Guidelines Standard requirements.
✗	Does not meet National Service Guidelines Standard requirements.

Level definitions	
SR	These recommendations represent the fundamentals of a good Memory and Cognition Clinic.
R	These recommendations represent criteria that further increase the quality of a Memory and Cognition Clinic.
PP	These recommendations represent mostly aspirational criteria.

Source: Audit Office analysis.

5.97 The GGC, MAS and RADAR service do not have visibility over what happens to a client after they are diagnosed, nor do they have further input into their care after they are discharged from the service.

5.98 In response to the draft proposed report, CHS advised that:

> In practice, referral back to the General Practitioner is made, who plays a central role in coordinating further referrals to supports based on individual patient needs.

5.99 Clinical specialists from the GGC and MAS do not routinely refer clients to additional community supports. Referrals to CHS services are also not consistently made, with some clinical specialists identifying long wait times as a rationale for not referring clients to community supports such as social workers. In practice, clinical specialists make recommendations to the client's GP so that they may make referrals on the client's behalf or provide information or suggest recommending that the client self-refer to support services or independently seek further support. A representative of GPs in the ACT who was

spoken to for the purpose of the audit indicated that providing referrals is challenging in the limited time they have in consults. There is a high risk of missed care when there is an imbalance in expectations between specialised clinicians and referrers.

5.100 In response to the second final proposed report, CHS advised that:

> CHS notes that the 'Shared Care Model between GP and non-GP specialists for complex chronic conditions' issued by the Royal Australian College of General Practice in 2023 is used by clinicians. CHS recognises that GPs play a vital role in dementia care coordination.

5.101 One private specialist assessment service for dementia in the ACT has a 'care navigator' role to assist clients with connecting directly with services, thereby lowering barriers to accessing support and increasing the chance that a client will follow through with receiving support services. The model adopted in Victorian CDAMS clinics (as discussed from paragraph 5.33) also enhances the client experience by providing a consistent and familiar point of contact. There is currently no such position at the GGC or MAS.

5.102 RADAR service clinicians make direct referrals to supports for clients. The RADAR service also employs a social worker, occupational therapist and dietitian at a total of 3.2 FTE, that can attend RADAR service home visits where necessary.

5.103 A review of selected appointment records sought to identify the support services and the frequency in which recommendations (for the GGC and MAS), or referrals (for the RADAR service) had been made to those services. Analysis of the selected appointment records shows that none of the services regularly recommend or referred clients to the categories of support identified in National Service Guidelines Standard 13.4. Notably, no service referred to group-based programs focused on well-being or evidence-based cognitive interventions.

5.104 Many clients with a dementia or Mild Cognitive Impairment diagnosis were not recommended any supports at all. Analysis of the selected appointment records showed that of the:

- sixty-six GGC appointments reviewed, 45 clients had a diagnosis of dementia or Mild Cognitive Impairment prior to or during their appointment at the clinic. Twenty-five (58 percent) did not receive a support recommendation from the clinical specialist in their appointment;
- forty-five MAS appointments reviewed, 22 clients had a diagnosis of dementia or Mild Cognitive Impairment prior to or during their appointment at the clinic. Nine (41 percent) did not receive a support recommendation from the clinical specialist in their appointment;
- twenty-nine RADAR service appointments reviewed, 26 clients had a diagnosis of dementia or Mild Cognitive Impairment prior to or during their appointment at the

clinic. One (4 percent) did not receive a support recommendation or referral from the clinical specialist (the client was already residing in a nursing home).

5.105 While support recommendations are at the discretion of the clinical specialist based on the client's needs, the differences in support recommendations between the services shows the variation in practice. Clients who access the RADAR service are more likely to receive recommendations or referrals for further support than those seen in the GGC or MAS. GGC and MAS clinical specialists rely on nursing staff to provide support recommendations to the client, but this is problematic, as the client is unable to meet with the nurse until their follow up appointment, which could be up to six months later.

5.106 National Service Guidelines Standard 13.4 states that if a service is unable to provide more detailed post-diagnostic support (e.g. due to lack of resources), it should refer clients to relevant, available and timely services with dementia expertise. A review of the selected client appointment records found that all three services did not regularly recommend clients to the support services described in National Service Guidelines Standard 13.4. CHS advised that 'in practice, referral back to the General Practitioner is made, who plays a central role in coordinating further referrals to supports based on individual patient needs'. No service referred to group-based programs focused on well-being or evidence-based cognitive interventions. The GGC, MAS and RADAR service do not meet the requirements of this standard.

Connecting clients to key services post-diagnosis

5.107 National Service Guidelines Standard 13.5 states:

> Where appropriate, Memory and Cognition Clinic connects clients to the following services, after the diagnosis is communicated:
>
> - Driving assessments
> - Dementia Australia
> - Community Care Services
> - Legal and financial counselling

5.108 These services are key support options for clients with a diagnosis of dementia or Mild Cognitive Impairment:

- driving assessments help maintain the safety of the individual and the public by assessing and potentially barring individuals with dementia from driving;
- Dementia Australia is the national peak body for dementia advocacy and support and provides a range of services to people with dementia and their families including counselling and education;

- community care services including My Aged Care, the National Disability Insurance Scheme and the CHS Community Nursing program provide care services for people living with dementia in the community; and
- legal and financial counselling services, including advanced care planning, are essential in helping clients with dementia and their family plan for future medical, personal and end-of-life care decisions by documenting and respecting the wishes of the person. An important aspect of this is selecting an enduring power of attorney to make personal and financial decisions, if the client no longer has capacity, to manage the persons affairs according to their wishes.

5.109 The audit did not consider the appropriateness of decisions made to either connect, or not connect, clients with the services identified in National Service Guidelines Standard 13.5 as this was considered a matter of clinical judgment, informed by a client's presentation, comorbidities, functional status, social circumstances and personal preferences. In this respect it is noted that clients with the same diagnosis may require different support services.

5.110 CHS advised that in practice, recommendations regarding ongoing management are provided to the GP, who plays a central role in coordinating further referrals to support based on individual patient needs. Therefore, the audit considered selected appointment records to determine the frequency by which the GGC, MAS and RADAR service recommended referring GPs connect clients with each of the services. The result of this analysis is shown in Table 5-9.

Table 5-9 Instances of clinical specialists recommending key services

	GGC (66 records)	MAS (45 records)	RADAR service (29 records)
Driving assessment	3	0	1
Dementia Australia	4	1	1
Community Care Services	5	1	14
Legal and financial counselling	10	4	1

Source: ACT Audit Office analysis based on a review of 140 selected appointment records.

5.111 Analysis of the appointment records showed low rates of referral to the services identified in National Service Guidelines Standard 13.5 and that the way in which clinicians recorded referrals to services was inconsistent.

5.112 CHS has not developed or maintained a repository of information, resources or available support services that may assist clinicians with easily identifying potential support options. Although clinicians use their specialist expertise to decide what services may be relevant to each individual client, CHS could better support clinicians in this decision-making by

providing them with easier access to information relating to the services identified in National Service Guidelines Standard 13.5.

5.113 National Service Guidelines Standard 13.5 strongly recommends that services connect clients with key support services where appropriate including driving assessment services, Dementia Australia, community care services and legal and financial counselling services. Analysis of the appointment records indicated low rates of referral to these services and the way in which clinicians recorded referrals to services was inconsistent. CHS has not developed or maintained a repository of information, resources or available support services that may assist them to easily identify potential support options. Although clinicians use their specialist expertise to decide what services may be relevant to each individual client, CHS could better support clinicians in this decision-making by providing them with easier access to this information.

Recommendation 6 **Repository of information, resources and available supports**

CHS should develop and maintain a repository of information, resources and available supports that clinicians can easily access and provide to clients and care partners following a diagnosis of dementia or Mild Cognitive Impairment where appropriate.

Recommendation 7 **Models of care**

CHS should develop and implement models of care for the GGC and MAS, and update the *RADAR Model of Care* as required, to reflect:

a) referral acceptance eligibility criteria in accordance with the requirements of the *CHS Medical Specialist Outpatient Referral Acceptance (Adults and Children) Policy*;

b) a framework for prioritising accepted referrals;

c) a formal process and protocols for managing and supporting clients and care partner(s) in distress whilst waiting for an appointment;

d) minimum standards for communicating diagnoses, test results and next steps;

e) protocols for the provision of a post-feedback follow up session and additional follow-up sessions, where it is identified by clinicians as required;

f) defined risk reduction information that is to be provided to clients diagnosed with early stages of dementia or Mild Cognitive Impairment; and

g) a common approach for the delivery of risk reduction information across CHS' specialist assessment services for dementia and cognitive decline.

6 Information collection and management

6.1 This chapter discusses the information that is collected and managed by the GGC, MAS and RADAR service for the purpose of client care and service improvement.

Summary

Conclusions

CHS does not effectively collect and manage information on the delivery of services by the GGC, MAS and RADAR service, to identify and report on the effectiveness of service delivery or whether there are opportunities for improvement.

A lack of standard operating procedures for inputting information into the Digital Health Record (DHR), and an absence of data collection policies, limits the services' ability to collect consistent data that can be used for monitoring and reporting purposes. The GGC, MAS and RADAR service are unable to effectively monitor performance data relating to referral rates and sources, wait times or staff workload and are unable to effectively monitor and report on performance.

Key findings

Client health information	Paragraph
Referrals to the GGC, MAS and RADAR service are sent to the RACS Administration Team to action. The information included in each referral is manually entered into the DHR by the RACS Administration Team. The information that is collected through the referral process is not standardised and information provided by GPs varies. There are no standard operating procedures to guide the recording of referral information in the DHR, which increases the risk of errors and inconsistences.	6.9
Throughout a client's journey, nursing, specialist and allied health professionals collect and record clinical information in the DHR. The information that is collected aims to provide an accurate and holistic view of the client that can inform appropriate treatment or next steps for the client. DHR functionality allows for users to enter clinical information on an as required basis and there are no mandatory fields. This can present a challenge for nursing, specialist and allied health staff as accessing client information may require them to navigate a multitude of fields in the DHR. The Health and Community Services Directorate is in the process of developing an education package to support outpatient DHR users. Nonetheless, it remains the responsibility of individual business units to establish standard operating procedures and policies to guide appropriate data collection in the DHR.	6.17

Client feedback

The CHS Consumer Feedback and Engagement Team (CFET) is responsible for collecting and managing feedback across CHS services. The CFM Procedure requires all feedback to be provided to the CFET so that it can be recorded in the RiskMan feedback module and managed centrally. Although this is a requirement of the CFM Procedure, CHS is not able to identify with certainty whether this occurs in practice. 6.27

A total of 1,298 feedback records were entered into the RiskMan feedback module between January 2022 and June 2024 and allocated to the RACS Division. The feedback records consisted of 654 compliments (50.4 percent), 587 complaints (45.2 percent) and 57 comments (4.4 percent). At the time of the audit, the RiskMan feedback did not allow for complaints to be allocated to, and recognised by, specific business units or services. It was therefore not possible to identify feedback that related specifically to the GGC, MAS or RADAR service. CHS advised the issue has been fixed and future data will be available for business units and services. 6.31

When recording feedback in the RiskMan feedback module, the CFET provides a brief description of the feedback in a summary field, which is limited to 250 characters. Information in the summary field of the RiskMan feedback module varies significantly, with some entries containing a few words and others providing more detail. The variation and inconsistency in the detail of the summary field may impact results that are produced when a search of the database is performed. 6.36

The CFM Procedure includes workflow diagrams to guide the process for collecting and managing client feedback. The workflow diagrams clearly articulate the required actions, roles and responsibilities that staff should follow when managing and responding to feedback. They provide reasonable guidance to staff and support consistent feedback management. The CFM Procedure does not define what role(s) or levels within the organisation are responsible for managing and responding to feedback, nor has the RACS Division developed any policy or procedural guidance to this effect. This increases the risk that feedback is managed inconsistently or inappropriately. 6.47

A review of 11 feedback records between January 2022 and June 2024 that were specific to the GGC, MAS and RADAR service shows that all of the feedback records were managed according to the established workflow. The feedback records included the original feedback, advice from the CFET where required and a record of the outcome. 6.54

According to the established workflow, all complaints should be addressed by contacting clients by phone or in writing. The review of the selected feedback records showed that nine out of ten clients or carer partner(s) that had made a complaint had been contacted. One complaint that was received related to the appropriateness of treatment from a clinical specialist. The CFET recommended that the clinical specialist contact the complainant directly to resolve the issue. The clinical specialist acted on this advice and contacted the complainant to discuss the 6.55

complaint. Due to the nature of the complaint, it would have been better for the complaint to have been addressed and resolved by an Executive Level Officer.

Use of data to report on and improve service delivery

6.61 Prior to the implementation of the DHR, CHS used the ACT Patient Administration System (ACTPAS) to manage central patient information. Outpatient services had access to data and reporting capability for services including referral data, workload, client hours and hospital readmission data. This information could be used to provide an indication of service performance. The RADAR service sourced data and reported on key information to governance forums with a focus on using the data to improve service delivery. For example, a *RADAR Overview Report* provided to the RACS Executive in August 2022 documented key RADAR service activity data that was used to highlight an increase in workload for the RADAR service and the potential need for additional staff. The GGC or MAS have not produced a similar report.

6.65 Due to DHR reporting constraints for outpatient service data, primarily due to inconsistencies in how services record information in the DHR, trends, issues, discrepancies, gaps and root cause of variances are not routinely identified and reported on. This means that the GGC, MAS and RADAR service are unable to effectively monitor performance data relating to referral rates and sources, wait times or staff workload and are unable to effectively monitor and report on performance to:

- assess whether services are meeting the needs of the community; or
- identify mitigation strategies to rectify performance issues.

6.75 The RACS Quality and Safety Committee regularly reviews consumer feedback data including: number of compliments, complaints and comments received; number of complaints resolved within the CHS target of 35 days; percentage of patient survey results that rated the services provided as ‘very good’ or ‘good’; and top three compliment and complaint themes. Complaint themes relating to conduct, information/communication/education and access were consistently highlighted in reports between August 2022 and February 2024 (18 reports in total). There was no further description for each theme. There is no evidence that the RACS Quality and Safety Committee discussed the cause of the themes being consistently raised.

6.81 In December 2022, the RADAR service conducted a *Geriatric patients readmitted within 28 days with RADAR involvement: clinical and social characteristics* clinical audit. The findings were used to identify potential service improvements for the RADAR service. There has not been a follow-up audit to determine whether the findings from this audit have improved the services provided by the RADAR service. Audits have not been conducted in relation to the GGC or MAS and there are currently no plans in place to evaluate these services.

Client health information

6.2 Since November 2022, the GGC, MAS and RADAR service have primarily used the DHR for the recording and management of client health information. Both clinical and non-clinical staff are responsible for collecting information. CHS administrative, nursing, specialist and allied health staff are expected to enter client information into the DHR at all stages of the client's journey.

Referral information

6.3 Referrals to the GGC, MAS and RADAR service contain both personal client information and clinical information for clients requiring an appointment. Referrals to the GGC, MAS and RADAR service are sent to the RACS Administration Team to action.

6.4 The information included in each referral is manually entered into the DHR by the RACS Administration Team. The information that is collected through the referral process is not standardised and information provided by GPs varies.

6.5 Accurate referral information is important to support the triaging process for the GGC, MAS and RADAR service. There are no standard operating procedures to guide the input of referral information into the DHR. The lack of standard operating procedures to guide the input of data into the DHR was consistently raised by CHS staff.

6.6 The RACS Administration Team advised that it had previously referred to an *Ambulatory Care Operations Manual* to guide the input of information and that this was a useful document. However, since the implementation of the DHR, the *Ambulatory Care Operations Manual* is no longer applicable. The development of a similar document for the DHR is still in progress.

6.7 Once referral information has been entered into the DHR, the RADAR service triage team triages all referrals that are received for the GGC, MAS and RADAR service. Triage is based on the information in the DHR relating to the referral and other relevant clinical information that may be available.

6.8 The RADAR service triage team advised that most of the time the referral information is sufficient for the purpose of triaging clients. However, on occasion, it may need to review other information in the DHR to complete the triage process. This may include information such as recent admissions or discharge summaries from the Emergency Department or the inpatient environment to get a better understanding of the client's history prior to triaging.

6.9 Referrals to the GGC, MAS and RADAR service are sent to the RACS Administration Team to action. The information included in each referral is manually entered into the DHR by the RACS Administration Team. The information that is collected through the referral process is not standardised and information provided by GPs varies. There are no standard operating procedures to guide the recording of referral information in the DHR, which increases the risk of errors and inconsistences.

Clinical information

6.10 Throughout a client's journey, nursing, specialist and allied health professionals record clinical information in the DHR. The information that is collected aims to provide an accurate and holistic view of the client that can inform appropriate treatment or next steps for the client.

6.11 The clinical information that is recorded in the DHR by clinical and non-clinical staff may include:

- the client's health history;
- regular medications;
- cognitive screening scores including a scan of the cognitive screening test that the client has completed;
- imaging and pathology results;
- referrals and letters; and
- advanced care planning information.

6.12 The DHR allows users to enter clinical information on an as required basis. There are no mandatory fields within the DHR, and users enter data in the fields that they determine are appropriate for the interactions with a client. This can present a challenge for nursing, specialist and allied health staff as accessing client information may require them to navigate a multitude of fields in the DHR when providing critical services to clients.

6.13 A review of a selection of client records for the GGC, MAS and RADAR service identified variations in how information is entered into the DHR. For example, records of phone calls with a client may be recorded in an 'encounters' tab of the DHR or it may be recorded in a 'notes' tab of the DHR. Users exercise discretion as to which tab the information is stored in. This increases the risk of information being overlooked by other users.

6.14 Whilst it is appropriate that a level of professional judgment applies when clinicians enter information in the DHR, variation in the information collected, and where it is stored, may take up staff time to seek out this information and potentially impact the quality of care that clients receive.

6.15 The Health and Community Services Directorate (formerly the ACT Health Directorate) has not provided DHR outpatient service users with any guidance on the collection and management of client clinical information in the DHR. However, the development of an education package to support outpatient DHR users is in progress. This is expected to include a component that focuses on data collection and management. As of December 2024, a completion date for the education package was not known.

6.16 Although the education package will provide high-level guidance on the use of the DHR and data collection, it will remain the responsibility of individual business units to establish standard operating procedures and policies to guide the appropriate recording of data in the DHR.

6.17 Throughout a client's journey, nursing, specialist and allied health professionals collect and record clinical information in the DHR. The information that is collected aims to provide an accurate and holistic view of the client that can inform appropriate treatment or next steps for the client. DHR functionality allows for users to enter clinical information on an as required basis and there are no mandatory fields. This can present a challenge for nursing, specialist and allied health staff as accessing client information may require them to navigate a multitude of fields in the DHR. The Health and Community Services Directorate is in the process of developing an education package to support outpatient DHR users. Nonetheless, it remains the responsibility of individual business units to establish standard operating procedures and policies to guide appropriate data collection in the DHR.

Recommendation 8 Collection of referral and clinical information

CHS should develop:

a) a standard operating procedure(s) for the collection and storage of referral information in the DHR relating to the GGC, MAS and RADAR service; and

b) guidelines that specify minimum requirements, including the fields that should be used, to support the consistent collection of clinical information in the DHR.

Client feedback

6.18 On 19 August 2020, CHS published a *Consumer Feedback Management Policy* (CFM Policy). The purpose of the CFM Policy is to:

> … outline the CHS approach to managing consumer feedback and provide specific advice on systems currently in place to support consumers and carers providing feedback and to support staff in responding to and acting on consumer feedback. This policy also emphasises the importance of receiving and responding to feedback promptly.

6.19 The CFM Policy is to be read in conjunction with a *Consumer Feedback Management Procedure* (CFM Procedure) that was issued on 18 October 2024. The purpose of the CFM Procedure is to:

> … outline the CHS approach to managing consumer feedback. It provides specific advice on supporting consumers and carers to provide feedback and supporting staff to respond to and act on consumer feedback. This policy also emphasises the importance of receiving and responding to feedback promptly.

6.20 According to the CFM Procedure, feedback 'refers to comments, compliments and complaints received from consumers, their family, carers or other interested parties in relation to staff and services provided by CHS'.

Collecting feedback

6.21 The CHS Consumer Feedback and Engagement Team (CFET) is responsible for collecting and managing feedback across CHS services. The feedback and corresponding management response is recorded in the RiskMan system by the CFET.

6.22 Clients and carers can provide feedback on services provided by CHS through various means including:

- phone, email and in writing;
- completion of an online feedback form (either online or paper based – feedback forms and collection boxes are located throughout CHS hospitals and community-based facilities);
- the ACT Health App; and
- the QR code on the *Consumer and Carer Feedback: Listening and Learning* poster.

6.23 CHS may also send a 'patient experience' survey after care has been provided. The surveys are sent to clients by text message or email and are available in 23 languages.

6.24 The RADAR service advised that all clients are provided with a feedback form for completion when discharged from the service. The GGC and MAS do not consistently provide clients with a feedback form, although clients are able to provide feedback to the CFET should they wish to do so.

6.25 The CFM Procedure requires all feedback to be provided to the CFET so that it can be recorded in the RiskMan feedback module and managed centrally. Although this is a requirement of the CFM Procedure, CHS is not able to identify with certainty whether this occurs in practice.

6.26 In response to the draft proposed report, CHS advised:

> It is possible that not all service areas are aware, noting that they are encouraged to scan a copy of feedback received such as thankyou cards or other gratuities. There is a known risk that service areas may be provided a hard copy feedback form and this feedback be responded to internally, without sharing with the CFET for including in the RiskMan feedback module, or that they feel the feedback may have a negative impact on them, so choose to not disclose the feedback.
>
> This is managed by having alternate methods for feedback to be shared, such as a telephone call or electronic contact direct to the CFET.

6.27 The CHS Consumer Feedback and Engagement Team (CFET) is responsible for collecting and managing feedback across CHS services. The CFM Procedure requires all feedback to be provided to the CFET so that it can be recorded in the RiskMan feedback module and managed centrally. Although this is a requirement of the CFM Procedure, CHS is not able to identify with certainty whether this occurs in practice.

Recording feedback

6.28 When recording feedback in RiskMan, the CFET is required to manually input the feedback that is received. According to the CFM Procedure, the CFET is required to ensure as much information as possible is entered against mandatory fields in the RiskMan feedback module. There are a number of mandatory fields relating to the client's personal and demographic details and the nature of feedback provided.

6.29 A total of 1,298 feedback records were entered into the RiskMan feedback module between January 2022 and June 2024 and allocated to the RACS Division. The feedback records consisted of:

- 654 compliments (50.4 percent of the feedback records);
- 587 complaints (45.2 percent of the feedback records); and
- 57 comments (4.4 percent of the feedback records).

6.30 At the time of the audit, the RiskMan feedback module did not allow for complaints to be allocated to, and recognised by, specific business units or services. It was therefore not possible to identify feedback that related specifically to the GGC, MAS or RADAR service. This also made it difficult for services to use client feedback to identify service improvements. In November 2024 CHS advised:

> This issue has been fixed and future data should be able to provide data by service area however the fix will not impact historical data.

6.31 A total of 1,298 feedback records were entered into the RiskMan feedback module between January 2022 and June 2024 and allocated to the RACS Division. The feedback records consisted of 654 compliments (50.4 percent), 587 complaints (45.2 percent) and 57

comments (4.4 percent). At the time of the audit, the RiskMan feedback did not allow for complaints to be allocated to, and recognised by, specific business units or services. It was therefore not possible to identify feedback that related specifically to the GGC, MAS or RADAR service. CHS advised the issue has been fixed and future data will be available for business units and services.

Priority ratings and criteria

6.32 According to the CFM Procedure, feedback is to be assigned a priority rating. The priority rating and criteria are shown in Table 6-1.

Table 6-1 Feedback priority ratings

Priority rating	Criteria
Priority one	Used for feedback received from the Minister's office, Directorate Liaison Officer or Human Rights Commission.
Priority two	Used for feedback received from a current inpatient.
Priority three	Used for all other feedback

Source: CHS *Consumer Feedback Management Procedure*, page 3.

6.33 Of the 1,298 feedback records that were allocated to the RACS Division between January 2022 and June 2024, there were:

- 156 priority one records;
- 83 priority two records; and
- 1,059 priority three records.

6.34 When recording feedback in the RiskMan feedback module, the CFET provides a brief description of the feedback in the summary field. This field is limited to 250 characters.

6.35 A review of feedback records that were assigned to the RACS Division between January 2022 and June 2024 identified that the detail of information entered in the summary field of the RiskMan feedback module varies significantly. Some entries contained a few words and others provided more detail. The variation and inconsistency in the detail of the summary field may impact results that are produced when a search of the database is performed. Notwithstanding this observation, in response to the draft proposed report CHS advised that CFET always tries to include location or service identifying information where this is provided in the feedback.

6.36 When recording feedback in the RiskMan feedback module, the CFET provides a brief description of the feedback in a summary field, which is limited to 250 characters. Information in the summary field of the RiskMan feedback module varies significantly, with some entries containing a few words and others providing more detail. The variation and

inconsistency in the detail of the summary field may impact results that are produced when a search of the database is performed.

Managing client feedback

6.37 The CFM Procedure documents feedback priority ratings and feedback management workflows to guide the management of client feedback.

Feedback priority ratings

6.38 Priority ratings determine the process for the CFET to follow when managing feedback and determine the required timeframe for responding to feedback. Response timeframes for each priority rating are shown in Table 6-2.

Table 6-2 Feedback priority ratings

Priority Rating	Response timeframe
Priority one	Must be responded to in 24 hours.
Priority two	Should be responded to as soon as possible, and within 24 hours.
Priority three	Will be acknowledged by CFET within five working days of receipt and responded to either by phone or written response within 35 calendar days.

Source: *CHS Consumer Feedback Management Procedure*, page 10.

6.39 The RiskMan feedback module records details of all contact that is made with clients to discuss their feedback. CHS advised that:

> … information is captured in RiskMan and in a Q Drive (Internal file) structure. There are options for various data reports to provide different fields including [when a client has been contacted to discuss their feedback, who contacted the client and multiple entries if required]. Some of these reports would be quite length to pull detailed data for multiple consumers.

Feedback management processes

6.40 The CFM Procedure includes three workflow diagrams to guide the process for collecting and managing client feedback. Separate processes have been established for:

- priority one feedback;
- priority two and three feedback; and
- when client feedback includes a request for compensation.

6.41 The workflow diagrams clearly articulate the processes that should be followed when managing and responding to client feedback. They provide reasonable guidance for managing client feedback.

6.42 The CFM Procedure does not define what role(s) or levels within the organisation are responsible for managing and responding to feedback. CHS advised that:

> The Procedure does not define these roles as it is flexible, depending on the complexity of the complaint and the divisional executive's preference. For less complex feedback, it could be managed by an administrative staff member to contact a consumer, for something clinically focussed that requires response from the treating team, this would be directed by the divisional executive support team to the appropriate point of care. The responsibility does sit with the divisional executive but is delegated to their teams.

6.43 The RACS Division has not developed any policy or procedural guidance to identify who is responsible for managing and responding to feedback. The absence of clear roles and responsibilities increases the risk that feedback is managed inconsistently or inappropriately.

6.44 Business areas notify the CFET when a client feedback record has been addressed, and the record is subsequently closed. The CFET does not check that the information provided by the business area accurately reflects the actions that have been taken to address client feedback, leading to a risk that feedback records are closed without appropriate resolution. CHS advised that:

> … this is generally the responsibility of the Divisions, not the CFET team. However, they will review the information provided by Divisions to close feedback and seek additional information if they are concerned not all concerns have been addressed in the response.

6.45 In response to the draft proposed report CHS noted CFET '[does] review the response/outcome provided by the division to feedback to ensure there was a reasonable outcome and all components of a complaint have been addressed'. CHS also advised:

> Feedback received and confirmation an appropriate response has been actioned is ultimately the responsibility of the executive for the division. The CFM Procedure is deliberately flexible in its approach to responsibilities for what level of staff respond to feedback. The decision on who and how the response occurs is made based on the type and complexity of the feedback.

6.46 The CFM Procedure also does not include a mechanism for confirming whether the response is accepted by the client. CHS advised that:

> The CFET team don't generally contact the consumer to confirm they are happy with the response. However, this is done as part of the conversation with the point of care and includes confirming they are happy with the response or proposed improvements/changes as a result of the feedback. Where a written response is provided, the consumer is always provided with a way to contact the appropriate CHS team for any further concerns or questions.

6.47 The CFM Procedure includes workflow diagrams to guide the process for collecting and managing client feedback. The workflow diagrams clearly articulate the required actions, roles and responsibilities that staff should follow when managing and responding to feedback. They provide reasonable guidance to staff and support consistent feedback management. The CFM Procedure does not define what role(s) or levels within the

organisation are responsible for managing and responding to feedback, nor has the RACS Division developed any policy or procedural guidance to this effect. This increases the risk that feedback is managed inconsistently or inappropriately.

RACS management of feedback

6.48 Eleven feedback records that were specific to the GGC, MAS and RADAR service between January 2022 and June 2024 were reviewed for the purpose of the audit. The feedback records included:

- 10 records that were categorised as a complaint (one of these records included both a complaint and a compliment, but due to system restrictions in the RiskMan feedback module, only the complaint category was selected); and
- one record was categorised as a comment.

6.49 The selected feedback records were managed according to the established workflow. The feedback records included the original feedback, advice from the CFET where required and a record of the outcome.

RACS management of compliments and comments

6.50 The CFM Procedure prescribes that compliments and comments generally do not need to be investigated, or a response provided, unless this is specifically requested.

6.51 RACS Division representatives advised that it is the preferred practice to contact clients to acknowledge all compliments and comments. The Audit Office could not confirm the accuracy of this statement because whilst contact made by the CFET is typically recorded in the RiskMan feedback module, there is no way to conclusively determine whether business units report on all contact that is made in relation to consumer feedback.

RACS management of complaints

6.52 According to the established workflows, all complaints should be addressed by contacting clients by phone or in writing. A review of the 11 selected feedback records showed that of the ten feedback records that had been categorised as complaints, nine clients or carer partner(s) had been contacted to discuss the feedback that had been received. Of the nine that had been contacted, four had been contacted by the CFET and five had been contacted by RACS Division staff.

6.53 One complaint that was received related to the appropriateness of treatment from a clinical specialist. The feedback record identified that the CFET recommended that the clinical specialist contact the complainant directly to resolve the issue. The clinical specialist acted on this advice and contacted the complainant to discuss the complaint. Due to the nature

of the complaint, it would have been better for the complaint to have been addressed and resolved by an Executive Level Officer.

6.54 A review of 11 feedback records between January 2022 and June 2024 that were specific to the GGC, MAS and RADAR service shows that all of the feedback records were managed according to the established workflow. The feedback records included the original feedback, advice from the CFET where required and a record of the outcome.

6.55 According to the established workflow, all complaints should be addressed by contacting clients by phone or in writing. The review of the selected feedback records showed that nine out of ten clients or carer partner(s) that had made a complaint had been contacted. One complaint that was received related to the appropriateness of treatment from a clinical specialist. The CFET recommended that the clinical specialist contact the complainant directly to resolve the issue. The clinical specialist acted on this advice and contacted the complainant to discuss the complaint. Due to the nature of the complaint, it would have been better for the complaint to have been addressed and resolved by an Executive Level Officer.

Recommendation 9 ***Consumer Feedback Management Policy***

CHS should review and update the *Consumer Feedback Management Policy* to:

a) clearly define roles and responsibilities for responding to feedback; and

b) establish a process to confirm whether business units have appropriately addressed feedback.

Use of data to report on and improve service delivery

Patient data

Prior to DHR implementation

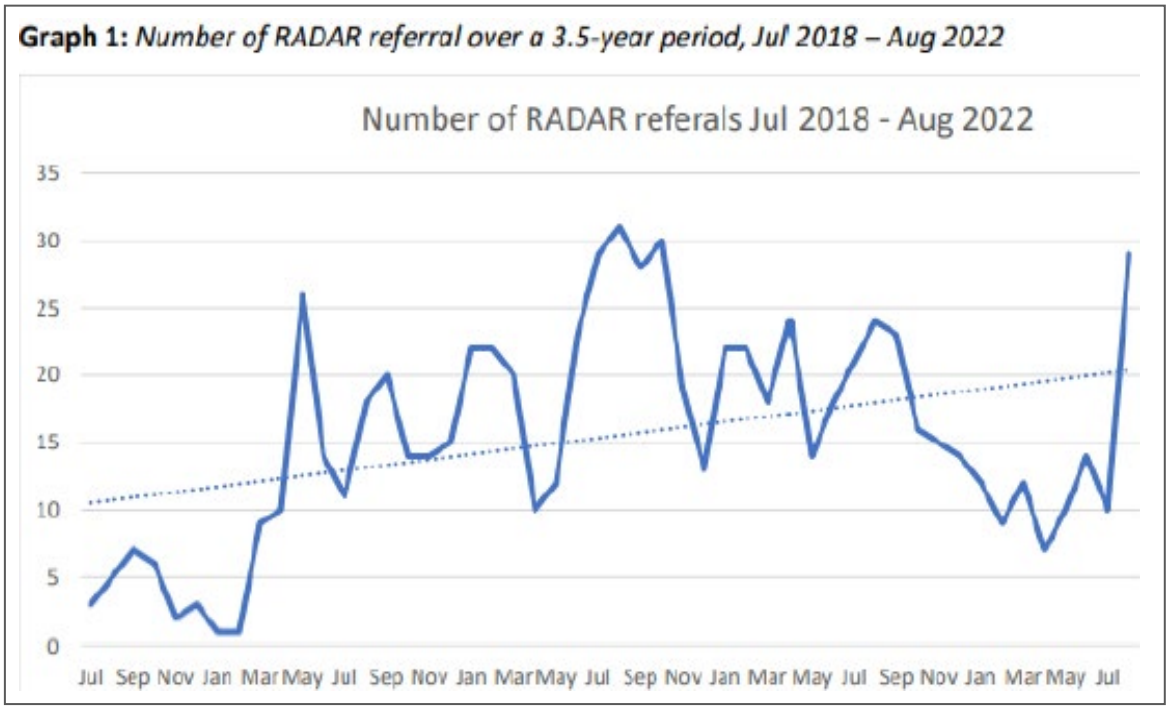
6.56 Prior to the implementation of the DHR, CHS used the ACT Patient Administration System (ACTPAS) to manage client information. Outpatient services had access to data and reporting capability for services including referral data, workload, client hours and hospital readmission data. This information could be used to provide an indication of service performance.

6.57 The RADAR service sourced data and reported on key information to governance forums with a focus on using the data to improve service delivery. For example, a *RADAR Overview Report* provided to the RACS Executive in August 2022 documented key RADAR service

activity data that was used to highlight an increase in workload for the RADAR service and the potential need for additional staff to improve service delivery. The report identified a fluctuation in referrals from wards between July 2018 and August 2022 and identified likely reasons for the results.

6.58 The number of referrals during this period and the data that was represented in the report is shown in Figure 6-1.

Figure 6-1 Example of RADAR service referral reporting prior to DHR implementation



Source: RADAR Overview Report August 2022, page 1.

6.59 The *RADAR Overview Report* also included data and analysis of key performance information relating to the RADAR service including:

- the service workload by source of referral from January 2020 to September 2022, providing a view of where client referrals to the service were coming from;
- the number of RADAR service direct and indirect contact with clients in minutes between February 2021 to September 2022. This analysis identified a rise in time spent with clients and noted that this is a pattern that would need to be addressed; and
- data that identified hospital readmissions noting that 'reducing hospital readmissions is a strategic priority commonly used as a performance metric'. The RADAR service used this data as an indicator of its performance in reducing monthly geriatric medicine readmissions in older adults.

6.60 The GGC or MAS have not produced a similar report to the *RADAR Overview Report* that was produced in August 2022.

6.61 Prior to the implementation of the DHR, CHS used the ACT Patient Administration System (ACTPAS) to manage central patient information. Outpatient services had access to data and reporting capability for services including referral data, workload, client hours and hospital readmission data. This information could be used to provide an indication of service performance. The RADAR service sourced data and reported on key information to governance forums with a focus on using the data to improve service delivery. For example, a *RADAR Overview Report* provided to the RACS Executive in August 2022 documented key RADAR service activity data that was used to highlight an increase in workload for the RADAR service and the potential need for additional staff. The GGC or MAS have not produced a similar report.

Prior to DHR implementation

6.62 Following the introduction of the DHR, outpatient services are no longer able to monitor key performance data or provide reports to the RACS executive. Due to reporting constraints for outpatient service data, primarily due to inconsistencies in how services record information in the DHR (refer to paragraph 6.4), trends, issues, discrepancies, gaps and root cause of variances are not routinely identified and reported on.

6.63 This means that the GGC, MAS and RADAR service are unable to monitor performance data relating to referral rates, wait times or staff workload and are unable to effectively monitor and report on performance to assess whether services are meeting the needs of the community or identify mitigation strategies to rectify performance issues.

6.64 Over the past 18 months, RADAR service staff have requested improved reporting functionality for the DHR, to support better monitoring of the RADAR service. This has not been forthcoming. The former ACT Health Directorate paused the development of tailored reports for outpatient services to focus on the implementation of a Data Remediation and Reporting Program that was established in August 2023. According to an update provided to the ACT Health Directorate Audit and Risk Management Committee on 26 November 2024, the Data Remediation and Reporting Program:

> … is a Territory-wide initiative funded by both CHS and ACTHD [ACT Health and Community Services Directorate] to deliver automated reporting for mandatory National Submissions and Operational Performance, using consistent, trusted & reusable data assets that are securely available on a unified Enterprise Data Platform (EDP).

6.65 Due to DHR reporting constraints for outpatient service data, primarily due to inconsistencies in how services record information in the DHR, trends, issues, discrepancies, gaps and root cause of variances are not routinely identified and reported on. This means that the GGC, MAS and RADAR service are unable to effectively monitor performance data

relating to referral rates and sources, wait times or staff workload and are unable to effectively monitor and report on performance to:

- assess whether services are meeting the needs of the community; or
- identify mitigation strategies to rectify performance issues.

Consumer feedback data

6.66 The RACS Division uses consumer feedback data as one mechanism to monitor the performance of services and identify service improvements.

6.67 As discussed from paragraph 6.21, the CFET is responsible for collecting and managing feedback across the ACT health system. CHS divisions are provided with consumer feedback data through regular reporting. This includes:

- weekly reports on open consumer feedback that are prepared by the CFET; and
- monthly reports on consumer feedback theme data. This data is incorporated in Quality and Safety Reports that are developed by Quality and Safety Business Partners.

6.68 Each of these reports relies on information entered in the RiskMan feedback module.

6.69 It is the responsibility of the Divisional Executive, or their delegate, to follow up on any outstanding feedback responses. CFET and RACS representatives advised that whilst there are meetings to discuss the open cases, the meetings are informal and there are no minutes or records of the meetings occurring. The CFET has since identified an intention to implement a more formal process, including the preparation of records and action items, to provide appropriate tracking of these meetings.

6.70 The RACS Quality and Safety Committee regularly reviews consumer feedback data including:

- number of compliments, complaints and comments received;
- number of complaints resolved within 35 days (the CHS target for this measure is 85 percent);
- percentage of patient survey results that rated the services provided as ‘very good’ or ‘good’; and
- top three compliment and complaint themes.

6.71 A review of data presented to the RACS Quality and Safety Committee between January 2022 and June 2024 identified that during this period:

- the average number of complaints resolved within 35 days was 80 percent. This was below the target of 85 percent;
- there were 460 compliments, 335 complaints and 37 comments reported (a total of 832 records). This was significantly lower than the 1298 records that were assigned to the RACS Division in the RiskMan feedback module. This indicates that the data presented to the RACS Quality and Safety Committee was not complete; and
- out of the 30 reports that were prepared during this period, 26 of the reports included patient survey results. Across the reports an average of 83 percent of clients reported that the care they received was 'good' or 'very good'.

6.72 The top three compliment and complaint themes were reported on in 20 of the 30 reports that were produced during this time. The top three themes for both compliment and complaint themes related to:

- conduct;
- information/communication/education; and
- access.

6.73 Complaint themes relating to conduct, information/communication/education and access were consistently highlighted in reports between August 2022 and February 2024 (18 reports in total). There was no further description for each theme. There is no evidence that the RACS Quality and Safety Committee discussed the cause of these themes consistently being raised.

6.74 Consumer feedback data was not available at the business unit or service level. As discussed from paragraph 6.30, at the time of the audit the, the RiskMan feedback module did not allow for feedback to be allocated to, and recognised by, specific business units or services. Therefore, consumer feedback relating specifically to the GGC, MAS or RADAR service could not be identified.

6.75 The RACS Quality and Safety Committee regularly reviews consumer feedback data including: number of compliments, complaints and comments received; number of complaints resolved within the CHS target of 35 days; percentage of patient survey results that rated the services provided as 'very good' or 'good'; and top three compliment and complaint themes. Complaint themes relating to conduct, information/communication/education and access were consistently highlighted in reports between August 2022 and February 2024 (18 reports in total). There was no further description for each theme. There is no evidence that the RACS Quality and Safety Committee discussed the cause of the themes being consistently raised.

Service audits and evaluations

6.76 In December 2022, the RADAR service conducted a *Geriatric patients readmitted within 28 days with RADAR involvement: clinical and social characteristics* clinical audit. The purpose of the audit was to:

- evaluate the clinical and social characteristics of RADAR service clients referred from the GMU and readmitted within 28 days; and
- gain some insight into the complex range of risk factors contributing to hospital readmissions of older adults receiving support in transition to home from hospital.

6.77 The audit aimed to provide direction regarding areas where future research should focus and support funding requirements to assist with identifying clients at risk to address modifiable clients and system factors through tailored interventions. It was also suggested that audit outcomes may also reduce unplanned readmissions. The audit included clients referred to the RADAR service upon discharge from inpatient geriatrics wards at the Canberra Hospital during a 12-month period between July 2020 and June 2021.

6.78 The audit found that RADAR service clients have complex health care needs, both social and medical. It also found that 9.1 percent of the overall number of readmissions identified were avoidable and that there was a high post-hospitalisation mortality at 12 months.

6.79 The audit was the first conducted for the RADAR service that analysed a complex range of risk factors contributing to hospital readmission of older adults receiving a transitional care service at CHS. The findings were used to identify potential service improvements for the RADAR service. There has not been a follow-up audit to determine whether the findings from this audit have improved the services provided by the RADAR service.

6.80 Audits have not been conducted in relation to the GGC or MAS and there are currently no plans in place to evaluate these services.

6.81 In December 2022, the RADAR service conducted a *Geriatric patients readmitted within 28 days with RADAR involvement: clinical and social characteristics* clinical audit. The findings were used to identify potential service improvements for the RADAR service. There has not been a follow-up audit to determine whether the findings from this audit have improved the services provided by the RADAR service. Audits have not been conducted in relation to the GGC or MAS and there are currently no plans in place to evaluate these services.

Audit reports

Reports Published in 2024-25	
Report No. 04 – 2025	Gaming machine licensee regulation
Report No. 03 - 2025	ACT Government long-term plans and strategies
Report No. 02 - 2025	Energy efficiency standard for rental properties
Report No. 01 - 2025	Management of the Growing and Renewing Public Housing Program
Report No. 14 - 2024	Facilities management and support services for ACT Courts
Report No. 13 - 2024	Invoicing and payments for Digital Health Record hosting services
Report No. 12 - 2024	2023-24 Financial Audits – Financial Results and Audit Findings
Report No. 11 - 2024	Governing boards of selected ACT Government entities
Report No. 10 - 2024	Safer Families Levy
Report No. 09 - 2024	2023-24 Financial Audits – Overview
Report No. 08 - 2024	Annual Report 2023-24
Report No. 07 - 2024	Reusable Facility Services Procurement
Report No. 06 - 2024	Business Transformation Program: ICT renewal activities
Reports Published in 2023-24	
Report No. 05 - 2024	Management and oversight of ACT Policing services
Report No. 04 - 2024	Planning and delivery of services for young people with moderate to severe mental health illness
Report No. 03 - 2024	Management of the Growing and Renewing Public Housing Program
Report No. 02 - 2024	Management of key contracts under A Step Up For Our Kids
Report No. 01 - 2024	Urban Tree Management
Report No. 11 - 2023	2022-23 Financial Audits – Financial Results and Audit Findings
Report No. 10 - 2023	Human Resources Information Management System (HRIMS) Program
Report No. 09 - 2023	2022-23 Financial Audits Overview
Report No. 08 - 2023	Supports for students with disability in ACT public schools
Report No. 07 - 2023	Annual Report 2022-23
Report No. 06 - 2023	Implementation of the ACT Aboriginal and Torres Strait Islander Agreement
Report No. 05 - 2023	Activities of the Government Procurement Board

These and earlier reports can be obtained from the ACT Audit Office's website at http://www.audit.act.gov.au.