Evaluation of the initial compliance assessments for the National Regulatory System for Community Housing

Final report

23rd June 2015

ARTD CONSULTANTS
strategy & evaluation

Contents

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1. Introduction

1.1 National regulatory system

The National Regulatory System for Community Housing (NRSCH) seeks to:

- Provide a consistent regulatory environment to support the growth and development of the community housing sector
- Pave the way for future housing product development
- Reduce the regulatory burden on housing providers working across jurisdictions
- Provide a level playing field for providers seeking to enter new jurisdictions.

Full implementation of the system began on 1 January 2014, following six months of testing and evaluation with a small number of providers nationally. The system is being introduced in participating jurisdictions over an agreed transition period.

The NRSCH is a system where community housing provider are registered once they can demonstrate the capacity to meet the requirements set out in the National Law—including meeting the National Regulatory Code which sets out the performance outcomes and requirements that must be met by registered community housing providers.

Community housing providers that are registered under the NRSCH are required to periodically demonstrate compliance with the National Regulatory Code. Standard compliance assessments are scheduled to take place annually for providers registered as Tier 1 or Tier 2; and biennially for Tier 3 providers.

Compliance assessments may also be scheduled outside the standard frequency where regulatory concerns about compliance exist. This can occur either because of performance concerns or because a provider is undergoing significant change. These assessments are said to have been 'triggered' and are generally targeted only at those performance outcomes where regulatory concerns exist.

1.2 Initial compliance assessments

The initial round of compliance assessments started in October 2014 and involved 15 providers. There are 14 providers whose primary jurisdiction is NSW and one where it is South Australia. Fourteen providers are completing a standard compliance return and one provider has been scheduled for a targeted assessment.

The intended scope and focus of compliance assessments is documented in draft guidelines that have been given to participating providers as draft *Provider Compliance User Guide*.

The initial compliance assessment involves:

- Reviewing information and evidence submitted in a standard compliance return (and evidence previously submitted as part of the registration assessment)
- Analysing and where necessary gathering additional evidence in order to make an assessment of compliance
- Preparing a compliance determination report for the provider. The compliance determination report will include
  - a brief statement confirming compliance or non-compliance with the National Law
  - any findings outlining areas where the provider could take action prior to the next Standard Compliance Return to improve the comprehensiveness and rigour of evidence submitted to better demonstrate the achievement of the outcomes
  - findings outlining areas where the provider needs to take action to address a minor non-compliance – termed partial compliance (and requirements for reporting back on the closure of the non-compliance).

Separate to the compliance assessment process, the Primary Registrar may take Enforcement Action to bring the provider back to compliance where the non-compliance is serious or the provider has failed to remedy the non-compliance.

1.3 Evaluation of the initial compliance assessments

In February 2015, ARTD consultants were engaged to undertake an independent evaluation of the initial compliance assessments. The purpose of the evaluation is to identify and recommend any changes to the compliance guidelines and processes prior to full implementation of compliance assessments.

Specifically, the Terms of Reference for the evaluation of the initial compliance programme are to:

1. Assess whether existing guidelines, procedures and systems for compliance are fit for purpose for Tier 1 and 2 providers including multi-jurisdictional providers; and for different organisational and delivery contexts.
2. Consider whether the guidelines, procedures and systems for compliance will be appropriate for Tier 3 providers
3. Assess whether regulatory staff are (and should be) able to consistently and systematically apply these guidelines, procedures and systems for compliance
4. Recommend refinements and changes to appropriate compliance guidelines, procedures and systems.

1.4 Evaluation methods

The methodology for addressing the terms of reference involves a rolling-series of surveys and consultations focused on collecting evidence from community housing providers and registrars involved in the initial compliance assessments and broader consultations about the roll-out of the compliance process with other stakeholders.

The key evaluation methods cover:

Primary evidence from the initial compliance assessments

- Analysis of the compliance return survey (distributed by the NRS Project Team)
- Desktop review of compliance assessment reports
- Design, delivery and analysis of a post assessment survey of participating providers
- Post-assessment focus group with providers (in Sydney)
- Interviews with Registrar analysts undertaking compliance assessments
- Workshop with jurisdictional Registrars to discuss key policy and practice issues for implementation of a nationally consistent compliance process

Additional evidence to inform roll-out of the compliance process

- Consultation forum with Tier 3 providers (with workshops in Sydney and Brisbane)
- Desktop review of compliance assessment guidelines
- Interviews with community housing peak bodies in NSW, Queensland and South Australia to discuss possible implications for the roll-out of compliance

1.5 Limitations of the evaluation

The nature of the initial round of compliance assessments placed limits on the generalizability of the evaluation findings—in particular:

- All but one of the initial round of compliance assessments were undertaken by the NSW Registrar—limiting the extent to which evidence could be collected about the national consistent of compliance assessments
- The vast majority of providers in the initial round of compliance assessments had previously participated in compliance assessments under the previous NSW regulatory system—limiting the extent to which evidence could be collected about the experience of providers undertaking any form of compliance assessment for the first time
- All of the initial compliance assessments involved Tier 1 and 2 providers—limiting the extent to which evidence could be collected about the national consistent of compliance assessments.

While additional evidence was collected from Tier 3 providers and peak bodies to identify potential issues associated with the roll-out of the compliance process (see Section 1.4), further issues may arise for non-NSW providers and Tier 3 providers during the full roll-out.

1.6 Evaluation report

This report presents the findings based on primary evidence about the initial compliance assessments and additional evidence about the roll-out of the compliance process—covering

- a desktop review of the compliance guidelines and assessment process
- a compliance return survey of providers participating in the initial compliance round (n=15)
- a compliance determination survey of providers that had received a determination report (n=7)[1]
- a desktop review of completed draft compliance determinations (n=8)[2]
- a workshop with NSW providers participating in the initial compliance assessment process (n=12) and a face-to-face interview with the SA provider (n=1) participating in the in the initial compliance assessment process
- workshops with Tier 3 providers in NSW (n=6) and Queensland (n=6)
- interviews with NSW and South Australian Registrar analysts undertaking compliance assessments and Queensland Register who will undertake compliance assessments in the future
- workshop with jurisdictional Registrars to discuss key policy and practice issues for implementation of a nationally consistent compliance process.

The evaluation report is structured into three sections.

- Guidelines, procedures and systems for assessing compliance (Section 2)
- Guidelines, procedures and systems for making a compliance determination (Section 3)
- Conclusions for each of the Evaluation terms of reference and recommendations for refinements and changes to support the full roll-out of compliance (Section 4).

[1] The determination survey achieved a 100% response rate for the 7 providers t
hat had received a final determination report by the end of April 2015 (to allow time for the findings to be incorporated into the draft evaluation report).

[2] The desktop review of compliance determination covered 100% of reports completed by 22 May 2015 (to allow time for the findings to be incorporated into the evaluation report)

2. Assessing compliance

2.1 Approach to assessing compliance

Whereas the registration assessment confirmed the capacity of providers to meet all conditions of Registration, the compliance assessment seeks to confirm the actual achievement of the outcomes and requirements of the National Law.

The approach to assessing compliance involves:

- reviewing information and evidence submitted in a standard compliance return (relevant to the Tier of Registration) through the NRSCH CHRIS portal—consisting of:
  - Non-financial performance report
  - Financial performance report (FPR)
  - Community housing asset performance report (CHAPR)
  - Standard business documentation - core documents relevant to the Tier of Registration including
    - Business Plan
    - Annual Report (or equivalent)
    - Strategic Asset Management Plan
    - Tenant Satisfaction Survey
    - Board report showing performance vs plans
    - Risk management plan and register
    - Appeals and Complaints Register
  - Notification of significant changes to policy and procedures
  - Actions to address the finding and recommendations from previous registration and compliance assessments.
- reviewing the results of the registration assessment where the provider has already submitted evidence to demonstrate that they are compliant with the outcomes and requirements of the National Law
- following up on lines of enquiry, and where necessary gathering additional evidence, to determine the achievement of the outcomes and requirements of the National Law.

2.2 Time and resources to complete the compliance return

Providers have six weeks to complete and submit the standard compliance return. The draft *NRSCH Compliance User Guide for Community Housing* states that "where registered providers have effective data systems and business documentation, the preparation and submission of the (standard compliance) return should be a straightforward and streamlined process."

Overall, providers participating in the compliance assessment indicated that the process and requirements for the standard compliance return were reasonable—but given that providers were still developing their systems and reporting arrangements to make it easy to demonstrate compliance, many providers did not experience the process as 'straightforward and streamlined'. In particular, key findings from the compliance return survey were that:

- More than half of the participating providers (56%) indicated that the six weeks for completing the compliance return was difficult to achieve.
- On average, providers spent an estimated 20 person-days completing the compliance return—made up of 4 days collating data for the CHRIS return, 5 days collating core documents; 7 days completing the FPR and 4 days completing the CHAPR.
- Around, 70% of providers spent more than 5 days completing the FRP; 55% spent more than 5 days collating core documents; 40% spent more than 5 days completing the data on the CHRIS return; and 20% spent more than 5 days completing the CHAPR.

Participating providers highlighted that:

- The amount of time and resources to complete the compliance return was broadly similar to that required for the registration return—given that the required reports and evidence were comparable. While the majority of providers expected this, one provider commented that a misleading expectation had been set during the briefings that the time and resources needed for the compliance return would be substantially less than for the registration return.

  > *"This is certainly NOT to the case and was misleading - resulting in our organisation setting aside too little time for completion. Completion was not simple and is almost as involved as the registration process. Completing CHRIS was exactly the same as registration. Briefing organisations that we just need to provide advice of changes since registration is not accurate."*

- For some providers, their sensitivity about the resources needed to complete the compliance return was compounded by the relatively short turn-around time from their registration assessment.

  > *"The Board is most concerned that they were required to review all the information yet again so soon after Registration and they were concerned of wasted Company resources for no value…Having to do this process so soon after Registration undermined staff and Board morale around the whole Registration process, and fuelled cynicism that it has just become a tick box exercise that costs us resources and doesn't add value"*

- Most providers acknowledged that the time and resources needed to complete the compliance return reflected the fact that they were still developing their systems

and reporting arrangements to make it easy to report the required information. For example,

  - Aligning the completion of tenant surveys to the compliance return date. One provider commented that their tenant survey analysis report was not complete by the return due date so had to be submitted subsequently and only in draft form.
  - Calculating rent foregone and rent outstanding was not straightforward due to the fact that different parts of the business have historically reported this information after the compliance return due date.

- A number of providers highlighted that significant time and resources were needed to finalise the FPR—given that the required format was different to their internal reporting arrangements. This issue is explored further in Section 2.3.2

- A number of providers indicated that, as long as requirements in the standard compliance return do not change, the time and resources needed to complete subsequent compliance returns is likely to substantially decrease as they improve their internal reporting systems and compliance reporting becomes part of business-as-usual.

2.3 Provider feedback on the Compliance Return

Overall, providers participating in the compliance assessments indicated that the evidence requirements for the compliance assessment were clear and reasonable—although there were a number of areas where issues were raised.

2.3.1 Core Documents

All providers participating in the compliance assessments indicated that they were clear about what core documents were required to be submitted with the compliance return—and that these documents were readily available as existing standard business documents. This covered the

- Business Plan
- Strategic Asset Management Plan
- Tenant Satisfaction Survey
- Board report showing performance against business plan goals
- Risk management plan & risk register
- Appeals and complaints register.

Providers understood the rationale for submitting these documents—in that either they were submitting documents that had been updated since registration or were required to demonstrated actual compliance (compared to capacity to comply).

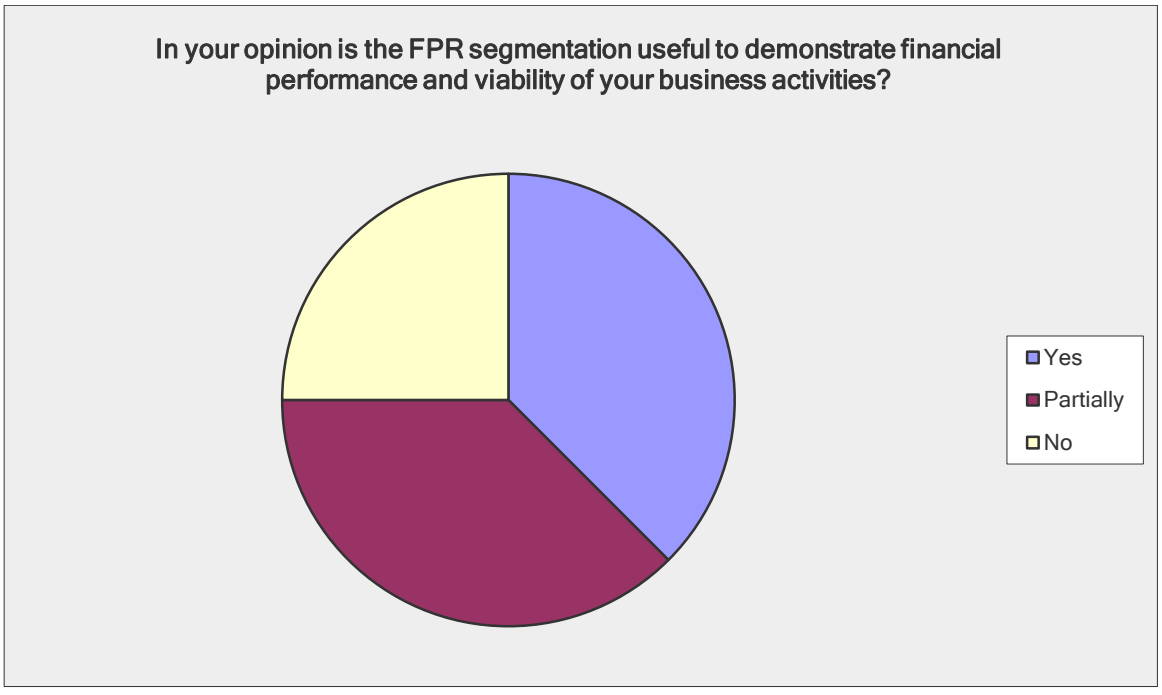
2.3.2 Financial Performance Report

In line with the findings of the Evaluation of the NRSCH Registration Assessments, there are mixed provider views about the format of the FPR—in particular the segmented reporting format.

Some providers commented that the segmented reporting format did not align with their internal financial reporting—requiring significant time and effort to the extract and report financial data in the required format.

Other providers indicated that the FPR segmentation was useful in helping them demonstrate the financial performance and viability of their business activities. Around three-quarter of respondents to the provider compliance return survey, indicated that the FPR segmentation was useful (37%) or partially useful (37%)—with only one-quarter (25%) saying it was not useful (Figure 1).

Figure 1: Provider views of FPR segmentation



Some providers raised particular concerns about the segmentation down to the level of owned verses managed properties—which may be of interest internally but seemed irrelevant to assessing the financial viability of the registered entity. They highlighted that providers had a make a range of assumptions to generate segmented financial reports—and suspected that these assumptions would not be consistent across registered providers.

Some providers had already invested in system changes to make it easier to report financial data in the segmented format—whereas others are waiting in case further changes are made.

> *"FPR requires extensive work (around 40 hours for our annual compliance return), as its structure does not align with our financial reporting. We need clarity if it is changing, otherwise we will invest in re-aligning our financial reporting. However, this is significant project that we would require certainty on FPR format before commencing."*

The vast majority of providers (88%) indicated that they wanted to continue to report financial information via an Excel spreadsheet (rather than via an on-line form) because it provided greater flexibility in extracting and collating information from their internal reporting systems.

Regardless of the format and structure of the FPR, providers indicated that they were unsure of the 'value' of the FPR because they had not yet seen summary and comparative financial data to demonstrate how it is being used by regulatory staff and what segmentation demonstrates about the financial viability of providers.

> *"The segmented reporting requires a lot of work and despite numerous requests I have not been able to establish what the segmented reporting information is used for."*

2.3.3 Community Housing Assets Performance Report

Providers participating in the compliance assessments were broadly satisfied with the format and data requirements in the CHAPR—although there remains some confusion over the definition and classification of some assets.

Over 80% of providers indicated that the definition of community housing assets was clear—although a small number of providers were unclear and had to seek clarification from Registrar analysts about the correct classification of assets against the five asset types referred to in the National Law. Areas for clarification included the treatment of:

- properties acquired as a condition of vesting arrangements
- properties acquired using surpluses over and above conditions associated with vesting arrangements
- assets which consist of bedsits and individual rooms in Boarding House type accommodation
- NRAS and affordable dwellings managed on behalf of other entities such as local government Councils.

Once the classification of assets was clarified, most providers indicated that it was relatively straightforward to complete the CHAPR.

2.3.4 Response to registration recommendations

About half of the providers participating in the compliance assessments had to provide evidence of the closure of recommendations made at the time of registration. Of these, the majority (70%) indicated they were clear about the scope of the recommendations and what information had to be provided.

The small number of providers that indicated they were not clear what information had to be provided because of the broad and general nature of the recommendation made at the time of registration.

> *"[The Registration Assessment] needed to be clearer about what was required under the recommendation—which was to "develop and implement strategies to ensure value for money for future planned maintenance".*

Issues associated with the specificity of recommendations and the required response to recommendations is discussed further in relation to the compliance determinations (Section 3).

2.3.5 Specific evidence requirements

The majority of providers participating in the compliance assessments reported that they were clear about the specific evidence requirements related to affiliated entities, community housing development plans and partnerships.

- *Affiliated entities*

  All but one provider was fully satisfied with the clarity and relevance of evidence requirements associated with affiliated entities. For the provider that raised concerns, they reported a 'one-off' issue that required clarification with the Registrar—which was resolved prior to submitting the compliance return.

  Given that during the evaluation of the Registration Pilot, considerable concerns were raised about the lack of clarity of evidence requirements for affiliated entities, the survey findings may point to improvements to the guidelines and communication of evidence requirements.

- *Partnerships*

  All but two providers were fully satisfied with the clarity and relevance of evidence requirements associated with partnerships—the key issue being the ease of updating partnership contact information in CHRIS and, more broadly, the materiality of needing to provide contact lists for partnership arrangements.

- *Community housing asset management and development plans*

  Most providers were satisfied with the requirements to submit asset management and development plans—and were able to utilise existing business documents. A small number of providers queried the lack of guidance on what regulatory staff

were looking for—and suggested that periodic update could be provided by Registrars on any systemic issues founds about the quality and comprehensiveness of plans in demonstrating compliance with the performance requirements.

2.3.6 Guidance and support in completing the return

Participating providers were very positive about the availability and professionalism of regulatory staff in answering questions and providing clarifications about the compliance process and evidence requirements. The support from analysts was cited as the single most important source of guidance in completing the compliance return.

In contrast, while providers indicated that they extensively used the range of guidance documents (Compliance User Guide; Evidence Guidelines; Financial Viability Guide)—many providers indicated that they found it somewhat cumbersome having to refer to multiple documents and use registration specific documents (such as the Registration Return Guide) in order to complete the Compliance Return. These providers also raised concerns that there was no single 'source of truth' covering the performance requirements, evidence requirements, metrics and data definitions—linked to how information was inputted through the Compliance Return.

Providers were positive about the CHRIS portal for submitting the Compliance Return—but highlighted the need for a stand-alone Compliance Return Guide to avoid having to continually reference other documents.

2.4 Regulatory staff feedback on the Compliance Return

Registrar analysts in NSW and South Australia that undertook compliance assessments indicated that the standard compliance return provided the core information needed to commence the compliance assessment and that no significant issues with the return had been identified during the initial compliance round.

At the same time, analysts raised a number of issues that need to be considered to improve the robustness and national-consistency of the compliance process.

- **Identifying key compliance risks**
  Analysts highlighted the 'steep learning curve' associated with developing the necessary understanding of the NRSCH performance requirements as they apply to a range of different organisational and delivery contexts of registered providers—so that compliance assessments remain focused on the most significant compliance risks.

  Analysts recognised that sharing information within and across Register offices about identified partial non-compliance and lines of enquiry where there is a concern about non-compliance will be critical to ensuring robust and national-consistent compliance assessments—particularly for analysts undertaking compliance assessments for the first time.

- **Consistency of guidance documents**
  Analysts indicated that the current guidance documents for compliance assessments were somewhat cumbersome—in that analysts needed to cross-reference multiple documents and there were examples of minor inconsistencies and omissions between these documents. While no fundamental flaws were identified, analysts highlighted that any difficulties and inconveniences they experienced were likely to be exacerbated for providers undertaking the initial compliance assessment.

- **Screening compliance returns**
  Analysts highlighted the importance in the process of an initial check of the compliance return for completeness to ensure there are no obvious omissions or inaccuracies. Ideally, this would be completed within two weeks of receipt of the return being received.

  Further, NSW analysts highlighted the value of a triage processes whereby they reviewed the set of current compliance returns and split them into two groups—those where no significant compliance risk was identified during the initial assessment (and where it was likely that a compliance determination could be made within a predicable timeframe) and those where a compliance risk was identified requiring more detailed investigation. While the results of this initial assessment were not communicated to participating providers, it enabled the NSW analysts to complete draft determination for 7 providers within the standard timeframe

- **Value of segmentation of financial data in the FPR**
  There were mixed views amongst analysts about the value and use of segmentation of financial data in the FPR. Some analysts strongly supported segmentation in that it allowed them to check the internal consistency of key community housing metrics submitted with the compliance return and provided them with important insights into the key business drivers impacting on an organisation's financial viability.

  Other analysts challenged the value of the segmentation highlighting concerns about the integrity of the assumptions used by providers to prepare segmented financial reports and the fact that the performance requirements refer to the financial viability of the organisation as a whole—rather than the different parts of its business.

  However, based on the initial compliance round, there was no evidence to prove or disprove the value and utility of segmentation of financial data—rather it highlighted strongly held views from analysts about what they are looking for in assessing financial viability.

2.5 Tier 3 specific issues

While no Tier 3 providers participated in the initial compliance rounds, a series of workshops were held with Tier 3 providers in NSW and Queensland to investigate potential issues for their future participation in the compliance process.

Based on their experience of the registration process, Tier 3 providers flagged a number of potential issues for compliance.

- **Time and resources needed to submit required evidence**
  Tier 3 providers indicated that the collation and submission of the required evidence was very time consuming and in some cases involved additional costs in seeking professional advice to prepare data in the required format (e.g. segmented financial reporting).

  For Tier 3 providers whose main business was community housing, most were satisfied that the time and resources for registration was a worthwhile investment in improving their policies, procedures and systems—and they expected that participation in compliance assessments would be more straightforward.

  For Tier 3 providers where community housing was only a small part of their business (e.g. specialist homelessness services; multi-functional providers), most saw limited relevance in the regulatory standards to their core business—and therefore felt that future compliance assessments were likely to remain burdensome and a drain on their limited resources. These providers believed that they were already demonstrating the quality of their services through other mechanisms (e.g. contractual compliance and quality systems) and therefore the community housing regulatory requirements added another level of 'red tape'.

- **Evidence requirements**
  Tier 3 providers indicated that there were opportunities to streamline evidence requirements given overlaps between ongoing contractual compliance reporting to funding bodies and regulatory assessments. Some Tier 3 providers raised concerns that the Evidence Guidelines were heavily focussed on examples of evidence that related to the operation of Tier 1 and 2 providers—but that were less relevant to Tier 3 providers. This was particularly relevant in terms of setting appropriate expectations about requirements for Tier 3 provider asset management plans and business plans.

  In addition, some providers raised examples where they were requested by regulatory staff to submit evidence such as tenant surveys which are not part of the Tier 3 evidence requirements.

- **Value of segmentation of financial data in the FPR**
  Tier 3 providers indicated that segmentation of financial data in the FPR was likely to remain an additional cost for their business—given that the majority of providers

reported that they had to pay for additional accountancy services to collate their financial data in the required format.

- **Additional support**
  Tier 3 providers indicated that regulatory staff had been very constructive and supportive in explaining the scope and focus of the evidence requirements—and their ongoing availability to answer queries was the most important resource throughout the assessment process.

  Providers also highlighted the value of the support for industry bodies—particularly in Queensland where additional resources were provided to the industry body to deliver a capacity building project for Tier 3 providers.

  In preparing for the first compliance assessment, Tier 3 providers highlighted the importance of:

  - Clear advice about the date of the next compliance assessment—so that Tier 3 providers can commence their preparations at least 6 months prior to the due date for the compliance return
  - Access to CHRIS portal for the compliance return – so providers can familiarise themselves with the specific data requirements and ideally being to populate the return as information becomes available
  - Support and advice about appropriate ways for Tier 3 providers to use existing business documentation to demonstrate the achievement of regulatory outcomes —particularly in relation to asset management and financial viability
  - Ongoing access to regulatory staff to answer queries about demonstrating the achievement of regulatory outcomes
  - Ongoing access to support from industry bodies to build capacity to meet the regulatory requirements.

3. Compliance determinations

3.1 Approach to determining compliance

Regulatory staff are required to make an assessment of compliance for each performance outcome and compliance overall. The Analyst Compliance Guide emphasises that regulatory judgement has to be used and that there is no hard and fast rule or score that can be used to determine compliance—rather the focus is on ensuring there is sufficient information about the provider's performance to make an informed judgement about compliance. If not then additional targeted lines of enquiry should be carried out to the extent needed to make an informed judgement.

The approach to determining compliance involves:

- Recording evidence used to make an informed judgement about compliance with each performance requirement
- Identifying specific lines of enquiry to gather additional evidence in order to be able to make an informed judgement about compliance
- Recording a draft assessment of compliance for each performance requirement using standard definitions:
  - *Compliant*: At the time of the assessment the performance outcome is determined as met and / or the information seen does not reveal potential non compliance – acknowledging that the regulatory regime does not seek to prove compliance.
  - *Partially compliant*: The provider needs to take action to address minor non compliances / reach complete compliance with a particular performance outcomes—and the action required is
    - Relatively minor and the issue can be resolved in a short period
    - The deadlines for the provider reaching compliance are reasonable and likely to met - i.e. evidence of progress has been seen
    - Its overall impact on financial viability, services to residents and contractual performance is relatively insignificant
    - Has been accepted by the provider and can be completed by the provider i.e. they have the resources, track record, expertise
  - *Non-compliant*: A significant failing has been identified and / or the senior management / governing body have not accepted, recognised or demonstrated they are able to resolve the problem.
- Identifying any recommendations for action:
  - *Compliant*: Recommendations where the provider needs to take action to maintain compliance with a particular performance outcome in the future

  - *Partially compliant:* Recommendations where the provider needs to take action to address current minor non compliances / reach complete compliance with a particular performance outcomes

- Preparing a draft determination report (produced through the CHRIS system)
  - stating whether the provide is compliant / partially compliant / non-compliant for each of the seven performance outcomes
  - documenting any recommendation for action for a particular performance outcome
  - stating whether the provide is overall compliant / non-compliant
- A peer review process prior to send the report to the provide to confirm that the documented compliance assessment supports the proposed regulatory judgements in the draft determination report
- Providing an opportunity for the provider to review and comment on the draft determination prior to its finalisation (including providing additional evidence to demonstrate full compliance)
- Preparing a final determination report including notifying the provider any additional targeted monitoring and/or the date and scope of the next compliance assessment which may be earlier than the standard schedule.

3.2 Time to determine compliance

The draft *NRSCH Compliance User Guide for Community Housing* states that regulatory staff have a minimum of eight weeks to complete the compliance determination from the compliance return due date—while noting that "the time taken to carry out the assessment will depend on whether in addition to the standard return further regulatory engagement is necessary."

In practice, three of the 15 providers involved in the initial compliance round received a draft determination report within eight weeks, four received the draft within 16 weeks and eight will receive a draft after more than 18 weeks since submitting their return.

There are a number of factors that impacted on this timing.

- For eight providers, one or more compliance risks requiring detailed investigation were identified at the initial assessment. In many of these cases, an on-site visit was organised to gather additional evidence in order to be able to make an informed judgement about compliance.
- A number of NSW determinations were delayed because of the timing of the initial round of compliance assessments—which corresponded with a peak workload period in the NSW office in transition providers to the national system prior to the NSW deadline of 30 June 2015.

A number of the providers participating in the initial compliance round expressed concerns about the perceived delay in completing the draft determinations—and indicated that they had received limited communication about the reasons for the delay. While providers appreciated that a number of 'one-off' factors contributed to these delays, they highlighted that compliance determinations need to be completed as quickly as possible to ensure providers have sufficient time to respond to any significant risks prior to the next scheduled assessment. Their expectation for the full roll-out is that:

- A timeframe is agreed for Registrars to complete a standard compliance determination (for example, 8 weeks after submitting the compliance return)—for providers not requiring a more detailed investigation of specific compliance risks
- Where a more detailed investigation of specific compliance risks is required, the Registrar communicates with the provider about the scope and focus of the additional investigation and the anticipated timeframe for reaching a draft determination.

In terms of the commencement date for compliance assessments, Tier 1 and 2 providers were broadly comfortable with the current timing based on a commencement in October—given that this allows them time to have audited financial statements and annual reports prepared while ensuring that the submitted information in up-to-date and relevant for the particular year. The difficulty for Registrars of having compliance assessment outstanding over the Christmas period was noted—but it did not appear appropriate to push the commencement back either forwards or backwards.

3.3 Documenting compliance determinations

A desktop review of ten draft and final compliance determination reports highlighted that the assessment documentation is comprehensive and systematic. In particular:

- Assessments are recorded against each performance requirement within each performance outcomes
- The documentation in the assessments provides an appropriate audit trail—referencing the source of evidence and information used—particularly if a finding of partial compliance is made
- The language used in the assessments is generally analytical and factual—and would be appropriate in cases where a provider requested to see their assessment.

Across the desktop review of ten providers:

- All providers were determined to be overall compliant
- Six of the ten were fully compliant across all performance outcomes
- A total of six partial compliances were recorded (three partial compliances for one organisation; two partial compliances for one organisation; and one partial compliances for another organisation)

- A total of ten recommendations were made—six specifically related to partial compliances; and four related to action to maintain compliance with a particular performance outcome in the future.

While it is beyond the scope of the evaluation to validate the assessments and determinations, a number of observations can be made based on the desktop review.

- The explanation of determinations and recommendations was clear when the full assessment was read—but the nature of the partial compliance and the recommendation to address it often were more difficult to understand based on the limited information in the determination report send to the provider. Providers raised a number of examples where they needed to seek advice from regulatory staff about the scope and focus of recommendations contained in the determination reports (see Section 3.4).
- The language used in one part of one assessment report could be misinterpreted as not being sufficiently objective. In this case, the analyst recorded that "Available evidence has certainly not proven that <Provider X> is already as hard and dry as a rock with no more excess to squeeze … It is not clear that opportunities for reduction in operating expenses have been explored with the same rigor shown for negotiating <funding concessions> from the <government funding body>". Given that providers could request to see an assessment, it is important that assessment language remains analytical and avoid any perceptions of subjectivity.

3.4 Provider feedback on compliance determinations

Overall, providers that had received their compliance determination indicated that they were satisfied with the outcome—although a number of comments and queries were raised.

3.4.1 Requests for additional evidence to demonstrate compliance

All providers that had received their compliance determination indicated that they either had no requests for additional evidence or relatively minor requests that were straight-forward to respond to.

For providers still awaiting the finalisation of their compliance reports, a number reported very productive site visits from regulatory staff that provided a very effective mechanism to discuss any concerns about demonstrating compliance and for communicating provider's approach to maintaining compliance.

However, providers expressed a desire for greater transparency in requesting additional evidence.

- A number of providers cited examples where analysts had made verbal requests for additional evidence—without any formal communication to provide an audit trail for the request.

  "The analysts appeared to be attempting to gather evidence verbally. I felt it inappropriate not to have a written audit trail of evidence provided. I asked for clear written request of what further information required"

- A number of providers suggested that all requests for additional evidence (through requests for additional data or as part of site-visits) should state the reason the information / site visit is being requested and the specific compliance risks that are being investigated.
- In one isolated example, a provider indicated that they were "offended by the tone" and perceived "aggressive attitude" of a particular analyst in requesting additional evidence—expressing concern that the analyst was "fishing without making clear what they were looking for". In follow-up interviews, the organisation acknowledged that this was an isolated incident and was not representative of their experience of dealing with analysts in this office.

3.4.2 Clarify of compliance determinations

All but one provider that had received their compliance determination was fully satisfied that the compliance assessment findings were adequately documented in the compliance determination report.

Essentially, the compliance determination simply states whether the provider is overall compliant or non-compliant—and whether they are compliant, partially compliant or non-compliant with each performance outcome. While some providers highlighted that it would be useful to have more commentary where a finding of partial compliance was made (see Section 3.4.3), there was a general acceptance from providers that it was appropriate that the compliance report remained as brief as possible and focused on the actual compliance determination. All providers indicated that the utility of the compliance assessment for Boards and senior management was solely linked to the draft and final determination—and not the assessment process needed to reach this determination.

3.4.3 Utility of the recommendations

A total of ten recommendations were made in the completed determination reports—covering five organisations involved in the initial compliance round.

Overall, there were mixed views about the utility of the recommendations in assisting organisations to identify areas to address partially compliances or to remain compliant in the future—with most of these organisations raising queries about the clarity of the recommendations.

Providers commented that there was generally insufficient detail provided in the determination report to understand the compliance risk identified by regulatory staff which led them to make the recommendations.

For example, one provider commented that a recommendation to "Update the Operational Plan to ensure it remains aligned to organisational objectives and other planning documents" provided no indication of the specific nature of any current misalignment that the provider should examine.

In another example, the provider was unclear of the rationale, scope and focus of a recommendation to "critically review operational processes and the scope of services to identify opportunities for possible reduction in unit costs"—given it is unclear whether the recommendation relates to the adequacy of internal management review processes or the appropriateness of business unit costs. If the later, the provider challenged the extent to which it was relevant for the regulator to make recommendations about staffing and overheads costs rather than the outcome of financial viability.

In a third example, the provider questions the value of a recommendation to "continue with the replacement of its current IT system in order to enable reporting on NRS Metrics" when this was already documented as part of the submitted evidence.

While providers highlighted that it was appropriate that recommendations were framed broadly to avoid any risk of regulatory staff appearing to tell providers 'how to run their business'—overly generic recommendations made it hard to understand how to respond.

There was also some confusion about the nature of recommendations against performance outcomes where the provider was assessed as compliant.

> *"Even though we were fully compliant against all outcomes, we received a recommendation to develop sensitivity and scenario testing for the financial forecast. It was unclear whether this was suggested as an observation for improving compliance in the future—or a shortcoming in our current compliance status"*

4. Conclusions and recommendations

4.1 Overall findings

The findings from the evaluation of the initial round of compliance assessments confirmed that the proposed core arrangements for compliance assessments are broadly fit for purpose—namely:

- A standard compliance return based on providers submitting updates to the core business documents and metrics required as part of the registration return and specific additional evidence needed to establish compliance
- A structured assessment process that allows Registrars to review information and evidence submitted in a standard compliance return and where necessary to gather additional evidence linked to specific lines of inquiry in order to document findings and make an assessment of compliance
- A standard process for communicating the draft determination of compliance and draft recommendations to address any minor non-compliances—so that the provider can provider additional evidence or challenge the draft determination prior to finalisation
- A standard format for communicating the final determination of compliance and recommendations.

While key informants raised a number of improvement opportunities related to these core arrangements, the evaluation findings highlighted that these arrangements provide the foundation for:

- A robust and proportionate system for compliance assessment for Tier 1 and 2 providers (Term of Reference 1)—while recognising that there may be implementation issues that need to be addressed for providers new to any housing regulatory system, multi-jurisdictional providers and for different organisational and delivery contexts (see improvement opportunities 1, 2, 3 and 6 below)
- A robust system for compliance assessment for Tier 3 providers (Term of Reference 2)—while recognising that additional action is needed to ensure compliance remains proportionate to the size and focus of Tier 3 community housing activities (improvement opportunities 1,2,3, 6 and 7 below)
- A systematic methodology for jurisdictional regulatory staff (Term of Reference 3)—while recognising improvement opportunities to ensure nationally-consistent implementation of the compliance process (see improvement opportunities 4, 5 and 8 below).

4.2 Potential improvement opportunities

The evaluation finding highlight a number of areas for potential improvement for the full roll-out of compliance assessments—although the limited scope of the initial round of assessments covered by the evaluation means that these areas are presented as 'improvement opportunities' rather than formal recommendations.

Further, the National Working Group and Registrars are already working on a range of ongoing process and system improvements as part of the roll-out of registration assessments—and these will need to be considered in responding to the findings of this evaluation.

4.2.1 Compliance communication strategy

Appropriately, the vast majority of effort and attention to date in the NRSCH has been on the Registration process—reflecting providers interests in getting through the 'gateway' to becoming a nationally registered community housing provider and regulatory staff interests in registering providers for the first time or undertaking assessments to transition providers from state-based regulatory systems to the national system.

This focus is reflected in the number and content of current NRSCH guidelines—which are strongly focused on the registration process. The publically-available information on the compliance process is currently limited to a

- one-page description of the compliance process in the Regulatory Framework
- a brief description of the six-stage compliance process on the website
- a two-page Fact Sheet on the six-stage process.

In addition, providers participating in the initial round of compliance assessment had access to the draft *Compliance: Provider User Guide* that provided more details about the compliance process—although this document is not yet publically available.

The evaluation findings highlighted that there are currently a number of areas of potential confusion for registered provider as a result of gaps in the publically-available information and different descriptions of the compliance process (see Section 4.2.2). Key questions for providers are:

- How is the standard compliance return different / similar to the registration return
- In addition to submitting a standard compliance return, what additional evidence gathering activities may occur as part of the compliance assessment process
- How is the scope and focus of the initial compliance assessment different / similar to the registration assessment
- How is the scope and focus of the initial compliance assessment different / similar to the subsequent standard compliance assessments

- How is the scope and focus of triggered compliance assessment different / similar to the standard compliance assessments
- What is the timeframe for undertaking and completing compliance assessments
- What is the key document that describes the requirements to demonstrate compliance

Improvement opportunity 1: Development and implementation of an NRSCH compliance communication strategy to inform all registered providers (and providers currently seeking registration) about the scope and focus of compliance—linked to consistent information about the compliance approach and process in an updated Compliance Fact Sheet and comprehensive Compliance: Provider User Guide (see improvement opportunity 2).

4.2.2 Compliance user guide

Currently, detailed information about evidence requirements to demonstrate compliance are split over a number of documents—including the NRSCH Evidence Guidelines, Tier Guidelines, Registration Return Guide (which providers details of the performance requirements, metric and definitions mirrored in the Compliance Return), and Financial Viability Guide.

Providers and regulatory staff highlighted that there was no single 'source of truth' and provided examples of inconsistencies and ambiguities between the existing documents—as well as a disconnect between the registration focus of these documents and the need for a 'stand-alone' compliance guide.

It was suggested that since the vast majority of regulatory effort over the long-term would be focussed on compliance (given that compliance is ongoing whereas registration is one-off), consideration should be given to producing a Compliance Guide that consolidated all of the existing information about performance requirements and evidence into a single document—rather than updating existing documents. Ideally, the Compliance Guide would provide:

- A description of the approach to compliance (including descriptions of the key compliance activities and concepts—such as compliance and partial-non-compliance and the nature of recommendations (see Section 3.1)
- Key requirements to demonstrate compliance with each performance requirement
- Details of the scope and focus of standard documentation required to be submitted with the compliance return
- Details of the non-financial metrics and thresholds required to be submitted with the compliance return
- Details of the financial and asset performance reports
- Details of the format compliance return (aligned to the structure of information requirements in the CHRIS portal)
- Standard glossary and technical definitions of all key data items.

While the existing *Compliance: Provider User Guide* provides a good starting point, it requires providers to constantly cross-references other documents and does not provide detailed guidance on completing the standard compliance return.

Improvement opportunity 2: Development of a comprehensive Compliance Guide to assist providers and regulatory staff to more easily understand and meet the requirements to demonstrate compliance for each of the performance requirements.

4.2.3 Compliance process timeframe

The evaluation findings highlighted the importance of establishing clear expectations about the length of time for the compliance process—while retaining the flexibility for regulatory staff to tailor the duration of the process to the level of compliance risk.

While taking into account the limited scope of the initial compliance round, reasonable expectations appears to be that:

- The date for the initial standard compliance assessment is scheduled at the time of the registration determination (so that providers have ample time to prepare for their first compliance assessment)
- Providers have six weeks from the commencement of the initial standard compliance assessment process to submit the standard compliance return (although this may be able to reduced to four weeks for subsequent standard compliance assessments)
- Regulatory staff have eight weeks to complete a standard compliance determination (after the date the compliance return is submitted)—for providers not requiring a more detailed investigation of specific compliance risks
- Where a more detailed investigation of specific compliance risks is required, the Registrar communicate with the provider about the scope and focus of the additional investigation and the anticipated activities and timeframe for reaching a draft determination
- Where a triggered compliance assessment or additional monitoring activities are to be undertaken, the Registrar communicate with the provider about the scope and focus of the additional investigation and the anticipated activities and timeframe.

Improvement opportunity 3: Updating of the *Steps and Timetable for the Compliance Process* in the Compliance Guide (and Fact Sheet) to communicate clear expectation about the length of time for the compliance process.

4.2.4 Risk-based approach to compliance

The current publically-available information about the compliance process highlights that registrars intend to use a "nationally consistent risk profiling tool and process to assess the risk of providers' non-compliance on the future" and that the "final risk category (high, medium or low) will be communicated with the individual provider".

The risk profiling tool has yet to be developed and was not tested as part of the initial compliance round—although the determination reports adopted a risk-based approach by communicating to providers whether additional monitoring activities were needed prior to the next standard compliance assessment.

While a nationally consistent risk profiling tool should remain part of the medium-term development plan for the NRSCH, it appears premature to commit to the development of a risk profiling tool for the initial roll-out of compliance assessments—given that systemic evidence about sector risk profiles and agreement on key risk indicators may only be known as the NRSCH matures. In addition, it would be important for any development process to involve extensive input from providers and industry stakeholders.

However to ensure a nationally-consistent approach to any additional monitoring associated with a judgement that there is a 'moderate or high' risk of future non-compliance, the *Analysts Compliance Guide* (Section 2.10.2: Risk profile and scheduling) could provide additional guidance on the approach to making decisions about any additional regulatory engagement and how this is communicated to providers.

Improvement opportunity 4: Updating of the *Analysts Compliance Guide* to provide additional guidance on the approach to making decisions about any additional regulatory engagement where a moderate or high risk of future non-compliance is identified and how this is communicated to providers in the compliance determination report.

4.2.5 Recommendations in compliance determinations

The evaluation findings highlight that improvements could be made to the way recommendations are formulated and communicated to providers in determination reports. Key issues are:

- The need to provide a brief statement of the context of the recommendation – specifically,
  - Which performance requirement(s) the recommendation relates to (and not just the performance outcome)
  - Whether the recommendation is about taking action to address a current partial non-compliance (and if so, what is the scope of the non-compliance) or about taking action to address a risk of future non-compliance compliance (and if so, what is the scope of the future non-compliance)

- The need to provide a clear statement of what will be assessed at the next compliance assessment to determine whether the current partial non-compliance or risk of future non-compliance has been satisfactorily addressed.

At the same time, it is important that determination reports remain brief and any commentary is in the form of a specific recommendation—rather than a justification of the evidence and analysis underpinning the recommendation.

Improvement opportunity 5: Updating of the Section on "*Making Clear and Useful Recommendations*" in the Analysts Compliance Guide to provide additional guidance on making recommendations—ideally with illustrative examples (and counterexamples) of clear and useful recommendations

4.2.6 Financial Performance Report

There are currently strong but divergent views about the utility and relevance of segmentation in the Financial Performance Report.

While it is clear that there is a cost to providers to extract and report financial information is the required format, many providers have already invested in system changes to meet the reporting requirements—so are equally cautious about proposals to move away from segmentation.

There are additional concerns for Tier 3 providers where the 'segmentation' concepts may be less relevant (e.g. specialist homelessness services) and a more 'simplified' financial report could be more appropriate.

Given the limited scope of the initial compliance round, there is insufficient evidence to make a recommendation about retaining, simplifying or replacing segmentation in the Financial Performance Report—although Registrars need to make it clear to providers what approach they intend to take for the full roll-out of the initial compliance assessments so that providers can prepare with certainty.

4.2.7 Supporting provider to prepare for initial compliance assessment

While Registrars are not responsible for supporting providers to prepare for compliance assessments, there are a number of areas where the regulatory arrangements can support the preparation process. This includes:

- Publishing periodic updates on common compliance risks identified nationally during registration and compliance assessments—particularly in relation to:
  - Areas where regulatory staff are commonly finding inadequacies in submitted evidence (e.g. evidence that the outcomes of appeal and complaint processes are acted on; scenario testing of assumptions in Tier 1 and 2 financial projections)

  - Additional evidence needed to understand the impact of changes to the provider's business plans
  - Emerging systemic compliance risks that impact on particular types of providers.
- Providing clear advice about the date of the next compliance assessment—so that Tier 3 providers can commence their preparations at least 6 months prior to the due date for the compliance return
- Facilitating access to CHRIS portal for the compliance return – so providers can familiarise themselves with the specific data requirements and ideally being to populate the return as information becomes available
- Promotion of resources developed by Industry Peak Bodies and Funding Agencies (e.g. NSW Federation of Housing Association's Benchmarking project; Queensland Shelter capacity building project)

Improvement opportunity 6: Development and implementation of an NRSCH strategy for supporting provider to prepare for initial compliance assessment

4.2.8 Reviewing evidence requirements for Tier 3

While it is important to maintain the integrity of the three-tier regulatory arrangements and associated evidence guidelines, there is considerable scope to review the evidence guidance for Tier 3 providers—including better use of existing reporting arrangements to demonstrate the achievement of the performance outcomes.

There is a risk that the current Evidence Guidelines for Tier 3 providers promotes administratively-based regulation focussed on submitted evidence—rather than outcomes based regulation focussed on actual performance. For some Tier 3 providers, such as specialist homelessness services with a very small number of community housing assets, it may be possible to review the evidence requirements to make greater reference to other assurance mechanisms such as homelessness service standards. For example, if a Tier 3 is fully meeting its contractual performance obligations, then there may be existing evidence they can use to demonstrate that they are meeting certain performance requirements under the NRSCH. It may then be possible to focus compliance assessments on key performance risks such as asset maintenance.

While this approach may predominately be relevant to Tier 3 providers whose core business is not community housing, there may be scope to review the evidence requirements for all Tier 3 providers.

Improvement opportunity 7: Prior to the commencement of the roll-out of compliance assessments for Tier 3 providers, updating of the *Evidence Guidelines* and the *Analysts Compliance Guide*, to review the evidence requirements for Tier 3 providers. Any chances would then be reflected in a new Compliance User Guide (see Section 4.2.2).

4.2.9 Capacity building for regulatory staff

All analysts involved in the initial compliance round recognised that they were on a 'steep learning curve' in developing their understanding of the NRSCH performance outcomes and the adequacy of evidence needed to make a judgement of compliance.

Analysts also recognise the challenges of retaining the focus on outcomes-based regulation—particularly for large, complex businesses and those undergoing significant change.

While there are a number of forums within and across Registrar offices to maintain the rigour and national consistency of assessments and regulatory engagement, analysts highlighted the importance of continuing to build "communities of practice"—particularly in relation to

- Financial viability and governance risks for large and complex businesses
- Asset management and development risks for providers undergoing significant change
- Probity and fraud risks
- Interpretation of evidence requirements for Tier 3 providers.

It may be appropriate for the Registrar office in each participating jurisdiction to nominate and then lead a particular national community of practice for analysts—as a way of promoting the rigour and national consistency of assessments across different offices.

Improvement opportunity 8: Development and implementation of an NRSCH communities of practice strategy to support analysts to maintain the rigour and national consistency of assessments and regulatory engagement