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THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

MELBOURNE

9.20 AM, THURSDAY, 10 OCTOBER 2019

Continued from 9.10.19

DAY 54

MR P.R.D. GRAY QC, counsel assisting, appears with MS B. HUTCHINS and MS E. BERGIN
MR G. KENNETT SC appears with MR B. DIGHTON for the Commonwealth
MS C. HARRIS QC appears for the Victorian Government

COMMISSIONER PAGONE: Ms Hutchins.

MS HUTCHINS: Commissioners, the first witness I call this morning has an order for a pseudonym applied. The witness will be referred to as Malloy. She has prepared a statement for the Commission which we will read out in evidence today.

COMMISSIONER PAGONE: Yes, thank you.

<MALLOY, SWORN [9.20 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: So you have prepared a statement for the Royal Commission.

MALLOY: Yes.

MS HUTCHINS: And it's dated 3 October 2019, but signed on 4 October 2019.

MALLOY: That's correct.

MS HUTCHINS: For the transcript, it's WIT.0485.0001.0001. Do you have a copy of your statement in front of you?

MALLOY: I do.

MS HUTCHINS: And your statement is true and correct to the best of your knowledge and belief?

MALLOY: It is.

MS HUTCHINS: Do you wish to make any amendments to the statement?

MALLOY: No.

MS HUTCHINS: I tender the statement.

COMMISSIONER PAGONE: Yes. Thank you. The statement of Malloy dated 3 October 2019 will be exhibit 10-20.

EXHIBIT #10-20 STATEMENT OF MALLOY DATED 03/10/2019 (WIT.0485.0001.0001)

MS HUTCHINS: Malloy, in your own time, would you like to read your statement for the Commission starting at paragraph 4.

MALLOY: I will.

MS HUTCHINS: You're free to remain seated, if you like, or you can stand if you prefer.

MALLOY: I would rather stand, thanks.

I go by the name of Malloy and I'm currently 84 years old. For the past two and a half years I've been working in collaboration with an organisation called Alice's Garage to help build cultural safety in aged care facilities and the broader community. Alice's Garage was established in 2016 by Dr Catherine Barrett. It is a social enterprise empowering LGBTIQ elders. Together, Dr Barrett and I created a resource called the Rainbow Makers: Cultural Safety and Older LGBTIQ Australians, in which I draw on my experiences as a lesbian elder to highlight some of the issues that are faced by the LGBTIQ elder community. This resource is attached to this statement.

I was born in Middlesex, England in 1935 and lived in Oxford until 1948. I had a sister and two brothers. In 1948 I moved to Australia with my family. I first realised that I might be a lesbian when I was 12 years old. My family found out when my mother caught me with one of my girlfriends in my bedroom. My mother tried to beat us both up. My father started to call me insulting names which continued for years. I did not have any support from my family whilst growing up. My siblings have never been able to cope with me being a lesbian and by the time I was in my 30s we lost contact with each other. I did not even know when my sister died. I am now trying to re-establish relationships with my two brothers, after 40 years.

Around 1960, when I was approximately 25, I had a breakdown when a girlfriend left me. I had been working at the telephone exchange at the time, and as a result of my breakdown, I lost my job. One of my supervisors took pity on me and invited me to come and live with her. She was a devout Catholic woman and in many ways became a mother figure. She taught me about the church. She suggested that I go to a home for wayward teenagers but I refused. She believed that I was mentally ill and suggested I see a psychiatrist, and I agreed.

Under this psychiatrist I was admitted to a psychiatric hospital as a voluntary inpatient. I was told if ever I go back to being a practising lesbian God would not love me. I was an inpatient for three months at this hospital and then an outpatient for six years. My psychiatrist tried various types of conversion therapy on me, including electroconvulsive therapy and LSD treatment. For LSD treatment, I would have to stay overnight at the hospital, weekly. Due to my treatment, I could not work any more. I went on to what, at that stage, would have been the equivalent of the disability pension.

Around the age of 26 I met a social worker called Marilyn who was trying to pull me away from the conversion therapy and get me to accept myself. I finally got to the point where I was brave enough to tell my psychiatrist I didn't want to see him any more. Marilyn recommended another psychiatrist who had a completely different attitude.

In the 1990s I joined a LGBTIQ Catholic support group called Acceptance which met monthly. This was a state-wide support group for gay and lesbian Catholics and was run by a sympathetic priest in Adelaide and it had the blessing of the then Archbishop Faulkner. My Acceptance group was started by a now retired priest, Maurice Shinnick. It was a controversial move by him, given the attitude towards LGBTIQ people at the time. I was very grateful to have this support group.

I met my partner, Natalie, in the 1990s through a gay and lesbian counselling service I was working at during that time. We were together for 22 years before Natalie passed away in 2014 at the age of 74.

Excuse me.

Natalie moved into a unit at the retirement village in 2006. I then moved into the unit next door to her in 2009. I continue to live in this same unit today. I remain a practising Catholic woman and I struggle with the attitude of the church towards LGBTIQ people. I do not know a lot of gay and lesbian people in the church because a lot of people either hide it or have left the church. I have always been open about being a lesbian and have experienced a lot of discrimination from people in the church because of this.

I have, in recent years, found comfort and support through several people and organisations such as COTA SA, ECH, BFriend, Catalyst and Alice's Garage, that are involved in supporting LGBTIQ elders. In 2016 I met Dr Catherine Barrett of Alice's Garage and she subsequently introduced me to Louise Herft who was working at the time as an aged care advocate with the Aged Rights Advocacy Service in Adelaide. At this time I was feeling very upset and confused about the situation I had found myself in with management at the aged care facility where I volunteer.

After my partner, Natalie, died I started visiting residents at the residential facility, many of whom suffered from loneliness and isolation. After undertaking some voluntary training in mid-2017 that was arranged by the nurse manager at the facility, I continued visiting residents at the facility, sometimes up to six residents a day, four days a week. I really enjoy being a volunteer and continue to do so today. It is unfortunate, however, that my volunteering journey at this facility was made so unpleasant by the nurse manager whose attitude and manner towards me was both humiliating and bullying.

Things came to a head when I received a letter dated 24 October 2017. It stated that there had been "a number of concerns from residents when you are visiting them. It has been reported that you are not always respecting their privacy and at times

interfere with their health and wellbeing." When I read this letter, I was horrified. It did not make any sense. I could not think of any times when I acted inappropriately. After reading the letter, I asked to talk with the nurse manager to understand what the problem was. The meeting with the nurse manager was very uncomfortable. When I arrived, she tried to close the door to her office. I asked for the door not to be closed as I felt intimidated.

During this meeting, I asked her to explain what the complaints were and who were making them and she said she was not allowed to disclose this information. She also said that I was not allowed to talk about my sexuality with the residents. I replied, "That's against the law." And she went on to tell me that I could visit one male resident because he liked me. She then back-flipped and said that I was to meet with the activity coordinator who would allocate two or three people that I could visit. I was devastated to be told that I was no longer allowed to visit all my usual residents and to hear that they had been complaining about me. After the meeting, I went home very upset. I felt that I –

excuse me –

...after reading the letter, I asked to talk to the nurse manager to understand what the problem was.

I think I've read that.

MS HUTCHINS: Malloy, you're at the start of paragraph 23.

MALLOY: 23, that's right, I shouldn't have had the water.

After the meeting I went home very upset. I thought that I was being treated very unfairly. I could not think of any incidents that would meet the description of the nurse manager's allegations. I did not hide that I was a lesbian at the facility. I carry around a rainbow lanyard and would speak to staff about it if they asked. But the fact that I am lesbian is not something I would actively go and speak to residents about. I do not think they would have ever known what my sexuality was. I felt like the residents liked me for the companionship I gave them. I also felt that even if I had told the residents I was a lesbian, this would not have been an issue.

I decided to speak to Dr Catherine Barrett who put me in touch with Louise Herft from Aged Rights Advocacy Service (ARAS) in Adelaide because I was an older person experiencing discrimination and psychological abuse from an aged care manager. Louise Herft met with me in December 2017 to discuss what had happened. With my permission, Louise called the nurse manager to discuss the complaint and arrange a meeting. Louise later told me that during the telephone conversation when the subject of my sexuality was raised, the nurse manager kept saying things to Louise like, "We don't have people like that here" and "People don't want to hear about things like that."

When Louise asked for details of the complaints or to see evidence of the complaints in file notes or other facility records, the nurse manager refused to give them, stating confidentiality of the residents. It was clear she had a homophobic bias towards me. A meeting was arranged at my unit with the nurse manager, another facility staff member, Louise and me to discuss the complaint. At the meeting I was extremely nervous. It was very stressful and I felt I was under attack by the nurse manager. It brought back memories of my father and the horrible way he treated me when I was growing up. Having Louise at the meeting with me was great. She challenged the nurse manager several times about the alleged problems and helped me to get my perspective across.

Despite being asked again, the nurse manager would not spell out what the complaints were. Her manner was very confrontational and defensive and she attempted to leave the meeting a few times. Her staff member looked very uncomfortable during the whole meeting. It was so overwhelming that at one stage I started to cry. At this meeting, a compromise was reached where I could continue to volunteer at the facility with a smaller number of residents. After this meeting, when I was at the facility visiting residents, the nurse manager started to avoid me. As a result of her behaviour, I felt very uncomfortable when I was at the facility.

For some time after the meeting, I did not visit as many residents as I used to but now I am back seeing however many I want. There are a lot of lonely residents. And currently there are not many volunteers at the facility. I believe that complaints were never actually made and that it was the nurse manager's personal issues with my sexuality that caused her attack. This is plainly discrimination and it should not be allowed to occur. I am not aware of any consequences to the nurse manager for the way she treated me.

I have become actively involved in advocating for LGBTIQ people in aged care. In addition to the Rainbow Makers publication mentioned above, I have also been interviewed by the program, The Feed, on SBS and I have also given seven presentations at conferences and meetings in Adelaide and interstate, including national conferences on elder abuse and on LGBTIQ issues. These activities have transformed my life. The facility is aware of my story, yet I have never received an acknowledgement or an apology for what occurred. It seems the facility has turned a blind eye to what has occurred. However, the attitude of the nurse manager towards me has changed. She no longer bullies me and I'm more comfortable in the facility.

This facility has done nothing to promote an LGBTIQ inclusive culture. I am not aware of the staff undertaking any specific training to help educate them on the needs of LGBTIQ people. This discrimination has had a significant impact on me. It has brought back memories of younger days. I experienced a lot of discrimination when I was younger and these events brought back all of those negative feelings. I think LGBTIQ people should be treated with respect and people should be able to be themselves without having to hide their sexual orientation.

I feel that LGBTQI elders are not speaking up about issues they are experiencing in aged care. Due to LGBTIQ elders not speaking about the discrimination they are experiencing, it may seem to other people that there is no issue. I believe there should be mandatory training on caring for LGBTIQ elders. This training should be for all staff at all levels of these organisations and facilities. Steps should be taken to make sure LGBTIQ people, particularly elders who have often suffered through a life of non-acceptance, are made to feel welcome and safe in residential aged care facilities.

I was involved in a poster with the national LGBTIQ Health Alliance which clearly announces that LGBTIQ people are welcome here. Something like this should be clearly displayed at the front door of all residential care aged care facilities. Thank you.

MS HUTCHINS: Thank you Malloy. Is there anything further you would like to say to the Commission today?

MALLOY: No.

MS HUTCHINS: Thank you. No further questions.

COMMISSIONER PAGONE: Malloy, thank you very much for coming to give your evidence to the Commission. It's very important that we, the government and the community generally hear stories like yours and we are very grateful for you to be here. Thank you very much.

MALLOY: Thank you. Good.

<THE WITNESS WITHDREW [9.41 am]

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Commissioners, our next witness is Ms Ann Wunsch.

<ANN DOMINICA WUNSCH, AFFIRMED [9.42 am]

<EXAMINATION BY MR GRAY

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner.

What is your full name?

MS WUNSCH: Ann Dominica Wunsch.

MR GRAY: You are the executive director of the quality assessment and monitoring operations area within the Aged Care Quality and Safety Commission, Ms Wunsch.

MS WUNSCH: That's correct.

MR GRAY: You've prepared two witness statements so far for the Royal Commission.

MS WUNSCH: Yes.

MR GRAY: The first statement dated 22 July 2019 is exhibit 8-3, and in relation to that statement, you gave oral evidence in Brisbane on 8 July 2019.

MS WUNSCH: Yes.

MR GRAY: And your most recent statement, your second statement, is WIT.0411.0001.0001, a statement dated 18 September 2019; correct.

MS WUNSCH: Yes.

MR GRAY: If you just kindly have a look at the screen in front of you, do you see a page appearing bearing the document ID I just read out.

MS WUNSCH: Yes.

MR GRAY: Is that the first page of the statement you've prepared dated 8 September 2019?

MS WUNSCH: Yes.

MR GRAY: Now, I understand you wish to make an amendment to annexure B of the statement, which I believe is on page 26, in the second bottom row, final column, where it says "assessment contact" do you wish to have that read "unannounced assessment contact"?

MS WUNSCH: Yes, I do.

MR GRAY: Thank you. Now, having made that amendment are there any other amendments you wish to make to your statement?

MS WUNSCH: No.

MR GRAY: To the best of your knowledge and belief are the contents of the statement, having made that amendment, true and correct?

MS WUNSCH: Yes.

MR GRAY: Thank you. I tender the statement.

COMMISSIONER PAGONE: The statement of Ann Dominica Wunsch dated 18 September 2019 as amended will be exhibit 10-21.

EXHIBIT #10-21 STATEMENT OF ANN DOMINICA WUNSCH DATED 18/09/2019 (WIT.0411.0001.0001)

MR GRAY: Thank you, Commissioner. Ms Wunsch, I want to ask you some questions about the process of accrediting a new provider for the first time. In your statement, at paragraphs 8 to 12, you address a question that was asked.

When undertaking the accreditation process for an approved provider, does the aged-care quality-and-safety Commission assess and consider whether the applicant will provide aged-care services to people with special needs? If not, explain why this is so.

And you addressed that question at paragraphs 8 to 12 on pages 2 and 3. The application form for accreditation is at tender-bundle tab 40. I will just ask the operator to bring that up, please. This is the application form you referred to in your statement.

MS WUNSCH: Yes.

MR GRAY: If we go to page 9502 – we see here the beginning of a section dealing with the requirements of the standards, setting out a table with a series of fields for the assessor to complete in relation to questions raised by the standards; is that right?

MS WUNSCH: This is the application for accreditation that will be completed by the service seeking accreditation.

MR GRAY: So the assessor doesn't fill in any of this material.

MS WUNSCH: The service fills this in.

MR GRAY: Thank you. Now, you've said in your statement that for example, with respect to standard 1(3)(a) and 1(3)(b), the assessor will assess and consider how the service will comply or are complying with their obligations to continuously improve as against aged-care quality standards. The difficulty at this point is that the service-provider hasn't commenced providing services; correct?

MS WUNSCH: Yes; that's correct.

MR GRAY: So the assessor's job in reviewing this application is to consider whether there's – what? Enough information provided in these fields to - - -

MS WUNSCH: There is evidence provided by the service that goes to the requirements under standard 1, where we're referring to standard 1. And that may be by way of material the service has prepared to provide to prospective consumers, the policy documents that they have created, the training programs that they have created, the information about their purpose, their intent, consumer-facing information that they've created. So there would be a range of pieces of evidence that a service would put to their self-assessment to evidence the way they will meet these standards in relation to the consumers that they will be admitting.

MR GRAY: Is it, essentially, a desktop exercise, reviewing whether the quality standards are met to the degree necessary for the Commission to award accreditation to a service on the strength of this application form?

MS WUNSCH: For the purposes of a commencing service, yes. And following that, though, we undertake an assessment, an unannounced assessment contact at the service, once that service has commenced operations. And the initial accreditation is for a period of 12 months, and during that 12-month period, there may be a number of contacts with the service, depending on the regulatory intelligence the Commission receives. It could be referrals; it could be information from the public. And at about the – about six to nine months into their operation, they then undergo a complete re-accreditation audit. That is an on-site audit, scheduled to – for the number of assessors and the number of days required to understand the scale and scope of that service.

MR GRAY: Now, the quality standards against which the initial accreditation application is assessed are the standards in schedule 2 of the quality-of-care principles; is that right?

MS WUNSCH: Yes.

MR GRAY: So we'll bring them up please, operator, tab 129. Thank you. And if we go, please, to sections 16 and 17 on page 15 – this is the source, the statutory source of the – delegated legislative source of the obligation to meet the requirements of the standards; correct?

MS WUNSCH: Yes.

MR GRAY: And then if we go, please, operator, to page 22, 0022 – we there see standard 1, from which you drew the examples that appear in your statement, Ms Wunsch.

MS WUNSCH: Yes.

MR GRAY: There's a consumer outcome, an organisational statement and then requirements, and that's the pattern for each of the eight standards in schedule 2.

MS WUNSCH: That's right.

MR GRAY: It's not possible, to assess the consumer outcome at the point of an application for accreditation; is that right?

MS WUNSCH: To the extent that there are no consumers in the service, that's right.

MR GRAY: It would be possible to some extent, to consider compliance with the other requirements in the standards; is that right?

MS WUNSCH: Yes.

MR GRAY: And at the point of awarding of initial accreditation, that's simply done on the papers; is that right?

MS WUNSCH: That is a – an assessment done on the basis of an application and the self-assessment and any other material that is before the delegate at the time; yes.

MR GRAY: And the self-assessment is a piece of paper that's been received from the applicant itself; is that right?

MS WUNSCH: It's a document that – where the service must complete the information against each of the 42 requirements of the aged-care quality standards.

MR GRAY: There's no interview, then, with the person making the application to test whether that person shows leadership in relation to matters of inclusion and respect for consumers, things of that nature. Is that right?

MS WUNSCH: I don't believe that we would seek that information unless we had a reason to; based on the information that was in the self-assessment, there may be a reason to make contact with that service.

MR GRAY: There may be a reason? Are you saying that you know that there has been a case where contact was made with a service because of an omission of material or a question raised by material in the application paperwork?

MS WUNSCH: I understand that we have had from time to time – we make contact with services fairly routinely through the process, where we have come to a view that the application was incomplete or information was – in the self-assessment was incomplete. It's – I couldn't talk to the frequency of that, though.

MR GRAY: All right. Could we just go forward in the document to standard 7(3)(b), please, operator. Yes; thank you. Just go back one page. Thank you. Do you see there in standard 7(3)(b), Ms Wunsch, there's a requirement for the organisation to demonstrate a number of things but (b) is that workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity and there are other workforce competency and capability issues raised by standard 7?

MS WUNSCH: Yes.

MR GRAY: Does the Commission consider the make-up of the workforce of the body seeking accreditation as a – either a home-care service or a residential-care service? I beg your pardon. I withdraw that. Accreditation relates only to the residential-care services at this stage.

MS WUNSCH: Yes.

MR GRAY: Doesn't it.

MS WUNSCH: Yes.

MR GRAY: Right. I'll withdraw the question and ask it again. Does the Commission seek information in relation to the composition of the workforce for any entities seeking accreditation as a residential-care service?

MS WUNSCH: It seeks that information through the self-assessment. So we would expect that the provider would evidence the composition and the competency of the workforce through the material that it submits in relation to standard 7.

MR GRAY: And how does the Commission assessor considering an application for accreditation try to assess (3)(b), which requires interactions which are, necessarily, interactions that are going to happen in the future, to be kind, caring and respectful of identity, culture and diversity?

MS WUNSCH: We would consider that the service's policy documents in relation to these matters, the training programs that they would evidence and other supporting material that they would evidence in their self-assessment would provide the basis for that assessment.

MR GRAY: And if there isn't proof that the workforce has been trained in questions of cultural safety, what's the outcome of the assessment of the accreditation application? Is there a fail?

MS WUNSCH: We would come to a view on whether the service met the standards for the purposes of awarding accreditation. It may be, that we seek further information, but I couldn't talk to a specific example on that.

MR GRAY: Is training, proof of training of the workforce in cultural safety a necessary condition of getting accreditation?

MS WUNSCH: Evidence that a service – I'm talking about the range of materials that a provider may use to evidence this particular requirement. I believe that that would be a relevant piece of evidence.

MR GRAY: I don't think you answered my question.

MS WUNSCH: Sorry.

MR GRAY: You said it would be a relevant piece of evidence, and that's useful to know; thank you, but you haven't answered my question, which is "Would training, proof of training of the workforce in cultural safety be a necessary condition of getting accreditation, a mandatory condition if you like?". If you don't have that proof, you don't get accreditation. That's my question.

MS WUNSCH: That's – so – no. That's not a mandatory consideration.

MR GRAY: All right. It's not even a mandatory consideration that has to be considered?

MS WUNSCH: Sorry; it's not a mandatory requirement.

MR GRAY: No; it's not a mandatory requirement. Should it be a mandatory requirement?

MS WUNSCH: We ask providers to evidence how they meet requirements. The way that they meet those requirements is, essentially, up to them. We test their evidence and come to a view about whether it meets a requirement of the standards.

MR GRAY: There's a fair degree of discretion allowed to the assessors who make the decision about the accreditation application; is that a fair remark?

MS WUNSCH: Yes. However, there are expectations that a service will be able to evidence meeting requirements, and we need to satisfy ourselves, that a requirement is met.

MR GRAY: Ms Wunsch, do you consider that cultural safety – I better just ask a question about cultural safety first, and then I'll ask the question I was going to ask.

MS WUNSCH: Sure.

MR GRAY: Do you have an understanding of what cultural safety is?

MS WUNSCH: Yes, I do.

MR GRAY: And what is it?

MS WUNSCH: Cultural safety is defined by the person, the consumer, and it goes to their view that their identity is respected, valued and understood by the service in the way that support and services are provided to them.

MR GRAY: And is it your view, that unless the environment created within the relevant – let's call it – let's limit this discussion to residential care – unless the environment created within the residential-care facility is culturally safe, then there's a real risk that the clinical-and-personal-care needs of the residents won't be understood?

MS WUNSCH: That's absolutely the case; yes.

MR GRAY: Yes, and if the clinical-and-personal-care needs of the residents are not understood, not only will there be a failure to provide clinical and personal care in accordance with other aspects of these quality standards, but there'll actually be a real risk to the safety, health and wellbeing of the residents; correct?

MS WUNSCH: Correct.

MR GRAY: So cultural safety is, quintessentially, a safety issue, including, potentially, a clinical-safety issue; do you agree with that?

MS WUNSCH: I agree. I agree, that it is embedded across all of the eight standards. Yes.

MR GRAY: So doesn't it follow then, that the quality Commission shouldn't be awarding accreditation to a commencing service unless it is satisfied, that there's proof that the workforce has been trained in advance in cultural safety?

MS WUNSCH: It's the responsibility of the provider, to evidence that they can meet the standards. When we are assessing a commencing service, it may be the case and it is often the case, that the service has a core capability and that capability is developed as the – as they begin to admit consumers to the service and that the quality and the evidence in relation to meeting cultural safety is enhanced over time as they recruit and develop their – the scale of the service to effectively support the number of consumers that they plan to and intend to provide services to. So we would see - - -

MR GRAY: Thank you for that. But what's the answer to my question, in your personal view? Doesn't it follow from the answers you gave before, that the quality Commission shouldn't be granting accreditation unless it's satisfied, that there's proof that the workforce has been trained in advance in cultural safety?

MS WUNSCH: My answer to your question is that the Commission satisfies itself on the basis of the information provided to it at the point of time of an application with a self-assessment, that a service can evidence - - -

MR GRAY: But you're just describing things that are done with respect to paperwork. I was asking you for your opinion on a particular point.

MS WUNSCH: Sorry.

MR GRAY: Are you able to answer the question? Doesn't it follow from your earlier answers, that the quality Commission shouldn't be granting accreditation to a commencing service unless it's satisfied, that there is proof that the workforce has been trained in advance in providing cultural safety?

MS WUNSCH: My answer is – my answer to your question is that the Commission does need to satisfy itself, that the service can demonstrate cultural safety, and that may be through a workforce-training program, and that may be able to be evidenced to the extent that there is a workforce in situ. And – but that changes over time. So I think that the evidence that they would provide at a later point would be different to the evidence that they would provide at the point where they are submitting an application as a commencing service.

MR GRAY: I think that all amounts to a disagreement with the question or with the proposition I asked you. In other words – I think that all amounts to a "no" to my question. You're saying it's good enough if there's some sort of promise that the workforce will be trained in the future. Is that what you are saying?

MS WUNSCH: No. I'm saying that the basis by which we would make a decision in relation to a commencing service would be on the evidence available at the time that we – but we still must be confident, that those requirements are met to the extent that they can be met prior to consumers being present at the service and that the assessment that follows that assessment would seek to understand the consumer experience and a broader assessment.

MR GRAY: Well, I'll leave it there. Now, you've referred earlier to the important point about follow-up visits.

MS WUNSCH: Yes.

MR GRAY: And there's no doubt, that it must be difficult, to determine an accreditation application with regard to the outcomes that are couched in the quality standards as now framed since July this year, without there actually yet being any operations in existence. That makes the follow-up visits all the more important. Doesn't it.

MS WUNSCH: Yes.

MR GRAY: Yes. Now, when's that first unannounced visit?

MS WUNSCH: Usually within the first three months of operation.

MR GRAY: Usually within the first three months?

MS WUNSCH: Well, in most cases it would be within the first three months of operation.

MR GRAY: So does that mean it could be longer than three months?

MS WUNSCH: It's possible, but our operating-procedure is to schedule a visit within the first three months of consumers first entering that service.

MR GRAY: Why isn't it more prompt than that?

MS WUNSCH: It's an unannounced visit, and we do not want to signal when we're coming. And so we provide a window so that we don't telegraph when we are coming.

MR GRAY: So are you saying that, in fact, it could well happen the day after operations commence?

MS WUNSCH: It could, and if we had regulatory intelligence that informed a need or a concern, we would do that. But we want to maximise the value of that visit to the service, to consumers and to the public, and therefore – we know that, if we – if it's scheduled at a point in time where there are more consumers there, the value of the visit is enhanced by our opportunity to understand a broader cross-section of consumers at that service, noting, though, we do want it to occur as soon as possible so that we have a further basis to understand the quality of the service being delivered in that service.

MR GRAY: What's the approach the quality Commission takes to whether a service which has in its resident population CALD people or ATSI – that is Aboriginal and Torres Strait Islander – people or LGBTQI people – the extent to which they've adopted the action plans under the aged-care diversity frame-work? What's the approach of the quality Commission to compliance with or implementation of those action plans if those populations are present in the resident facility?

MS WUNSCH: The – our approach is to – we have linked those action plans to our guidance document, and we see the action plans as a valuable resource for services. We use those action plans in our engagements with providers. For example: last week the Commission was joined up with the centre for cultural diversity on a workshop on culturally-inclusive care, and we distributed the action plans and used them to assist providers to understand how they can meet the aged-care quality

standards. We see them as a fantastic resource, and we encourage providers to engage with them.

MR GRAY: If the provider – we're talking about particular facilities, because your focus in the Commission in monitoring quality and safety in accordance with the quality standards is at a service level; is that right?

MS WUNSCH: That's right.

MR GRAY: So we are talking about a particular service.

MS WUNSCH: Yes.

MR GRAY: Say a residential facility.

MS WUNSCH: Yes.

MR GRAY: Do you – that is you, your assessor teams – only consider a particular action plan if you've received information that there are members of a particular diverse-needs group relating to that action plan present in the population of the facility?

MS WUNSCH: No. No. The action plans are relevant to all services, and that's why they are linked to standard 1 and our guidance material. And, in fact, the actions in those action plans are often relevant to a broader group than the special-needs group that they were developed for. For example: in the CALD action plan, there's a reference to services using Skype, Face Time or other technologies to link consumers with their families overseas et cetera. But that action is actually a relevant one for services to use to assist all consumers linked with their families, where they don't have opportunities to have direct contact with them. So we see a value in the action plans beyond the particular groups that they were developed for.

MR GRAY: Would it be appropriate in your personal opinion, for those action plans to be made a mandatory element of the quality standards?

MS WUNSCH: No. I don't agree with that proposition. I see these action plans as an examples document and to assist providers to identify where they currently stand and where they can select from a menu of opportunities and examples to improve their performance in relation to each of the special-needs groups. And I think that for some of the actions – they may be difficult to, necessarily, evidence, and others are easier to evidence. And I think services should find the actions that are relevant to the particular – their stage of development and see them as an opportunity to improve their performance.

MR GRAY: Would it be or is it appropriate in your view, for the degree of adherence by a particular provider to the action plans to be a mandatory relevant

consideration that assessors should consider in determining whether there's been compliance with the quality standards?

MS WUNSCH: No. I don't believe it should be a mandatory requirement - - -

MR GRAY: Mandatory relevant consideration.

MS WUNSCH: Relevant consideration.

MR GRAY: That is something that must be considered in the course of the assessor deciding whether there has been compliance with the quality standards.

MS WUNSCH: No. I believe that the – our guidance material, which is set out to establish intent, reflective questions, actions for providers – there are – there's scope within that guidance where services can well evidence that they meet the requirements. However, it's a really valuable resource for them to use, along with the other resources that are linked to our guidance material. And in standard 1, the culturally-inclusive standards developed by the centre for cultural diversity – sorry – the centre for cultural diversity in Victoria – that tool links directly to the requirements under the aged-care quality standards. So if you look at culturally-inclusive care through that self-assessment, you can evidence that you meet the aged-care quality standards. It is another way of evidencing meeting standards. And I think all of these documents that we link to are there because they provide guidance and support to providers. We want providers to choose how they evidence they meet standards.

MR GRAY: So does it follow, that the action plans under the diversity frame-work have no greater authority than any other piece of guidance and – I'll let you answer that.

MS WUNSCH: They are relevant, important tools and resources. They have significant resource links to other material. There's a high degree of consistency between what they say and other resources that we link to in our guidance material. And I think that they – that services do refer to them, because we see evidence of those actions in our assessments.

MR GRAY: Well, thank you, but it sounds to me as if they're no more authority than any other document outside the statutory frame-work. That sounds like the tenor of your answer.

MS WUNSCH: We haven't – so, counsel, I agree, that we haven't suggested that they are more authoritative. We see them as relevant, important, useful, but we don't – there's no hierarchy in our guidance material where we say this is a "must go to" particular resource, this is an optional resource.

MR GRAY: If an approved provider, either seeking accreditation or having achieved accreditation when the question of compliance with the quality standards

comes up at some later time, just hasn't turned their mind at all to the action plans – that wouldn't lead to an assessor finding they haven't met the quality frame-work. Is that the gist of your evidence?

MS WUNSCH: Counsel, we assess against the standards and the requirements. We require that services are able to evidence best practice in relation to meeting the aged care quality standards, and so we would seek to understand the basis by which they have provided evidence and how that references best practice.

MR GRAY: It sounds like providers can ignore the action plans and there won't be any consequence under the quality-review or accreditation audit frame-work.

MS WUNSCH: The relevant evidence to meet the requirements is highly consistent with the material in the action plans. It's not a case, that they are such different pieces. In fact, we routinely see elements of the action plans in the evidence that providers put forward as meeting the requirements. Whether or not they say that they have sourced these particular actions through the action plans or not is really – it's entirely up to them. But we ask them to evidence what is best practice in – "How do you evidence best practice?" And they would say, "Well, we've looked at the action plans; the Department of Health is the competent authority that developed them, and this is how we evidence that we meet the requirements".

MR GRAY: I want to ask you a question about conditions of allocation on places for residential-care services, and you were asked a question about this on page 3 of the statement.

When undertaking the re-accreditation process, does the aged-care quality-and-safety Commission (a) assess and consider whether the approved provider has one or more places allocated to a person with special needs?

Just to explain that – you know that there's a process by which under ACAR's places can be allocated with a condition that priority should be accorded to a person with a particular special need answering a list of so-called special needs that appears in the Act?

MS WUNSCH: Yes.

MR GRAY: Correct?

MS WUNSCH: Yes.

MR GRAY: You know that?

MS WUNSCH: Yes. I do.

MR GRAY:

(b) assess and consider the information about the approved provider on My Aged-care insofar as provision of aged-care services for people with special needs is concerned, if any, and if so, investigate the reliability of any such information?

MS WUNSCH: Yes.

MR GRAY: And then there's a follow-up question. Now, just focussing on the first of those, question (a) – the gist of your answer at paragraphs 13 and 14 is that the information about whether places have been allocated – that are subject to conditions about giving priority to special-needs groups – isn't necessarily a focus of any inquiry, save that it might inform the assessment team's knowledge about the likely composition of the people in the facility; is that right?

MS WUNSCH: Yes.

MR GRAY: And there isn't any follow-up on the question of ensuring that the approved provider has followed through with the requirements in the condition to try to accord priority in allocating that place to a person with the relevant special need.

MS WUNSCH: That's right, because our assessment is against the requirements of the standards; yes.

MR GRAY: They're the quality standards that we had up on the screen – in schedule 2 of the quality-of-care principles.

MS WUNSCH: Yes. That's right. Yes. Yes.

MR GRAY: And they don't speak of holding approved providers to any promises, in effect, that they've made in order to obtain a residential place in an ACAR round.

MS WUNSCH: Yes. That's right.

MR GRAY: So it's just not something which is within the scope of the quality Commission's role. Is that how you see it? That is the function of seeing whether that promise has actually been fulfilled is not something within the quality Commission's role; is that how you see it?

MS WUNSCH: That's right. That's right.

MR GRAY: Should it be?

MS WUNSCH: I believe that we should be seeking to evidence the services, the – sorry – the information that a service puts to us for the purposes of making an assessment against the standards. And I believe that we do that through the application, where consumer characteristics can be described. We do that through – we're now also providing assessment teams with information that is on My Aged-care.

MR GRAY: Well, is that a slightly different question? In My Aged-care a facility can now indicate that it has a specialisation in catering for a particular special need.

MS WUNSCH: Yes. That's right.

MR GRAY: Right. And is that what you're talking about now?

MS WUNSCH: Yes. Yes.

MR GRAY: My question is about a slightly different topic, although perhaps it's related.

MS WUNSCH: Yes.

MR GRAY: My first question that I asked you was about whether the Commission should have a role in, in effect, keeping providers honest with regard to the conditions on which they obtained an allocation of a residential place in an aged-care allocation round, an ACAR.

MS WUNSCH: Yes. Sorry; no. I don't believe we should. That's the responsibility of the department that has funded the service for that purpose.

MR GRAY: All right. All of the regulatory functions of the department are supposed to be transferring to the Commission next year.

MS WUNSCH: Yes. Yes.

MR GRAY: That's right. Isn't it.

MS WUNSCH: All of the regulatory – I think that may – I think that would need to be clarified.

MR GRAY: All right. So it's not totally clear, which functions are going to go - - -

MS WUNSCH: That's right; yes.

MR GRAY: Do you know whether any – have you been involved in any discussion with the department – that is the Department of Health.

MS WUNSCH: Yes.

MR GRAY: About the transfer of a function of, in effect, keeping the approved providers honest with respect to compliance with the conditions on which they were allocated residential-care places?

MS WUNSCH: No, I have not.

MR GRAY: Let's now go to that second aspect of the question that appears in the box on page 3, the question that you were beginning to answer a minute ago - - -

MS WUNSCH: Yes, okay.

MR GRAY: - - - about veracity of the information that appears on My Aged Care when an approved provider indicates that at a particular facility there's a specialisation indicated for a particular special need.

MS WUNSCH: Yes.

MR GRAY: So, for example, on My Aged Care the approved provider is now able to say at this facility we specialise in caring for people in the following language groups.

MS WUNSCH: Yes.

MR GRAY: Or for Aboriginal and Torres Strait Islander people.

MS WUNSCH: Yes.

MR GRAY: Things of that kind can be claimed on My Aged Care.

MS WUNSCH: Yes.

MR GRAY: Up to the date of your statement, it appears from the contents of your statement that the Quality Commission had no role during either assessing accreditation applications or in conducting assessment contacts or assessment audits in checking the veracity of those claims. Is that correct?

MS WUNSCH: I believe our role in relation to this was established over the last few months in relation to the introduction of the Aged Care Quality Standards, and we agreed with the Department of Health that it would be a relevant consideration for us to provide information to assessment teams that includes information about claims made on My Aged Care to – as a piece of regulatory intelligence that we would provide the assessment team as, in part, in their work pack. That would be alongside the application for accreditation and – yes.

MR GRAY: I will change my question to remove the concept of a role.

MS WUNSCH: Okay.

MR GRAY: And I will just ask, has the Quality Commission - - -

MS WUNSCH: Yes.

MR GRAY: Had the Quality Commission up to the date of your statement, used information about claims of meeting special needs appearing in My Aged Care to inform its assessment and monitoring activities?

MS WUNSCH: The date of my statement being 18 September - - -

MR GRAY: I think that's right, yes.

MS WUNSCH: Yes. So we commenced in September. And so I can't go to the date specifically but in September we commenced the process of giving information to assessment teams in relation to the claims made on My Aged Care.

MR GRAY: Okay. Well it must have – this isn't intended to be a trick question.

MS WUNSCH: No, no, I understand.

MR GRAY: I will bring it up. Page 4, paragraph 15.

MS WUNSCH: Yes.

MR GRAY: Please call out paragraph 15, operator. The second sentence there seemed very clearly to be saying that the details appearing on the My Aged Care service provider portal wasn't used.

MS WUNSCH: That's right. That's correct.

MR GRAY: To inform the Quality Commission's assessment and monitoring activities to date, up to 18 September.

MS WUNSCH: Yes.

MR GRAY: And that information that you're referring to there is a global reference to details on the My Aged Care portal. So it must include these representations about - - -

MS WUNSCH: Yes, that's right.

MR GRAY: - - - being able to meet special needs.

MS WUNSCH: Yes.

MR GRAY: So it wasn't used up until 18 September, but you are saying now there are discussions underway and - - -

MS WUNSCH: No - - -

MR GRAY: - - - that assessment teams are briefed with that information.

MS WUNSCH: So it's not that discussions are underway. We had discussions with the department in the first half of 2019. We had intended to implement this from 1 July. It's the case that we, due to considerable other competing priorities around the introduction of the new standards that we hadn't achieved that date. But we had – we commence it in September and at the point of time of the statement on 18 September, it is the case that we hadn't commenced that. But the plan and the intention and the implementation of that is underway and we can evidence that.

MR GRAY: Thank you. Now, in 16, the next paragraph, you describe what was then your intention and is now a reality - - -

MS WUNSCH: Yes.

MR GRAY: - - - that is, the information appearing on My Aged Care in relation to a particular facility is briefed to the assessment team.

MS WUNSCH: Yes.

MR GRAY: And let's just explore briefly how it's actually used because you've said:

Assessment teams will consider evidence of how the service is meeting the needs of consumers as detailed in their specialisations information primarily but not exclusively under standard 1(3)(a) and (b) of the Quality Standards.

Now, they're the standards we had up on the screen a short time ago.

MS WUNSCH: Yes, sure.

MR GRAY: And we will restore them to the screen please, operator. They are page 0022, thank you, yes. And they are requirements that:

...the organisation demonstrate each consumer is treated with dignity and respect with their identity, culture and diversity value and care and services are culturally safe.

It isn't clear, is it, that considering compliance with those matters encompasses considering whether claims of specialisation are accurate or misleading. It depends on whether somebody has been induced by the claim and has actually entered the service and then you can consider whether that consumer or that resident is being treated with dignity and respect with their identity, culture and diversity valued and that the services to them are culturally safe, but if they haven't entered the service, you can't consider those matters. What do you say to that?

MS WUNSCH: I would say that there are other ways to understand this particular issue and if we went to standard 1(3)(e) which refers to information provided to each consumer is current, accurate and timely, that we have a way of understanding what

the service offering is in relation to groups for which they are claiming to support or have potential to support. So there is a capability under other requirements of standard 1 to evidence this issue.

MR GRAY: And have you trained your assessors to consider the matter in that light under 1(e)?

MS WUNSCH: Yes, we are doing that as we speak. Yes.

MR GRAY: Now, I want to ask about cultural safety, not necessarily with respect to the cultural safety shown by the organisation that is being assessed but cultural safety on the part of your commission. There's suggestions in the evidence that it's considered by providers to be a vital of importance that assessors receive training on the needs of people identifying as being members of diverse groups.

MS WUNSCH: Yes.

MR GRAY: There are claims in the material, for example, Samantha Jewell's statement at 43(g) that:

It is evident that such training and expertise is lacking in many assessors.

Firstly, could you please give a summary of a content, duration and thoroughness of the training that is provided to assessors on cultural safety and, secondly, any evaluations of the efficacy of that training that occurred.

MS WUNSCH: The training that is provided to assessors begins with the training that they receive on induction, which we have cultural competence online modules. Our training is provided using adult learning principles. It includes face-to-face training, online, resources provided to assessors and toolbox sessions that are ongoing. We have training that meets the ISQua standards for surveyor training and that program is accredited and that's the training that leads to registration as an aged care quality assessor. That training is subject to ongoing accreditation audits every four years and is evaluated through that process.

MR GRAY: So the first set of references to materials and the toolboxes - - -

MS WUNSCH: Yes.

MR GRAY: - - - that's essentially online, is it? Is ISQua, face to face? Is any of that face to face.

MS WUNSCH: Yes. Yes, the training that each assessor receives for the purpose of becoming a registered aged care quality assessor is a training program that includes face-to-face training, online modules and – and the – that training is – they are assessed and deemed as competent and they must pass that training program in order to be registered; that is foundational training in order to reach registration.

MR GRAY: Is the cultural safety element of the training face to face, or any part of it?

MS WUNSCH: The training that they receive in relation to people with special needs is face-to-face training. For example, we engaged with the LGBTI Health Alliance to run face-to-face training across the country, to all our assessor workforce to train them in relation to the needs of LGBTI people and the – and it was delivered within a cultural safety – using a cultural safety lens. The training that they have received in relation to other special needs groups, including the care leavers, Forgotten Australians, Stolen Generations, is also delivered face-to-face using resources that are on the Department of Health's website. We use a combination of subject matter expert and our own internal training resources to deliver this training.

We have a continuing professional development program every year which involves a mandatory content. And the 2020 program, which is currently being finalised will also include cultural safety and will build on the training that we've already delivered across these areas. We usually present this material in the context of special needs groups but we also will be looking at cultural safety as a concept and as it is integral to the standards in our ongoing education that we deliver to assessors.

MR GRAY: In your statement, you refer to training in relation to Aboriginal and Torres Strait Islander people, CALD people, LGBTI people.

MS WUNSCH: Yes.

MR GRAY: You've just mentioned Forgotten Australians.

MS WUNSCH: Yes.

MR GRAY: What about the other particular needs groups; are they – is it a case of, there has got to be a limit to the training that is required so you really focused on those four groups so far.

MS WUNSCH: We certainly have primarily focused on those groups but our training for assessors is both on methodology and process and improving quality of evidence-gathering and also building their capability to assess under the Aged Care Quality Standards but we usually have a component that goes to the content of the standards and diversity and special needs groups has been a focus of that.

MR GRAY: The question about following up the efficacy of the training, is there validation of the effect of the training either at a general level or an evaluation of the competency of the assessor after the training?

MS WUNSCH: There is formative and summative assessments conducted in relation to our assessor training. There is certainly evaluations of training where we seek feedback from assessors on the value and the – and further training requirements that they may have identified during their training.

MR GRAY: Feedback from the assessors who are undertaking training?

MS WUNSCH: Yes, but we also are informed by feedback we receive from the sector, from services, from consumers and from complaints about our services to develop training on those particular areas where we need to continuously improve.

MR GRAY: I want to ask you about interpreters. Firstly, in the context of assessment contacts and assessment audits and even review audits, so during visits, in other words – are you reading something while giving your evidence?

MS WUNSCH: No.

MR GRAY: No. I just want to ask you about the interpreters. You've mentioned some figures in your statement. Firstly, interpreters used by assessors during visits.

MS WUNSCH: Yes.

MR GRAY: You refer to this topic in your statement at paragraphs 59 and 60. You give the level of expenditure as being about 75,000, a little short of $75,000 in the last financial year.

MS WUNSCH: Yes.

MR GRAY: That seems low. It seems to suggest that use of interpreters is not as widespread as one might expect during the many, many visits that are conducted by the Quality Commission during a 12-month period. In paragraph 63 you have noted that data on assessment visits isn't captured to the level of showing the use of particular interpreter services for particular language groups. But, clearly, bills are available in relation to those visits, otherwise you wouldn't have been able to calculate the $75,000 figure. Firstly, does that $75,000 seem low to you?

MS WUNSCH: I haven't considered it as – over a period of time. So I would need to consider whether what the trend data looked like in relation to that. It may be the case that where service – the consumer cohort within a service changes over time, that the pattern of our usage of interpreters would change.

MR GRAY: All right.

MS WUNSCH: It is the case that we would go to a service and maybe find a particular consumer or consumers that may benefit from an interpreting service that we hadn't been able to identify before. But that information is captured at that particular visit and that information is recorded on our system at the end of the visit. So we are seeking to update the requirements for interpreters on a regular basis.

MR GRAY: With regard to the point about a deficiency in the data – my words – in paragraph 63 which is currently on the screen, are you going to change your methodology so that in the future the Quality Commission will capture data on how

many consumers require access to interpreters during visits, that is, assessment contacts, review audits and accreditation audits?

MS WUNSCH: It's certainly something we could consider. In a visit, it may be that an interpreter is interpreting for numbers of consumers or one or two specific consumers. It may be useful for us to understand what that picture looks like in more detail. So – we're certainly open to looking at how we could capture more information in relation to that.

MR GRAY: Operator, please put up paragraph 32 of Ms Wunsch's statement, annexure E. This is an annexure relating to aspects of the Quality Standards and how the Quality Commission approaches – I don't know if verification is the right word, but assessment of – if we go to page 32, please, operator – page 32. There is – I beg your pardon, I withdraw that. I was mistaken. This is an annexure in which you've identified actions in response to the government action aspect of the Diversity Framework, that is, the government action plan under the Aged Care Diversity Framework. And on page 32, under item number 2, one of the actions is:

Ensure that feedback from Aboriginal and Torres Strait Islanders, CALD and LGBTI consumers is captured proportionately at quality review and accreditation.

So quality review is the home care version of what the commission does to assess compliance with the Quality Standards; correct?

MS WUNSCH: That's right.

MR GRAY: And accreditation is, obviously, the process we've been speaking about this morning – at residential-care facilities; is that right?

MS WUNSCH: Yes.

MR GRAY: Now, consumer-experience reports are administered to a sample of residents at a residential-care facility during an accreditation audit; is that right?

MS WUNSCH: Right.

MR GRAY: Are consumer-experience reports also administered during other visits now, or is it, simply, accreditation audits?

MS WUNSCH: It is the case, that we use the questions in consumer-experience interviews at other visits. The difference is that we're not seeking, in those other visits, to achieve statistically significant sample for the purposes of publication on our website. But the value is in having the engagement around those questions and understanding the consumer experience.

MR GRAY: Without capturing the data about how many people are requiring interpreters of their first language into English, how are you satisfying yourself that

your assessors are actually complying with this action item to make sure that consumer-experience reports are being administered proportionally to those special-needs groups, including the CALD special-need group?

MS WUNSCH: Those particular interviews are not – would not proportionally capture special-needs groups, because they're conducted randomly. It's the case, though, that - - -

MR GRAY: Sorry; the consumer-experience reports, interviews would not capture the special-needs groups proportionally?

MS WUNSCH: Necessarily – they may, but it's – they are randomly applied. So the – it's the case, though, that the other interviews that we conduct through purposeful sampling are more likely to identify particular individuals, because we are sampling for a purpose. And in relation to standard 1, we are seeking to understand the lived experience of people with special needs as they experience care in a service.

MR GRAY: Finally I want to just ask a few questions. I think I can finish this examination within a few minutes rather than breaking for morning tea now, if that's all right, commissioners.

COMMISSIONER PAGONE: You think you'll finish the witness completely? Sure.

MR GRAY: Thank you. I want to ask a few questions about the complaints processes within the Commission.

MS WUNSCH: Yes.

MR GRAY: I know that's not your particular area within the Commission, but just – since you're here, I'll just ask you. If you don't know the answers, just tell the commissioners that. Firstly are complaints, in effect, earmarked by reference to whether they've been made by a person who is a member of one of the special-needs groups?

MS WUNSCH: Not unless the complainant seeks to provide that information as part of their complaint.

MR GRAY: And if they do, then is there, in effect, a special field so that one can identify in the data how many complaints are coming from people who identify as a member of that particular group?

MS WUNSCH: I'm sorry. I'm not aware of whether it's a special field. I know that there is a capacity to understand that in terms of searching. But I don't know whether it's through a particular field or not.

MR GRAY: Now, whether it's through a particular field or not or some other functionality, once that's identified, are stake-holders in – is there some way of reaching out to stake-holders who have an interest in promoting the interests of those special-needs-group members? For example: if you've got a veteran who's made a complaint, do you then have a capacity to notify the department of veterans' affairs or the RSL about the complaint so that advocacy and assistance can be offered to the person making the complaint?

MS WUNSCH: The complaints resolution group has significant engagement with stake-holders around particular issues and concerns. So they are engaged with various special-interest organisations, and harking back to my previous information about the workshop that we conducted with the centre for cultural diversity last Friday – the national manager of operations of complaints was also part of the workshop, and we talked to service-providers, aged-care providers about the particular types of issues that tend to come through complaints in relation to special-needs groups. And, admittedly, it's from the data that we have available to us, but it's, certainly, an area we are seeking to engage with those organisations and service-providers about; yes.

MR GRAY: Mr Klinge's given evidence that the quality Commission does not have processes in place to identify veterans in formal complaints and to provide that information to the DVA, and the secretary of the DVA gave evidence that she at least wasn't aware of complaints being provided to DVA if they had been made by complainants.

MS WUNSCH: That's right; yes.

MR GRAY: And she expressed an intention to ask the Commission for that to occur in the future. Do you have any comment?

MS WUNSCH: I think that – we will want to explore that with DVA. Absolutely; yes.

MR GRAY: Interpreters with respect to complaints – you identify there's only a little over $7000 spent on interpreters in the complaints area of the Commission in the last financial year. I suggest that seems very low indeed. There were only 170 phone calls in which interpreters were engaged. Do you have any way of knowing what proportion of phone calls that represents against the total?

MS WUNSCH: I don't know that information. I understand that in many cases the initial complaint is made on behalf of a person who may not be able to communicate in English over the phone. The complaints-resolution group do seek to engage interpreters and also do seek to have face-to-face engagements with complainants where that is appropriate to – with an interpreter to assist. And they also use interpreter services.

MR GRAY: No further questions, commissioners.

COMMISSIONER PAGONE: Yes; thank you, Ms Wunsch, for your evidence.

MS WUNSCH: Thank you.

COMMISSIONER PAGONE: You may leave.

MR GRAY: Mr Kennett has a question he wishes to ask.

COMMISSIONER PAGONE: Yes. I see.

MR KENNETT: Ms Wunsch, earlier today Mr Gray asked you some questions about the application process for accreditation. Do you recall that?

MS WUNSCH: Yes.

MR KENNETT: And there were questions about standard 1(3)(b).

MS WUNSCH: Yes.

MR KENNETT: He asked you whether there were – whether there was a necessity for the applicant organisation to have trained its workforce in cultural safety.

MS WUNSCH: Yes.

MR KENNETT: Do you recall those questions?

MS WUNSCH: Yes.

MR KENNETT: I wonder if you could clarify for us at that point in the process, when an application has been made for initial accreditation – is it normal, for the provider to have the entire workforce in place at that point?

MS WUNSCH: No, it's not.

MR KENNETT: So would they have a core group of workers? Or what position would they be in, in relation to their workforce?

MS WUNSCH: They would have a core group. They would have, certainly, the infrastructure and the plans and the policies and other pieces to evidence their meeting the standards in relation to proposed staffing and existing staffing.

MR KENNETT: And would it be usual, for their workforce to expand gradually as the facility builds up with consumers?

MS WUNSCH: Yes; that is the case, absolutely the case.

MR KENNETT: Thank you. That was my only question.

COMMISSIONER PAGONE: Is that, Ms Wunsch, because as a matter of practicalities, until they get the accreditation, they don't know whether they can commit the funds needed for the additional staff?

MS WUNSCH: Yes, commissioner, and also that their planned commencement may be phased in a way to meet particular consumers' needs that enter the service at the outset, at the beginning of that service. And so it's, usually, a phased development.

COMMISSIONER PAGONE: But the questions, though, seem to be about accreditation, where it isn't a matter of an existing facility adding another activity to the existing structure and infrastructure but rather creating a new line of activity, and hence, they might need the accreditation for the – before they go off and get the additional staff is what, I think, I've understood from the question that Mr Kennett's asked you. Is that correct?

MS WUNSCH: Sorry, commissioner. I'm not entirely sure where you went there.

COMMISSIONER BRIGGS: Can I try and come at this another way that might help?

MS WUNSCH: Yes.

COMMISSIONER BRIGGS: We might be able to start from the assumption that the majority of providers who get accreditation for new places for people already have accreditation elsewhere. So for example: we might have a BUPA that might start a new facility. So they're not starting from scratch. So it may well be very reasonable, to be looking for workforce plans and so on, based on that existing accreditation; would you agree?

MS WUNSCH: I would agree, that for aged-care providers that have existing services – they would be able to evidence this in a multitude of ways. My case study that I was considering in answering this question was for a single stand-alone service, because that would be the baseline for understanding this particular issue.

COMMISSIONER BRIGGS: Do you know the proportion of newly-approved providers who are truly new providers and, secondly, the proportion of that that are providers for special-needs purposes?

MS WUNSCH: I don't have that information with me, more than happy to understand that and provide it to the Commission.

COMMISSIONER BRIGGS: That would be good.

MS WUNSCH: Yes.

COMMISSIONER BRIGGS: That would be good, because we can see the extent of the issue, I think.

MS WUNSCH: Yes. Yes.

COMMISSIONER PAGONE: I think you've answered my question, which was really upon understanding the model that you had in mind was a single stand-alone new entity as it were.

MS WUNSCH: Yes. Yes. Yes.

COMMISSIONER PAGONE: And then we need to test whether that's the relevant model to have in mind.

MS WUNSCH: Yes.

COMMISSIONER PAGONE: But that has clarified that for me; thank you.

MS WUNSCH: Thank you.

COMMISSIONER PAGONE: Mr Gray, anything? Thank you. You may now go.

MS WUNSCH: Thank you.

COMMISSIONER PAGONE: Thank you.

<THE WITNESS WITHDREW [10.57 am]

COMMISSIONER PAGONE: Mr Gray, we will have the usual break at this stage. Mr O'Meara was, however, not due to start until 11.45; is he ready to start half an hour earlier?

MR GRAY: Yes, he is.

COMMISSIONER PAGONE: All right. So if we will resume at quarter past 11 – would that be convenient .....

MR GRAY: Thank you. Yes. Indeed.

ADJOURNED [10.57 am]

RESUMED [11.18 am]

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. I call Dr Philip O'Meara. Mr O'Meara or rather Dr O'Meara is already present in the witness box.

<PHILIP IAN O'MEARA, AFFIRMED [11.19 am]

<EXAMINATION BY MR GRAY

MR GRAY: Dr O'Meara, what is your full name?

DR O'MEARA: Philip Ian O'Meara.

MR GRAY: Thank you. You are the director of the participation and inclusion branch in the Department of Health and Human Services, Victoria.

DR O'MEARA: That's correct.

MR GRAY: Thank you. You've made a witness statement for the Royal Commission, WIT.0378.0001.0001. Do you see the first page of that statement on the screen before you now?

DR O'MEARA: I do.

MR GRAY: Now, in response to a request, you've caused to be made a document which provides references to information that appeared in paragraphs 33 to 42 of the statement and I will ask that that be displayed for you as well. RCD.9999.0230.0001.

DR O'MEARA: Yes.

MR GRAY: Is that the document you have caused to be prepared which gives references to the information in paragraphs 33 to 42?

DR O'MEARA: That's correct.

MR GRAY: Thank you. Now, with respect to the statement, which is a statement dated 17 September 2019, and the references to the paragraphs I mentioned, with respect to both of those documents in combination, to the best of your knowledge and belief are the contents of the documents true and correct?

DR O'MEARA: Yes, they are.

MR GRAY: Commissioner, I tender those documents as one exhibit.

COMMISSIONER PAGONE: As one exhibit, yes. All right. Well, the witness statement of Dr Philip O'Meara of 17 September 2019 and the further information in relation to paragraphs 33, 35, 37 to 42 will be exhibit 10-22.

EXHIBIT #10-22 WITNESS STATEMENT OF DR PHILIP O'MEARA DATED 17/09/2019 (WIT.0378.0001.0001) AND FURTHER INFORMATION IN RELATION TO PARAGRAPHS 33, 35, 37 TO 42 (RCD.9999.0230.0001)

MR GRAY: Thank you, Commissioner. Dr O'Meara, your statement relates to a designing for diversity approach that is available within the government of the State of Victoria, doesn't it? Before I ask you questions about that particular approach, I want to ask you a couple of questions about the state of affairs prior to the introduction of Designing for Diversity and, in particular, could I ask you about a program which applied in particular as an element of the Home and Community Care program in Victoria from about 2012 onwards. Is it the case that Home and Community Care became CHSP in Victoria in recent times?

DR O'MEARA: That's correct.

MR GRAY: CHSP in Victoria still has many of the attributes of the previous Home and Community Care program, does it?

DR O'MEARA: During transition arrangements, that's correct.

MR GRAY: And when did the transition commence, roughly?

DR O'MEARA: So my understanding, and noting that this is not something directly within my remit but I do have an understanding of how the arrangements worked, the transition arrangement commenced, I believe, in 2016 and has taken place over that time, and some of the kind of final parts of that transition arrangement conclude in the middle of next year.

MR GRAY: So the plan is that the transition will be complete by the middle of 2020; is that right?

DR O'MEARA: That's correct.

MR GRAY: All right. Now, an element of what was formerly known as Home and Community Care program and is now CHSP under the transition you've described, was there a policy known as diversity planning and practice?

DR O'MEARA: Yes, there was.

MR GRAY: And could you describe any aspects of that diversity planning and policy practice that involved assistance given to service providers to either create

human services that catered for diversity or to transform existing services into services that cater well for diversity.

DR O'MEARA: Of course. So there's probably two broad points to make. The first is that the diversity planning and practice approach was, as you've mentioned, part of the Home and Community Care program. It was a framework in its own right. So one part of that assistance that would be provided to – that would be available to providers was the framework and the guidance. So the guidance was very detailed. It included multiple steps that providers were asked to undertake over the course of a year to assess need and to plan for that and then to review it. So I just wanted to explain the kind of framework element of it.

And the second part is a number of roles which existed which supported that – that approach being given effect in practice. So – and they were based in the community providers. So, for example, four different roles as part of that – as part of that program: access and support officers, wellness and reablement officers, Aboriginal development officers and also diversity officers. And so this, if you like, was a workforce that helped to support the application of the approach in the Home and Community Care program.

MR GRAY: Can I just ask about the last of those roles first.

DR O'MEARA: Yes.

MR GRAY: Were those diversity officers also known as diversity advisers?

DR O'MEARA: Yes. You're using the right term, not me.

MR GRAY: And was the diversity adviser role funded by – I will just use the expression "government"; I'm not certain what the mix of state and federal contribution to the program might have been or might be under the current transition, but let's just say government. Was it a role funded by government to assist the particular service provider which was, what, typically a community organisation?

DR O'MEARA: That's right.

MR GRAY: And to assist it in what way?

DR O'MEARA: So, yes, it was funded by government, so originally by the Victorian Government as part of the Home and Community Care program and co-funded during the transition arrangements from state carriage of that service to the future state where the Commonwealth will have sole responsibility for it.

MR GRAY: Thank you, and the role of the diversity adviser, I think you said they were actually in the community.

DR O'MEARA: Yes, they were.

MR GRAY: So attached to the particular community organisation that had the grant under the program to provide community care services. What were they actually – what was their function in that organisation?

DR O'MEARA: So the first thing to note is that there was, to my understanding, 10 advisers. And that's across the State. So it wasn't the case that every service provider had their own adviser. But it was a capacity to support on an area basis the planning work to be undertaken to understand the community need. So they would work with a number of service providers in a particular area. They would assist those service providers to follow the framework that I mentioned a moment ago. And the first part of that is knowing your community and their needs. So drawing upon data that's available for that purpose. And there's multiple sources of that data to kind of understand the need at a local level which is obviously very variable across the State and then to plan, including jointly to – jointly across different service providers.

So they would be brought together to talk about how they would collectively meet the needs of the diverse population of that geographic area. And so, if you like, it had a kind of proactive capacity to work to prompt a collaborative way of working in place and also to look at the data and work out who might not be accessing services, who might need them. So look at what the kind of – what the gap was between the known population groups of a particular area and those who might be actually accessing services at the time and then tailor approaches to better support those groups, including making them feel safe to approach services.

MR GRAY: Thank you. And just to clarify if I didn't ask a question about this at the outset, when we're talking about the community organisations who had grants presumably under Home and Community Care now in transition as CHSP, the services in question include services to people over 65 years old who are requiring care in the community or even low level, care at home; is that right?

DR O'MEARA: Yes, that's correct. Yes.

MR GRAY: Now, the second of the four roles that I wanted to ask you questions about in particular was access and support – I think you mentioned access and support or access and support officers.

DR O'MEARA: That's right.

MR GRAY: I can't recall the exact expression you used. Could you please tell the Commission what was or what is access and support?

DR O'MEARA: So the access and support function, so performed by access and support officers was in two parts. So the first part, to my understanding, was assisting directly individuals who, for a range of reasons, often because they come from diverse community backgrounds, who were facing barriers to accessing the home care support to which they might be eligible and which was available. So they

had a direct interface with potential clients who were seeking support. And the second part of their role, to my understanding, was system improvement, which was – so that was really working back into government to make sure that at a kind of more systemic level the kind of improvement of the system to better respond to these – to this need at the outset was being met.

MR GRAY: Thank you. With respect to the role of assisting individuals who might be facing barriers, does that include navigation services, that is, putting them in touch with the information that they might require to make decisions about what services might meet their needs and then assisting them to understand that information and possibly linking them with a service?

DR O'MEARA: So again, noting my only high level knowledge of the program, that is my understanding. So I think it was the role – that part of the role of the access and support officer was of a navigation function.

MR GRAY: Thank you. Now, to the best of your knowledge, understanding that you don't have a direct supervisory role in respect of access and support, what's the current status of access and support; is it subject to the transition that you mentioned?

DR O'MEARA: It is subject to the transition. So the positions that I've mentioned across the four different categories are funded until the end of this financial year so to 30 June next year. And so during this period, the Commonwealth, with the lead on the program - - -

MR GRAY: On the program CHSP?

DR O'MEARA: Yes, CHSP, is undertaking some trials of different models of navigation functions and, to my understanding, one of the models that is being considered during that trial phase is akin to the access and support function, which is performed under the Victorian model.

MR GRAY: And is this part of the national navigator trials, do you know?

DR O'MEARA: Yes, that's my understanding.

MR GRAY: All right. And so if there was evidence that had been given to the Commission suggesting that there's, in essence, still trials or pilots running until about mid next year in relation to the navigation trials, does that raise a concern in your mind about whether there's going to be continuity of access and support service provision to the Victorian community by about – at about the middle of next year?

DR O'MEARA: Of course, we would certainly like to see continuity rather than disruption in the service or the benefits that the approach that has been taken in Victoria has, in our view, delivered. So I understand that there are discussions at officials' level between the Commonwealth Department and the Department that I'm

part of, and we certainly have an interest in seeing the navigation model or models which might be put in place by the Commonwealth resolved early in 2020 to such that there wouldn't be any disruption to existing services or benefits.

MR GRAY: All right. Thank you. Now, separate from the transition of those programs that I've been asking you about, there's a methodology that's being rolled out progressively within the Victorian State Government which you speak to in your statement called Designing for Diversity. Is that a correct summary of the gist of what you describe in your statement?

DR O'MEARA: That's right. Look, it's being rolled out, firstly, in the Department of Health and Human Services, so by me and my team. It's certainly shared more broadly across government and is available to others but we're kind of starting with our department.

MR GRAY: Thank you. Now, just before I ask you some questions about what is it - - -

DR O'MEARA: Yes.

MR GRAY: - - - I'm just going to ask you about what's the need for it, what's the status of either government department or a particular human service modality for which a government department has a responsibility that calls for the need to have this framework. And could I ask you to look at what you've said in your statement at page 22, please operator, paragraph 121 might be a good place to start. You've said there needs to be:

...a significant shift in practice by policy makers and service designers. This includes an evolution from a purely population-specific approach to diverse communities towards greater recognition of the variability within groups themselves and of the complex intersectional effects of multiple and compounding factors on outcomes for individuals.

So what's the current state of play that raises the need for Designing for Diversity?

DR O'MEARA: So I think, and this is a more general point, I mean, it's - - -

MR GRAY: It is meant to be a general question. I'm not asking you to comment on any particular department or service provider or service modality, but to address my question at a general level.

DR O'MEARA: Yes. So the first thing I would say, and in part of what we are trying to seek – we're seeking to achieve through is consideration of the needs of diverse communities at the outset of any piece of work. And I think – and so to go back to your question, I think in the past, across many areas of kind of public administration that hasn't always been the case. So I think it's – it has been in the case – it has been the case in the past that policies of all kinds have been developed

without due consideration of the complex needs that people have, and including whether that arises from their backgrounds and elements of diversity. So – and – so that's the first point.

The second point I would make is we know that the health and wellbeing outcomes – so this is to come at it from a Department of Health and Human Services perspective - - -

MR GRAY: Health and wellbeing outcomes, did you say?

DR O'MEARA: Yes, that's right. So, you know, are people well, are they physically healthy, are they mentally healthy, are they safe and secure; these sorts of high level outcomes that are our primary orientation, we know are not – that there's quite variable experiences across different cohorts and the Commission will have heard this in an aged care context but it's true more broadly as well, that particular groups don't fare as well in terms of those type of life outcome measures. And one way that we can go about improving that is by equipping people to consider those needs at the outset on any piece of work that we do, and so that's the kind of the underlying reason for us undertaking this piece of work.

MR GRAY: Thank you. And in paragraph 121 when you talk about a population-specific approach, what do you mean by that? Are you talking about an evolution from a purely population-specific approach?

DR O'MEARA: Yes.

MR GRAY: What do you mean by that?

DR O'MEARA: So, thank you. So what I would say is as we have got better over time and thinking about different needs that I would say the first stage of that was thinking about different population cohorts. So it might have been to have a focus on the needs of culturally and linguistically diverse groups or LGBTIQ groups but – and so what I – I suppose what I'm trying to get at is a kind of a single population group approach without understanding that even within that group there's a kind of a world of diversity. So, you know, what we talk about in terms of this approach is diversity within diversity and acknowledging that.

And so we are trying to go from a view where we kind of view individuals through one frame or – to a much more sophisticated approach which acknowledges that diversity of the lived experience even within what looks like one group.

MR GRAY: Yes. Has that the got a connection with person-centred care?

DR O'MEARA: It does, and so person-centred care is, yes, quite foundational for us as a department. So it's the first of our strategic directions, and we would see the concept which is outlined in my witness statement and which I know has been spoken about in this hearing is intersectionality. So intersectionality is for us this

concept of diversity within diversity. And the idea that an individual may, because of the multiple rather than one strand of their identity, face additional barriers to either accessing services, which are there for them or to participating in community life. And so we see intersectionality as the kind of theoretical underpinning of this initiative and a vital ingredient in making person-centred care effective.

MR GRAY: Thank you. Could we go, please, operator, now to paragraph 60 through to 62 on page 12. We will just leave that on the screen for Dr O'Meara to have access to but I will just ask this question: what is Designing for Diversity, what are its key elements and purposes?

DR O'MEARA: So Designing for Diversity is a set of resources that we developed for our own people within the Department. So the Department is obviously a big organisation. We have lots of people who are doing policy work or service design work across a range of portfolios, be that health or community health, alcohol and other drugs, child protection, family services. So a huge array of services. The purpose of this tool was to equip any of our people who are commencing a piece of reform or significant service design work and with the necessary information and prompts to grapple with the complexity of lived experience and need at the outset of that work. And so I can describe in a little bit more detail what the resources are, if that's more helpful.

MR GRAY: Well, thank you, and you furnished the Royal Commission with lists of the resources. Perhaps we will just ask the operator to display them on the screen as we go. We have got your fourth exhibit which is VIH.0025.0001.0046. If we go to the next page we have the start of that list of resources. And you have also furnished the Royal Commission with the principles, I won't ask them to be displayed, the principles of design and the key elements of design.

DR O'MEARA: Yes.

MR GRAY: If you want to speak to any of those matters, please do so.

DR O'MEARA: Look, briefly, so again going back to the purpose of this. This is not an attempt to provide a kind of a default Diversity Framework. What it is, is a set of resources which give all of the kind of detailed background but they're kind of more core documents which are really the principles, the key elements and the rapid review tool, are a set of resources which prompt people to think about those needs. So it will ask people - - -

MR GRAY: Let's bring that up. It's VIH.0025.0001.0036 please, operator. And the explanatory page is on the next page after that cover sheet, and then the checklist of prompts begins after that. If we go to the next page, that's the rapid review tool and then are these the prompts that you just mentioned?

DR O'MEARA: Yes, that's right. So it's, in effect, looking at different parts of the policy development process that a policy adviser in working within the Department

would go through, and so in this case it's starting with a kind of population and kind of needs analysis. This is framed at a very high level. It is – because it's meant to work across any number of portfolios rather than being specific to a particular type of system. So it's deliberately trying to ask generic but hopefully pertinent questions of the person leading the work so that they can consider at the outset those matters that we think are really important.

And so this is one example and this rapid review tool takes the user through eight or 10, I think, such questions. And then one of the other documents, which is the key elements document, gives kind of some examples of different ways of giving effect to – or different ways of meeting diverse community need in the design.

MR GRAY: VIH.0025.0001.0028, if we go past the cover page, we get to the introductory explanation and then we have a table of key elements described with working examples. So we go then – this is the document you have in mind, Dr O'Meara?

DR O'MEARA: That's right, yes.

MR GRAY: If we go to the next page please, operator we have an example of the way the document works.

DR O'MEARA: So what it's trying to equip someone to do is, you know, if you are working on a reform or design process, here is some of the things that you should have regard to. So in terms of what's the governance of the reform, how are you bringing people together. So members of the community, how are you drawing on expertise in doing that. How are you making sure you hear the breadth of the voices that are essential to hear to make sure that that piece of work is well thought through and well catered to the need, ultimately. And on the right-hand side it's giving some examples. So they're absolutely only examples. What it does illustrate is that it's – and what we're trying to, I suppose, prompt people to consider that it's not only about getting the right people in the room, it can also go to enabling them to participate well as well.

So where you are, for example, engaging people with a disability, making sure that the space that you create and the technology that's available supports their needs so that they can properly participate and contribute their perspective in that design phase.

MR GRAY: In these materials and in your witness statement at paragraph 69(c) you speak of the importance of approaching the design of service provision by way of a co-design methodology.

DR O'MEARA: That's right.

MR GRAY: Can you explain that.

DR O'MEARA: So I mean, fundamentally, that's about designing with people and rather than it being something that's department only driven. So – and there's any number of different ways of doing it in different kind of co-design methodologies. So, I mean, there's kind of formal and fairly traditional ways of doing that through reference groups and advisory groups but also more contemporary design methodologies which involve people in defining the problem that's trying to be solved, and coming up with solutions and kind of testing those solutions through a process to come up with the ultimate kind of design.

MR GRAY: So at least to this extent, is it true to say that it's Victorian Government policy in the area of human services provision for service providers to consider their service delivery model through a co-design approach?

DR O'MEARA: So I mean, I think it's – I think we're heading in that direction, that's absolutely the direction that is set. And I think in certainly all of our more contemporary work that would be the case. And we would expect that that is the case at the service delivery level as well.

MR GRAY: Thank you. I want to ask, finally, about data and data collection and the importance of data.

DR O'MEARA: Yes.

MR GRAY: You've mentioned that topic in your statement. Is it also an element of the Designing for Diversity approach itself; that there should be, in effect, collection of data so that needs can be understood on a continuous longitudinal basis?

DR O'MEARA: Yes, that's absolutely the case. So in equipping, again, our people to design well from the start, that goes to all of the elements which are kind of pretty core aspects of public administration and which allow us to assess whether we are having the impact we intend it to. So that means being clear about what outcomes you are looking for from the outset in terms of health and wellbeing but, more importantly, in the context of the particular initiative collecting the data which will enable you to assess whether that need is – or whether that outcome is being achieved. And that goes, obviously, in the context of diversity, to collecting detailed data on different diverse groups and so being as comprehensive as possible in terms of the data collection, but then also being able to measure by more than one strand of diversity as well.

And, you know, we're getting better as we go and we have some initiatives which are being put in place with this more sophisticated approach which we would see as both good trials, but should they work well the kind of future of data collection and outcomes measurement from our perspective.

MR GRAY: I just want to suggest to you that – I'm not talking about the agencies that you have some responsibility for considering these initiatives over; speaking more generally, I suggest that there's a little bit of a pattern of data being collected if

it happens to be data that relates to billing or other administrative matters or possibly to the preparation of plans for care of individuals. But there doesn't seem to be a deliberate attempt to set out to capture data from the outset about the needs of diverse groups in a way that proper analysis can occur about trends and aggregated phenomena. In designing for diversity, which is a work in progress, I understand, what's the intention; is it that the data capture should be designed from the outset irrespective of whether it's convenient for administrative billing or particular individual needs so that it can give government a picture of developing trends and needs on an aggregated level, or is it something different?-

DR O'MEARA: So yes, I think that would be fair to say. So to come back again to the kind of outcomes framework which is our starting point, as a department that's our kind of core orientation and informs our design process. So – and that's about outcomes for people.

MR GRAY: So even if it isn't necessarily useful for a billing or a funding or a grant quantification purpose it's something that the Victorian Government wishes to cover for future planning purposes, is that - - -

DR O'MEARA: That's right. We would see it as being – and, again in saying that, it's a work in progress and we have to adapt our systems as we go to capture that broader range of data but we see that as essential in being able to assess whether the – whether or not what looks on the surface like good health and wellbeing outcomes are actually shared across a range of groups, including diverse communities.

MR GRAY: Now, you say in your statement that you haven't yet got to the point where Designing for Diversity has been applied in the aged care sector which in Victoria includes quite a number of public sector residential aged care facilities, doesn't it?

DR O'MEARA: That's right yes.

MR GRAY: So I'm not asking about the aged care sector, but with respect to the various human services in relation to which Designing for Diversity has been implemented, you give a number of examples in your statement of some of the services in question. At page 19, under the heading Measuring Outcomes you give an example of data collection and outcomes for children and families; at the foot of the page is where that particular sub-heading appears, Measuring Outcomes.

DR O'MEARA: Yes.

MR GRAY: And I won't read it out to you and you are very familiar with it. But then going over the page, you refer to the compilation of:

...an indicator library to support the consistent, routine collection and analysis of outcomes –

this is in paragraph 107.

DR O'MEARA: Yes.

MR GRAY:

...outcomes data across its service delivery systems.

Can you explain what that work involves and what the function of the indicator library will be in the future?

DR O'MEARA: Yes. Yes, of course. The indicator library is something that will be built over time and will help us collect the information that we need to know whether the outcomes that we've articulated as a department are being met. So, again, it all cascades from kind of the highest level outcomes and then applies in different service contexts. So the kind of structure of the outcomes framework is around outcomes, measures and then indicators. So the measure, there might be an outcome which is around safety of Victorians. The measure might be something like increasing safety and remembering that in our – from our perspective that can apply in a range of different service contexts.

And then the indicator might be where you're collecting data across those different service contexts which we can then pull and use very readily to form a picture about the extent to which we're meeting that intended outcome for particular groups. So the indicator library is kind of like a, for the Department's perspective, like a minimum dataset but that will be built over time and will enable us to very readily draw upon the right data across different systems to form a picture about how people are faring.

MR GRAY: The Commission, on an earlier occasion, has received evidence that in the context of data analytics it's very important to deliberately set out to design data capture from the outset in that way that involves foresight about the way indicators are going to be used in the future. Is this idea connected with the compilation or the development of the indicator library you've just spoken about?

DR O'MEARA: That's right, yes.

MR GRAY: And that paragraph, 107, I take it that isn't limited to the example given about the particular adoption of a more intersectional approach to data collection in the context of children and families. It's a free-standing paragraph relating to the approach that has been taken to data collection across human services more generally; is that right?

DR O'MEARA: That's correct. So that is right. The reference to children and families is because we're effectively in that portfolio undertaking a proof of concept of the approach. So that's current work, and that's informing a broader roll out so it's absolutely the intention to do that across the range of departmental functions.

MR GRAY: Thank you. No further questions, Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Dr O'Meara. Very helpful. Thank you very much. You may go.

<THE WITNESS WITHDREW [11.59 am]

COMMISSIONER PAGONE: Well, you are doing very good speedy work, Mr Gray. Who is next?

MR GRAY: Well, we now may have a hiatus and – no, we've remedied the risk of a hiatus. We have another witness.

COMMISSIONER PAGONE: Is the other witness Ms Drozd?

MR GRAY: Yes, Ms Bergin will now take over, Commissioners. Thank you.

COMMISSIONER PAGONE: Yes, Ms Bergin.

MS BERGIN: I call Elizabeth Drozd.

<ELIZABETH DROZD, AFFIRMED [12.00 pm]

<EXAMINATION BY MS BERGIN

MS BERGIN: May it please the Commission. Your full name is Elizabeth Drozd?

MS DROZD: That's correct.

MS BERGIN: Have you prepared a statement for the Royal Commission, Ms Drozd?

MS DROZD: Yes, I have.

MS BERGIN: And is there a copy of your statement in front of you?

MS DROZD: Yes, there is.

MS BERGIN: Could you verify that it's yours?

MS DROZD: It is mine.

MS BERGIN: Ms Drozd, do you have any amendments to your statement?

MS DROZD: Yes, just a couple of amendments. 61(c): that should read "Chinese-Community Social Services". So – the same words but in a slightly different order. And 61(i) – the Spanish provider is called United.

MS BERGIN: Thank you, Ms Drozd. Apart from those amendments – do you have any other changes to your statement?

MS DROZD: No, I don't.

MS BERGIN: I tender the statement of Elizabeth Drozd dated the 26th of September 2019.

COMMISSIONER PAGONE: Yes. Well, the statement of Elizabeth Drozd dated 26 of September 2019 will be exhibit 10–23.

EXHIBIT #10–23 THE STATEMENT OF ELIZABETH DROZD DATED 26 OF SEPTEMBER 2019

MS BERGIN: Ms Drozd, you are the CEO of the – Australian Multicultural Services Inc.

MS DROZD: That's correct.

MS BERGIN: And you've also served as the Victorian Multicultural Commissioner in 2008 to 2015.

MS DROZD: That's correct.

MS BERGIN: AMCS was established 36 years ago.

MS DROZD: That's correct.

MS BERGIN: And when it was first established, for the first 28 years, AMCS was – had a focus on Polish people; is that right?

MS DROZD: That's right.

MS BERGIN: And then in 2011 AMCS broadened its client base to include people from other CALD groups.

MS DROZD: That's correct.

MS BERGIN: Why did AMCS make that change, Ms Drozd?

MS DROZD: To put it simply: we didn't want to be surprised by the future. The make-up of ethnic communities in Victoria is changing, and the Polish community went down from number 7 in size to number 31, and we felt that we had expertise that we could share and utilise for the benefit of other ethnic communities. So that was the reason.

MS BERGIN: Ms Drozd , during that time in about 2011, were there any other ethno-specific approved providers in aged care?

MS DROZD: It's about the same number like now. Many ethnic communities haven't been able to establish their own specific services. It was easier, to establish ethno-specific services in the 1980s, than it is now, I believe.

MS BERGIN: And why is that?

MS DROZD: There was a particular initiative. A lot of the ethno-specific organisations started in the late 1970s and early 1980s. It reflects the Commonwealth government policy, including providing some funding, and also those communities at the time were larger in size than some of the communities that are now – so it really comes down often to the actual size of a particular community in terms of population but also leadership within those communities. So we were fortunate to be supported by an Italian organisation called Co As It when we were first established.

MS BERGIN: Ms Drozd, could you describe for the Commission the services provided by AMCS.

MS DROZD: So our services have changed over the years; initially our focus was mainly on migrant settlement and also establishing senior support groups et cetera, in the early 1980s. Over the years that has changed, and it's mainly support for ethnic seniors, but also we have an employment assistance program for immigrants who are looking for employment. We have adult community education classes, emergency relief. So the services that we provide for seniors, which is what I would focus on, is a range of – I will use the acronym, CHSP – and also home care packages, which we've been providing since 1993 as well as Community Visitor Scheme, which is slightly outside of CHSP and home care packages; so these are the services that we provide.

MS BERGIN: I read that AMCS also provides by bilingual direct care staff for other providers who have contracts with consumers to provide CHSP services; is that right?

MS DROZD: That's correct.

MS BERGIN: And you run community engagement programs?

MS DROZD: Yes; we do. That's one of our strengths. We believe that it's very important, to engage with ethnic communities to establish trust, rapport and to be there with them, celebrate the important days, to provide information and work in a collaborative and partnership manner.

MS BERGIN: Ms Drozd, you said that the – your client base is quite diverse, and in your statement you explain that approximately 85 per cent of your clients are from a CALD – 95 per cent are from a CALD background.

MS DROZD: That's right; so we are very much inclusive, and we do have clients of Anglo-Celtic background. We are happy to support anybody who would like to be supported by us, but we, certainly, specialise in supporting ethnic seniors.

MS BERGIN: Yes. And approximately 12 per cent of your clients are homeless or at risk of homelessness.

MS DROZD: That's right.

MS BERGIN: So there's – and there would be an intersection between the two groups for example?

MS DROZD: Yes; there is. There is. Migration can include a range of vulnerabilities and challenging situations. So, certainly, they are situations where we may receive a phone call from – I remember, once from a Vietnamese senior in Seddon, who was asked to leave and needed to find a place to sleep that night.

MS BERGIN: Ms Drozd, you say that at AMCS you welcome specific requests for multicultural services.

MS DROZD: Yes. We do. So overall for us as an organisation we really embrace diversity. It's part of our mission. It's who we are as an organisation. For us, there is no such thing as something being too difficult, too challenging when it comes to cultural diversity. So that's really what it's about, and we try to make sure that we employ staff and do everything possible to meet each individual person's needs, depending on what they are, and, of course, each person may have different preferences and particular situations and life experiences that they've had.

MS BERGIN: Yes, and does it make good business sense, to have a focus on multicultural services, for AMCS?

MS DROZD: Yes, it does, although I have to say we wouldn't describe it that way, because we come from a slightly different perspective. For us it's who we are and what we do. It's our purpose. That sort of description would be used mainly by large mainstream organisations or perhaps private organisations, but it, absolutely, makes sense from all sorts of point of view, including from a business perspective, because ethnic communities are aging at a faster rate than the general population, and that reflects the migration waves that we've had to Australia, including the 170,000

displaced persons that came between 1947 and '53 and then also the large migration waves of Italian, Greek, Yugoslav immigrants and others.

MS BERGIN: Yes. So perhaps a better way to describe it is that it makes – it's consistent with AMCS's business values.

MS DROZD: Absolutely. Absolutely. That's right. And part of that is respect diversity and being client-driven and – et cetera. But it's also about doing the right thing and meeting the aged-care quality standards as well.

MS BERGIN: Ms Drozd, you mentioned that part of AMCS's work is to prepare information resources for other providers so that they can respond to CALD-senior needs in a more-appropriate way.

MS DROZD: Yes; it's – we see that as part of our mission, being the voice for ethnic communities, but also utilising our strengths, bilingual, bicultural skills to work in a partnership, because from our perspective we are all in it together.

MS BERGIN: Operator, could you bring up RCD.9999.0204.0001? Ms Drozd, this is an example – as I understand, an example of your work in co-ordination with other organisations and the Department, a multicultural perspective on dementia case studies and community perceptions in the north-west region of Melbourne. Could you tell the Commission whether you've been or your organisation has been involved in training other providers associated with this work?

MS DROZD: So not particularly with this work, but we, certainly, have had a range of initiatives in relation to cultural-awareness training, and we do that regularly. I remember we partnered once with the Russian Arabic community, and we ran RAP, which was Russian Arabic and Polish cultural and language training. In relation to this particular project, we were asked by the State Department of Health and Human Services to develop perspectives about dementia in ethnic communities.

MS BERGIN: Yes. How is this work funded?

MS DROZD: So it was funded – it's – the HACC logo is on the report; so that was the previous name for CHSP. It was funded by the State Department here through their Home and Community Care program – which was the old name at the time.

MS BERGIN: Thank you, Ms Drozd. Now, in your statement, you talk about the barriers that people with diverse experiences can have, accessing – when they try and access aged-care. What are the most common problems and what services are available to address these problems?

MS DROZD: So the first barrier that comes to mind is truly being able to communicate, being able to communicate in English, and we know that migrants who came in the 60s and 70s: they often haven't had the same opportunities to acquire good English. We also know that when people retire, they – opportunities to

speak English also reduces. So let's assume someone retired at 65 and they are 80 years of age now; technically speaking, the only English language sort of speaking opportunities is – may be with their grandchildren. If – they are likely, if they of ethnic background, to participate in ethno-specific activities much more; so that's known as language regression. So information about services is another matter. So communication, being able to express what you need and what you would like: that's one. Number 2 is actually information provision. As I mentioned in my statement, what we also know from the census data is that certain ethnic communities do not use the internet in a significant way, up to 60 per cent, even. So when information is available online – well, that is not information that they can access.

Also often what's needed is support. It's – it can be quite a difficult situation, particularly when crisis occurs, to be able to pick up the phone, know where to ring – and now we have a national system with My Aged Care – to be prepared and answer the questions that are being asked, about 20 questions, to feel comfortable about it but most importantly to express what you need, to answer the questions in a way that will result in access to services that you need.

And if I can give an example – I was – I had an aunty here, and she had difficulty, accessing services. I attended an assessment that she had, and she wasn't going to get the right services, because the question about incontinence wasn't asked, and towards the end of the assessment I did have to step in and correct the situation, because the way she was answering the questions – for example: "So how are you managing with your meals?" "I'm all right. I'm all right." "Do people come and see you?" – and said "Yes, yes; neighbours and friends come". So that can give an impression to an assessor that a person is in fact doing well. But that's not necessarily the case. We have to remember that that generation, particularly, had to – and if they migrated here, they had very limited support services, and they had to rely on themselves. Many of them lived through the war, through six years of war. Some were deported to do slave labour, and so therefore for them, a question – "How are you managing?" – they have to manage, because there's actually no other way.

MS BERGIN: Ms Drozd, was this assessment an assessment by a My Aged Care assessor for a home-care package or some other service?

MS DROZD: It's – no; it was an ACAS assessment, a comprehensive assessment.

MS BERGIN: You mentioned in your statement that one – and you mention now that one-on-one support or face-to-face support is important in addition to client advocacy, and you mentioned the specialised support program-slash-access and support in Victoria; could you please describe what those services relate to?

MS DROZD: I couldn't speak more highly about this initiative, and I – the staff at the department of health and human services here in Victoria really need to be admired for the foresight and initiative that they had few years ago; in recognition that there was significant aged care reforms happening in the aged care sector, they

established what's known as access and support. On My Aged Careare this program is listed as specialised support services, and we are fortunate to have 54 positions based in various organisations. AMCS has equivalent of seven days a week of staff who are the bridge between services and the whole service system for – not just in relation to aged care, because it can be access to housing, if someone is experiencing homelessness, and so it has been the bridge between the services and also people who really may have difficulty, accessing the services, are not ..... family assist them, don't know what they can ask for; they know what they need, usually, but, certainly, it comes down to being able to express that as well.

We've had the program for several years, and one of the things that I've asked our staff as part of preparing to be here today is how many hours it takes on average to on-board a client and link them to My Aged Care, and it's between four and five hours in our case. When I consulted other H – access and support workers – it can vary; it can be 20 hours and in an extreme cases even 55 hours, that was given to me. Clearly that wouldn't happen, necessarily, in one week; it may happen over six months, but if a case is particular complex and if someone has no family at all or there was a family breakdown, that's what can happen. But each of those roles function slightly different, and it's a particular organisation's decision. In our case we aim to assist as many people with access as possible.

MS BERGIN: So what would a typical day in the access and support program worker look like? You mentioned, I think, you have one person on full-time equivalent.

MS DROZD: Yes. Yes. So 70 per cent of that role is spent on one-on-one assistance. So it's actually visiting clients at home, explaining My Aged Care and what's available, contacting My Aged Care, being there with the client, and then any follow-up, if it's needed, any referrals are done by that particular worker. And 30 per cent of that role is spent on community engagement, which means information sessions, and it's bilingual information sessions. So when we visit various ethnic communities and senior groups, we make sure we either have a worker that speaks that language or we organise an interpreter.

MS BERGIN: So if the access and support worker doesn't speak the language of the particular client, they would organise an interpreter?

MS DROZD: Yes, or use one of the colleagues. So we work as a team. That's what great about AMCS. So we have staff who speak many languages, and some staff are more than just bilingual. So we – first and fore-most we tap into that, if it's possible, and otherwise we organise interpreters.

MS BERGIN: So say for example a client's due to have an ACAS assessment in Victoria and they have had assistance from the care worker at AMCS through the access and support program but there's a language barrier; who would fund the interpreter on that scenario?

MS DROZD: We are able to access interpreters as part of the program. So we – organisations that are funded through CHSP: there's a system in place that – we can access that without us having to pay for that; occasionally we do, but there's a system in place that – we are able to tap into that, just the way doctors are able to access interpreters free of charge to them.

MS BERGIN: Yes. I see. So you could access a TIS interpreter to accompany the client through the ACAS assessment; is that right?

MS DROZD: It doesn't mean that it's necessarily TIS; it can be whoever wins the contract in Victoria. That can change. So it used to be VITS, Victorian Interpreting and Translating Service. We are given a code and an organisation that we need to use for that process.

MS BERGIN: I see. So it's part of the support and access-program funding that makes provision for interpreters, not – it's not through the Commonwealth.

MS DROZD: Yes. Not necessarily, from what I know, but we, certainly, also use TIS at times as well.

MS BERGIN: Okay. Thank you, Ms Drozd.

COMMISSIONER BRIGGS: Excuse me; might I also ask – is the support for general practitioners provided through the Victorian government, or is that a common - - -

MS DROZD: No, no; it's a Commonwealth - - -

COMMISSIONER BRIGGS: It's a Commonwealth - - -

MS DROZD: It's a national program; absolutely. It's been in place for few years now.

COMMISSIONER BRIGGS: Thanks. I wasn't familiar with that. Thank you.

MS BERGIN: Which groups is the access and support program primarily directed at?

MS DROZD: It can be directed at any community, but as I mentioned in my statement, there are more than 200 different communities in Victoria. So that can create a bit of a challenge; in our case as a way of prioritising and considering how we can assist ethnic communities the most or what is the biggest impact that we can achieve, we focus particularly on the largest ethnic communities. So it is Italian community – the census data showed that here in Victoria there were 41,000 Italian seniors, 33,000 Greek seniors, and we focus particularly on those communities, inclusive of all, but we aim to employ staff who speak those languages, because that's – the demand is particularly there.

MS BERGIN: Sure. And as to the access and support program – does that only focus on CALD groups, or does it also focus on clients with other diverse needs?

MS DROZD: It focusses on CALD needs.

MS BERGIN: Why do you think it's been so successful from your perspective? You mentioned – correct me, if I'm wrong – that you consider it a great success. Why is that?

MS DROZD: Yes. Absolutely, and I believe – I've worked in the community-services sector and with migrant communities since 1991. I believe it's been successful because it's been designed and it responds directly to identified community needs. So that's why it's successful. It's going to be continue successful; it will be successful across the country, if it was implemented. We are just lucky, that it started here in Victoria and it exists.

MS BERGIN: Yes, and in identifying what the particular needs are – of the community – was research conducted, or has it been more grassroots-driven through having people placed with providers who specialise in CALD services?

MS DROZD: I suspect it was a combination of both. So, clearly, that came – that was initiated by the State Department of Health and Human Services, but that Department has had a long tradition of working very closely in partnership with ethnic providers and multicultural providers.

MS BERGIN: Thank you, Ms Drozd. I'm informed that this program is only available in Victoria. Do you know why that is?

MS DROZD: It is because it was thought of and initiated by the state department here and the staff who work there. But it was also funded by that Department. So it was funded purely by Victoria for the benefit of ethnic senior Victorians.

MS BERGIN: So setting aside that program now for a moment and turning to AMCS's business – what additional navigator services do you provide to your clients? So by that I mean assisting clients to access aged care for example? Is that something you do – other clients?

MS DROZD: So we have the access and support role. But it's not the only person. So staff in those two roles – and it's one full-time, and another person works an additional day. That's not the only thing that we do. I – the approach that we have is that – everybody who has contact with clients: we want them to know how to access My Aged Care and the process of doing that. So we have several co-ordinators of volunteers, and they do referrals for My Aged Care as well. I have done referrals to My Aged Care as a way of testing the system and knowing what it's like, because I started my work as a community development practitioner, and I still believe that the best way to know and to learn is by actually doing. So as – we – as many staff as possible do that, and it's working.

MS BERGIN: Also on the topic of service navigation, you mentioned that you're aware of the navigator trial in your statement and that it has some deficiencies. Could you tell the Commissioners a bit more about that, please?

MS DROZD: So when we heard about this new initiative – and it was unfortunate that the access and support roles were actually not consulted when this idea came up. But when we found out about the organisation that was successful to implement that program, we made contact, and we continue to work with them. We – I understand that there have been some difficulties during the implementation. I am not sure, that navigating the system can work as successfully when it involves volunteers, which is really what it is.

MS BERGIN: And given the importance of communication, are there also limits to the telephone interface that's being used in the navigator trial?

MS DROZD: I imagine there would be all sort of difficulties. You – operating the whole telephone system and My Aged Care can be quite changing for a number of reasons. So it can take a good hour to be on the phone and – particularly when there's an interpreter involved. I do have to say that, whenever I've used My Aged Care and on the basis of what staff say to me, the use of interpreters by My Aged Care is good. It's good. It's not as good on a Saturday; that's understandable, but the My Aged Care staff are really quite consistent in making sure that interpreters are available and used when someone cannot speak English when they contact them, even if there's a family member available and as part of the process they still want to use an interpreter, which is good.

MS BERGIN: I want to come to that topic, perhaps now. You mentioned in your statement that there can be a high cost associated for example, with translating home care package agreements proposed for clients with providers, where the clients from a non-English-speaking background, and you give an example for an agreement – a quote for an agreement to be translated in writing into the Tetum language, which is the national language of East Timor, in addition to Portuguese, and the cost it was $3500 for a single agreement; is that right?

MS DROZD: Yes, yes, because translating is done by the number of words. So that's where the cost come in, and the cost would be similar to other languages as well. It's –that's how it works, and now with the individual funding, the question for providers is who pays. Does this cost come out from a package, which for level 2, that would be a very significant amount, almost a quarter. And particularly at the beginning of the service, which is when the agreement will be needed, that creates quite a challenge. So these are the dilemmas that providers have. And CALD providers particularly or – well, ethno-specific providers – in a way it's a little bit easier, because you will do one agreement, and that will work for 50 Macedonian clients. When it's a multicultural provider or any mainstream provider who pays for that service, we – the Elder Rights Advocacy organisation is saying that the organisation needs to pay for that, but I'm not sure that it's that black and white.

MS BERGIN: So on that example did the client proceed to get a written translation prepared?

MS DROZD: Not on this instance, but what the client has requested in this case is that her monthly statement about income and expenditure or profit and loss for her home care package language – she likes that in the Tetum language, and we have found a way and negotiated an agreement for her, how this information will be received by her. So at the moment it is working.

MS BERGIN: It's working, and do you know off the top of your head what sort of cost is involved for the interpretive work?

MS DROZD: So the way we do it now is that the worker actually goes to the client's home and actually explains the statement. That's how we do it.

MS BERGIN: I see. So it's an oral interpretation. And while the interpreter's there, would the client also be receiving home care package services at the same time?

MS DROZD: No. So we don't use an interpreter in this case. It's actually the care-adviser, that goes to see the client, or it's done over the phone for the statement, because the services can be quite similar. So personal care for example or domestic assistance – it is the same description on the statement every month.

MS BERGIN: I see. Yes. Okay. Thank you. Would it be the case, that some clients that fall into the category that we're talking about now may not have any English – any literacy?

MS DROZD: Absolutely.

MS BERGIN: And do you use interpreters to assist clients who experience that difficult?

MS DROZD: Yes, we do. Our approach – the approach that we prefer is that – we utilise staff as much as possible. So for example we have two Greek-speaking case managers, two Italian-speaking case-managers, and when we recruit for additional roles, we – language spoken is treated as on the same level like qualifications and experience in our case, because that's what clients prefer. So we utilise that level – that option for communication, but we also have, of course, bilingual direct care staff who can also assist with the communication as well.

MS BERGIN: Thank you, Ms Drozd. Ms Drozd, there was a significant wave of East Timorese migrants in the late 90s into Australia, and I'm interested to understand how – whether you've got the care worker that you mentioned who attends with the particular client each month to assist her understand the statement. Is that an employee of AMCS?

MS DROZD: Yes. So we – I suppose so. I haven't checked. We do both. So we have our own staff, but we also broker in; so if we do not have an employee who speaks a particular language or has other attributes and skills or knowledge that a client indicated as their preference, then we broker in from other organisations. But it doesn't mean that a client from a particular community wants actually a worker from – who speaks that language. What we find is that some clients are quite big on an anonymity, privacy and confidentiality. They don't necessarily want – a Filipino senior may not want a Filipino-speaking worker or Tagalog. The same, we have an Italian client who really liked his Polish care worker from the council prior to getting a home care package and his choice was to continue with that worker. So he is paying $60 an hour for that worker to continue with him, which is more expensive than normally it would be, but that was his choice. So that's how we accommodate clients' preferences.

MS BERGIN: Ms Drozd, what solutions do you offer clients such as the East Timorese person that you mentioned who may be struggling to understand the terms of the agreements available as they go through the process of selecting a home care provider.

MS DROZD: So we look for solutions for practical solutions. We are transparent and honest in our communication. We do that right at the beginning when an initial client inquiry comes – comes through. If we are not able to meet a particular client's needs we say so because in the end it's not going to work for – for that person and for us as well. Clearly, we want to provide services in a way that actually – that results in client satisfaction, otherwise it's just not a good arrangement. So we are transparent and then we communicate and negotiate and look for satisfaction – mutual satisfaction arrangement so I know with that client everything is working the way we have communicated and – yes.

MS BERGIN: Thank you, Ms Drozd. Now, turning to the topic of workforce, you mention in your statement that some of your staff have a migrant experience and can relate to challenges and barriers and, at times, financial and severe economic hardship, trauma, war experience and know firsthand what it means to live in a country where you don't speak the first language. Can these skills be trained in a workforce?

MS DROZD: I believe they can. We also employ Anglo-Celtic Australians. You know, we employ people who identify as being gay or lesbian. And over the years I have observed that if someone is willing to learn, is interested and has empathy for another human being, is able to get a deep level of understanding what it may be like for someone who doesn't speak English or someone who experienced trauma or lived through a migration experience. And migration has a price; it's often associated with uprooting and leaving what you know and what you are familiar with and living in an environment and sometimes migration is actually not by choice.

There are couples where perhaps the husband wanted to come and the wife didn't but in the end a decision has to be made and has been made. So I see the benefit of our

staff having that experience, absolutely. I think it's an additional value-adding. It helps in being able to understand ethic seniors much more even if they come from another culture. Just knowing what it's like, it means a lot and people sense that and they know that.

MS BERGIN: Yes. You mention the value "empathy". Is that a value that you look for in recruiting workers to AMCS?

MS DROZD: Absolutely. Absolutely. So non-judgmental, quick learner. They – it's – I think being – I believe that being a care worker is quite challenging. It's because of consumer-directed care and the focus on client choosing, I am not always comfortable with us changing workers on the basis of clients' preferences to the extent that is requested. So if I can give an example. A worker who was trained as a psychologist overseas, she – her English is limited, so she is not able to work in her profession. She works as a care worker. She was vacuuming at a client's home. It was a hot day. She came to the kitchen and wetted her face, and the client got very upset that this happened in her kitchen sink, not the bathroom. And she asked for that worker to never come again.

I find that – I am, as a professional, someone who manages an organisation, that supports ethnic seniors, I think it's a matter of balance between rights, and including rights of the workers. I don't believe our balance is right, not just AMCS but overall as an industry, the casualisation of the workforce. It is – I cannot think of any other profession where you come to work and you don't know what hours you will work a particular week. That may change because the client, you know, just maybe finds it difficult to get on with you or has a different preference. I believe that in terms of workforce, which is what you asked for, I think the whole issue of casualisation is a big issue and but also getting the right balance between fairness for all concerned.

MS BERGIN: Thank you, Ms Drozd. You mention in your statement that at AMCS you don't use the expression "culturally safe". That's a term used in the Aged Care Quality Standards and I wanted to ask you what terms you prefer and why you prefer not to use the expression "culturally safe".

MS DROZD: So I think culturally is the rather new expression that is now part of the new Aged Care Quality Standards and clearly we will use it in official correspondence and when we have an audit and we provide our evidence and self-assessment, that is the expression that we use. But in our day-to-day language in meetings, et cetera, with staff we continue to use something that's a bit more descriptive, like culturally responsive, responsive, culturally appropriate, so that's where we're coming from. Perhaps we will start using it in a greater sense but at the moment we certainly don't and that's the reality, but we clearly know what that means.

It's about people feeling safe to ask for – for what they need and what they would like. It's part of their sort of not being concerned and worried that if you make a

complaint, there may be retribution. You know, it is describing the Aged Care Quality Standards.

MS BERGIN: Yes, I appreciate that you understand what it means. The word "safe" can also sometimes imply some sort of risk, and I was wondering is "culturally safe" an expression that doesn't translate well in some languages?

MS DROZD: Absolutely. And I know for migrants, I've worked with ethnic seniors for 28 years and I wouldn't use the word "safe", "cultural safety". This would be clearly – this is a bureaucratic jargon that we have and – but the word "safe", the first thing that comes to my mind, am I not safe and will I not be safe. We also have to remember that Australia had a White Australia Policy and it was not safe for people to be migrants of ethnic backgrounds at the time. They did not feel – well, they were – yes, the policy was such where people didn't feel included and treated equally and have access to the same opportunities as others had. So I will continue to use it but very carefully.

MS BERGIN: Yes, thank you, Ms Drozd. We discussed at the start of your evidence, the concept of AMCSs business model of care and business values, and I wanted to circle back to that now that I am coming to the end of your examination and ask you is it your view that diversity should be part of business as usual for providers across the board?

MS DROZD: Absolutely. Absolutely. I hope that as part of this continuous improvement, as part of the hearings of the Royal Commission and efforts to – for things to improve and change, I mean, clearly, we are having a Royal Commission because there's a reason for that, and more than one reason. I hope that CALD seniors and people from – with other special needs as well, in the case of AMCS this is what we focus on particularly, is that people will feel included, heard, that their needs and preferences will be met or certainly providers at least will try their utmost to do that. It is not always possible. The reality is there's a shortage of staff, particularly with certain languages.

There are other challenges but I think as long as all of us try to do whatever we can to make a difference and practical difference and to respond to people's needs and their particular preferences, things should work much better. But diversity, it's something that's very important because that will continue for at least another 10, 20 years and even further because the Chinese community in Victoria is now the second largest ethnic community in Victoria, and probably Australia. And the Indian community has doubled in size in Victoria in five years. That's extraordinary.

MS BERGIN: And given those sorts of numbers, can other providers learn to develop to provide care and to train their staff to provide care in a way that's culturally appropriate?

MS DROZD: They can and I hope they will. Clearly, it comes down to commitment. Communication, cultural awareness, so commitment for me is the

start. Commitment from management, from boards. I think wonder in terms of solutions perhaps there should be ongoing professional development made as a requirement for boards and for management. We don't have that at the moment. Other professions have ongoing professional development. It would make a difference if boards and management had actually ongoing professional development about cultural diversity as a requirement. Not all providers reflect – for example, their boards reflect the diversity of the population that they serve.

MS BERGIN: Yes. And is composition of a provider's board also important?

MS DROZD: Yes, it is because it is boards that develop and approve strategic plans for organisations. It is boards that approve budgets. So it certainly starts at that level as well. And it's very important that it's not done in a tokenistic way but reflect the true commitment and wanting to make a difference.

MS BERGIN: Thank you very much, Ms Drozd. Commissioners, that concludes my examination of this witness.

COMMISSIONER PAGONE: Thank you, Ms Drozd. That has been very helpful indeed.

MS DROZD: Thank you.

COMMISSIONER PAGONE: You are free to go.

<THE WITNESS WITHDREW [12.41 pm]

MS BERGIN: Would this be an opportune time to have a lunch break, Commissioners?

COMMISSIONER PAGONE: It would. Now, the next witness you had planned for quarter to 3.

MS BERGIN: Yes. Just let me check with my instructor. Yes, we can call Mr Panter at 2 o'clock after the luncheon break.

COMMISSIONER PAGONE: All right. In that case, we will adjourn until 2 o'clock.

ADJOURNED [12.42 pm]

RESUMED [2.02 pm]

COMMISSIONER PAGONE: Yes.

MS BERGIN: I call David Colin Panter.

<DAVID COLIN PANTER, AFFIRMED [2.03 pm]

<EXAMINATION BY MS BERGIN

COMMISSIONER PAGONE: Yes, Ms Bergin.

MS BERGIN: Mr Panter, have you prepared a statement for the Royal Commission?

MR PANTER: I have.

MS BERGIN: And is there a copy of your statement there in front of you?

MR PANTER: There is.

MS BERGIN: Do you have any amendments to your statement?

MR PANTER: No.

MS BERGIN: Is it true and correct to the best of your information and belief?

MR PANTER: It is.

MS BERGIN: I tender the statement of David Colin Panter dated 26 September 2019.

COMMISSIONER PAGONE: Yes, the witness statement of Mr David Panter dated 26 September 2019 will be exhibit 10-24.

EXHIBIT #10-24 WITNESS STATEMENT OF MR DAVID PANTER DATED 26/09/2019 (WIT.0448.0001.0001)

MS BERGIN: Mr Panter, you're the CEO of ECH Incorporated.

MR PANTER: Correct.

MS BERGIN: And ECH is a non-denominational not-for-profit organisation established in 1964.

MR PANTER: Yes.

MS BERGIN: You also have some other roles in the aged care sector; could you describe those for the Commissioners?

MR PANTER: I'm the elected board director for South Australia and Northern Territory to the board of Leading AgedServices Australia, one of the peak bodies. I'm also the chair of the South Australian Council of Social Service, and through that elected board director to the Australian – to the board of the Australian Council of Social Service.

MS BERGIN: Mr Panter, you have 40 years' experience in health and social care in both the UK and Australia.

MR PANTER: That's correct.

MS BERGIN: And could you please describe ECHs business both before and after 2014.

MR PANTER: Yes. So ECH was created back in 1964 as a provider of housing to war widows and over 50 years it grew into the large sort of aged care provider providing independent living housing or retirement village housing as well as home care and wellness services and residential aged care, and by 2014 it had 11 residential aged care facilities so with 1200 licensed beds and at that point it was the biggest provider of such a service to the State of South Australia. But at that same time the board made a strategic decision to move away from residential aged care to sell that part of the business and to refocus itself on providing housing and home care to older South Australians.

MS BERGIN: Why did the board decide to sell its residential care business?

MR PANTER: I think there were a couple of factors. This was just before my arrival; it led to my arrival to take the organisation forward on the next step of its journey, but there's a couple of reasons. One was the increasing issues around compliance and particularly around the capital upkeep of those facilities and the ability to raise capital investment to invest to keep them updated. But the overwhelming view and reason was around recognising that older people themselves increasingly were voting with their feet and wanting to stay at home. And given that we had such a strong housing base, given that we provided houses for over 50-odd years, we have got almost 2000 housing units now across South Australia, that we should focus on expanding that enabling people to have a home in the community as they age but increasingly providing home care services to people in their traditional homes.

MS BERGIN: And your recruitment was part of the strategic - part of the implementation of the strategic decision by the board to move more specifically into home care; is that right?

MR PANTER: That's correct. I mean, I think the - as with many aged care organisations, they're content to be - I wouldn't say stagnation, but a lack of movement in the leadership. So within ECH I'm the third chief executive in 55 years; the first was there for over 30 and my predecessor there for almost sort of 20, and then I've been there for four and a half. The board decided - and it was appropriate for my predecessor to leave at that point and to bring in somebody new who had perhaps a broader range of experience around housing and home care, and to transform the organisation and it has been a real privilege to be given that mandate by the board to modernise and transform an organisation exactly as we have been doing.

MS BERGIN: Mr Panter, how significant was the sale of the residential care business to the innovation work that you had been asked to do?

MR PANTER: It was critical because both in terms of freeing up sort of management capacity and board capacity to do the strategic thinking because, again, that compliance regime around residential aged care can actually take a huge amount of energy and time within organisations and become the dominating focus, no matter what the intent is to innovate, but it also created the capital to be able to invest in innovation. And so we've been able to use the funds from the sale of the residential aged care facility business to invest that and to use the return from that investment to be able to fund a whole range of innovation not just in the way in which we are responding to the diverse needs of the community but into technology companies, into different styles of housing, for different types of groups in the community as they age.

MS BERGIN: Could you give the Commissioners an example of the work that the sale - the innovation work that the sale funded?

MR PANTER: Well, so, for example, in terms of our housing, we have been able to think very differently about the type of housing we provide and respond more appropriately to the changing needs of older people by - we were an organisation that largely had housing which was on a retirement village model where you bought into that housing and had very little rental. We now have 30 per cent of our housing rented because we have responded to the growing need in housing stress amongst older people, particularly older women, to be able to provide them with an affordable rental accommodation as an alternative to the private rental sector.

But our work that we are doing in technology – so we have a significant – we've been able to use some of those funds to buy a significant share in a small tech company, developing a home monitoring system called Billy care, which is a great example of how we are able to extend our service in enabling people to carry on living independently in their own homes longer.

MS BERGIN: How have care recipients responded to the use of technology in the home?

MR PANTER: It has been really positive. I mean, I think if people can see that it has a real benefit and that's both the individual care recipient, the older person themselves, but also the family. And that's what we love about Billy, is that through an app it gives family confidence that their mum, their dad is doing okay at home. It's also non-intrusive; it doesn't have a camera. It works on movement sensors. But from the older themselves that are using it, the feedback that is coming back to us now, is they were a bit au fait - didn't really necessarily want to have it. They could see it was going to have some benefit for their family.

But what it's really done and what they keep saying to us it's stopped all the nagging phone calls because their son or daughter can now see that they're up, they're out and about, they've had their breakfast today, et cetera, by looking at the app and therefore the conversations that they're having now with their children and family are back to where they should be, around the quality of life, around what's happening in people's lives, not checking up whether somebody has done something.

MS BERGIN: So you mentioned that the Billy app doesn't use cameras. How can residents see that - sorry how can family members see that residents, their mums or dads are up for the day, for example?

MR PANTER: It's just using – so it uses motion sensors which detect movement around the home and by attaching those to a magnet we can see whether a door is opened or the fridge door is opened, the pill box is opened, and that information is collected and gets fed into – through an app. So from a family member's perspective they can look at their app and they can see, okay, Mum has had her breakfast between 8 and 9; that's a green tick. That task has been done. So it uses that movement information to translate it into information that people can then look at readily any time they wish to on their app. And they can also look at patterns as well.

So – and from a provider perspective that's what we are very keen to look at is, for example, not necessarily whether somebody has been to the toilet twice a night but whether or not their toilet behaviour has changed significantly, because if suddenly they're going to the toilet more that's probably a good indication that they may have a urinary tract infection which we know left unchecked could result in a fall. So as soon as we see the change in the toileting behaviour, we can check that they have or haven't got a urinary tract infection and prevent a potential fall.

MS BERGIN: So does ECH have staff actively monitoring the data through the Billy app?

MR PANTER: That's correct, yes. And our - our care managers who look after home care packages have access to that information for any of their clients that are using that system.

MS BERGIN: So five years down the track, I think it must be since the sale of the residential care business, how does ECH regard that strategic decision at the moment? How is it going?

MR PANTER: I think my board is incredibly pleased, I think they're seeing the sort of changes that they hoped we would see as an organisation. We have been able through focusing on our sort of home care activity to grow that part of the business and also within the way in which we market that, we can be incredibly authentic in terms of, you know, we have no - if there is any vested interest in somebody going into residential aged care, we don't have that because we don't provide that service. And so it's really liberated us to be able to focus on what we are now about, which is essentially to enable people to stay living at home independently for as long as they wish and, increasingly, if they choose, to have a good and respectful death at home. And we enabled about 300 people last year to have a good and respectful death at home.

MS BERGIN: And is that through use of palliative care services in home care packages or a range of things?

MR PANTER: It's through a range of – actually some - within the home care package some with more complex needs require specialist palliative nursing and we can bring that in from partnership organisations like the RDNS where required, but we have some of that skill within house, and we're growing that skill.

MS BERGIN: Say a home care client - you identify or the client identifies or their family member identifies a possibility that they may need to enter residential care. How is that regarded?

MR PANTER: So I mean, if – essentially, from our sort of perspective, if somebody leaves one of our home care packages to go into residential care we sort of treat it as a failure on our part. We are not denying their right to be able to go to residential care; it's about what can we learn from that. Were there things that we could have offered as a service. Were there things we could have done differently that would have avoided that decision having been made, and through that process, we have been be able to identify a number of factors which we think are a key catalyst, if you like, for people entering residential aged care either earlier than they ideally wanted to or they didn't want to and they've ended up there.

And so for example, number 1 in that list at the moment is carer stress, and it's due to the large numbers of people on the national prioritisation list for home-care packages and families desperately trying to keep mum or dad at home and then it all just becoming too much. After that it's access to a GP for very simple things like a medication review. That's what led us to innovate by actually getting a GP in our own employment who can actually undertake some of those medication reviews. And at the moment we're very pleased. We – from the data we've got and when you look at the national data – about 45 per cent of people in a home-care package eventually end up in residential aged-care. Our current equivalent figure is around

15 per cent, 15. So we believe the sorts of actions and the learnings we're making to carry on supporting people at home are working, and we'll continue to work at that.

MS BERGIN: You mentioned the queue for home-care packages. Has that had a noticeable impact on your opportunity to grow at ECH?

MR PANTER: Absolutely; it has. We know that – we've currently got around about 170 people on our – in our care who are waiting for a home care package and are surviving at the moment on the Commonwealth Home Support Program. Unfortunately the more of the Commonwealth Home Support Program that gets consumed by people waiting for packages, the less availability there is in that program for people who have the low level needs that it was originally intended to. And that has an impact on some of the diversity work we're doing and the services we can provide.

So, certainly, they're not growing as quickly, and also – and this is a South Australian perspective, but we're a South Australian provider; in the old system, before consumer-directed care, a formula was used to allocate packages relative to the number of population over 70 per thousand. And under that basis, South Australia would've got a higher percentage than its straight population share because of the more-aged nature of that population. That approach no longer exists, and so – under old formula we would've got around – as a state about 11 per cent of the available packages compared to being eight per cent of the population generally. But in the current model, where that factor isn't in play, South Australia, I think, on the last quarter report was – just under seven per cent of available packages were coming to South Australia. So we feel that there's less packages than should come to South – coming to South Australia, but, equally, people generally are frustrated; they've not got the packages. That impacts on our business.

COMMISSIONER BRIGGS: Can I just unpack that a little bit and try and understand it. Is it, in moving to the national-prioritisation system, that South Australia might've been provided previously, loosely, according to its said need but, because we've got a national system now, it's firstly going to the needs of those with a higher priority nation-wide and then it comes down lower to state or regionally based packages?

MR PANTER: That's correct. In the old world, the allocations were to the providers – so there was greater ability to control how many packages – whereas now, as you say, it's individual need, which then depends upon the different ACAT services in each jurisdiction, using the same benchmarks, the same approaches and assuming that that's a level playing field.

COMMISSIONER BRIGGS: Yes.

MR PANTER: And I think in reality, certainly, from a South Australian perspective, it doesn't feel that – feels, we're getting less packages than we actually need – of the ones that are available.

COMMISSIONER BRIGGS: Well, I think that's clear nation-wide. Yes.

MS BERGIN: Thank you, commissioner. Mr Panter, I want to ask you now about the work that has been done under your leadership on ECH's diversity statement. Operator, could you please bring up tender bundle 114? This is the ECH diversity statement?

MR PANTER: It is; yes.

MS BERGIN: Now, I notice that – a couple of things about it. One is that it's much broader than the concept of special needs in the Act or in the diversity framework.

MR PANTER: That's correct. And that goes back to when we were looking at how best to enable the organisation to develop and grow and move forward. We went back to an approach which was very much taking all our key policies and redeveloping those in the context of a human-rights perspective. And so that human-rights perspective now pervades all that we do, and our diversity and the whole issue of self-determination sits within that broader context of our human-rights approach.

MS BERGIN: And it says that the diversity extends to an array of knowledge, world views, skills and perspectives.

MR PANTER: Absolutely.

MS BERGIN: How is the diversity statement applied in ECH's business?

MR PANTER: So it's used both in terms of the internal workings – so the example that you have on display here is a poster that's across all of our sites to remind staff and our service-users what we're about in terms of diversity and our inclusive approach. But it's also used to guide our activities in terms of – when we're thinking strategically about a new issue, how do we ensure we are inclusive. If we're thinking about design in a new service – how do we do that; if we are doing advocacy work, where is the focus that we should be placing. And in some ways the example I've already given about the shift in our housing from, largely, being buying into to increasing amount of rental was again informed by this approach, because we could see in terms of social disadvantage and particularly amongst that group of older women that there were issues there that we should be trying to ensure our services were inclusive to, and having a rental option was an important part of that.

MS BERGIN: How is the diversity statement connected, if it's connected at all, to the Commonwealth's diversity frame-work?

MR PANTER: I wouldn't say there's a direct connection other than the word "diversity", and I understand and, clearly, am aware of the diversity frame-work and know many of the team involved in that. And, certainly, this takes that and translates it into practice on the ground.

MS BERGIN: So is this really saying that diversity should be business as usual?

MR PANTER: Absolutely. It's – to my mind, you cannot talk about person-centred care without talking about diversity, because person-centred care for me within that human-rights context is about starting where the individual person is, and that means looking at their unique history. And that takes you straight to diversity.

MS BERGIN: How much cultural change was required around that time, 2015, when the statement was rolled out?

MR PANTER: I think it has – certainly, has been a journey, and it's taken a lot of effort and consistent effort. For my mind diversity is not something you can play with or is a nice frilly add-on. It's got to be core to the business, and it has to inform the way in which you do your core business. So, for us, that's just as much about what happens in our recruitment process for staff, our induction for staff, how we advertise our services to the community, how we guide the way in which we practise in our day-to-day delivery of a service. All is part of the diversity frame-work.

And I think it's also again – and shouldn't need to say this, but I think I will, because I think it's important to recognise, and it is in my statement – that I am very much and have been since I was 15 an openly gay man, for whatever that means. And so we also had to be really clear as part of this journey that we're on – that this in ECH has not been about my personal mission as a gay man who happens to be the chief executive. This is about the business, and this is about the Board, and it's my Board, that's led this process, and the Board, that makes key strategic decisions about things like whether we should go for the Rainbow Tick accreditation process, whether we should be focussing on particular activities. So it's a Board decision. I clearly provide information on a whole range of things to the Board as – along with the rest of my exec team and indeed our other stake-holders, including our consumers. But the Board make the decision. So I just don't want to get anybody to get away with the idea of thinking that somehow, well, ECH has done this because the chief exec is gay and the chief exec always gets his way. It's not the case.

MS BERGIN: Thank you for clarifying that, although I haven't heard anyone suggesting that and wasn't trying to suggest that myself.

MR PANTER: No, no.

MS BERGIN: What challenges has ECH experienced in embracing diversity as usual?

MR PANTER: I think it's been about that issue of authenticity. It's been about how do you actually make sure that it's something you're not paying lip service to, and therefore you do have to put the time and the energy in terms of the staff into training and development. There's no reason to believe that our workforce is any different to the wider community; they will come with their own views, values et cetera et cetera. And it's our responsibility as their employer, to help them look at what being

inclusive means, what diversity is about. And so that does take time and energy and resource, to actually make sure that we're providing the support to our staff. And so that can be a challenge. But also, it's where we are looking at – I suppose this is relevant to my last statement, that when we get some of the criticism or we get concerns raised either by our staff or, indeed, by our clients – that we respond appropriately.

So for example: when we – when the country was going through the process of the same-sex marriage postal survey, ECH took a very clear position, that it was in favour of marriage equality. And the Board asked me to communicate that to all of our service-users and all of our staff. And so I wrote to all 15,000 of our service-users, saying that we believed this was a very important issue, this is why and this is why it was important to older members of the LGBTI community and that we weren't clearly telling them whether they should go "yes" or "no" in the survey but we, certainly, wanted them to participate and encouraged them to do so.

We had a staff member who self-identified as a born-again Christian, whatever that might be determined to be, who produced a pack of information, of the letter, of posters, of various things and graffitied across them all and sent that pack to every one of my Board members, saying "Did you know what your chief executive is doing? He's a sinner; he's promoting homosexuality et cetera et cetera". Now, my Board dealt with that and could deal with it because of our diversity statement and because they had made the decision, not – it wasn't my personal campaign. And that staff member after being counselled made the decision for themselves that they could not be part and could no longer work for us because of the views that we were taking being incompatible with their particular values. And so we had to say "Farewell" to that member of staff.

Likewise we've had examples with our service clients, where – if a service-user exhibits racism or homophobia, then we will talk and work with that individual to help them – us understand what their position is and then for us to provide them with information and support. But if at the end of the day they still say, "Sorry; we are not prepared to accept a staff member from you who happens to be gay or happens to be African", then we've – will say that we won't provide a service and will help you provide – find another provider. And we've done that on two or three occasions. So again that's the sort of the tough end of the challenge if you like, that – diversity and having a diversity statement isn't just all the nice fluffy stuff. It's actually having a real edge to that, because that is the only way, I believe, that communities, those people in those particular communities, be it the CALD communities, Aboriginal, LGBTI, know that you're real and mean what you say.

MS BERGIN: So is it partly about trust, Mr Panter?

MR PANTER: I think trust is key. I think people have to be able to trust an organisation when it says that it's inclusive and will – our advertising tagline is "Stay who you are, where you are".

MS BERGIN: Now, I'm conscious in having this conversation that there's a definition of "special needs" in the Act and you critique it and say that it's not helpful, to use badges, because that can compartmentalise people, and someone may identify with the number of the attributes. So I want to be conscious of that in asking you this question, which is "How are older people stereotyped as they age in your experience?".

MR PANTER: I think that older people, generally, in my view, tend to be infantilised as they get older, and we take away from them decision-making powers and the notion of being able to take responsibility. And therefore people often don't get to live the life that they want to lead and end up with something which is not what they want. And so that for me is my overriding observation, and that then plays out within individuals, within families, within certain circumstances around what that means for how decisions are made about whether somebody for example can stay at home.

There's a lot of mythology out there about – somebody with dementia can't carry on, living at home alone. In reality we support a number of people with dementia. It very much depends on their circumstances, where they're at in their particular journey with dementia and how we can best support it, and that's where something like Billy comes into play. So there are things we can do. So I think we have an overriding stereotype and then we also tend to think that people, as they got older perhaps become more fixed in their ways. And that's why I think it's particularly true in the case of the diversity question where a lot of providers I've spoken to about the work that we do say, well, how do you deal with that? Don't your normal residents, clients, care recipients, don't they get worried, don't they complain about it?

And I have to say we've certainly not found that the case at all and, indeed, it was encouraging that when we sent out the letter for the - around the same-sex postal survey, we got overwhelmed with emails and letters from a whole variety of our service users saying how wonderful it was that we were taking that stand. So, again, I don't think we can afford to say that as people get older they get more fixed in their ways and are more prejudiced against certain sections of the community.

MS BERGIN: Thank you, Mr Panter. Now, I want to move to the topic of navigation and access and ask you how ECH supports clients to navigate aged care services and what role do cultural ambassadors, for example, play.

MR PANTER: Yes. So, again, I think it's not surprising that many people comment on how difficult it is to find your way through the My Aged Care system. And certainly what we find and, again, I think this is common with a number of providers, is that the most likely advocate for somebody in going through the system is an older daughter. Sometimes an older son but usually in our experience an older daughter. And so if I then take the example of the older LGBTI community, a gay man of 80, for example, increasingly is unlikely to actually have any children or may

have had children but then lost contact with them because of them coming out later in life or whatever.

And so when we did our co-design work with older members of the LGBTI community this issue of navigation and finding your way through the system came up as a really big issue. And so we worked with the community to come up with a service response which is our LGBTI Connect service. And so, essentially, what that means is that we now employ on a part-time basis, currently two older lesbians, two older gay men and an older transwoman, and they act as those ambassadors, those navigators. They're the face of ECH out in the LGBTI community that people can approach to help find their way through the system.

And we launched that service a year ago and it has been incredibly popular and particularly, I think the key was also for us in understanding which, again, is perhaps not necessarily understood; that for the older LGBTI community, then services generally may not be accessible but also how you actually communicate with a group that is not necessarily confident in their own identities. And particularly in an environment – and, again, in South Australia now there is no dedicated LGBTI newspaper or magazine, there's no dedicated venues, so there's no obvious place. So when we launched LGBTI Connect we decided, and the board made this decisions, that we would just have to advertise in the mainstream.

And we - we literally had our connectors' portraits, you know, bigger than life size, on the sides of buses and trams around Adelaide, during the Feast Festival which is the main, sort of the Mardi Gras version for South Australia, and full page adverts in the local News Corp paper, The Advertiser, advertising the service because it was the only way we could approach that group. And so – and we found that it has been successful, that people have found those individuals and those individuals now help people get into the system. Our frustration is, having done all that, we are then not able to necessarily – and we found that those people need a service at that lower level in terms of the Commonwealth Home Support Program, then what we found is that we often cannot then provide a service because we are fully booked in those services in the current CHSP model of the block funding.

And because the consumers don't have a say and can't direct the funds for that component of their service, then we can't provide them with a service if we are fully booked. And so we have had situations where we have got, say, an older gay man at the point where they're happy to receive a service and wish to have that from us but we have not been able to provide it and despite being able to provide access to another provider, they won't necessarily go to the other provider because that other provider cannot guarantee or the individual doesn't feel confident that they are going to be inclusive and respect them in the same way that we would if we were providing the service, but we really struggle with that.

MS BERGIN: So with services such as the LGBTI Connect initiative or other services provided through the diversity vision that ECH has, how do you resource extra services?

MR PANTER: So I mean, I think the extra services that we provide tend to be around the social connection because we understand at ECH that the glue in actually helping somebody carry on staying at home for as long as they wish to, in addition to the service is the social connection. It's how do people – how are they connected, and often it's good old-fashioned neighbourliness that has often evaporated in today's landscape. We know that from our own housing that where people benefit is just from having that sense of somebody being able to pop in. There's a knock on the door; if they don't come one day they'll check they're okay. They can see people out and about doing things around their units and go out and have a chat.

So we use some of our, if you like, our returns from our investments not just in innovation but in a benevolent role to create opportunities. And within the LGBTI space, for example, we provide a range of different activities, be they bus trips, outings. We have participated in organising dinners and lunches, social events that enable these people who are often isolated in their own homes to reconnect. And, again, I think it's really important to just reflect on the nature of how somebody may find themselves; you know, I can think of a 93-year old gay man who has no family at all for a whole variety of reasons. And the only living relative they're in contact with is a niece in another capital city in another State.

They had a partner for 50 years. They died. And all of their peers have died, and so they're completely alone. And with no communication, newspaper, no venues; even if they have the confidence to go and actually use something like that, it's very difficult. So we found the social connection work and for that individual getting them involved in outings, getting them involved in events. You know, we've got a Feast Festival coming up in the beginning of November. ECH will have a very large contingent in the pride parade on the Saturday evening, one of the opening events. Last year we had about 70 people, some staff, but a large number of our older service users from the LGBTI community marching with us. And those sort of events help people to connect and they connect then outside of that event and get that social connection, which is just so vital to enable somebody to carry on living independently at home.

MS BERGIN: And is providing social connection then one of the ways that the aged care system can respond to diversity?

MR PANTER: I think - absolutely. I think – again, it's - the aged care sector is good at thinking about social connection and we are beginning to think more broadly around intergenerational. Obviously the work, you know, sort of currently in vogue around young people, preschool kids and older people, but you've got to think about that in diversity as well, and whether that's the CALD communities, whether it's the Aboriginal communities or the LGBTI.

MS BERGIN: You mention at paragraph 10 that the current aged care system does not prevent innovation in responding to diverse needs, but equally it does not incentivise it. How can thought leadership in the aged care system be incentivised and better respond to diverse needs? It's a big question, Mr Panter.

MR PANTER: Yes. And I think it's about – so certainly, for providers who wish to innovate, they can do that. My view is that they're not overtly encouraged. It goes back a bit to where we started in the description with ECH that when you're an organisation where all your business, if not the main part of it, is residential aged care and there's such a focus on that, then it's really difficult to lift your head up, potentially, and to think about some alternatives and think about other things. So I think that there are a range of providers who have been able to do that and who are able to create some space to think differently.

But as I say, it's not necessarily encouraged in the way in which we then pick those up and share those across the sector as a whole. And, again, I've made reference in the statement to the better practice program, which is a Commonwealth-funded program to try and share good practice and we were a recipient in that recent process for our LGBTI Connect service. But I don't really get any sense of how those things are really lifted and celebrated and then others are encouraged to adopt. And so I think it's about how you incentivise within a system providers who might be time poor, might be focused on a whole range of other things, how do you encourage them to adopt good practice from elsewhere that has been proven?

MS BERGIN: Should it be from the bottom up, so led by providers and by their staff and care recipients?

MR PANTER: I think that there's a big element of that and I think there are opportunities that can be used to do that. So, you know, we're in conferences – and at the moment, I mean, it's the Aged Care Services Australia conference happening now. It's the LASA conference at the end of the month. That's an opportunity for the industry to share good practice and to – but you've actually got to get to the conference. And again, if you're focused on the running of the business and that's dominating your time, it's sometimes difficult to step out. And then when you look at things like the accreditation regime, nobody is going to necessarily get a black mark for not innovating compared to other things. So, again, it informs how organisations' chief executives, boards spend their time and what they focus on. So there could be more encouragement, more incentive to adopt better practice from elsewhere.

MS BERGIN: Operator, could you please bring up tender bundle 102. I read in your statement, Mr Panter, that ECH decided to undertake the Rainbow Tick accreditation.

MR PANTER: We did.

MS BERGIN: Why was that?

MR PANTER: Because we wanted to look at a way in which we could genuinely, again, demonstrate to the community that we were real about this and were committed. So we have done that in other aspects, so with our work with Aboriginal communities, we have a reconciliation action plan, for example. And so with the

LGBTI community we had the opportunity to look at the Rainbow Tick accreditation, and we decided that it was right for us, and would be a good process to go through to challenge us and to actually ensure that we were delivering what we thought we could deliver.

MS BERGIN: And just turning to that document on your screen there for a moment, this is an extract from the My Aged Care website. If you check – operator, could you please turn to the second page. If you click the check boxes under, for example, special needs group and LGBTI and then search on those terms, it will display the providers who have indicated that they're LGBTI inclusive in provision of home care packages, for example. What's your view about the ability of providers to indicate that they're LGBTI inclusive?

MR PANTER: I mean I think, without some form of accreditation, it's fairly meaningless. I mean I'm not saying that people aren't - don't have good intention and believe, but again, you know, the number of times I've had conversations with fellow chief executives who say, well, why do you bother doing the Rainbow Tick because in my organisation we treat everybody equally, we treat them all the same. And I have to stop them and say, well, that's the whole point; we are not all the same and you shouldn't be treating everybody the same. You should be responding to what their needs actually are. So I think that, yes, there will be people who tick that box but who come from that school who think, well, we treat everybody the same.

MS BERGIN: When you say "treat everyone the same", you mean treat everyone equally without necessarily thinking about structural disadvantage or special needs.

MR PANTER: Absolutely. That's right. You know, so it's - and the depth that you go to with the Rainbow Tick accreditation to really look at how your organisation operates is significant even down to, you know, it's very basic things just like your forms that you complete. You know, if you only have a male and a female box to tick, what does that say about people who are intersex or transgender. If you don't have a box or you don't have a field in your system for somebody to share their sexuality, then what's that saying? So just actually the basic questions that you need to ask and absolutely people have the right to refuse to respond but if you don't ask, then that in itself is sending a signal to that person about how welcome you are.

MS BERGIN: Mr Panter, how many other aged care providers in South Australia have achieved the Rainbow Tick accreditation?

MR PANTER: None so far.

MS BERGIN: So ECH is the only provider?

MR PANTER: Correct.

MS BERGIN: And are you aware how many other providers there are in Australia who have Rainbow Tick?

MR PANTER: I think on the current listing there are eight organisations nationally who provide some degree of aged care service. I think there are only three on the list, ourselves included, who are aged care exclusive. So I know, for example, like Uniting within New South Wales is a large organisation covering a whole range of areas, have the Rainbow Tick across all that they do. So there are five organisations like that, and then there are three which are just aged-care specific.

MS BERGIN: Should other providers be incentivised to obtain the Rainbow Tick accreditation prior to being able to check the "LGBTI-inclusive" box on My Aged-care?

MR PANTER: I think that the simple answer is "yes", but equally – that can be a long process. It, usually, takes about 18 months, for an organisation to go through all the steps necessary to get the Rainbow Tick accreditation. So it's a long process. I also think it would be assisted, though, if there was some validation of those boxes through the standard accreditation process. So very simply, using an example I've already given: if your forms of an organisation do not include the ability to ask the right questions – that should be picked up in your standard accreditation, and there should be some commentary on that – not just let it go silent.

MS BERGIN: And should that apply to other diverse characteristics as well?

MR PANTER: Yes, it should.

COMMISSIONER BRIGGS: Can I ask, when you say "incentivised", what do you mean in this context? Incentivised to get a Rainbow Tick?

MR PANTER: I think it's about providing the – so for me, incentives are both in terms of – whether as an explicit incentive in terms of – something is only on offer, if you have demonstrated. So if you're a residential-aged-care provider and there are specific residential-care places for LGBTI, you absolutely should have to demonstrate that you have done the Rainbow Tick. So – to be able to get to that service. But I think more generally the – for me incentives are about the way in which the routine system works and what is seen as being significant or not. And all too often issues around diversity in the accreditation process are not taken seriously, don't warrant high-enough an issue to give you a "not met". They're almost like sort of – it's nice, if you've got them; you don't have to have them.

And I just find it fascinating, that – for the Rainbow Tick accreditation we had two assessors from QIP for a week in the organisation, interviewing a diagonal slice throughout the organisation, from the Board to frontline staff, but they also talked to clients, they talked to stake-holders in the community in order to come up with their assessment, and I compare that with the accreditation we had, the last accreditation for our home-care packages, where we had again two assessors but for three days,

looking at a whole raft of things. So for me it's about how the basic system pays due attention to things like diversity and incentivises people.

COMMISSIONER BRIGGS: That's what I thought you meant; thank you.

MS BERGIN: Mr Panter, turning to that definition of "special needs" in the aged-care Act, what is your view about its breadth? Is it broad enough? What else should it include? Should it be approached differently?

MR PANTER: I think again for me – two things. One is – my critique of the list is that – I do have difficulty with it, which I've put in my statement, around a – the move – which is the move away from what we had prior to the diversity frame-work and what we now have in the diversity frame-work, with that broader group of special needs being identified. And I'm not wishing to be disrespectful of the needs of each of those groups; absolutely. But for me there is a big difference between those groups that have been systemically exposed to discrimination by government and others over many, many years – and whether that's Aboriginal community, whether it's the – if you're an 80-year-old gay man, you spent half of your life being illegal or a mental-health condition; there's a big difference between those experiences and the other sorts of experiences. I'm not wishing to say one's good or bad; it's just there's a difference, and the list dilutes some of that importance, some of those – for some of those groups by putting it in the larger group. And for me, if the focus was genuinely on a person-centred approach within that human-rights context, then everything else flows, and that's how we would identify whether there were other groups, new groups, new needs which were – need to be addressed in particular ways.

MS BERGIN: You mentioned the diversity frame-work. What is your view about the action-plan actions to support LGBTI elders?

MR PANTER: I think it's a valiant attempt by the committee, the subcommittee, and it has all the right things in. But my concern is deliverability, because as far as I can see, there again – there is nothing in there that actually holds the system and providers to account, and there's a lot of discussion in there about evaluation, being through having working-groups and looking at developing reports and evaluating. But there's nothing in there around data collection. So I don't quite – how we're going to analyse the impact, if we're not actually collecting any data. And that's a bigger issue outside aged-care. There's a big debate running around the 2021 census, as to whether or not there's going to be questions in the census around sexuality and gender identity; so – if we don't collect data, how do we know who's using our services, how do we know if any of those action plans are having an impact, and therefore you're left in many respects on people being good consumers, and for a disadvantaged group who lack confidence and – in the system – they're not, necessarily, going to be the people speaking out and raising a concern about their provider.

MS BERGIN: You – I understand that you heard the evidence of the diversity panel on Monday.

MR PANTER: I read the transcript; yes.

MS BERGIN: They gave evidence in relation to the response by advocacy groups to the draft action plan.

MR PANTER: Yes.

MS BERGIN: Did you want to respond to that in your capacity as a member of LASA?

MR PANTER: Yes. I think just to clarify – I think – LASA, as with the other peak bodies, is a membership organisation. We – LASA doesn't have any sort of control over its members other than who it allows to be a member. And so as a member organisation, it takes on board the views of its members, and with a diverse membership, you get diverse views. And so absolutely, going back to what I was saying earlier on about – if you're a provider who is a residential-aged-care provider and you're already feeling the weight of compliance, then it's easy, to see the diversity element as another bit to the red tape. So I think that that, to my mind, is part of the reflection on the evidence that was given around what the views were – of the peak bodies. I, certainly, know as a LASA Board director that any issue that my organisation has raised with LASA around diversity they have been a hundred per cent supportive of, and they've actually helped spread the news of the work that we're doing around things like LGBTI Connect, and so in that sense they've been positive.

But in terms of the feedback on the diversity frame-work, then it comes from that base of what the membership overall views might be. And at the end of the day, it's where that sits. I think that's – the issue that I took out of the evidence from colleagues on Monday was what weight that plays for the department and government on where they finally end up with – in terms of the outcome of that frame-work. And did their voice weigh heavier than the subcommittee's voice or from other stake-holders who were arguing. I don't believe it's sufficient, just to say the peak bodies thought there was more red tape to be a reason for not putting in data collection for example.

MS BERGIN: Okay. Thank you for that clarification, Mr Panter. I want to take you to paragraph 21 of your statement. You suggest that an aged-care system that responds to diversity would have consumer-directed care from entry to residential care. How important is a consumer-led model of care to good outcomes for residents?

MR PANTER: I think the – given that we're on that path to being down a consumer model, we have to do it whole-heartedly or not at all, and – because we're creating frustrations for individuals and their families. As I already have indicated, we're too

often in a scenario where we've got a good relationship with an individual member of the LGBTI community but they only have a low-level need through CHSP and we're completely full and we cannot provide that service and so we can only offer it to them by helping them find another provider and nine times out of 10 that person then says "I'll wait until you have got availability. I'll go without". They should be able to direct. Similarly at the residential-aged-care end – it's no good, you having been in a situation where you have had a home-care package from us for example – and you are very happy, that your life-style, your attitudes, your outlook, who you are is being recognised and respected – to then have to think about not just the issues of going to residential aged-care but – "Will I still be me when I get to that residential aged – can I still be me in that facility?".

Now, on that score, we – part of our responsibility as a provider with the Rainbow Tick accreditation is – we're working with other providers to try and ensure that we've got some pathways locally for people to be able to move into residential, if that's their wish, into an environment which will be inclusive. But we can't guarantee that. And so that for me is why I think, if we're going to have the consumer-directed model, it has to be across the whole spectrum and cannot just be for one chunk in the middle.

MS BERGIN: You mentioned for example in the first dot point that in that context an aged-care system that responds to diversity will have – will be person-centred and have a human-rights-based approach, and you've mentioned a few times today that ECH adopts that approach. What are some features of the existing system that make delivery of a genuine person-centred human-rights-based approach difficult? It's a big question.

MR PANTER: Yes. And it's the old adage of what you measure produces particular results. And so I think we still, as a sector and as a system, in the early days of trying to really understand what being person-centred is actually about. It's too easy, to say that without actually going through the real challenges that actually delivering that might mean. And I use an example around home care to illustrate the point. It's sort of – when we go into somebody's home, we can spot – it sounds trivial, but we can spot that somebody – that there's a rug on somebody's floor that's a potential trip hazard. Our job is to highlight that and point that out. We have no powers to nail the rug down or to take it out of the house. That is the individual's right, to live with the risk of having that rug, because, for them, the beauty of that rug, what it means to them, may far outweigh the fact that it could trip them up and create a fall and they break their hip. That is their choice. That's their decision.

When you take that same approach and apply it to health interventions – absolutely; we can say to somebody "You're not very good at taking insulin for your diabetes; perhaps you need to think about something else", and I've heard this is a real example, someone who was told that they should go to residential aged-care because they weren't taking their insulin, and, thankfully, they had a supportive family, who said, "Well, actually Dad's not taken his insulin regularly for the last 70 years of his

90-year life. He'd rather live with the risk, and we happy, that he lives with the risk of that still and stay in his own home and not go to residential aged-care".

And for me, those are the sorts of real – it's where the sort of rubber hits the road with person-centred care, when the system enables that person to genuinely take risks and to make decisions, doesn't infantilise them and that we have an accreditation system that also respects that and therefore doesn't penalise, if you genuinely are responding to what, that person is saying, they need and what they want to do.

MS BERGIN: Are there elements of the design of the system in the UK which based on your experience may be useful to consider by way of improvement here?

MR PANTER: I think one of the biggest changes in the UK that was starting to come in when I was still working within the UK and have followed since is the more-general point about – if you are going to have an aged-care system that responds more to – more holistically to somebody's needs and person-centred approach, you also need to be radical in the way in which the system is structured and the way in which funding, particularly government funding, is organised to support that, because certainly – so there are some examples in different sectors and in different geographic areas in the UK that have enabled organisations to bring together different streams of government funding and other services into a single pool.

So before I left Brighton Hove City Council, we were a pilot in the area of child-health services and improving child health, and we created a children's trust which brought together all the historic education funding, because in the UK local government runs the schools. So I had 79 schools; all their funding, the national-health-service spend on childcare within the city as well as – that included general-practice spend – as well as child protection, were all pooled for us to be able to bring that same resource to get better improvement in the outcomes for young people. To my mind, that's the sort of innovation we need around aged care because I see too many times people essentially ending up in residential aged care when they didn't wish to or earlier than they thought they would need to because of the silos of the current system. And so be that the way in which the GPs work, so it is ludicrous, to my mind, that somebody can end up in residential aged care simply because they have not had a medication review done in many years. We have seen that where somebody - because of the drugs that they've been on and repeat prescriptions for many years are interacting, that's what causes their leg to swell up. That is what causes them to become immobile. That's what causes them to end up in hospital, then they get the hospital-acquired infection and then before you know it they're in residential aged care. All because a medication review wasn't done in a timely way.

And we have really struggled in trying to get, sometimes, GPs to do those medication reviews. There's an opportunity to get pharmacists to do it but they have got restrictions on how many they can do. That's what led us to make the decision to employ a GP so that we can just provide that service to the person. Because that was the problem. Now – so I've used that to illustrate that for me a system, if it's

genuinely looking at getting the best outcomes for older people, to have the best life possible as they age and to end their life with dignity and respect, we need to look at how we can pool the resources from across different parts of government – and I appreciate that's complex because it's not just Commonwealth but it's State as well, when you look at hospital funds, but we have got to be able to do that, I think, in order to get a genuine person-centred approach.

MS BERGIN: When you talk about pooling funds and the model you mentioned in the UK where you established a trust and pooled funds to support the work you were doing in children's health, is there a limit in our system, as it stands at the moment, because of consumer-directed care allocating funds in a particular way?

MR PANTER: I don't think that necessarily that is a block to that. I think it creates another challenge but, again, the person-centred should be consumer friendly. So you should still be able to offer choice but it is about how is that – because at the moment the funding is coming through different streams, in terms of – you know, again, we had a debate the other day with a public hospital provider because they told us that the person we were providing services to on a level 4 package in the home who was dying was ineligible for state-funded palliative care because they were on a home care package. That is not correct.

So it's more about how you pool the resources together. You still have consumer choice as part of that, but it's about how the services are commissioned, if you like, in order – it is interesting, it gives you a sense of the pace in which some of these things are being looked at elsewhere. I was approached the other day about a possible position in the UK which actually was creating an organisation to do that commissioning for a population of two million across, essentially, the equivalent of six primary health networks that we have here, and two state boundaries. And it looked like a very interesting job to be able to combine all the resources around social care and aged care for that population to be able to deliver much better outcomes.

And that's the sort of innovation I would like to see here. Even the opportunity to pilot in one or two areas, geographic areas, the pooling together of resources to be able to get a different outcome, not just for the individual older person and their family but also at the end of the day for us all as taxpayers because also I think there's a huge amount of waste in the current siloed approach in the way in which resources are used.

MS BERGIN: So when we talk about pooling resources, does that stand in contrast to a market-driven model?

MR PANTER: No, because I think it's – again, it's about being clear about the difference between the commissioning, how you make the services available and then how these services are actually operated. So I think that they're not – again, not incompatible; it's about how the funding works. At the moment we have got funding from the Commonwealth for home care packages, isn't restricting the market

necessarily in terms of how that is utilised. It's simply a question of saying that these are the funds through primary care, through hospital care, through aged care that currently get spent for older people in a particular area, by pooling that all together are we able to use that differently, enable it to go further, create more opportunities, provide better care and better services.

MS BERGIN: Thank you. Commissioners, that concludes my examination.

COMMISSIONER PAGONE: And in relation to the funding that ECH had, that came, did it, from the sale that took place in 2014?

MR PANTER: That's correct, yes.

COMMISSIONER PAGONE: But some of that seemed to have been to substitute some property for other property; did I misread your statement? So if I have understood you correctly, by 2014 ECH was the largest provider - - -

MR PANTER: Yes.

COMMISSIONER PAGONE: - - - having had a number of facilities. Some facilities were sold but you have acquired other units.

MR PANTER: No, so we've always had our housing units.

COMMISSIONER PAGONE: Yes.

MR PANTER: And we sold our residential aged care facilities and what we have done since then is build more housing units utilising some of those funds.

COMMISSIONER PAGONE: Right.

MR PANTER: To increase the range of housing that we can offer to people.

COMMISSIONER PAGONE: And was that decision made at a time when you were involved with ECH or not?

MR PANTER: So the decision to change was made prior to my arrival.

COMMISSIONER PAGONE: Right.

MR PANTER: And then the board decided, having reached that decision, having enacted that decision, it was then, right, now we really need to think about how we're going to go forward, what our strategic plan is. We need new leadership to take us on that next step, and that's when I was recruited with that mandate to transform the organisation and take it on the next step of its journey.

COMMISSIONER PAGONE: I realise that you started in the role in March 2015.

MR PANTER: Yes.

COMMISSIONER PAGONE: I was wondering, though, whether you had been involved with a part of the decision about - in 2014, had been, as it were, with you – and the word I use was involved; so were you on the horizon at that stage? Did they know about you or were you simply the next step of a process that the board had started?

MR PANTER: I was the next step, yes. I had no involvement with ECH prior to that.

COMMISSIONER PAGONE: And ECH stands for what?

MR PANTER: Enabling Confidence at Home.

COMMISSIONER PAGONE: Right.

MR PANTER: When we were created in 1964 it was Elderly Citizens' Homes because it was about providing homes to elderly citizens.

COMMISSIONER PAGONE: The same letters.

MR PANTER: The same letter. And when we looked at rebranding - to use the market jargon - ECH had such value, people recognised it, but when you said Elderly Citizens' Homes – because people would say what does ECH stand for. You say Elderly Citizens' Homes, and people's face would drop because by 2015 "homes" was associated with nursing homes, residential care homes, not people's actual homes. And we were going to be spending some money on looking at rebranding and, again, it's an interesting way in which we operate at ECH that it was actually a frontline member of staff who emailed me one day to say, "Look, David I know the board is looking at a new name for the organisation but every time you are out and about talking to us you tell us that part of our job is to enable people to have confidence at home, so why can't enabling confidence at home be the new meaning of ECH".

And so we said "Absolutely. Well done. Thanks very much, we will save squillions on marketeers" and we adopted the name at that point.

COMMISSIONER PAGONE: Presumably, the actual registration of the corporation is ECH rather than the full name.

MR PANTER: Yes, ECH Incorporated.

COMMISSIONER PAGONE: So it doesn't really matter. And I see that you're created as a not-for-profit. I assume that that is meant as a technical description. It's not a charity. It's a not-for-profit rather than a charity?

MR PANTER: That's correct, yes. So we are not-for-profit and, in fact, I increasingly use the term we are profit for purpose because we do need to recover the costs of what we provide. It's what we do with any profit in terms of how we reinvest that back in expanding and developing our services.

COMMISSIONER PAGONE: And is part of the funding – I mean, all these questions are prompted in part by the beginning of your evidence and partly by the last question that was asked – but is part of the funding model connected with a charitable arm of ECH; does it have an entity which is able to attract tax deductible funding?

MR PANTER: It does. And what we've found though is that, again, with the – with moving away from residential aged care we were historically a benefactor to legacies, etcetera. And that stopped entirely. And so we have had to rethink that charitable arm and our fundraising arm in the context of what we now do because it's not seen in the same way. Likewise, we lost all our volunteers, for example, when we lost – when we moved away from residential aged care. We've now got over 150 volunteers but they're doing very different things because they're actually going into people's homes, organising some of that social connection activity. They're undertaking those sorts of things rather than going into an institution.

So - and it's the same with the giving. That we've - through some of our key suppliers we've been able to generate some funds for specific activities and events. But the general notion of sort of what we were used to in terms of legacies just don't flow through in the same around home care as they used to in residential aged care.

COMMISSIONER PAGONE: And although this has not really been part of the focus, are those details available on the public record or would that need to be a different inquiry?

MR PANTER: Which details?

COMMISSIONER PAGONE: The details about the funding and the mix between charitable donations and not-for-profit status.

MR PANTER: I mean, they're available on public record in terms of our annual accounts and those sorts of mechanisms.

COMMISSIONER PAGONE: They're published in the annual accounts, are they?

MR PANTER: That's right, and the annual reports. Yes.

COMMISSIONER PAGONE: All right. Thank you.

MS BERGIN: Nothing arising. Thank you, Commissioner.

COMMISSIONER PAGONE: Thank you. Thank you, Mr Panter. Thank you for giving that information. I think we've found it very interesting and helpful.

MS BERGIN: If the witness may be excused please, Commissioner.

COMMISSIONER PAGONE: The witness may be excused.

<THE WITNESS WITHDREW [3.11 pm]

COMMISSIONER PAGONE: It was you I was looking at. It's only 10 past 3.

MS BERGIN: Yes.

COMMISSIONER PAGONE: Yes, what are you going to do next?

MS BERGIN: We're going to adjourn for the day until 9.15 tomorrow, if the Commission please.

COMMISSIONER PAGONE: Yes. All right. We'll adjourn till 9.15 tomorrow.

MATTER ADJOURNED at 3.11 pm UNTIL FRIDAY, 11 OCTOBER 2019

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