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THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

MELBOURNE

10.00 AM, TUESDAY, 10 SEPTEMBER 2019

Continued from 9.9.19

DAY 48

MR P. ROZEN QC, counsel assisting, appears with MS E. BERGIN
MR S. FREE SC appears with MR B. DIGHTON for the Commonwealth

<NICHOLAS GERARD HARTLAND, ON FORMER OATH [10.00 am]

<EXAMINATION BY MR ROZEN

COMMISSIONER BRIGGS: Mr Rozen.

MR ROZEN: Thank you, Commissioner, good morning. Good morning, Dr Hartland.

DR HARTLAND: Good morning.

COMMISSIONER BRIGGS: Before we begin, Dr Hartland, I might just remind you that you remain under your previous oath.

DR HARTLAND: Thank you very much.

MR ROZEN: Thank you, Commissioner. Dr Hartland, we reached a point in your examination late yesterday afternoon where I was asking you about a particular de-identified case where a younger person had been through the ACAT process and had been assessed as being eligible for residential aged care. And what I was seeking to do with you was try and understand, from the perspective of the Royal Commission, the steps that have been followed in reaching that point. And I drew your attention to a document – I won't ask for it to be brought up at the moment – which you explained to us was a referral for an ACAT assessment, and the document was dated 22 August 2018. Do you recall - - -

DR HARTLAND: Yes, I do recall.

MR ROZEN: - - - yesterday afternoon. I asked you, and this appears in the transcript at page 4908 for the benefit of others – I asked you whether that form was the assessment that there were no appropriate alternatives available; do you recall that? And you informed us that no, that wasn't where that assessment had been made.

DR HARTLAND: That's right.

MR ROZEN: I then - - -

DR HARTLAND: Sorry, that's – can I just - - -

MR ROZEN: Yes. Certainly.

DR HARTLAND: - - - qualify that. That is not the form where we would expect an assessment to be made.

MR ROZEN: Yes. Okay. Thank you. You, in fact, drew our attention to an intermediate step between that referral and the ultimate determination of eligibility for aged care, and I'm reading from your answer at transcript 4909, line 22. You said:

> *So there's an assessment that is conducted by the national screening and assessment form.*

And I responded "Yes" and you said:

> *That is effectively the needs test, the needs assessment as to whether this person would be eligible for aged care services and so that occurred on 23.08.*

Or 23 August. And you then went on – and this is at line 33:

> *On the information available to me, and then the letter was signed by the delegate the next day.*

And I then asked you what you were reading from; it was apparent you were reading from some documents in the witness box and cutting a long story short, overnight some further documents have been provided by the Commonwealth to the Royal Commission and we're grateful for that, and thank you, and they have been added to the general tender bundle. There were five additional documents provided and just for the record they have been added as tabs 189 through to 193 of the general tender bundle. I just want to ask you about one of those and it's tab 191, if that could please be brought up, CTH.1023.1000.0013. This has been redacted to remove personal information both of the person - - -

DR HARTLAND: Yes.

MR ROZEN: - - - who was being assessed and also the assessor.

DR HARTLAND: Yes.

MR ROZEN: But I think you would agree with me, wouldn't you, Dr Hartland, that it's the document that relates to the same assessment that I was asking you about yesterday under tab 41.

DR HARTLAND: Yes, that's right.

MR ROZEN: These are additional documents relating to that ACAT assessment. Now, we see at the top right-hand corner there's the national screening and assessment form comprehensive assessment for this particular applicant for aged care services.

DR HARTLAND: Yes.

MR ROZEN: Is that right? And if we go to the third page, which is .0015 we see a heading Assessment Details about a quarter of the way down the page:

Date of assessment 23 April 2018.

You see that.

DR HARTLAND: Yes, thank you counsel. Yes.

MR ROZEN: Yes. Is this the missing step, if I can put it that way, that you were drawing our attention to yesterday?

DR HARTLAND: Yes, it's – well, the situation is more complex than there just being one step, but this is the document that, together with the Summary of Assessment provides the information for a delegate to make a determination of whether the person is eligible for aged care.

MR ROZEN: Yes.

DR HARTLAND: Yes. Now, there is one step further which is, this document is based around a needs assessment so it looks at various domains of function for the young person and assesses what their care needs are in relation to aged care service offers. The document itself doesn't encompass a question specifically on the availability of alternative sources of care.

MR ROZEN: This is the section 6(1)(b) requirement - - -

DR HARTLAND: That's right.

MR ROZEN: - - - that we talked about yesterday.

DR HARTLAND: But it's quite relevant and in a sense that assessment would be conducted outside of the questions in this document, but when you come to the summary, that this document has, we would expect to see a reflection of that decision process in relation to 6(1)(b) irrespective of whether the questions specifically cover it. And so the assessment process would have this needs assessment but also should consider evidence in relation to 6(1)(b). I think if you look towards the end of the document what you'll find is that there's no record of that being undertaken in this case. And that's also the case with the Summary of Assessment. So that, as you would kind of conclude, is a problem for this case. I don't know whether or not that means that there was no proper consideration of 6(1)(b) but it is certainly the case on the evidence in front of us that that decision step in this case was not properly documented.

MR ROZEN: Thank you. I'll see if I can unpack that. Would you agree with this proposition: there's nothing in either the documents the Royal Commission originally had in relation to this case or the documents that were provided to us last

night which are now behind tabs 191, 192 and 193, there's nothing in there that records any consideration of the section 6(1)(b) consideration.

DR HARTLAND: I would agree with that proposition, yes.

MR ROZEN: Okay. It may be the case that the assessor took into account section 6(1)(b) but it's not clear from the documentary record. Do you agree with that?

DR HARTLAND: I agree with that, yes.

MR ROZEN: That means we have no way of knowing from the records, firstly, whether they took into account 6(1)(b). Do you agree with that.

DR HARTLAND: Yes, I think that's logically entailed, yes.

MR ROZEN: Yes. And if they did, we don't know what they did to take into account 6(1)(b). We don't know what phone calls they made, we don't know who they spoke to, etcetera, do we?

DR HARTLAND: No, that's right.

MR ROZEN: No. And this is not quibbling over a minor detail, is it, Dr Hartland? And what I mean by that is section 6(1)(b) is a very important principle in ensuring that younger people only end up in aged care if there is no alternative for them. That's the purpose of 6(1)(b), isn't it?

DR HARTLAND: Well, that's – that's right. I – it's not a minor detail; I accept that characterisation. I think we do need to keep in mind as we step through these documents, and there are other documents which we've looked at where you can see some consideration, but we do need to keep in mind as we go through this process that the overriding structural issue here and why this has been such an intractable problem relates effectively to the lack of alternatives in the community. Obviously decision-making is important to get it right and when we talked about this yesterday, I hope I didn't come across as someone who thought that what we had at the moment was nirvana and there was no prospect improving our processes.

I hope that if you step back and look at the way in which we've changed the assessment guidelines, our efforts to improve the process, that we are seeking to improve the decision-making process here, but we do need to keep in mind that this is an issue which requires more options in the community and the aged care decision-making processes can only take you so far in fixing this problem.

MR ROZEN: Look, I understand all that, Doctor, and I understand there's some complexities here, but I'm really just focusing on quite a simple narrow question and that is whether from an examination of the documents in this case we can see any evidence of consideration of 6(1)(b) and I think you've agreed with me that we can't see any.

DR HARTLAND: No, I agree with that, yes. Sorry, it was a very longwinded way of saying I agree with that.

MR ROZEN: No, that's all right. You also agree with me that section 6(1)(b) is important because it expresses in the clearest terms, doesn't it, that aged care really has to be a last resort for this cohort, and it does so importantly in objective language. Perhaps if it could be brought up. It's tab 41, please, operator. We can just remind ourselves of what it says. Section 6 of the document which is, I think, page 6. That's right. If 6(1)(b) could be highlighted there about a third of the way down the page, please. I suggest the significant thing about 6(1)(b) is it's expressed in objective language, isn't it, Doctor. I think you know what I mean by that. It's not couched in terms of an opinion being reached by the decision-maker. It says in terms:

> *...there are no other care facilities or care services more appropriate to meet the person's needs.*

Do you see that?

DR HARTLAND: Yes, it's a factual question. Yes, that's right.

MR ROZEN: And I suggest to you that to give effect to that principle really puts quite a heavy onus on the person making the assessment to satisfy themselves that there are no more appropriate care services or care facilities available to that person.

DR HARTLAND: Yes. To properly make a decision and to have documented it, the decision-maker needs to turn their mind to that section.

MR ROZEN: Yes.

DR HARTLAND: And have evidence in front of them, that's right.

MR ROZEN: Indeed. And that evidence, without wanting to be – put an exclusive list, could involve making contact with local services, local facilities that – that have as part of their objectives to provide facilities and services for that particular cohort. Here, it was a person who was palliative, wasn't it? This particular case concerned someone who had - - -

DR HARTLAND: Yes.

MR ROZEN: - - - palliative care needs.

DR HARTLAND: So we would expect ACATs to have a good map of local services available to them.

MR ROZEN: Yes.

DR HARTLAND: I mean, that's the point of funding effectively an assessment capacity based in local communities.

MR ROZEN: Yes.

DR HARTLAND: In addition, as we discussed yesterday, they are not necessarily going to be the experts about disability responses, although this was a palliative case.

MR ROZEN: Yes.

DR HARTLAND: And so we expect them to consult with the relevant authorities and whether – in an NDIS area, that's the NDIS. You know, I looked again at our guidelines and I think you can see that that, while the guidelines as we discussed yesterday are complex, and there might be a case for clarifying them, it does come out on page 8 that there's a strong expectation that they'll have regard to the input of the support coordinator for an individual who's in the NDIS and so we would expect ACATs to undertake that process and obviously good decision-making principles would tell you that they ought to document it. And there's no evidence, as you point out, that that's occurred in this case.

MR ROZEN: There's no evidence and under the guidelines there's no express requirements for there to be evidence, is there? It doesn't say that your processes for reaching this conclusion have to be set out in any way, does it? That's what the previous – the 2014 guidelines said that, you told us that yesterday.

DR HARTLAND: I'm not sure I would accept that, but, you know, we did discuss whether the – yesterday, whether the guidelines could be clearer. You know, the – together the current guidelines talk about the need to contact the NDIA and the more broad guidance in the manual talks about the need to properly document all aspects of the decision. So I think together it would be a long bow to say that there's no guidance that sets out a reasonable expectation that ACATs ought to have contacted the NDIA and ought to properly document that in their case notes.

MR ROZEN: But Doctor, I've been through all of these forms overnight – now, I'm not suggesting I'm perfect, I may have missed something, but I can't even see a box that needs to be ticked in the forms that you provided to us overnight to say that there is no more appropriate service or facility. Am I missing something? Can you point the Commission - - -

DR HARTLAND: No, I think in my first answer I told you that the form that you had in front of you was a needs assessment form and it didn't specifically have a question in relation to that.

MR ROZEN: Why is that? Why doesn't the form draw the assessor's attention to the need to consider this point? Isn't that a gaping hole in the process?

DR HARTLAND: So, I mean, gaping holes, you know, I'm not sure that I – I'd characterise it like that.

MR ROZEN: Well, you characterise it in another way, Doctor. It's a gap, isn't it?

DR HARTLAND: Perhaps a potential area for improvement. The form is a needs assessment form that's focused on the impact of an impairment on the person's social functioning so it's designed to collect information about the person's life circumstances and their needs for aged care. It's not been intended to actually specifically collect evidence about 6(1)(b). The process as set out in the guidelines and the guidance that we give to people about decision-making makes it clear that they ought to turn their mind to that, but it is true that we don't have a form which is as simple as tick a box which requires them to do that.

So is this an area that could be improved; well, you know, I think if you step back and look at what we – what guidance we have give – given to people, you know, it would be my expectation that ACATs would do this and document it properly. But, you know, obviously we're talking about a case where this hasn't occurred and we have in the context of the urgent circumstances pathway, produced a form with the bespoke purpose of requiring structured information collection so I think there would be merit in expanding this, but I don't actually think that it's a problem with the needs assessment framework as such.

MR ROZEN: All right. Now, I've asked you about one assessment in the Royal Commission's materials which is the one behind tab 141. There is another one behind tab 142. Without going to that in any detail, can I ask you whether you have had an opportunity to read through, firstly, the documents behind tab 142 concerning the second case of a younger person who had been assessed as eligible for aged care?

DR HARTLAND: I think it would assist me if you brought it up. But if it's the aged care contact record, just to make sure that we're on the – we're talking about the same document.

MR ROZEN: We'll have it brought up. If we could go to the – probably the simplest thing would be to go to page .0014, please.

DR HARTLAND: Yes, I'm familiar with the documents that you have in relation to this.

MR ROZEN: You've had a look at that.

DR HARTLAND: Yes.

MR ROZEN: Just as with the other case we've been talking about, the one behind tab 141, some additional documents were provided in relation to this assessment.

DR HARTLAND: That's right, counsellor.

MR ROZEN: And the position is the same, isn't it? We don't see anywhere the record of the decision-maker expressly turning their mind to the question of section 6(1)(b)?

DR HARTLAND: So I think in this case – and I'll need to just flick through a document to check this, so I think if you go to the aged care client record, which is, for this case, the equivalent of the form we were just discussing, again, we would have expected on page 8 of 9 of that document to have seen a write-up that reflected their consideration of that matter - - -

MR ROZEN: Sorry, can you give us the - - -

DR HARTLAND: - - - and we don't find it.

MR ROZEN: Can you give us the page number in the top right-hand corner, please, the code?

DR HARTLAND: CTH.1026.1002 - - -

MR ROZEN: This is in the documents you provided to us last night.

DR HARTLAND: 0068, yes.

MR ROZEN: Overnight; is that right?

DR HARTLAND: Yes, that's right.

MR ROZEN: It's the national screening and assessment form.

DR HARTLAND: It's the second last – third last page of that.

MR ROZEN: It's tab 190, if I'm right. Is it CTH.1026.1002.0006; is this the - - -

DR HARTLAND: No, it's not that form that I was referring to, but - - -

MR ROZEN: Sorry, Doctor, can you just read out again the code in the top right-hand corner on the first page of the document?

DR HARTLAND: On the first page of the document, excuse me, counsel, CTH.1026.1002.0058.

MR ROZEN: Yes. So that's tab 189, please, operator. That's the aged care client record for this particular case.

DR HARTLAND: That's the document I was referring to, yes. Thank you.

MR ROZEN: That's the one.

DR HARTLAND: Yes.

MR ROZEN: Is there any particular page you would refer us to?

DR HARTLAND: Eight of nine.

MR ROZEN: Eight of nine; so that ends in .0068.

DR HARTLAND: That's right.

MR ROZEN: And that's a redacted summary of the – of the case in the box?

DR HARTLAND: That's right.

MR ROZEN: Is that right? Do we see anywhere there a reference to a consideration of section - - -

DR HARTLAND: It has the same deficit that we discussed with the previous case; that's right.

MR ROZEN: Okay. That's probably all I need to ask you about in relation to that, Doctor. Can I move to the next question, that is the question of auditing. You told us yesterday that there's no auditing done of ACATs by the department of the assessments; is that right?

DR HARTLAND: There's no third party auditing at this point. Our agreements with ACAT give us the capacity to do so. We are developing a quality assurance framework for ACAT decision-making that involves a self-auditing process and that's why I didn't rely on this when we talked about this yesterday because your question was clearly related to auditing from outside the ACAT process, but in relation to quality assurance, we ask ACATs, or we require ACATs to self-audit their documents which is basically to check that they have been properly constructed and then we require their organisations to sample those self-audits and to report against them in terms of the quality of the decision-making that's reflected in it.

So I think there – while I accept your proposition yesterday that there would be merit in the department looking at third party audits, I wouldn't want to leave you with the impression that the department is completely flat-footed and unconcerned about quality assurance. We are developing a quality assurance capability but it's not matured to the extent that it now compasses targeted third party audits.

MR ROZEN: How typical are these two examples that we've looked at; the first two the Commission looked at, Dr Hartland - - -

DR HARTLAND: Yes, I know. A fair question.

MR ROZEN: - - - I'm not suggesting we've cherry picked here. These are the two that we looked at; are they typical?

DR HARTLAND: So in preparing for this Commission I've looked at these documents. We looked at – we also in our evidence to you highlighted four appeals because one of the questions had related to - - -

MR ROZEN: Yes.

DR HARTLAND: - - - audits or appeals and so we looked at all of those cases. And in addition, in considering the emergency pathway that we were talking about yesterday, we looked at the cases that had been run through that to see if that worked. So that's another 10 cases. As it turns out, in all of those 10 cases the problem was actually the reverse of what we've been talking about. So all of the appeals concerned cases where an ACAT had rejected someone as being eligible for residential aged care.

MR ROZEN: Yes.

DR HARTLAND: And the person or someone on their behalf had found that that was an unreasonable decision and because it had left the person without any support and had appealed the decision in order to overturn the rejection. So in the macro, the cases that are before us are certainly mixed. So you've got two cases where there doesn't appear to be proper consideration. All of the other cases and, you know, they're not a random survey – sample, right - - -

MR ROZEN: Yes.

DR HARTLAND: - - - but all of the other cases that have come to my attention have actually had the reverse problem where 6(1)(b) had been applied too harshly and there was not, in fact, reasonable community-based options for the person and denying them aged care would have had a deleterious effect on their life.

COMMISSIONER BRIGGS: So can I ask, before counsel proceeds with that, going back to your urgent circumstances guidelines, below – and I understand homelessness, below homelessness there are a series of three about adequate housing supports, unexpected death or loss of a carer, and exposure to domestic violence.

DR HARTLAND: Yes.

COMMISSIONER BRIGGS: When I read your witness statement, Dr Hartland, I thought two things. I thought I can really see how these guidelines have been developed. They're about compassion and dealing with individual circumstances. But on the other side of that, we've got this question of last resort warehousing, you put someone somewhere and you forget about them. And this is the challenge of a system where the search in the first instance for the appropriate alternative is key to the future of people's lives, circumstances and their aspirations. So, for example, a

woman escaping domestic violence, I would be shocked and horrified if she went into aged care.

So it strikes me that there's quite a serious issue in and around these guidelines and whether or not that compassion balance has been thought through about best interests of person and longer-term compassion for where they might go. Have you got any comment on that?

DR HARTLAND: Well, I think I would agree with everything you've just said there. You know, I think if you look at what's happened with the changes in the guidelines, we've been searching for the right balance. And it's certainly the Department of Health's view that aged care is not appropriate and it's a provider of the last resort. But the balance that we find difficult, and it's reflected in the way that the guidelines have changed is it does need to be an available provider of the last resort and all of those – all of those circumstances when you look at those individual cases and the appeals, you can see why it was a necessary response to keep that as an option.

And I recognise, and I hope I would not have given the impression that I'm blasé about once you're in aged care that can be a life-altering decision and we saw from the cases that you had yesterday that can often be a decision that has a really negative effect on people, but there are other cases where to have stopped, you know, a frail homeless person with an alcohol problem that needed to be close to their family in a remote area and there's nothing else, that that's actually a reasonable and compassionate thing to do. You know, I think, reflecting overnight, where I would push for change, and I do recognise that counsel suggested, you know, should we be more structured about the way in which we require 6(1)(b) to be decided and more disciplined about a third party audit.

You know, I think those are capacities we should develop, but actually if there was one thing that I was going to change and push for at the moment, it would be – well, the overriding thing is to get these people in contact with a disability service, but the thing that - - -

COMMISSIONER BRIGGS: Or other appropriate services.

DR HARTLAND: Yes.

COMMISSIONER BRIGGS: I don't think this – the NDIS is similarly not a catch-all for everything.

DR HARTLAND: Yes.

COMMISSIONER BRIGGS: It's a service designed for people with particular forms of disability.

DR HARTLAND: Yes.

COMMISSIONER BRIGGS: Women leaving domestic violence don't fall into that.

DR HARTLAND: They would still need an aged care need. So I – this isn't opening up aged care as a refuge. It's saying if a person has an aged care need and they're fleeing domestic violence, they should be treated urgently.

COMMISSIONER BRIGGS: Okay.

DR HARTLAND: That's the intent of those circumstances.

COMMISSIONER BRIGGS: That's encouraging to hear. I'm wondering whether, as part of these circumstances, you've thought about a review point for these individuals or not.

DR HARTLAND: Yes. Thank you. So I was about to go to an area of the form which counsel hasn't drawn my attention to, but there is an area called linking support, and effectively this is a way of keeping in mind that we need to review these cases and while we would hope that if you have connected someone to a disability service and it was able to better place to think about the person's needs and their life goals and how to assist them, that that system would be able to kind of keep in contact with them. As we look to improve the decision-making around aged care, we have a process called streamlined assessment that we're developing.

One of the things that we're trying to do is expand that offer with ACATs which is about keeping in contact with someone with special needs. And so if there was an area of the form that you were talking about, counsel, that I would change, it wouldn't be the needs assessment questions because they're needs assessment about aged care needs but it would be that area. And I think there would be merit in looking at whether we can use that capacity in the system to keep in our own minds as well the disability system, that there's a person in aged care that someone should be mindful of keeping in contact with.

COMMISSIONER BRIGGS: Thank you.

DR HARTLAND: And I think that goes to your – what you were suggesting.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Thank you, Commissioner. Dr Hartland, it may just be me but 6(1)(b) has been there since 2014. It's five years ago and yet we're seeing assessments done as recently as last year that make no reference to a consideration of what is required to be done under 6(1)(b); that's the position, is it not?

DR HARTLAND: Yes, we have two assessments.

MR ROZEN: Yes, and you can't tell us whether the two are typical or not because there's no auditing done that would enable you to tell us that, other than the self-auditing that you've referred to?

DR HARTLAND: Well, no - - -

MR ROZEN: That's a "yes" or "no", Dr Hartland.

DR HARTLAND: No, I can't give you that external assurance.

MR ROZEN: Yes. And before 2014, we had an identically worded provision going back to 1997 concerning younger people. 22 years ago. And yet we don't seem to have a process now, as we -- as I stand here, we don't seem to have a process in the Department of Health and its ACAT process to ensure that aged care is a last resort for younger people, because ultimately that's what we're talking about, isn't it, Doctor?

DR HARTLAND: So I don't think that's correct. It is right that we don't do third party audits. As I've said, we're developing a quality assurance capacity and I – you know, I've said to you that I agree that this would be a useful thing to do. But if your question is about we don't have a process to ensure, I think you need to take a wider view of the whole process, and so what I said to you yesterday is that you need to see this decision-making and documentation also in the context of the flows that we're trying to create through My Aged Care, and as a part of that, we do have a process for pushing – making sure that we get people into the NDIS before they present for a screening and an aged care assessment.

So I'm not going to come and say there's nowhere in our assessment and assurance process that we could improve. That would be, you know, a patently ridiculous position to put to you, but there are things that we are doing that are attempting to address the problem that you're identifying.

MR ROZEN: Because, of course, that's the key, isn't it, with this group of people, that we need to ensure that the processes that are in place stop them getting to that ACAT - - -

DR HARTLAND: Exactly.

MR ROZEN: - - - assessment unless that really is genuinely the last resort? Because we know once we get there, the case we looked at, 22 August 2018, a referral, 24 August - - -

DR HARTLAND: August, they're in, yes.

MR ROZEN: - - - in aged care. I mean, it all happens very quickly, doesn't it?

DR HARTLAND: Yes, that's right.

MR ROZEN: And so it's vital, isn't it, that the system does everything it can to stop that what Dr Morkham refers to it as the pipeline.

DR HARTLAND: Exactly, yes.

MR ROZEN: Is it – yes.

DR HARTLAND: We're absolutely on a unity ticket on that.

MR ROZEN: All right. And I think it's fair to say, isn't it, that the department is not doing as much as it can presently in that regard? There are some plans in place; is that right?

DR HARTLAND: Well, they're more than plans. Look, there – we are always trying to improve our processes. We have worked with the call centre to make sure that they're clear that they need to ask a person to go to the NDIS. We've worked with the guidelines to make sure that it's clear that ACATs ought to contact the NDIS. Could that be clearer? We've talked about that. Yes. So it's not that it's just a plan in prospect, there are actually material processes that are trying to achieve the outcome that we both agree on. But it is the case that the department can do more, and I don't think I've said anything different either today or yesterday.

MR ROZEN: All right. Time is short, and one final matter I want to ask you about – we touched on this yesterday – and it's that that group of younger people within residential aged care who are not eligible for the NDIS. Yesterday in your evidence you told us that you thought that was quite a small group. Do you recall saying that yesterday afternoon?

DR HARTLAND: Yes, I do.

MR ROZEN: Are you aware that the issue of how best to address that group has arisen in the context of the project board, that is, overseeing the implementation of the action plan? Is that something that was drawn to your attention.

DR HARTLAND: No, I don't have – that wasn't specifically drawn to my attention, but I'm not surprised it was raised.

MR ROZEN: Okay. Do you get the minutes of the meetings of the project board?

DR HARTLAND: No, I don't.

MR ROZEN: Do you think, given the role you have in relation to this, especially post your experience today at the Royal Commission, that it would be a good idea for you to be apprised in what's going on in implementing the action plan?

DR HARTLAND: Well, to the extent that any of the actions need to encompass assessment and client pathways, then I'd be pretty confident that the project board would task me.

MR ROZEN: Well, take it from me there's plenty of discussion in there about ACATs and the assessment process. That's been front and centre in their considerations, Doctor. Are you aware of that?

DR HARTLAND: No, I'm not, but, look, I think we just – we need to be a little cautious here. It may well be that these documents have been provided to the relevant assistant secretary who manages these things.

MR ROZEN: Right.

DR HARTLAND: So I don't think we can assume that it hasn't been given to me that there's a failure of the organisational process, but I don't have direct evidence that I can offer to you on that.

MR ROZEN: That's all right. That's not really the main point I'm making, but I want to ask you about one thing that appears in the minutes of the most recent minuted meeting. There has been a subsequent meeting, but we haven't been provided with the minutes. They're probably not completed yet.

If I could ask the operator, please, to bring up tab 137 of the tender bundle. And whilst that's being brought up, you will see, Doctor, these are minutes of the YPIRAC action plan project board from 29 July 2019. We understand this was the second meeting, there was an earlier one in June, second meeting of the board, and if I can draw your attention, please, to page 0056 at the bottom of the page – sorry, at the top have the page, agenda item 4, if that could be highlighted for us, please. And do you see that the heading is – or the issue that was being discussed:

AIHW.

That's Australian Institute of Health and Welfare:

Pathways of younger people entering permanent residential aged care report.

I think I asked you a little bit about this yesterday. It's the 2019 report that's been produced by the AIHW, and you will see that at the meeting the DSS representative noted that:

The report shows that between 12 and 25 per cent of young people in residential aged care are going into aged care for end-of-life care rather than disability.

And we saw two examples of that yesterday in the evidence, didn't we, concerning the late Mr Burge and the late Mr Dodds? You were here when that evidence was given.

DR HARTLAND: Exactly.

MR ROZEN:

> *12 and a half per cent of admissions have cancer as their first listed condition, 80 per cent of whom die within 12 months of entry. Around 25 per cent of entrants in the report had cancer listed as a condition at all. It is possible some of these entrants also have disability.*

And then if we - - -

DR HARTLAND: So - - -

MR ROZEN: - - - just highlight the next paragraph, please:

> *This is a challenge for health, because if entry to aged care is closed to all under 65s with the assumption that NDIS will care for them instead, there will be a substantial unmet need.*

And you would agree with that proposition, wouldn't you, that these people who fall outside NDIS eligible would constitute an unmet need in such circumstances?

DR HARTLAND: Well, yes, that's entirely consistent with what I've been saying - - -

MR ROZEN: Yes.

DR HARTLAND: - - - that aged care is an option of last resort and it ought to be, if it's needed, reasonably available, yes.

MR ROZEN: Indeed. It's the next paragraph that I want to ask you about, though, if that could be highlighted. Now, I know this is not you, you're not the health representative on this board, but:

> *The Minister of Health stated they have recognised this complexity and are shaping the legislative amendment proposal to close aged care to under 65s with this in mind, making sure that it's not closed to those who still have no other option for care and accommodation.*

Are you familiar with the legislative amendment proposal that health is shaping to close aged care to under 65s?

DR HARTLAND: I'm aware that some work has been done to create – to develop a legislative proposal, but, as far as I'm aware, there's no final form for that proposal.

MR ROZEN: As you understand it, what's the nature of the proposal that is being shaped?

DR HARTLAND: There is no final proposal, as I understand it. The nature of the issue – and it arises from the evidence statement that we've given – is that at the moment we have what I think would be called the transitional arrangement with the NDIA. We have decided that rather than have the young person directly in a residential aged care directly funded by the NDIA, we would keep them under the Aged Care Act and have an arrangement behind the scenes whereby the NDIA would compensate health for the cost of that, and there's some background to that, but that's the way in which we've accommodated young people with disability who are NDIS participants in aged care.

The reason for that is if we'd decided that they ought to be directly funded by the NDIA, what would have happened is that we would have needed to close the Aged Care Act to these people, and that would have had two consequences. So the first consequence would have been that they would not have any protections in relation to quality safeguards complaints under the Aged Care Act, and at the time that these arrangements were developed the NDIS Quality and Safeguards Commission wasn't in existence, so that looked like extremely unwise thing to do.

The second complexity would have been that in it exiting them from the Aged Care Act and putting them in under the NDIS Act, the bond would have been refunded to the person if they had a refundable accommodation deposit, and that would have jeopardised their security of tenure in the aged care facility because they would effectively have to go out and come back in. And again, you know, thinking about the balance that you've raised with us about compassion and not wanting to have this as the default option, that again looked like an extremely unwise thing to do.

So we developed interim arrangements, and they've been facilitated by a temporary exemption to the NDIS Quality and Safeguards provisions to allow these arrangements to occur, but that's a temporary decision and in any respects, in any – in other respects, these temporary arrangements are quite complex and, you know, my view is that these young people who are NDIS-eligible, the prime way of helping them and assisting them is to get them in contact cleanly with a well-resourced disability agency that's well placed to understand their needs, aspirations and help them. And so the arrangement I prefer to see as much as possible is that there's a direct relationship.

But we do have these problems in the Aged Care Act, and this means we will have to come to some legislation in our Act possibly to get a more satisfactory and cleaner way of dealing with this issue, but we don't have a final option at this point. And whatever we do – and I think this is what this paragraph is pointing to – whatever we do that tries to make sure that the governance and funding responsibilities are really

clear for young people who are NDIS-eligible, we need to be cognisant that there's going to be a small group who are not NDIS-eligible, and we need to make sure that aged care can still function as a provided last resort for these people. So this is a very complex space, and I think, whatever happens, it won't be as simple as you're saying. No one under the age of 65 ever darkens our doors again.

MR ROZEN: Dr Hartland, you provided the Commission with a comprehensive 124-paragraph witness statement about young people in residential aged care, but nowhere do we see any reference to this proposed legislative amendment which goes to the very heart of the matter the Royal Commission is looking at. Is there a reason why you didn't mention this in your witness statement?

DR HARTLAND: I don't believe that's a correct statement, actually, counsel, with respect.

MR ROZEN: Where do we see it?

DR HARTLAND: I'll just see if I can find it. So if you look at paragraph 42 of my witness statement.

MR ROZEN: 42.

DR HARTLAND: The question I believe was:

> *Have you considered alternative funding arrangements?*

And the material there effectively takes you to similar considerations to the ones that I've just outlined.

MR ROZEN: Yes, but it's all expressed in the past tense, isn't it, Doctor:

> *The department explored alternative funding arrangements in early 2016 prior to the commencement of the NDIS rollout through consultations with DSS and the NDI. Alternatives included making legislative amendments.*

And so on. There's no discussion there about any current proposal in 2019.

DR HARTLAND: I think if you look at paragraph 43, you'll find that it references that.

MR ROZEN:

> *The Commonwealth is currently considering alternative funding arrangements. The department is providing advice to government on this matter.*

DR HARTLAND: Yes. I'd be surprised if you found that that was unsatisfactory.

MR ROZEN: It would take more than my reading ability to read into that that there's a current legislative amendment such as the one that was described in the minutes.

DR HARTLAND: No, I think – I think my evidence to you is that there's no final current legislative amendment.

MR ROZEN: Well, final legislative amendment proposal, whatever we want to call it, there's something somewhere in the Department of Health that's looking at excluding younger people from residential aged care in legislative form; is that right?

DR HARTLAND: No. I think my evidence to you just a little while ago, and I'm happy to go over it again, was that that's not the case.

MR ROZEN: Okay.

DR HARTLAND: The – I mean, I'm happy to elaborate on that but what I thought I had explained to you was that we understood that we needed to come to legislative amendments both to address this issue about how to, as much as possible, keep people directly funded by the NDIA but also to make sure that we could still accommodate people who needed aged care support. So that's not the case that – my view is that it's not the case that the final solution will be simply closing the Act but there is some need for legislation.

MR ROZEN: If the Commission was to serve a notice to produce on the Commonwealth seeking documents in which there is a discussion of any current legislative amendment proposal, would such a notice bear fruit? Can you in your mind's eye see a documented record of a present legislative amendment proposal?

DR HARTLAND: I don't believe that there's a final draft of a bill. But the notice would necessarily have to encompass whether it was going to Cabinet in confidence matters.

MR ROZEN: Right. That concludes the questions I have of Dr Hartland.

COMMISSIONER BRIGGS: Okay. I've got a couple of questions. Can I just ask a very simple yes or no type question. Younger people in aged care who are basically have cancer, patients who are clearly dying from cancer; are they excluded or included in the NDIS; do you know, Dr Hartland?

DR HARTLAND: So I – I think that this is an area where DSS and NDIA will be better placed to comment. But it may be that if their only care need is palliative, they do not meet the NDIS eligibility criteria.

COMMISSIONER BRIGGS: That's what I thought. So what is the Department of Health doing to work with the States on better pathways towards hospice arrangements for these young people for appropriate palliative care?

DR HARTLAND: So there – I believe you've had some evidence from Louise Riley about our efforts in palliative care, and I haven't fully refreshed my memory about that, but I think this is an area where we know that – we have offered some additional funding to the States to encourage their efforts in palliative care, and negotiations are still occurring in relation to whether that would be accepted. Irrespective of whether that's successful, palliative care is a known, like supported accommodation for people with disability, it's a known area where the social net, there is not enough community-based options and look, I think that would get back – get me back to it would be desirable for there to be more support options in the community, primarily a State responsibility, but again, as we discussed with young people in residential aged care I think there will be circumstances where aged care is a provider of last resort.

COMMISSIONER BRIGGS: What's the department doing to work through with the States those issues around better hospital pathways so that when people come out of hospital, they don't rush into or get pushed, as we heard yesterday, into aged care rather than directed toward the NDIS?

DR HARTLAND: So we are working with our State colleagues to run the Health Ministers' Advisory Council. That involves regular discussions on aged care. You know, in the – I think both sides are aware that more could be done here and that there's opportunities for local collaboration with aged care and the wider set of health services. But I think this is an area where, again, you know, going – progress has been slow, yes.

COMMISSIONER BRIGGS: What is the department doing to address the issue of the seeming shortfalls in slow stream rehabilitation that we heard so much about yesterday?

DR HARTLAND: Again, this is an issue that we raised with the states with AHMAC. You know, I think it's also an issue that is cropping up in the NDIS and its interface with health because it's an area where roles and responsibilities need to be clarified, and I saw in some of the evidence that the Disability Reform Council is looking at that. You know, the State health systems access to slow stream rehabilitation is very patchy across the country. And, you know, it's an area where, if you look at the failures that some of the cases that you had with your – brought to your attention, effectively the crucial point actually was lack of access to slow stream rehabilitation, yes.

COMMISSIONER BRIGGS: We'll certainly be having a look at that. Can I follow up the thing I asked you to check out overnight if you had time, and that is the funding arrangements associated with people – young people with disabilities who

are in aged care and have access to the NDIS. Can you briefly describe what those funding arrangements are, please, Dr Hartland.

DR HARTLAND: So once they're in residential aged care, under our Act we pay whatever care needs – for whatever care needs they're assessed at through the Aged Care Funding Instrument.

COMMISSIONER TRACEY: So basically they get, what's the equivalent, dare I say this, because I hate acronyms, the ACFI funding entitlement.

DR HARTLAND: That's right. Yes. So they get treated, as anyone would under the Aged Care Act. We then effectively send an invoice to the NDIA for those costs with three relatively minor exclusions. So the NDIA won't pay for the homelessness supplement, the oxygen supplement or the veteran's supplement but they're very minor payments in the scheme of things, and then the NDIA provides the Department of Health with funding. So this is a complex – well, I mean, it's a fairly complex administrative process. Hopefully it's completely invisible to the person needing support, and it arises because, as I said, we'd needed to keep people under the Act to ensure that they were protected.

COMMISSIONER BRIGGS: So there's no additionality on top of the ACFI which is really the question I'm asking. So if these people were living in the community, I put it to you, Dr Hartland, that they would be entitled to more supports than if they're in aged care?

DR HARTLAND: So the NDIA does have the capacity to – it will take for their care needs the ACFI result and compensate the Department of Health for the expenditure that it's incurred under its Act but it does have the capacity to buy for that person, effectively, through their plan, supports above what the Department of Health would pay. And that's actually similar to some of the arrangements that we talked about in relation to the YPIRAC program. So depending on that amount of support provided to the person, you may well get much closer to what they would receive in the community.

COMMISSIONER BRIGGS: And fundamentally they receive less than they would in the community and I suspect and, indeed, I will be asking your colleagues from the Department of Social Services, how much more they might receive and the nature of those different services that they might receive were they living in the community, and I'm inclined to think that those services would be more suited to their needs. But let me ask you about a comment on something else.

DR HARTLAND: Well, the – look, I think this is obviously an area where the Department of Social Services and NDIA are better placed to comment on what they would get – of a person in their system who is in aged care and getting a top-up compared to that same person in the community, you know, without an aged care support. They're better placed to tell you about the relativities between them. I just emphasise that for these people who are NDIS eligible, it's – they don't only – it's

not necessary that they only get the Department of Health funding. They can access additional funding through the NDIA.

COMMISSIONER BRIGGS: All I can say about this issue is to repeat what counsel said in his lead-in yesterday, that young people with disabilities is a clear area where Social Services, NDIS, Department of Health, States and Territories and various other stakeholders need to be working together, rather than separately and doing buck passes. I don't want you to comment on that; I just want you to understand that that would be the view of certainly this Commissioner. But what I want to ask you about is human rights issues. How do you reconcile long-term placement of younger people with disabilities in residential aged care without human rights obligations concerning the rights of people with disabilities to live independently in the community?

DR HARTLAND: So I think if this is the only available community-based placement, then it's a reasonable way of responding to the person's need. I – you know, the Aged Care Act has not been designed to – it doesn't make reference to the UN conventions so, you know, it's an Act - - -

COMMISSIONER BRIGGS: Human rights, yes.

DR HARTLAND: That's designed to support old people – older people with frail ageing. So it's clearly not the first response that one would expect for young people with disability. But I, you know, I think that the evidence I've given you over the last couple of days is that it may well be a necessary provider of last resort in some circumstances and hopefully in minimal cases.

COMMISSIONER BRIGGS: I put it to you, Dr Hartland, that the current system is at best a national embarrassment and at worst, a national disgrace.

DR HARTLAND: Look, I wouldn't want to say anything that undercut the desire to reform this area, and to as much as possible get young people into the NDIS as soon as possible and to have them properly funded. You know, I think it's not really for me to comment or not on the statement that you've made about a disgrace or embarrassment but I wouldn't want to leave the Commission with the impression that I thought, or the Department of Health thought that nothing further could be done and we ought to just wash our hands of the matter. You know, we are looking to ways to improve the customer flows through the system and we are looking for ways to improve the decision-making processes in the system with the overriding objective that the best result for people is that they're efficiently and effectively placed in the hands of the agency that is best placed to help them, and that aged care is only ever a provider of the last resort when there is no other way of supporting that person.

COMMISSIONER BRIGGS: Thanks, Dr Hartland. I think we will be looking to see some fairly rapid movement on this front from you. Mr Rozen, do you have any further questions?

MR ROZEN: I don't. Thank you, Commissioner, no.

COMMISSIONER BRIGGS: Dr Hartland, you are excused from giving further evidence, and thank you. I know it's not been an easy task for you but we appreciate your honesty. Thank you.

<THE WITNESS WITHDREW [10.58 am]

MR ROZEN: Commissioner, the next witness is Michael Lye. I call Mr Lye.

<MICHAEL PATRICK LYE, SWORN [10.59 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Good morning, Mr Lye. Could you please state for the transcript your full name.

MR LYE: Michael Patrick Lye.

MR ROZEN: You hold the position deputy secretary, disability and carers in the Department of Social Security.

MR LYE: That's correct.

MR ROZEN: How long have you been in that role Mr Lye?

MR LYE: Since June 2017.

MR ROZEN: And within the structure of the department, you answer to the secretary.

MR LYE: That's correct.

MR ROZEN: And your division, if that's the right word, of the department oversights the NDIS, the National Disability Insurance Scheme.

MR LYE: That's correct.

MR ROZEN: Yes. Is that the right noun, is it a division or what is it called?

MR LYE: We call it – refer to it as a stream.

MR ROZEN: A stream, thank you.

MR LYE: A stream.

MR ROZEN: And Mr Peter Broadhead, who we will shortly be hearing from, answers to you in the hierarchy; is that correct?

MR LYE: That's correct.

MR ROZEN: All right. I wonder if tab 2 of the general tender bundle could please be brought up on the screen, CTH.0001.5000.2844. Do you recognise this, Mr Lye, as a statement made by the department in response to notice to give number 0356?

MR LYE: Yes, I do.

MR ROZEN: In that notice the Commission asked the department 23 questions which have been helpfully reproduced as we can see in boxes in the course of the statement. Did you play a role in preparing the department's response to this notice to give?

MR LYE: I did.

MR ROZEN: Did you play the primary role oversighting the response?

MR LYE: I did.

MR ROZEN: Okay. And can you tell us the answers that have been provided in the response are, to your knowledge and based on your researches, are true and correct answers to our questions?

MR LYE: Yes.

MR ROZEN: I won't tender it because I will get into trouble because it is already in evidence as tab 2, but I just ask, Commissioner, that you note that it is part of the general tender bundle. Before I start to ask you some specific questions - - -

MR LYE: Sorry, counsel, sorry, just to say to you that there was an answer in this – this statement which – in which we said that there were no documents or evaluations relating to a period of time, in particular in relation to the supported accommodation innovation fund.

MR ROZEN: Right.

MR LYE: And we later discovered – or recently discovered that there, in fact, was a document, and I think we've endeavoured to provide that to the Commission.

MR ROZEN: That might have been provided overnight; is that right?

MR LYE: I think that's right.

MR ROZEN: Do you wish to correct a part of the statement or are you happy with that just being noted?

MR LYE: Just for you to note that; that's the one thing I think that we realised yesterday, that we had a document that we hadn't previously discovered.

MR ROZEN: Okay. We're grateful for that. I won't be asking you about that and it's noted that you – without going to the words in the statement, that you would make that change. It's my fault; I should have asked you if there's anything you wanted to correct in that. Before I ask you about some of the matters that are discussed in your statement, I wonder if I could ask you – I assume you've been in the hearing room this morning?

MR LYE: I have.

MR ROZEN: And were you here all day yesterday as well?

MR LYE: I wasn't.

MR ROZEN: You were not.

MR LYE: No.

MR ROZEN: Okay. But you've heard the answers that Dr Hartland has given to various questions asked of him this morning by myself and by the Commissioner. What do you say to the question asked by Commissioner Briggs of Dr Hartland, that the current system in Australia in relation to young people residing in residential aged care is, at best, an embarrassment and at worst, a disgrace?

MR LYE: What I would say to that is that – I mean, I think very clearly and I think the department shares this view, that it is inappropriate for young people to be in aged care settings.

MR ROZEN: Yes.

MR LYE: I know we all would explain caveats to that, but I think it's important to say that we don't think it's an appropriate setting for young people with disability. And I think it's been an issue which is – which we have failed – manifestly failed to make inroads into. We have made some attempts at trying to address the issue. But we have – we have manifestly failed and that's evident in the numbers of people who still live in that setting – those settings. And I think that we have a very important job to do with the introduction of the National Disability Insurance Scheme to correct that.

MR ROZEN: You'd agree with the proposition that's been raised a number of times, including by the Commissioner just moments ago, that it requires a concerted effort, not only by the Commonwealth Government departments that are relevant, that is your department, Health, the agency that is responsible for the NDIS, but also relevant State Government agencies, health and housing. It requires a concerted effort by all of those players in the system, doesn't it, to address this problem?

MR LYE: It certainly does.

MR ROZEN: Yes. And I note your observation and appreciate it, for what it's worth, that the government has manifestly failed in this area. We know that when our governments collectively have to seek to get policy reform, that departments can work together, can't they? This is not beyond the ability in Australia. If the will is there and the resources are provided, then departments can work together to achieve significant policy objectives, can't they?

MR LYE: That's correct.

MR ROZEN: Yes. We can probably cite numerous examples but one that comes to mind over the last few years in Australia has been the stopping of boats of would-be refugees coming to Australia. We know that that's been an objective of the Commonwealth Government and it has required the input of a number of different departments and they've worked together and, within the terms of the policy, it's been successfully implemented, has it not?

MR LYE: Well, I'm manifestly not qualified to comment on that policy but I would point to the introduction of the National Disability Insurance Scheme as an example that I'm aware of - - -

MR ROZEN: Yes.

MR LYE: - - - where the Commonwealth and State Governments and community sector advocates and people with disability themselves have come together to – to agree a model of service and to be part of the implementation of that, which is not to say that it's been perfect but to say that I think it is a good illustration of that cooperation.

MR ROZEN: Yes. My point is really along those lines. That is, where the will is there and the resources are provided, we can work together, Commonwealth and States, various departments, to achieve significant reforms?

MR LYE: Yes.

MR ROZEN: And does it necessarily follow from your concession that we've manifestly failed in this area, that that's what's been lacking, the will to achieve better outcomes in relation to younger people in residential aged care?

MR LYE: I mean, I would characterise it as that the commitment to the National Disability Insurance Scheme represents a comprehensive way of addressing the issue.

MR ROZEN: Yes.

MR LYE: That – that's – just the advent of the scheme has had a long gestation from, you know, the Productivity Commission considering the concept through to government agreeing it and then a very – an implementation period. And so I think that will has been evident since collectively governments agreed to the National Disability Insurance Scheme. I think that – so that's a sort of a 2011 start date. And I would just say that notwithstanding the importance of that in actually addressing this problem and demonstrating that will to young people in residential aged care, but I'm very conscious of the fact that it's a very complicated reform and takes a long time, and, you know, people in real time are still living in residential aged care inappropriately, while we are doing – going about that task and so I'm seized of that.

COMMISSIONER BRIGGS: You still seem to see this arrangement as, it's our chunk to fix it now through the NDIS, rather than appreciating, I think, the subtlety of counsel's question, that this involves a concerted effort from Health, from Social Services, from the NDIS and from States and Territories who you failed to mention at all in your answer to the question, Mr Lye.

MR LYE: I agree with what you're saying, that it requires all those parties and that, in fact, the issue goes beyond the NDIS itself, but I think I would just say that we haven't had a mechanism like the NDIS which is demand-driven and person-centred at our disposal to attack the problem. And, you know, I imagine that you would ask me about the – the relationship we have with State and Territory Governments but we're spending a lot of time with them working together day in, day out on the sort of fundamental pieces that are required to address what's currently going on. And I think we have a good working relationship with them.

COMMISSIONER BRIGGS: Counsel?

MR ROZEN: Thank you, Commissioner.

We've heard evidence yesterday about the initiative that was in place between 2006 and 2011 which you describe in – well, not you, the department describes in the response to the notice to give, starting at paragraph 3. I want to ask you a little bit about that. Firstly, it was a five year initiative that was part of a quite significant Council of Australian Governments health reform, wasn't it? It was a $1.1 billion five year reform package of which this initiative formed part.

MR LYE: Correct.

MR ROZEN: Am I understanding that correctly? And before the current action plan which was announced in March of this year, and I'll ask you about that

presently, this was the most recent significant initiative to address this problem, was it not, the one between 2006 and 2011?

MR LYE: I mean, the most significant YPIRAC, young people in residential aged care badged plan, I think, as I said to you, obviously from 2011 onwards, the work around the NDIS encompassed, you know, how we're going to solve this problem as part of a design of a new disability insurance scheme, but yes, I think in terms of an initiative that you would badge as being targeted directly at young people in residential aged care, there's that initiative. There's the capital funding that we provided for, under the accommodation program, which is a little bit later and then this current one.

MR ROZEN: It's important, isn't it, that we understand the lessons to be learnt from the past in designing policy responses to this issue in the present?

MR LYE: Yes.

MR ROZEN: It's for that reason I want to ask you a little bit about that specific initiative between 2006 and 2011. You've already agreed with me that it was a COAG initiative, Council of Australian Governments, responding to a Senate report in 2005. Do you agree with that?

MR LYE: Correct.

MR ROZEN: And broadly speaking, the initiative had two goals, moving younger people with disability out of residential aged care and into appropriate supported disability accommodation. That was one – one broad aim. Do you agree with that?

MR LYE: Yes.

MR ROZEN: And it was also aimed at diverting further admissions of younger people at risk of an admission.

MR LYE: Yes.

MR ROZEN: So it was addressing the problem in terms of the cohort in residential aged care and the cohort that was at risk of going in.

MR LYE: Yes.

MR ROZEN: And you would agree with me that any concerted effort to address the issue that we're concerned with here has to tackle both aspects?

MR LYE: Yes.

MR ROZEN: At the time of that initiative, 2006 to 2011, the States and Territories had primary responsibility for disability policy and the provision of disability services.

MR LYE: That's right.

MR ROZEN: And, of course, the significant change, and you've already drawn our attention to this, since 2011 has been that the NDIS has gradually been rolled out over that time and it's a jointly funded State/Territory/Commonwealth initiative.

MR LYE: Yes.

MR ROZEN: Jointly funded but primarily administered through the department in which you work, the DSS.

MR LYE: We have policy oversight and the NDIA as an entity in its own right has the delivery of responsibility.

MR ROZEN: They deal with the operational side of it, you're dealing with the policy.

MR LYE: We deal with policy.

MR ROZEN: I understand. And the Commonwealth, going back to the 2006 to 2011 issue, the Commonwealth coordinated it as the level of government that was responsible for aged care. That was essentially its interest or input into that initiative?

MR LYE: Yes, and – and, well, I mean, with probably some level of input from – I wasn't there at the time but probably some level of input from our agency around disability policy.

MR ROZEN: Yes.

MR LYE: Because we were the custodians of the Commonwealth State disability services architecture, notwithstanding that our responsibility wasn't in that space. And I think there would have been – I think my understanding is that there were obviously health-related issues in that COAG bundle, and so probably the Department of Health had a health lens as well as an aged care lens.

MR ROZEN: In the department's response, we can see it at the bottom of the page at paragraph 7:

The Commission has been informed that during the period 2006 to 2011 –

that is the period of the initiative –

...the Commonwealth provided the following funding to each jurisdiction –

and we see various amounts starting with 40 million and a bit more for New South Wales. And then if we can scroll over to the following page, progressively smaller amounts provided to the other two States and then the Territories. I'll ask you to accept my maths, flawed as it is, that we get a total of just over $121 million provided, if we add up all those figures.

MR LYE: I'll accept your maths.

MR ROZEN: I ask you to accept that. What was that money provided for?

MR LYE: So just to clarify one thing. I think that funding was matched by the States and Territories. So I think the total money within the package was something like $244 million.

MR ROZEN: Yes.

MR LYE: Yes.

MR ROZEN: Okay. And it was presumably aimed at providing the supports in the community that younger people needed if they left residential aged care. Is that - - -

MR LYE: That's essentially it, yes.

MR ROZEN: Either if they left or if they were diverted from going into residential aged care.

MR LYE: Correct.

MR ROZEN: Just so I can understand that, did that involve building housing, dedicated housing, was that what part of the money was used for?

MR LYE: I'm not aware specifically but I imagine that in some cases it might have. You would be aware that the States have primary responsibility for provision of public and social housing, and so I suspect there was some money went to capital.

MR ROZEN: All right. In fairness to you, Mr Lye, I understand this is well before your time with – in your current role, obviously. I neglected to ask you earlier whether you have a background in this area prior to being in your current role, that is disability services?

MR LYE: I have worked – I have touched on disability policy at time. I've always worked in social policy and, you know, different social policy systems, so for my entire career, so my background, public background is in homelessness, in housing policy, yes.

MR ROZEN: And for how long have you worked in the Commonwealth public service?

MR LYE: This time, since 2010. Previously I had a couple of years, more time probably in State Government in social policy.

MR ROZEN: Right. Okay. Which particular State?

MR LYE: Queensland.

MR ROZEN: Okay. Returning to this initiative, you draw to our attention that it was evaluated in 2012, that is, the year after that five year period, and that evaluation was conducted by the Australian Institute of Health and Welfare and their report is behind tab 59. If I could ask the operator to bring that up for us. You actually extract a quote from that report, don't you, in the department's response to us?

MR LYE: Yes.

MR ROZEN: We see that at paragraph 14 and you note there, in the passage that you've quoted, that:

> *An estimated 250 people achieved the first YPIRAC objective, that is a move out of residential aged care to more appropriate accommodation.*

And you go on to note that:

> *Identified numbers of people also benefitted from other aspects.*

But if we can just focus on the first objective, that is, getting younger people out of residential aged care, we've got 250 people in a five year period. Most of those were in the younger cohort, that is under 50 years of age; that's right, isn't it?

MR LYE: I think so.

MR ROZEN: Yes. Is it too simplistic, and tell me if it is, to look at the money spent, $240 million-odd, as you've told us, 250 people out. We're looking at somewhere in the vicinity of what, a million dollars per person?

MR LYE: Someone wiser than me will tell me that there's a reason why that maths is too simplistic, but I think that your point about a lot of money spent, 240-odd million - - -

MR ROZEN: Yes.

MR LYE: - - - dollars for essentially 250-plus, 244 people either diverted or taken out of aged care, I would add those two figures together, I think probably represents what – what we got for our money.

MR ROZEN: Yes.

MR LYE: And I know there's other people assisted with what you might call the quality of their experience in residential aged care but that the AIHW points to, so 1400 people in total assisted.

MR ROZEN: Yes.

MR LYE: But essentially in terms of hard outcomes and the goal that we're seeking, diversion and people coming out, I think 500 is your answer, 500 people.

MR ROZEN: Yes. Do you know if there's been any follow-up on those approximately 250 people to know what became of them after 2012?

MR LYE: I'm not aware.

MR ROZEN: Do we take it that if there had been some follow-up you would be aware?

MR LYE: Well, I suspect that possibly they would have been clients of the State and Territory Governments and so, yes, there may have been some further follow-up of those people, but I'm not sure.

MR ROZEN: Okay.

MR LYE: Yes.

MR ROZEN: I don't mean to be cute here but the department was asked for a comprehensive response including identifying for the Commission any evaluation that was done of the 2006 to 2011 initiative, and you helpfully drew our attention to a mid-term evaluation in 2009 and this one in 2012. If there had been any subsequent follow-up in relation to those people, it's reasonable for us to assume that it would have been identified in the department's response, isn't it?

MR LYE: If we had conducted it.

MR ROZEN: Yes.

MR LYE: I think it's reasonable. I'm just saying to you that those people would have become clients of State and – at the time, State and Territory disability agencies and so whether there was some follow-up of that group – that group of people - - -

MR ROZEN: Yes.

MR LYE: - - - it might have occurred at the State and Territory level rather than the Commonwealth level.

MR ROZEN: Okay.

MR LYE: Yes. But I am not aware, I am not aware.

MR ROZEN: No. Can I give you a bit of homework, please, Mr Lye, and ask you to follow up on that for the Commission, please, and if the Commonwealth's solicitors could write to us informing us of what inquiries they've made of the States and Territories and what follow-up, if any, there was conducted in relation to that cohort. In designing this year's initiative, the one that was announced in March of this year, I suggest to you that that would have been a pretty useful thing to have made some inquiries about, what happened long term, medium to long term with that group. How many ended up back in residential aged care, for example. Is there any reason why that work wasn't done, as far as you're aware?

MR LYE: I'm not a – I'm not sure that us turning our mind to that in the preparation of this action plan would have been possible to go back and locate people. So if we hadn't done it before, I'm not sure how successful we would have been. I think the other – the other lens I would bring to this is that we are – we are seeking to understand the population of people who are currently, you know, at risk of entering residential aged care and young people, and people going through the NDIS planning process who are in residential aged care and using that information. That information is helpful in informing us about how do we design long-term arrangements for that population. Yes.

MR ROZEN: Can we go back to the 2012 evaluation. I just want to ask you about one of the tables in that document. That's tab 59, please, operator. And if we could go to page .0544, it's table 1. We see, if we focus our attention on the bottom third of the table, which is tracking state by state the number of permanent aged care residents aged under 65 by age group in State and Territory as at 30 June 2003 to 2011, we can see that through the years of this initiative, 2006 to 2011, the total number remained stubbornly over 6000, did it not?

MR LYE: That's correct.

MR ROZEN: A small reduction in fairness, perhaps two or three per cent overall there, but what does that – what's the lesson to be learnt from those figures in terms of the success or otherwise of that initiative? Does that suggest that the initiative ultimately, with the exception of the cohort we've just been talking about, the 250 or so, that ultimately it didn't really achieve its objectives?

MR LYE: I suppose my reflection on the – the 2006 initiative is that what we probably know now is that the size of the problem and the cost of providing appropriate supports for a person to live in the community who's under 65 is much, much greater than the money that was allocated in 2006. I mean, it just – it's really a drop in the ocean and I – and so, you know, the – it – the cost of providing support – a conservative estimate of the cost of provider NDIS support for people who are currently in the residential aged care to live in the community is probably more in the

order of seven to eight hundred thousand – seven to eight hundred million dollars per year. And so you could see that a $244 million initiative over five years is just not sufficient to make a dent in the problem.

MR ROZEN: Yes. We'll come back to that in a moment. I just want to ask you something about some evidence that we understand was given by the secretary of the Victorian Department of Health and Human Services about this initiative. Her witness statement is WIT.0420.0001.0001. And I want to ask you something about what appears at page .0008 of the statement, if that could please be put up on the screen. Thank you. Ms Peake deals with this program starting at the top of the page there at paragraph 45. Perhaps if we could have 45 to 47 highlighted, please. And you'll see there that the secretary of the Victorian department talks about a 2011 evaluation of the program, which I think is that document that we've just been looking at, the AIHW evaluation, found:

> *The individualised approach to the program delivered some improvements in the capacity of the disability service system and achieved better clinical and quality of life outcomes for people from the youngest cohort in the program.*

If I can just pause there in the reading, that's the under 50 group that we were talking about a moment ago, Mr Lye, is it not?

MR LYE: I think so.

MR ROZEN: She went on:

> *However, the program did not substantially alter interfaces between disability housing, health and aged care systems. Clinical interventions were not integrated into models of accommodation and support. Targeted models of care for the different cohorts were not mainstreamed and pathways through the different service areas and associated funding models were not significantly improved.*

And then at 47:

> *This was in part due to the positioning of the initiative as a disability reform, rather than as a truly multidisciplinary collaboration. The lack of a formative evaluation strategy meant that opportunities were missed to refine the program as it was implemented. There was inadequate investment to extend the program beyond the youngest cohort.*

Can I just ask you, given that you were central to design of the current action plan, the 2019 action plan, do you have any response to those observations made by Ms Peake? Is she right when she says that that was too much about a disability reform rather than being a multidisciplinary collaboration of the various agencies?

MR LYE: Yes, I think that's a fair – I think that's a fair assessment.

MR ROZEN: Has that been taken into account - - -

MR LYE: Yes.

MR ROZEN: - - - in the design of the current action plan?

MR LYE: Yes. The – I mean, one of the principal things that I think we recognise and has been a source of considerable work is getting to the bottom of the relationship between health departments and health workers, and people working in the NDIS, and trying to unpick both systemic and cultural practices, because that is a key driver of inappropriate referrals to aged care for young people with disability. And so I think it is a lesson from the 2006 initiative that there probably wasn't any accompanying targeting of that set of practices, both systemic and cultural, particularly in the health area. But Ms Peake's comment about that applies equally to housing, I think, is also important, that you've got to come to grips with all those systems and they've got to work together to get success. So I think that is clearly a shortcoming of the 2006 initiative.

MR ROZEN: Thanks, Mr Lye. Commissioner, I'm about to go on to another topic. I was wondering if it might be helpful to have a short break.

COMMISSIONER BRIGGS: I think that would be a marvellous idea, Mr Rozen. How about if we resume at – if we make it a temporary adjournment and we resume at 20 to 12?

ADJOURNED **[11.31 am]**

RESUMED **[11.47 am]**

COMMISSIONER BRIGGS: Mr Rozen.

MR ROZEN: Thank you, Commissioner. Please excuse me, Mr Lye, for a moment. Can I just clarify one matter arising from something I said this morning. I didn't intend to give the impression that the documents which we received overnight from the Commonwealth relevant to the ACAT assessments were being provided for the first time. They had actually previously been provided to us, and they were provided again last night because they became particularly relevant as a result of the examination. So if I gave the impression they hadn't been produced, I didn't intend to do that. They were produced in response to a notice at the appropriate time.

COMMISSIONER BRIGGS: Thank you, and that, in fact, is what Mr Hartland said yesterday, I think. So thank you.

MR ROZEN: Yes, indeed. Thank you. Can I also indicate for the benefit of Mr Lye that the next direct experience witness will be called at 12.30, so it might be necessary to interpose him during your evidence. I've discussed that with your senior counsel and that should all okay, but I'm just letting you know that's the plan.

Mr Lye, before we had our break I was asking you about the 2006 to 2011 initiative, and I think you agreed with me, as I understood your evidence, that there were certain lessons to be learnt from that. You were confident that they'd been taken into account in the design of a current action plan. Is that a fair summary of your evidence?

MR LYE: Yes.

MR ROZEN: I want to ask you about the period between the two – well, between the initiative and the plan, 2011 to 2019. Is it fair to say that to the extent that the Commonwealth was active during that period in addressing the concerns of younger people in residential aged care, it was through the rollout of the NDIS?

MR LYE: Primarily.

MR ROZEN: Yes. There was no specific initiative or program that was in place during that period addressing the particular needs of young people – younger people.

MR LYE: I mean, save for, you know, internal policy work – internal policy work geared towards the NDIS, the safe initiative, the – you know, the creation of the attempt to create more housing stock and respite stock.

MR ROZEN: Yes.

MR LYE: Yes.

MR ROZEN: They're matters that are addressed in the response - - -

MR LYE: Correct.

MR ROZEN: - - - that the department has provided to the Commission. And I'm not, by that question, seeking to belittle the size of the reform that has been constituted by the rollout of the NDIS. It's obviously a very major bit of policy reform that has been undertaken during that intervening period. I'm sure you'd agree with that proposition.

MR LYE: Yes. I mean, I would just comment that nothing less than the work towards the NDIS probably is sufficient to deal with the problem, based on what we knew. So, you know, if we had of said "Okay. Well, let's –" and we did. We had a capital program which was a commitment from are the previous government which no doubt increased the stock and helped a number of people, but none of those

initiatives at that scale were going to solve the problem. The NDIS has a capability and a funding stream and design to really manifestly deal with the problem.

MR ROZEN: There was one intervening event that I do want to ask you about, that is, one event between 2011 and 2019. That was the Senate Community Affairs References Committee, which released a report after it conducted an inquiry into the adequacy of existing residential care arrangements available to young people with severe physical, mental or intellectual disabilities in Australia, and you refer to this at paragraph 25, I think it is, of the response. Perhaps if that could be brought up. It's page .2849 of tab 2 in the general tender bundle. We have in evidence the Commonwealth's response to the recommendations that were made by that committee report. I won't ask you about them in detail, but you say in the statement, the last line of paragraph 25:

> *DSS took the lead on the Commonwealth's response to the committee's report which was tabled on 7 February 2017.*

What does that expression mean:

> *DSS took the lead on the Commonwealth's response.*

Does that mean DSS prepared the response?

MR LYE: DSS would have coordinated the response amongst relevant agencies, and so we – taking the lead would mean that we would have been the primary owners of the document and the response and we would have worked with the Department of Health, I presume at the time, the NDIA and other relevant entities.

MR ROZEN: I understand. Does that mean you personally were involved in the preparation of the response?

MR LYE: No.

MR ROZEN: Okay. I asked Dr Hartland yesterday about the first recommendation that had been made by that report. Perhaps in fairness to you we should bring it up. It's tab 115 in the general tender bundle, and if I could ask you – ask the operator, please, to go to recommendation 1, which is – if we just scroll through the pages. There it is at the bottom of page 4. If recommendation 1 could please be highlighted in the box. Are you familiar with this recommendation, Mr Lye?

MR LYE: I am.

MR ROZEN: Yes. And I won't read through it all, but it was a recommendation that the Australian Government compile a database of younger people using ACAT data, Aged Care Assessment Team data. And the information which would be included in such database is that listed at the bottom of the page, including, you see the fifth dot point, the factors that need to be addressed for the person to move out of

the aged care facility. The government response to that was to note that the recommendation had been made, and then there is a long and detailed response about difficulties of acquiring data by reason of privacy provisions of the Aged Care Act and so on. I won't go to that in detail, but it's the case, is it not, that the government did not implement that recommendation of compiling a database which set out the five matters set out there?

MR LYE: I believe that's correct.

MR ROZEN: Yes. And the fifth matter – sorry, if we just go back to the box for the moment, please, Operator. The fifth matter there, "The factors that need to be addressed for the person to move out of the aged care facility", is, in fact, a matter that the project board is currently investigating as part of its implementation of the action plan, isn't it, Mr Lye?

MR LYE: I would make a slight distinction. I think that the planning process – the NDIS planning process is the best way to get at – to get to the heart of that dot point.

MR ROZEN: Yes.

MR LYE: So the access process and the planning process is actually designed to identify what are the things that a person needs to live in the community, and so that process is happening via that – the NDIS process. I think we are doing a separate bit of work which is to look at – it's a complicated piece of work, but looking at what are the things we've observed in people who have successfully exited – young people who've successfully exited aged care, what are the characteristics of those people and what are the attributes that have enabled them to exit. And that is a way of us enabling us to then work with the NDIA around prioritising people's exit. So, for example, what we do know is that – that the successful exits are in part people who have spent a relatively short period of time in aged care.

MR ROZEN: Yes.

MR LYE: And that probably is self-evident to some people, but that's one of the many things we're kind of looking at to say, "Well, to the extent that we have people who have been in aged care for less than 12 months, let's not let that – let's move quickly on that population because it's a – it might help us as a success factor of enabling people to live in the community."

MR ROZEN: Yes. It comes back, doesn't it, to the point I was asking you about earlier, that a follow-up of those approximately 250 people that left under the previous initiative would be helpful information, wouldn't it, to know whether they were sustained departures from residential aged care or whether some of them ended up back in residential aged care?

MR LYE: I do agree. I don't – I don't think that we would ever refuse that additional information if it were possible to collect, and I – and I'm not sure whether it was possible to collect the information or not.

MR ROZEN: Well, it's probably pretty difficult now, I would agree with that, but it wouldn't have been that difficult, presumably, to have done it, perhaps an annual follow-up of a selection of some of those people in the years 2011 through to the current year. Would you agree with that?

MR LYE: Look, I agree that the – in concept, yes. I'm not sure whether the systems at the time would have enabled us to do – to construct that to do that.

MR ROZEN: You see, from an outsider, Mr Lye, you've got the expenditure of half a million dollars, Commonwealth State – sorry, 240 million was the figure you gave us earlier, a significant expenditure of public moneys. It seems curious that there wouldn't be some follow-up to see whether that was money well spent. I mean, for all we know, half that 250 ended up back in residential aged care because the supports provided to them in the community were inadequate. That would represent sound evaluation of a policy, wouldn't it, to ask those sorts of questions?

MR LYE: I agree. I agree precisely with what you're saying - - -

MR ROZEN: Yes.

MR LYE: - - - in relation to 2006 and more recently. I'm just not sure whether what the committee was asking for was technically possible to deliver.

MR ROZEN: Yes, I understand.

MR LYE: Yes.

MR ROZEN: If I could then turn attention, please, to – sorry, before I leave the recommendation, that was a sensible, straightforward recommendation, wasn't it, to put together a database to inform the development of future policy in this area?

MR LYE: I think it's a – it's a reasonable recommendation to say, "Let's understand the people we're dealing with here."

MR ROZEN: Yes.

MR LYE: That's right, and I think it's kind of exactly the thing that we do as a process of the access process for the NDIS, which is where we sit down with people and we talk to them and we establish what their goals are. We are trying to understand the person and what their needs are, and then we try and formulate a package around that person. So it's precisely the exercise we're going through with – under the address.

MR ROZEN: We need to be careful, don't we, Mr Lye? Not all younger people in residential aged care are eligible for the NDIS. Do you agree with that?

MR LYE: Look, that's been our experience that around – I think around 95 per cent to date have been eligible, and a small number haven't.

MR ROZEN: Where does the figure of 95 per cent come from, Mr Lye?

MR LYE: You're testing my memory. I believe it's a figure that comes from the NDIAs, you know, accumulated, you know, access requests versus access granted stats.

MR ROZEN: All right. You'd probably refer us to them for further questioning about that figure if that's where it's come from, from the NDIA?

MR LYE: I believe so.

MR ROZEN: All right. We turn then to the current plan, the action plan. You tell us in – or rather the department tells us in – just excuse me a moment. Sorry, Mr Lye. At paragraph 49, if that could be brought up from tab 2, please. The next page, please:

> *The Commission is informed –*

at paragraph 49:

> *…that in October 2018, DSS was asked by the officers of the then Minister for Families and Social Services, the honourable Paul Fletcher, and Minister – Assistant Minister Henderson to develop a strategy to address the issue of younger people in residential aged care.*

Were you the officer at DSS that was – to whom that request was extended?

MR LYE: I believe so.

MR ROZEN: Yes. And October 2018 is, of course, one month after the Royal Commission was announced – this Royal Commission was announced. Was the ministerial request to you couched in terms of, "We need this plan because the Royal Commission is going to be examining the issue of younger people in residential aged care"?

MR LYE: No, not to my knowledge. No.

MR ROZEN: Is it just a coincidence that eight years or seven years after the previous initiative this one arose so shortly after the Royal Commission was called?

MR LYE: What I would say to you is that from where I – from where I sit, young people in residential aged care as an issue has been a significant focus for the – for the government, and, for example, there wouldn't – look, I can't recall a Senate Estimates hearing in the time that I've been in my position where we haven't provided to government senators - - -

MR ROZEN: Yes.

MR LYE: - - - a snapshot of where we stand in terms of young people in residential aged care, and it was a particular focus for the Assistant Minister. And I believe in part that's because she was interacting with people in the community who were telling her this was a very important issue. And so my memory of October 2018 is that this was the next phase in a continuing exhortation to us to take this issue seriously, and I think the work that we had commenced in twenty – late 2017/2018 in relation to both SDA, Specialist Disability Accommodation, and into the health interfaces were in part because of – because of this issue. So, you know, there was a long – there's been a long consideration of the need for attention to the issue. I think the government wanted to shine a light on it.

MR ROZEN: Yes.

MR LYE: It may or may not have been, you know, coincident with the start of the Royal Commission, but I wasn't aware of that.

COMMISSIONER BRIGGS: Why then, Mr Lye, did the department persist for so long in maintaining its cruel policy that the Commonwealth couldn't meet the cost of nursing and allied care for young people with disabilities in the program?

MR LYE: You're referring to the – prior to the DRC decision around health supports?

COMMISSIONER BRIGGS: Yes. Yes.

MR LYE: Look, I think from my perspective, the – we had initiated a discussion around provision of clinical supports for people with disability because it became obvious to us that the APTOS principles that had been designed to govern the rollout of the NDIS, while providing, you know, some level of guidance, were not specific and concrete enough to engage with at an operational level. We took the view that it was very, very important to insist that people with disability involved with the NDIS not be denied access to mainstream health services. It's a very important part of the NDIS.

The States took the contrary view to say that where a – clinical supports were a function of the person's disability, that the NDIS should fund that. We – although we couldn't agree for a period of time with the States around that issue, we did get agreement, I think it was, from memory – I think it's in the statement from December 2018, to make sure that while we were trying to resolve these issues that people did

not – weren't – didn't fall through the gaps. And so while in that phase, I believe that some people would not have had some clinical supports in their plans, State and Territory Governments were prepared to meet those requirements while we negotiated an outcome.

So I think there was an intent there both to – well, a recognition that the APTOS principles didn't provide enough specificity to deliver services and provide continuity for people. And I think there was a – while we couldn't agree, we hadn't resolved it, there was also a determination that it was very important we not let people fall through the gaps. So I think there was an intent not to leave people stranded. Now, I don't – I don't pretend that there would not have been individuals who weren't – who didn't fall victim to that issue and – but the intent was to try and make sure that didn't happen.

COMMISSIONER BRIGGS: Why then was this presented to the public as it was a statutory issue rather than an administrative practice when you're now able to change this approach without legislation?

MR LYE: Look, I think it goes to people's interpretation of the scheme, the intent of the scheme, and I think we – and I don't know that anyone would disagree that just because we have a National Disability Insurance Scheme that we then say that it's acceptable for people with disability not to have the same access as other Australians to mainstream services, like health services. I just think that that's a really important principle - - -

COMMISSIONER BRIGGS: Yes.

MR LYE: - - - which we held very strongly to. In Commonwealth State relations we –I'm sure it won't surprise anybody that we are very kind of mindful of an attempt, and probably recognise we do it ourselves, around shifting the goalposts between jurisdictions. In this case, what was at risk was people's fair access to mainstream services. As we went on in that discussion and we maintained our view of the world and the states maintained theirs, we – I think it's fair to say that the Commonwealth, the NDIA and DSS went back and said, "Okay. Let's look at this afresh. What are we trying to achieve? What is in the best interests of the individual?" And I think we decide ourselves that there was a way to agree a practical outcome for health interfaces that would provide – that would basically be in the interests of participants and not violate that important principle of the NDIS.

So we did actually go back and say, "We're at an impasse here. Let's look at this problem from every angle. Let's look at this a different way." And we got significant assistance from, you know, people on the board of the NDIA, for example, who brought their wisdom, people with lived experience, to the problem and we looked at it afresh and we said, "Well, it's very important that we get an outcome here."

COMMISSIONER BRIGGS: So these things can be done.

MR LYE: Correct.

COMMISSIONER BRIGGS: Mr Rozen, I interrupted your flow of questions.

MR ROZEN: No, thank you, Commissioner. If I could just ask a follow-up question on that if I might, Mr Lye. I noticed you didn't respond specifically to Commissioner Briggs' question about why it was presented to the public as a statutory limitation on the NDIS – sorry, on the NDIA, rather than it being an administrative decision that had been made not to make those particular payments. It's the case, isn't it, that it was expressed as a statutory limitation?

MR LYE: I honestly can't recall that it was, but I would say to you in the spirit of the question that it certainly in our minds, the APTOS principles which were agreed between the Commonwealth and States, and the States were a really important construction and we – we did argue that our reading of those principles which had been agreed - - -

MR ROZEN: Yes.

MR LYE: - - - meant that we shouldn't fund certain things. In the course of that discussion we very much did that.

MR ROZEN: I think you accepted a moment ago that despite a will to ensure that people didn't slip between the cracks during that time that there may well have been individuals who did not receive the support that they would have had the policy been differently applied?

MR LYE: Well, I think – I think what I would say is that, I mean, yes – yes, that I don't doubt that people fell through the cracks.

MR ROZEN: Yes.

MR LYE: But I suspect that the issue that we have had is that while we didn't have a more concrete set of arrangements between the Commonwealth and the State, people applied the APTOS principles as they saw – as they best understood them, and so the NDIA would have said the APTOS principle means we won't fund this in your plan. An official from, you know, a state health department or working in a hospital in New South Wales would have applied the APTOS principle as they understood it. And the net effect of people choosing their own interpretation or staying with their own interpretation of what was a high principle, I think would have meant that in some instances people didn't get a service that they were entitled to.

And that is obviously one of the reasons that we, in the disciplinary reform council process, prioritise this work because we could see that clearly there was a problem.

MR ROZEN: What was the duration of the stand-off. Are you able to tell us?

MR LYE: Look, there's a number of reasons why it took time to negotiate but, you know, possibly 18 months - - -

MR ROZEN: I see.

MR LYE: - - - is my memory, so you know, that it took from go to whoa.

MR ROZEN: It's possible, isn't it, during that 18 month period there were younger people in residential aged care who, had they been provided with that additional support may have been able to leave residential aged care?

MR LYE: Look, it is possible. I mean, I think that the – you know, you'd want to align that with the rollover scheme and see how far we had got into access and planning discussions with how many people. But I do think that – you know, what I would say to you is I can't tell you that there weren't people who were worse off as a result of that.

MR ROZEN: After that long interlude, can we go – can I take you to the 2019 plan, and in particular, can I ask you about the briefing note that was cleared by you on 6 March 2019 that led to ministerial approval, ultimately, of the plan. It's behind tab 145 of the general tender bundle. And do you recognise that, Mr Lye, as the front page of a general brief that you cleared to go to Minister Fletcher?

MR LYE: I do.

MR ROZEN: Together with Assistant Minister Henderson. This is the briefing note that gave effect to that request that you received from both the Minister and the Assistant Minister back in October of 2018.

MR LYE: That's right.

MR ROZEN: What has happened in the intervening five months or so, was there – you tell us, presumably a consultation process?

MR LYE: So largely an internal process with the NDIA and with Health - - -

MR ROZEN: Yes.

MR LYE: - - - to develop the plan.

MR ROZEN: Yes.

MR LYE: I think we refer to it in our evidence that there was targeted consultation with a number of organisations, confidential consultation in which we put material to – to them and they provided feedback to us, so – but that was not a full-blown public consultation.

MR ROZEN: That targeted consultation was with various organisations including the Summer Foundation.

MR LYE: Correct.

MR ROZEN: The Younger People in Nursing Homes Alliance.

MR LYE: Correct.

MR ROZEN: And Youngcare, I think, were the three organisations that were the focus.

MR LYE: I think that's right. Yes.

MR ROZEN: Without taking you to each of the documents which are in the tender bundle that record that to and fro between the department and those organisations, there were a series, or at least two presentations made by the department to those organisations of the proposed plan, feedback – you will need to say yes to be recorded on the transcript.

MR LYE: Yes, yes.

MR ROZEN: Thank you. And feedback came by way of verbal feedback at sessions when slides were shown to them of what was envisaged; is that right?

MR LYE: Yes, yes.

MR ROZEN: And there was also some written feedback provided.

MR LYE: Correct.

MR ROZEN: Is it fair to say that the original proposal that was put up by the department to those three organisations in that targeted consultation process was quite a bit more ambitious in terms of goals than what is ultimately reflected in the action plan?

MR LYE: Well, my reading of the goals that we've agreed are ambitious.

MR ROZEN: Yes. My question is a different one. I mean, we can argue the toss about how ambitious they are but the original goals were more ambitious, weren't they?

MR LYE: I'd have to go back and have a look at – if I could look at the - - -

MR ROZEN: Yes, let's do that. So if you go to tab 10, please, of the general tender bundle and according to the DSS statement, this was the first proposal that was put up to the three groups on 9 January 2019. So about six weeks before the briefing

note that I just took you to a moment ago. And if we can go to the second page of that which is .1943, they're the six goals that were originally proposed by the department. Am I understanding it correctly?

MR LYE: Yes.

MR ROZEN: If we look at the first goal:

Halve the number of NDIS eligible younger people in residential aged care by 2022.

That is a considerably more ambitious goal than ultimately appears in the action plan, isn't it?

MR LYE: That goal is now 2025, that's correct.

MR ROZEN: And the 2022 goal is limited to those under 45?

MR LYE: I think – I mean, my reading of our goals is that we are supporting the entire population in residential aged care to get out by 2025.

MR ROZEN: Yes.

MR LYE: And – and those under 45 by 2022.

MR ROZEN: Yes. But the goal - - -

MR LYE: And that - - -

MR ROZEN: Sorry.

MR LYE: And I think that reflects a judgment that, if you look at the – the pace at which we expect special disability accommodation to ramp up - - -

MR ROZEN: Yes.

MR LYE: - - - that that – that that is an achievable target and that it's possible that the – that the first – the first goal which doesn't separate out younger people with the older cohort within the young people population, would not be matched by the development of SDA coming through, in the pipe line.

MR ROZEN: I understand.

MR LYE: So I do accept your point that the goals is – I do accept your point that the goals are less ambitious than the – what was discussed.

MR ROZEN: Yes.

MR LYE: Yes.

MR ROZEN: Okay. Thank you, so that's the answer. And that first goal, for example, of halving the number of NDIS eligible younger people in residential aged care by 2022 has become a goal of supporting people to leave if that's their choice. That's quite a different goal, isn't it, to that one which is numerical and measurable. We've ended up with a very different sort of goal, haven't we?

MR LYE: On one – on one hand, maybe, but we – we don't have within our policy remit the ability to do more than test people's willingness to move. We – the choice and control principle of the NDIS, we don't have an ability to go beyond that.

MR ROZEN: Yes.

MR LYE: If you understand what I mean.

MR ROZEN: Yes, I understand.

MR LYE: And so it's always – it will be a rider – it's a rider that's – it's an integral feature of the NDIS. So we – we can't say to you that we have a goal to – for everybody who is under 65 to be out of aged care.

MR ROZEN: Yes.

MR LYE: We have that goal, we're very clear about that, that it's not an appropriate venue for people with disability, and we will get to the entire cohort of people. We will seek to get them, to give them the option and seek to encourage them to – to live in the community because of that primary belief, but we can't make them.

MR ROZEN: Yes, I understand.

MR LYE: And so the goal is – the goal is to get everybody out.

MR ROZEN: Yes.

MR LYE: But way can't overstep our mandate as we have with the – that we have with the NDIS. It's not up for – it's not up for negotiation. It's not up for negotiation in part because people with disability advocated for and gained a scheme where they would be in the driving seat around choice and control. So we don't have a degree of freedom there, so the goal can't be beyond – I don't believe can be beyond that.

MR ROZEN: Okay. I understand that.

MR LYE: Yes.

MR ROZEN: We may be at cross-purposes. I'm just trying to establish a simple point which I think you've answered, that is, that the initial goals were more ambitious than what emerged from the consultation process and I'm just trying to understand that because it's almost counter-intuitive. One would have thought that a government would go up with a proposal and after consultation with advocacy groups might end up with something more ambitious rather than less ambitious. I'm trying to understand why you ended up with a less ambitious set of goals as a result of consulting with the advocacy groups. Are you able to enlighten the Commission there?

MR LYE: I think – I think our – I mean, look, our judgment is that we want to have something that's achievable and the worse thing we could do, I believe, is say that we can do something by 2022 which we can't achieve.

MR ROZEN: Is that what they told you, that your initial goals were not achievable.

MR LYE: No, I don't believe – I don't believe they would have. I think they would have encouraged us to set a stretch goal, to set an ambitious target. I'm sure that was the case.

MR ROZEN: We don't really have time for me to take you to all of the documents. But the documented responses did come back, I suggest to you, and tell you that the goals were too ambitious. For example, they were based on assumptions about the availability of specialist disability accommodation which were not realistic under current government policy approaches. That was the feedback you got, wasn't it, from the Summer Foundation?

MR LYE: I'd have to go back and have a look, but I mean, that is my judgment that that was the case. I said that to you in my answer that I believe that the – if you look at what we would expect with the SDA pipeline - - -

MR ROZEN: Yes.

MR LYE: - - - that the more ambitious goals are not achievable. That said, I think it's probably too early – it's probably too early to tell.

MR ROZEN: Yes. I'm just trying to understand why the more ambitious goals were put up in had the first place by the department if they were, as you now say, not achievable. What's the explanation for that, was there a lack of understanding on the part of the department about the availability of specialist disability accommodation?

MR LYE: I think we – I think we wanted to genuinely test propositions with the – with the sector.

MR ROZEN: Right. Okay.

MR LYE: Yes. And I think – I think, you know, that we will often go out and test things and then people will give us a view one way or the other.

MR ROZEN: I don't think anyone is going to be critical of the department for consulting with the organisations. I'm just trying to understand the process. Can I take you back to your brief, please, and there's two things I want to ask you about it. This is tab 145 of the tender bundle and if we could go to page .1899, please. Firstly, I want to ask you about money, about what sort of funding is attached to this plan. If I can draw your attention to paragraph 24, please, in the middle of that page, if that could be highlighted. So there's a recognition in the earlier part of the briefing paper, I suggest to you, that the NDIA would be central to achieving the goals of the action plan. Is that a fair summary of what precedes this paragraph?

MR LYE: Yes.

MR ROZEN: Yes. And then paragraph 24, the brief says:

> *As the NDIA is currently focusing on transitioning more than 200,000 participants into the scheme the timeframes set out in the action plan are constrained by competing priorities and resources. One of the actions in the action plan –*

perhaps that's a typo –

> *...refers to exploring the benefits of specialised plan implementation services, should result in fewer entries to aged care but this may be dependent on the NDIA having access to additional resources. Achieving other NDIA actions in the plan to provide better access to expert assessments and hold discussions with younger people in aged care about their accommodation could be accelerated with additional NDIA operating resources. This may require a decision by government.*

Is the Commission to understand from that that what you're seeking to communicate to the government and to the ministers is that we're more likely to achieve the goals in this plan if there's some additional resources made available to the NDIA?

MR LYE: Correct.

MR ROZEN: But the government's position was that there would be no additional resources made available to the NDIA to achieve the goals. That's right, isn't it?

MR LYE: No. No. The government has – has made decisions to increase resources to the NDIA to enable them to, in particular, implement their complex pathways process, which I think that paragraph kind of refers to, and so they have enabled the agency, I believe, the additional resources required to meet the goals in the plan, but - - -

COMMISSIONER BRIGGS: How much is that? How much in extra resources, Mr Lye?

MR LYE: So there's two – I mean, there's two separate processes that have sought to increase the staffing available to the agency to – to – to do a range of things, but in particular to implement the complex pathways process. But I can't give you a – a dollar figure.

MR ROZEN: There's no additional funding at all that's specifically linked to the implementation of this action plan, is there?

MR LYE: I mean, the – do you mean in an administrative sense or in a funding program sense?

MR ROZEN: Well, I'm a novice in such things.

MR LYE: Okay, I can – I'll go to both.

MR ROZEN: I'm just reading the briefing, if we go down the page to paragraph 27, it says:

Departmental funding NA.

Which I assume means not applicable. And if we go over to the following page just for completion, page .1900, right at the bottom under paragraph 35 it says:

Financial implications not applicable.

What are we to make of those references; that suggest there's no additional funding, doesn't it?

MR LYE: So the decisions that are taken by government in relation to resourcing of the agency were taken as separate to this process. The paragraph, as you rightly point out, refers to the – the fact that government needed to make that separate decision - - -

MR ROZEN: Yes.

MR LYE: - - - or decisions to resource the agency should they want to achieve the goals in the plan. And that's taken separately to this brief, those decisions. I think the second point I'd make is that it's not true to say that there's not funding to achieve the – the plan. The – the NDIS is a demand-driven scheme. It's about targeting that huge gun at – at the – at the problem and so the money flows as we identify people in the – young people in the aged care population, we seek to get them into the scheme and put the plan – plans around them. And there's – and that's a demand driven process so there's significant – I mean, there's significant funds at that. And so that the plan is not so much trying to identify, like we had done in

previous initiatives, identify a defined bucket of money to – to give to this – to these people, that is already there, designed into the NDIS.

COMMISSIONER BRIGGS: So in fact you're saying it's an entitlement driven system and should everyone at this moment desire to leave aged care, that that would automatically be funded should alternative accommodation and other supports be included as part of that – each individual's plan?

MR LYE: That's right. And so it's hugely important, the health interface and getting that issue of the supports that would give people the confidence to live in the community, to give them that confidence. So that health interface process that we went about separately is very important. The development of SDA is also hugely important and to – to people realising their goals but essentially this issue is now, with the NDIS, not necessarily one about additional funding. It's about getting the systems right and the development of the SDA market.

COMMISSIONER BRIGGS: And in effect your evidence earlier on that the cost at least assessed at one stage was about seven or eight hundred million to do so; is that what you would think would be the additional dollars that would then automatically flow to the NDIS to deliver this entitlement-based support system?

MR LYE: Yes, I mean, I'm just saying that the current population within the NDI – within the NDIS in residential aged care, younger people, you know, I think the average package costs at the moment are about $132,000 per annum.

COMMISSIONER BRIGGS: Right.

MR LYE: And if you multiply that out by the population that we're talking about, you get into that territory.

COMMISSIONER BRIGGS: Thank you, that's helpful. Thank you, Mr Rozen.

MR ROZEN: You understand where I'm going with this, don't you, Mr Lye. Your evidence earlier was that the 240 million spent on the previous initiative, 2006 to 2011, was a drop in the ocean, I think was your expression.

MR LYE: Yes.

MR ROZEN: The Commission is charged with, amongst other things, evaluating the likelihood of success of the current plan and it's there that the question of what sort of resources the government is making available to it becomes particularly relevant.

MR LYE: Material.

MR ROZEN: That's the context in which I'm asking you questions.

MR LYE: Yes. And, look, to be fair, what's not in the actual action plan - - -

MR ROZEN: Yes.

MR LYE: - - - and possibly for the purposes of this Commission we could write a better document, I think, to quantify like for like and so, you know, that would look like, you know, probably around a billion dollars per annum, you know, seven hundred to a billion dollars targeted at this group, and getting the processes right around that to make it happen. So the – that's what you're comparing; you're comparing $244 million over five years back in 2006 and you're comparing, you know, at least seven hundred to eight hundred million dollars per annum at the problem.

MR ROZEN: Yes.

MR LYE: So it's a very, very different – that's what we've got targeted at this, albeit that that – I acknowledge, that's silent in the plan. We don't talk about those dollars in the plan and we kind of assume knowledge, I suppose, that people understand we've got a demand-driven scheme here, and we've got to get this – that will flow so, yes.

MR ROZEN: Thanks for that clarification. Now, I think as had been suggested, Mr Lye, and I apologise to you for doing this, but the next witness, Mr Radley is available to be called and so I'd like to interpose him now, and Ms Bergin will lead that evidence, Commissioner.

COMMISSIONER BRIGGS: Mr Lye, we will see you, I think, after lunch.

MR LYE: Okay.

COMMISSIONER BRIGGS: Thank you.

<THE WITNESS WITHDREW **[12.33 pm]**

MS BERGIN: Commissioner, if we could please have a short five minute adjournment to allow Mr Radley an opportunity to enter the witness box.

COMMISSIONER BRIGGS: Of course, Ms Bergin.

MS BERGIN: Thank you.

ADJOURNED **[12.33 pm]**

RESUMED **[12.41 pm]**

COMMISSIONER BRIGGS: Ms Bergin.

MS BERGIN: I call Neale Marcum Radley.

<NEALE MARCUM RADLEY, SWORN **[12.41 pm]**

<EXAMINATION BY MS BERGIN

MS BERGIN: Operator, could you please bring up WIT.1251.0001.0001. Mr Radley, is there a copy of your statement there on the screen in front of you.

MR RADLEY: Yes.

MS BERGIN: Commissioner, I tender the statement of Neale Marcum Radley dated 3 September 2019.

COMMISSIONER BRIGGS: Yes, the witness statement of Neale Marcum Radley dated 3 September 2019 will be exhibit 9-8.

EXHIBIT #9-8 STATEMENT OF NEALE MARCUM RADLEY DATED 03/09/2019 (WIT.1251.0001.0001)

MS BERGIN: May it please the Commission.

Mr Radley, could I ask you to read from your statement commencing at paragraph 3, please.

MR RADLEY:

> *My name is Neale Radley. I am 52 years old. I have been living in a residential care facility for almost four years. The facility is about 350 kilometres from Melbourne and about 150 kilometres from Bendigo. I used to travel around Australia as a truck driver. I was an – independent and hardworking. In February 2014, I had a diving accident. It was on a houseboat with some friends and I dived into shallow water. The accident left me as a C3/C4 incomplete quadriplegic. Every day I am reminded of how different my life is now compared to before the accident. My accident was a mistake that I have to deal with for the rest of my life. My accident has forced me to learn how to live again.*

Before my accident I was an active person that loved the outdoors. I didn't like being shut in an office and kept between four walls. I enjoyed camping, fishing, sport, being fit and meeting up with friends on the weekend – weekends. I think being in good shape helped me survive the accident.

I now have some movement in my left arm. I can do things like drive my chair and shave, but I cannot move other parts of my body. I need a lot of help looking after myself. I have three siblings, one lives in Brisbane, the other two live near Bendigo as do my parents. They mean everything to me. My parents visit me nearly every day, and even though they have to drive for about an hour and a half from Bendigo, my dad calls me most nights. It hurts knowing what I have put my parents through. It is hard because I thought I'd be the one looking after my parents at this time of their life, but they are having to look after me instead.

After the accident I was treated in hospital before being moved to a spinal rehabilitation centre. I received a lot of help at rehab. Throughout the week I would have appointments with an occupational therapist, physiotherapist, social worker and specialised nurses. Together they pushed me hard to achieve my goals of becoming more independent. Going into rehab also allowed me to meet people who were living through similar circumstances. I realised that there are other people similar to me and it meant there was always someone to talk to.

Moving to the facility: I knew I couldn't stay in rehab forever, and I needed somewhere long-term to live. I looked for alternative – alternative disability housing but there was nothing available. My parents could not take care of me at home. My mum has Parkinson's disease and my dad is 86 and caring for my mum too. I had to make a decision. I wanted my family to know I was being looked after. After realising there was no other option, I was assessed by an Aged Care Assessment Service. Once assessed, I tried to get into some aged care facilities in Bendigo or Melbourne, but each one said that my care needs were too high. I wanted to move as close as – to mum and dad as I could. Where I live now was the only place that had a spot available to – for me.

I didn't have any other options so I took it. It was one of the most difficult decisions of my life. I didn't realise how good rehab was until I ended up in aged care. Usually I stay in the facility all day. My day starts about 9 when I am given my – my day starts about 9 when I was given my morning tablets and breakfast in bed. Around 10, two care staff clean me with wet wipes, dress me and put me in my chair. This usually takes about an hour and then the staff return about an hour later and bring my lunch in my – in my chair. They attach a device to my wrist to help me hold cutlery and feed myself. I stay in my room for the rest of the day until about 7.30 in the evening when care staff undress me and put me back into bed. They put my table next to me and set up my voice recognition software so that I can use my computer or change my – the television channels.

At 9 pm I get a bladder wash-out and take my evening – evening medication. The care staff turn me on my side throughout the night at 2 am, and 5 am they come in and turn me again. Each second evening about 7.30 care staff undress me and give me a couple of suppositories. I am wheeled into the bathroom and placed onto the toilet. I sit there for about an hour waiting for my bowels to move. I have no stomach muscles so it takes a while when I shower myself – then I shower myself, brush my teeth and shave. Two care staff then put me to bed.

Clinical care: The facility doesn't have the right people with experience caring for someone like me. If something happens to me that requires medical attention, then I am taken by ambulance to Bendigo. I have nearly died three times on the way to Bendigo during an emergency. Reliability and consistency of care mean everything to me. When care is reliable and I can have a routine and a plan, when I can get things done, it makes me feel more in control and comfortable relying on other people.

Once, my appendix burst and it was a day before anyone picked it up because my routine had not been followed that day. I knew something was wrong, but the staff didn't notice. I think that living in a facility with other residents meant that the care staff sometimes don't have the time to care for me in the way that I need.

When I first moved into this facility, my dad would come to the facility every second day and stretch my arms and help me with exercises. The physiotherapist at the rehab centre taught him. Then I was approved for my first National Disability Insurance Scheme plan in April 2016 and started to receive allied health services through my plan. Living in a rural area makes funding, finding services and using my plan difficult. It took a year and a half for me to find a carer. My OT and physiotherapist are in Bendigo. I have to email them if something is really wrong and the facility staff don't know how to fix it.

When I need to see the physiotherapist or OT, I have to book an appointment and travel to Bendigo or Melbourne. This means that I end up using a lot of my funding for travel and I usually need about eight hours of carer support to travel to Bendigo or Melbourne for an appointment. If I have to travel less, it would have extra money for extra services. I would be able to go out from the facility three times a week for the same price as I am for now, an outing once per week.

Before my accident, I was a social person. I enjoyed spending time with my friends and family. I didn't get to be social anymore. I didn't want people to come and see me here. I have seen a lot of my friends' faces when they do visit. I try to put on a brave face when I don't have much to talk about. When my friends come to the facility it feels like they are coming to visit me, rather than

just hang out. They come, they see me and they go. They don't come for a barbecue, watch a movie and stay the night if they needed to.

One of my biggest fears about coming in here was watching the people around me die. Since moving into the facility, about 30 or 40 people have died. The people who I have liked, admired and gotten close to while I've lived in here have all since died. I have to start distancing myself from people so I didn't have to deal with their death. Being in a place where people are constantly dying isn't the right place for young people. I feel isolated and alone. The only social support I have is a group in Bendigo called the Spinal Injury Resources and Support Network, SPIRE. It's a peer support program for people with spinal injuries. I have gotten to know members of the group and I can call them if I have a problem. The group meets every second Thursday of the month in Bendigo. I try to get there to as many meetings as I can.

If I have spare time after an appointment, and it's a good day, then my carer might take me around the lake in Bendigo. I have spent a lot of time on my computer. Otherwise I would just sit in my room and do nothing. My main goal for my NDIS plan is to get in supported housing in Bendigo. I want to live in the community and be close to my family. I have nicknamed my room Cell 14 because I don't have the freedom to get out. I feel like a prisoner. The outside doors are kept locked. When my bedroom door is shut, I cannot open it on my own. I have to ask someone to let me out and then to let me back in.

I know that the specialist disability accommodation SDA houses have automatic doors that can open and shut for you. In rehab I was encouraged to learn ways to do things without relying on people and to be independent, but in the facility has stripped my independence away. There are policies and rules that prevent me from locking – from looking after myself like a learned to in rehab. A lot of rules are made for older people or people with dementia but don't apply to me.

In March 2019, I was approved for SDA. It took me roughly six to eight months, if not longer, to get my application to be approved after submitting it. My NDIA support coordinator did so much work to make sure that the application had everything it needed, including an assessment by my OT. It received – I received an acknowledgement after we submitted the application, but it didn't – I didn't hear anything after that. I just had to wait. It felt like I was climbing a mountain.

It took so long that I tried not to get my hopes up along the way and hoped that I didn't miss out on housing because I was still waiting. A few places did become available in Bendigo, but I couldn't apply because I didn't have the approval yet. It was disappointing and frustrating. I didn't know if or when these places will become available again.

My biggest fear now that I have approval is a house becoming available outside Bendigo. I want to live in Bendigo, but I don't know how long it will take for a house to become available there. It's hard knowing when or where accommodation will become available, so I think maybe I just have to take everything that comes up. Even if I have to wait for it to be built, knowing that I have a place would please give me direction and make me feel like there was a light at the end of the tunnel.

I am going to a meeting this month with a planner who is thinking about building SDA in Ballarat and Bendigo. I don't want to get too confident about this meeting because so far when I do, I just get disappointed. The housing would have three bedrooms for two people with disabilities and one carer. I would like to live with someone of similar age and disability. It would be nice to live with someone with similar care needs and interests, and we might be able to through our challenges together.

I hope that if I get SDA, then Mum and Dad can take a step back and start living their lives. They have both given up their lives to look after me. I want to live in the community and be surrounded by people my own age. I want to be closer to my family and my support group. I don't want to be isolated like I am now. If I lived in SDA, I would be closer to services, hospitals and the support I need to live a happy life.

In SDA there would be less people dying around me. It would all make such a difference. Living in a bigger town would allow me to get more out of my life. It would allow me to use more of my NDIS plan on services and activities instead of travel. I want to be able to do a TAFE course, go down the street and enjoy myself and get around on my own. I cannot do that at the facility. As a quadriplegic, being independent means a lot to me, and being able to do even a few things without needing help or to ask someone would mean a lot. I am hopeful that I will get my freedom and my life back.

I wanted to give evidence to the Royal Commission because I want things to change. Even if it only stops one other younger person going into a nursing home, it would still be important. Aged care will never be appropriate place for young people to live.

MS BERGIN: Thank you very much, Mr Radley, for sharing your story with the Royal Commission today. It is appreciated. I have no questions for this witness, Commissioner.

COMMISSIONER BRIGGS: Mr Radley, thank you very much for coming in today to give evidence. I can't list as many of the things that you've raised, but issues about reversing the roles between yourself and your parents and the stress that that puts on them and on you - - -

MR RADLEY: Yes.

COMMISSIONER BRIGGS: - - - is pretty fundamental, as is the loss of privileges. Even to be able to control access to your own room is a terrible, terrible thing and, in many ways, quite cruel. I think we've been discussing this morning issues which you might have heard about how quickly SDA can be made available to people such as yourself, and it's distressing that it takes six to eight months just to get your application in the right form in order to get the supports that you might need, and that you've got to wait a long time.

And yesterday we heard a little bit about whether or not the system can provide for people who live in rural areas, and it disturbs me that it's very hard for people such as yourself to get the accommodation and supports you need, at least at this stage. I'm really grateful for you coming in today, and I want to thank you for your evidence, and you are excused, Mr Radley.

MR RADLEY: Thank you.

COMMISSIONER BRIGGS: - - - from further giving evidence. Thank you.

<THE WITNESS WITHDREW [1.00 pm]

MS BERGIN: May it please the Commission. Perhaps a short adjournment for lunch?

COMMISSIONER BRIGGS: Yes, I think we might adjourn till 1.30.

MS BERGIN: Okay. Thank you, Commissioner.

ADJOURNED [1.00 pm]

RESUMED [1.35 pm]

<MICHAEL PATRICK LYE , ON FORMER OATH

<EXAMINATION BY MR ROZEN

COMMISSIONER BRIGGS: Mr Rozen and Mr Lye, welcome back.

MR LYE: Thank you.

MR ROZEN: Thank you, Commissioner. Mr Lye, I'm not sure if you were present in the hearing room when Commissioner Briggs asked a previous witness, Dr Hartland, about the difference in entitlements that a person with a disability would have living in residential aged care on the one hand as compared to living in the community, so the same hypothetical person. Is that something that you can assist the Commission in relation to, or is it a question better directed to the NDIA?

MR LYE: Possibly the NDIA could add more specificity to it, but my general understanding is that the cost of providing the function, the service within the community is higher than what it would cost in aged care.

MR ROZEN: Yes. We know, for example, that the Aged Care Funding Instrument money, the ACFI amount, which is ordinarily payable as a subsidy by the Department of Health to an aged care provider, is administratively picked up by the NDIA in such circumstances, and the question is what beyond that would a person be entitled to whilst living in residential aged care, and perhaps as you suggest, that is something more appropriately directed at the NDIA?

MR LYE: Possibly. I mean, in general terms the – the plan would encompass things like capacity building and other activities to enable a person to engage with the community. Those sort of things that are part of a normal NDIS plan and that one component is, you know, acquitted by that cross-billing arrangement.

MR ROZEN: Yes.

MR LYE: But the NDIA could probably give some more specific details about the kind of supports that are in people's plans who are in residential aged care.

MR ROZEN: What's the legal or policy rationale for the different way in which the groups are treated?

MR LYE: I guess that we're attempting to recognise the reality, the current reality that people are in aged care. I think the action plan obviously shows our policy intent which is that we would – the idea of the NDIS is that those people are not in aged care, that they're in the community and that we're providing supports, an NDIS plan for them to do that. So we're recognising the current circumstances rather than, you know, that there's some – there's not a policy design in it.

MR ROZEN: Am I to understand from your evidence that looking at the Commonwealth as a whole and not dividing it up into agencies but looking at the Commonwealth as a whole, for a given person with a disability it's cheaper for the Commonwealth if that person is in residential aged care than if they're in the community?

MR LYE: Well, I mean, the – there is no – I would answer your question that there is no – there is – there's no architectural rules or anything of the NDIS, which would preference aged care over a person living in the community. There's no – there's no

– there's no rule or instruction or, in fact, it's against the policy design of the NDIS that someone would seek to get a – to use aged care because it's a lower cost than the NDI – than someone living in the community.

MR ROZEN: I understand that and perhaps indirectly you have answered my question. It is a lower cost.

MR LYE: It is a lower cost.

MR ROZEN: To the Commonwealth. Yes.

MR LYE: But it's against the policy intent.

MR ROZEN: Yes, I just wonder though, I have to ask you this, if some of the inertia that we have discussed in terms of committed efforts to get younger people out of aged care is, at least in part, explicable by the lower cost to the Commonwealth of leaving them there? What do you say to that?

MR LYE: Well, I'm not sure I agree with the premise of your question about inertia because I think we are working very hard and are very committed to helping people get out of aged care and into the community. But the – I mean, I think that the reality is that unless we have cultural change to divert people from coming into aged care, which has been discussed this morning, and also available accommodation and supports, people in the community, then it – then that's a practical impediment.

MR ROZEN: Are you, as a senior representative of your department, concerned about the evidence we heard this morning about the apparent absence of any consideration at the ACAT assessment level of alternative accommodation options that might be available for younger people?

MR LYE: I guess I'm concerned about the default to aged care as a general rule and I am concerned about that we haven't yet achieved a world where people have awareness at the frontline about the NDIS as the first and best option for people with disability. And I think that goes to the work we are doing with the States through DRC, but particularly we have initiated a hospital discharge pilot in South Australia where we are embedding people – effectively NDIS people – hospital liaison officers to, you know, get their hands dirty in that process, to connect with people and to intercept that status quo of defaulting to ACAT, and then ACAT being the most efficient pathway to a discharge outcome for the State health facility so very concerned that – that we disrupt that.

One of our learnings, I think, is that there's a – notwithstanding the available funding through the NDIS, that there's just a very efficient and accepted practice that goes on, and that's no fault of those people working at the frontline, they are trying to find an outcome under lots of pressure but we need to disrupt that and to say actually what we want is for a proper consideration and a timely consideration of someone's access to the scheme as the first and best option.

MR ROZEN: To take you up on your notion of default into aged care, because that seems to be very much what the evidence is revealing, looking at it from the point of view of an ACAT assessor working for a public hospital at a State level, their principal driver there is to get the long-term patient out of the hospital, isn't it? That's really what they're concerned to do.

MR LYE: Look, there is no doubt that – that hospital officials involved in the discharge process or the ACAT process, they're under huge pressure to free up available beds in hospitals.

MR ROZEN: Yes.

MR LYE: And – and that's a constant when – when we have talked to, and we've talked to all of the health CEOs as part of an attempt to try and establish a better level of communication with health departments, you know, that – that is, they feel that pressure very acutely. And so the South Australian pilot which is concluding soon and we're soon to commence bringing people on in hospitals in Victoria is really about having a person there who's – who has NDIS capability and knowledge to get involved with patients and to get them into the access process to work with allied health, to help them develop their request for access, and then to help with the planning process, and in particular, to start the conversation about accommodation and SDA with a person.

And so while it's early days there, the whole of – all the States and Territories are watching that, that first pilot in South Australia and then the coming pilot in Victoria where we simply have to embed somebody with the right knowledge and culture to – to provide and turn that default around.

MR ROZEN: The default needs to be the very opposite, doesn't it?

MR LYE: Correct.

MR ROZEN: People need to be defaulting away from aged care, not to aged care.

MR LYE: Exactly. Exactly.

MR ROZEN: And that's the fundamental challenge here, would you agree, Mr Lye?

MR LYE: That's right. And I think that – you know, to be honest, you know, if you trace back initiatives back to 2006, all the way through the learning is not only is this a question of resources, but it's a question of actually addressing that – that – the status quo, that culture which is – produce that feeder – feeder population of, you know, kind of 1800 to 2000 people every year into – into aged care.

MR ROZEN: Yes.

COMMISSIONER BRIGGS: If I'm right, Mr Lye, the funding differential relates to the level of the ACFI versus the level of something you called SIL, S-I-L. And if I'm right – and you can correct me if I'm wrong – the ACFI arrangement is about $81,000, whereas the SIL will deliver you of the order of $290,000 if you're in the community. So there's quite an incentive for a person with disability to be in the community in terms of funding, and I think the point needs to be made that there is a lot more funding for supports available for young people with disabilities in the community than is available through the ACFI funding formula. Would you agree with that?

MR LYE: That there's more funding, yes.

COMMISSIONER BRIGGS: Significantly more funding?

MR LYE: Yes. Yes.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Now, can I take you back to the briefing paper that I was asking you about before the luncheon adjournment. It's behind tab 145. And we've heard a lot of evidence, including from yourself, about the crucial role of the States and territories in addressing this what has been described intractable issue of younger people entering residential aged care and often spending many years, we just graphically heard just before lunch, at great cost to their quality of life and the quality of life of their families as well. And you spoke earlier today very clearly about the importance of involving the states and territories, particularly those departments with responsibility for health and housing. You recall giving that evidence earlier today, and we've heard it now from several witnesses.

In your briefing paper that proposed to the Minister and the Assistant Minister that this action plan be initiated, you addressed the question of involvement of States and territories at paragraph 34 which appears on page .1900. I'd like to ask you about it. The briefing paper says – it's highlighted on the screen:

> *We've not engaged states in the development of this action plan. Given states have been consulted extensively on SDA reforms, they may criticise the lack of engagement with them on this action plan, which is dependent upon substantial cooperation between the NDIA and state health and housing authorities.*

What was the rationale for not engaging the states on the development of the plan?

MR LYE: We don't engage them on every decision we take at the Commonwealth level. We don't.

MR ROZEN: Yes.

MR LYE: And from time to time that may be the instructions we receive to keep it an initiative confidential, or it might be budget-related. What is true in this case was that we had engaged with them extensively and, to be honest, not just on SDA but on the health interface which was a material issue here. You know, one of the – one of the reasons why the states would argue that people were coming into residential aged care was the failure to address the health supports issue – clinical health supports issue. So we were pretty confident about where they sat on it but, nonetheless, we said to the government, "Whenever we do things unilaterally, whenever we announce things as a Commonwealth initiative and have engagement, there's a risk they will criticise us."

MR ROZEN: We can rule out a failure to consult with the states on the basis of confidentiality here, can't we? That wasn't the reason for not consulting with them, or was it?

MR LYE: I think there was just a preference to initiate – to device the plan and then not to have it subject to lengthy consultation with the states and territories, and we did that on a risk basis that we had a pretty good understanding of where they were coming from. We didn't think there was anything in the plan that was unique that would necessarily cause them distress, but, look, it was a judgment that we took.

MR ROZEN: Was it a directive from the government?

MR LYE: It was a preference.

MR ROZEN: Preference on department's part or - - -

MR LYE: Government's part.

MR ROZEN: On the government's part. So you were reflecting government's preference? Am I understanding that correctly?

MR LYE: That's correct. And that has been the case on regular occasions with the – in this space.

MR ROZEN: All right. It's recognised in the briefing that the states, and presumably the territories, may criticise the lack of engagement. Have they, in your experience?

MR LYE: Not to my knowledge. I would be happy to go back and check, but I don't think so.

MR ROZEN: In the department's response to our notice, if I could draw your attention to paragraph 43 of tab 2 of the general tender bundle – it's page .2853. The question that was asked was:

What projections and/or assumptions underpin the commitments in the action plan?

An example is given of the role of states and territories, and the department has identified four projections and assumptions, the first of which is that:

The states and territories will act in accordance with their responsibilities for mainstream housing, including social housing, and encourage the availability of a private housing market which is accessible for people with disability or disabilities.

That rather strongly suggests, doesn't it, that consultation with the states and territories, at least to indicate to them that that's the expectation of the Commonwealth, could only be a good thing, couldn't it?

MR LYE: Possibly. Look, we engage – we would have engaged, if we had, with the – with disability officials, and I don't know that anybody would have objected on this basis. I think we have a separate challenge in the housing space which goes to the Commonwealth state housing agreement that we – where we fund, I think it's around six billion dollars per annum, and state housing officials are highly resistant to, I suppose, putting in place transparent data around what – around that investment. I think that – I think that is an ongoing issue which we face a challenge on.

MR ROZEN: You see, what I'm going to is understanding why this plan's going to succeed to any greater extent than the 2006 to 2011 initiative did. That's what the Commission's interested to understand and to hear from you about. There, we had a COAG initiative, all governments involved at the highest level, significant funding, five-year period. Here, we don't have that sort of COAG commitment. It looks like a unilateral Commonwealth initiative with no consultation with the states and territories. And subject to what you said to us earlier about NDIA funding, we've got no specific funding identified for this plan. So why do you say this is going to succeed?

MR LYE: I kind of don't – I can't – I don't – I don't agree with that proposition. I think that, as I said to you, to compare, you know, what was the maximum $244 million over five years versus where we intend to get to, which is, you know, in the order of seven to eight hundred million dollars per annum, like, that is a huge difference.

MR ROZEN: Yes.

MR LYE: That is a quantum difference, and I would trade COAG – COAG intervention on an issue with the COAG council DRC endorsement of what we're doing in this space, which I think we do have support for. So I think the two things are chalk and cheese. I think that what – the reason this initiative will succeed is because of that NDIS, you know, demand-driven assistance that is bespoke to each individual's needs, backed by the resolution of the mainstream interfaces around

health with the states and territories where we do have agreement and we are implementing agreement with the work we are doing around recognising the cultural barriers, which is the hospital discharge piece and with our work around the development of SDA, I think, you know, I am optimistic about this plan because of the scale of what we're doing, and I think we have learnt from 2006.

MR ROZEN: Can I just try to understand on the funding question, the evidence that you gave earlier about the NDIA being demand-driven, and the demand essentially driving the amount of money that is made available to meet people's needs. It's not the case that the NDIA doesn't have a budget. It does, doesn't it? It has an annual appropriation, like every other Commonwealth agency; is that right?

MR LYE: That's right.

MR ROZEN: And so that 700 million or whatever the figure has to be found within the existing budgetary allocation that the government has made available in any given year.

MR LYE: It does, but the government has made abundantly clear that as a person comes forth and wants to seek to test their eligibility, if they're eligible for the scheme they will be funded to the amount that is judged to be reasonable and necessary for that person. There is no question about that money being provided.

MR ROZEN: But does it follow then if there's a limited, finite budgetary allocation for the NDIA, that if extra money has to be found in relation to 100 or 200 or whatever happens to be younger people coming out of residential aged care in a given 12-month period, that that money has got to be taken away from some other aspect of the NDIA's functions, operations?

MR LYE: Well, I mean, that provision is fully funded for, and it will be provided. There's no – the government has been very clear on that point. There's no question about that. And, you know, in the short run, the expenditure in the scheme is lower than might have been anticipated at the outset, but over time that will – that might shift, and one of our jobs is to try and assess the forward estimates of expenditure. But the intention is that if you are eligible, you will get a service. That's the – that's the principle behind the insurance scheme.

MR ROZEN: I understand. So is it possible to see in the budget for the NDIA a specific allocation in relation to likely expenditure as a result of the action plan?

MR LYE: No. No. But – but I mean, I don't know how to express it in terms that people can see as being certain enough, but the – every person currently – young person currently in aged care who tests the eligibility for the scheme and is found – is approved, a plan is approved, that person will get the amount that's set in their plan.

COMMISSIONER BRIGGS: Mr Lye, I understand what you're saying. Let me ask the question another way. Given what you're saying, that the funding will be

forthcoming should anybody who is currently in aged care or who might otherwise be deemed eligible for aged care but they're fundamentally NDIS people and they apply for the NDIS, what then would be the reduction in the numbers of young people with disability in aged care as you implement this action plan?

So what I'm asking you is, three years time, in five years time, in 10 years time, where will those numbers go from about 5800 now to, in three years time, in five years time, in 10 years time, and – and will we still have 2000 people coming into the system each year as part of this rollover process? So there's two parts to the question.

MR LYE: So, I mean, to take the second part, I think we're probably at about – it's dynamic, but I think we're probably realistically down to about 1800 and, obviously, our plan is predicated on – was predicated on ensuring that 143 people each year, cumulative, don't come into residential aged care to achieve that target of halving the intake.

COMMISSIONER BRIGGS: The numbers under 50; yes?

MR LYE: Sorry?

COMMISSIONER BRIGGS: Halving the intake in the numbers under – is it 50 or 45? I can't remember.

MR LYE: I get confused with the different goals, but I think we're halving the intake into aged care for everybody by 2025 is my recollection.

COMMISSIONER BRIGGS: Okay. So halving the intake. So rather than 2000 a year, you would have 1000 a year coming in.

MR LYE: That's right. And that requires us to divert and, hopefully through NDIS plans which have a – you know, which enable a person to live in the community, by each year, by an extra 143 people.

COMMISSIONER BRIGGS: It's not a lot, is it? That's not going to achieve the purpose.

MR LYE: That part's not a lot. We would hope to overachieve on that, but – and then the other – the other part of this is around completing planning with, you know, all eligible people in the – with all people – young people in the – in the current population in aged care, with a view to encouraging them to elect to live in the community. Now, obviously there's that rider there of choice and control which we have to kind of recognise.

COMMISSIONER BRIGGS: Okay.

MR ROZEN: The last thing I want to ask you about is some evidence that we anticipate hearing from Dr Morkham later in the week who, as you know, is from the Young People in Nursing Homes Alliance, and if Dr Morkham's statement could be brought up, please, it's WIT.0372.0001.0001. And if we could please go to page .0013, and just to provide you with a bit of context here, up to this point in her statement, Dr Morkham has been talking about the default to aged care, so essentially what we were talking about just a few minutes ago, which she refers to as a pipeline. And you'll see at paragraph 49 if that could please be highlighted, she informs the Commission that:

> *The alliance strongly asserts that this pipeline approach to permanent residential aged care placement needs to be stopped. A practical way of bringing this about is to redefine residential aged care as a temporary or interim placement for people under 65 for a period of six months only. This placement will have the singular aim of developing and executing an exit strategy for the community for the young person in nursing homes over this time. From the alliance's experience, preventing permanent residential aged care placement of a younger person is easier than moving someone out after months or years. The latter is a far more complex, costly and risky process.*

And then she goes on at paragraph 50 to say:

> *To facilitate the change to residential aged care only being a transitional service for younger people, a key worker model is required. Each situation would be different and an individualised approach is required to manage each person's transition. The key worker's job is to work with the younger person, their families, the nursing home and providers from other systems such as health, mental health, NDIS, housing and community services to develop the exit strategy to the community that is available within six months or earlier.*

And if I stop there, is that an approach that you've discussed at all either with the advocacy groups or with the Department of Health, for example?

MR LYE: Look, I know – I'm aware it's been a discussion that's being had and it's a continuing discussion.

MR ROZEN: Yes.

MR LYE: And at the risk of saying something that then I will – that one of my staff will say differently in the panel discussion, I'm inherently uneasy about the idea that residential aged care be made a temporary option.

MR ROZEN: Yes.

MR LYE: I understand the point and I don't – I think there's some – there's much merit in what Dr Morkham is saying as a practical way of dealing with this, but I am inherently uneasy about the idea that we continue to allow even temporary access to

residential aged care because I think the temptation for some would be to try and prolong that. Now, you could introduce a set of rules to make sure it is absolutely temporary but I guess I have seen in other areas of social policy service delivery where we have relied on transitional models of assistance and I think it's kind of second-best policy. So one of the things that we – so that's not to say that we won't look seriously at that proposition.

I think the second bit is that we understand that while the SDA market is developing, that there may be some merit in trying to identify short-term accommodation options for people which are other than aged care. And that that in itself may involve us getting involved in the market to stimulate that. Certainly, the NDIA has indicated that short-term accommodation may be appropriate to provide people on their plans as an alternative to them going to residential aged care. So all of things I think are things we want to keep contemplating, talking with advocates and also with the Department of Health and NDIA about.

As to the key worker model, I would say that I think we'd need to be – I think it has merit put I suspect that in some ways that function is – is capable of being provided by support coordination within people's NDIS package. I'm open to the idea that the current arrangements for that might – might be tweaked to give effect to what Dr Morkham is talking about, but I think the two things might be – might be overlap. So I think – suffice to say that there's merit in having somebody who's in your corner who helps to navigate across service systems to make sure that the outcome you desire which is – which we hope is living in the community, is realised.

MR ROZEN: One thing that's abundantly clear from the discussion we've had, I think, Mr Lye, is that what is required here is some fresh thinking. You'll need to say "Yes" for the transcript.

MR LYE: Yes.

MR ROZEN: Thank you. That concludes my questions of Mr Lye.

COMMISSIONER BRIGGS: Okay. I just have one question, Mr Lye, and that is I don't have the numbers before me but there are quite a few, as I understand it, young people living in the community getting NDIS who are also getting aged care home support services. Why would that be under the current model?

MR LYE: To be honest, I'm not sure, and I don't want to pass the buck to my NDIA colleagues but I – I suspect one of them or my colleague, Peter Broadhead, might be able to tell you. I do have a recollection that we are – we don't necessarily see that as a long-term proposition. I think it's one of those areas where we're looking to – to make changes.

COMMISSIONER BRIGGS: Okay. That's helpful. Okay. Mr Lye, you're excused for giving evidence. Thank you very much for coming in today and being patient with the break in the middle of your evidence.

MR LYE: That's okay.

COMMISSIONER BRIGGS: Thank you.

<THE WITNESS WITHDREW [2.07 pm]

MR ROZEN: Speaking of breaks, we need a short break to make arrangements for the next witness who will be taken, again, by Ms Bergin.

COMMISSIONER BRIGGS: I thought we might, so we'll take a momentarily short break of the order of a few minutes.

MR ROZEN: Thank you.

ADJOURNED [2.07 pm]

RESUMED [2.17 pm]

COMMISSIONER BRIGGS: Ms Bergin.

MS BERGIN: May it please the Commission, I call Robyn Effie Spicer.

<ROBYN EFFIE SPICER, AFFIRMED [2.17 pm]

<EXAMINATION BY MS BERGIN

MS BERGIN: Robyn, what is your full name?

MS SPICER: My full name is Robyn Effie Spicer.

MS BERGIN: Have you prepared a document for the Royal Commission?

MS SPICER: I have.

MS BERGIN: Operator, could you please bring up document WIT.1245.0001.0001. Is there a copy of your statement there in front of you, Robyn?

MS SPICER: There is.

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

MS SPICER: No.

MS BERGIN: Is it true and correct on the basis of your knowledge and belief?

MS SPICER: It is.

MS BERGIN: Commissioner, I tender the statement of Robyn Effie Spicer, dated 30 August 2019.

COMMISSIONER BRIGGS: Yes, the witness statement of Robin Effie Spicer dated 30 August 2019 will be exhibit 9-9.

EXHIBIT #9-9 STATEMENT OF ROBYN EFFIE SPICER DATED 30 August 2019 (WIT.1245.0001.0001)

MS BERGIN: May it please the Commission.

Robyn, you're 69 years of age.

MS SPICER: That's right.

MS BERGIN: You live in central Victoria.

MS SPICER: Yes.

MS BERGIN: You live with your partner, Martin, who's here - - -

MS SPICER: Yes.

MS BERGIN: - - - in the Commission today.

MS SPICER: Yes.

MS BERGIN: You have one daughter, Jessie.

MS SPICER: Yes.

MS BERGIN: Jessie is also here in the courtroom today.

MS SPICER: She is.

MS BERGIN: Jessie is 37 years old.

MS SPICER: Yes.

MS BERGIN: Jessie lives in residential aged care facility in central Victoria near to where you live; is that right?

MS SPICER: That's correct.

MS BERGIN: Jessie was born with a rare chromosomal anomaly and has a rare physical and intellectual disability; is that right?

MS SPICER: That's right.

MS BERGIN: You say in your statement that Jessie is thriving in residential aged care.

MS SPICER: Yes, she is.

MS BERGIN: Jessie moved there in September 2013.

MS SPICER: Yes.

MS BERGIN: Robyn, could you share us a bit about Jessie, her interests and her hobbies.

MS SPICER: Well, Jessie, as a nonverbal person, she sometimes is described as a – an extrovert who can't speak, really, and she just thrives on communicating with other people in whatever way she can. She loves people watching. Because of the nature of her disability she doesn't have very good use of her hands or she's unable to read or write, those sorts of things, but people are central to her, and really connecting with people is the most important thing. The more the merrier. I think she's met half the courtroom here already, and she's just a gregarious loving, loving soul.

MS BERGIN: When Jessie was living with yourself and with Martin before she moved into residential aged care, what did life look like for the three of you?

MS SPICER: Life was really very, very busy for all of us, but especially for me in terms of Jessie's care. Jess needs to – apart from interpreting for Jess a lot of the time, taking her from A to B, all her physical care, showering and toileting and all those sorts of things were really up to me and it was hard – it was hard physical work on me. And I must say even now as I'm getting older, it's sort of – it's a lot for – for carers with people who have that level of physical disability. So every day I would get her ready to go off to her day centre, and that was lovely because she was able to have – I was able to have a few hours for all the washing and the cleaning that was associated, apart from work and all those things. So it's much like having a young – a young person, a toddler in the house in terms of physical needs.

But in terms of emotional social needs, Jess is up with people of her own age in so many ways. So it's sort of bridging the gap in that way, making sure that she has contact. She always had contact in regular secondary school as well as special developmental school. Despite the incredible differences in abilities, we were able to sort of navigate through those systems, through – because we felt that it was really important for her and I'm sure Jess would agree that she loved high school and she loved the special developmental school and everything had something to offer. And I think she sees everybody about her as having something to offer and she has something to offer them. In fact, when Jess went into aged care her step-sister, Martin's daughter, said to me, "Isn't it wonderful Jess – that Jess is going to be able to continue her life's work?" And I – I was sort of a bit surprised by that, and I said, "What do you mean by her life's work?" And she said to me "Making people happy." So it's been a huge transition for the whole family, but we really feel that there's an element of truth in that.

MS BERGIN: Robyn, you mentioned that Jessie went to local schools. How did that work?

MS SPICER: Well, we were lucky enough to have an integration aid for Jess whenever she went to regular schools, so she was able to access all the things that everybody else did. And there was some teachers who were fabulous and some not as fabulous but, on the whole, people were wonderful. Social interactions were difficult and it's not like she was invited to the birthday parties or any of those sorts of things, but at a certain level she – she had her place in school that was a valued place. And I did have parents say to me, "Thank you for sending your kid to our school because it's teaching my kids to appreciate what they've got". And I felt well, that's terrific.

MS BERGIN: Robyn, did attending school assist with Jessie's social development?

MS SPICER: Absolutely. Because Jess is unable to tell any secrets, she got in on all the goss at high school. And it quite amused the teachers and the aids that Jess was able to listen in on the goss, whereas other – you know, these friendship groups would certainly send other people off, you know, get out of the way, but Jess would be, "Oh, really?" So in many ways, yes, she just – she enjoyed it. She – look, I can't say that there wasn't discrimination by kids. There would have been. I wasn't hugely aware of it. But she probably would have got a few taunts and things along the way and I think Jess has actually developed a bit of a thick skin because of it. If anybody gives her a hard time she just – she looks at them with an expression of, "Is that the best you can do?" You know, which is years of having to handle being the odd one out, I guess.

MS BERGIN: Robyn, after Jessie left school, how did she maintain her connections with the local community?

MS SPICER: Well, at that time we were living in Greensborough and we decided that, really, for lots of reasons we'd like to live in the country. And we chose a

country town that was big enough to offer all of us opportunities and had a good centre – day centre that Jess could go to, and now I've forgotten the question, I'm sorry.

MS BERGIN: I was asking you, you mentioned that Jessie's very sociable and enjoys making connection with the local community.

MS SPICER: Yes.

MS BERGIN: And I wanted to ask you about Jessie's connections with the local community in central Victoria before - - -

MS SPICER: Well, yes.

MS BERGIN: Before moving out of home with you.

MS SPICER: Well, Jess has always been very well-connected throughout our town basically. Because it's not a huge place, huge number of people do – a percentage of people do actually know her and the other people at the day centre that she goes to are generally well-known in the town. A lot of them with were born there, so they've got lots of aunts and uncles and all the rest of it, and the network within that town is very strong. And there's a certain security within that because, for instance, a friend of mine has a son who is very autistic. And he roams the streets and he's got a set pattern where he goes. And one day he went out of his pattern and he went perhaps a kilometre out of town, and that mother said to me, I had 20 phone calls just from local people to say, "Do you know where he is, because we've just spotted him".

So – and, "We're keeping an eye on him": or, you know, letting her know. And I think that small country towns, so – and Jess has always been involved in the cappuccino set, put it that – set. She's always gone to the festivals and, whatever is on in town Jess goes to, and she still does, yes. So those things haven't changed since she's gone into care, fortunately. We've been able to keep that going.

MS BERGIN: Yes, I want to ask you about that, Robyn, but first can I ask you about what signs there were that prompted you to start looking into other options for Jessie. How did you know it was time for Jessie to potentially move out of your home?

MS SPICER: Yes. Well, up until that time, Jess had always been incredibly cooperative with all our daily routines, all the awkward showering. You know, because Jess is so unbalanced, it's not an easy task and it's really a lot harder with somebody who's being uncooperative. So without putting too fine a point on it, it was really very difficult. And also we'd go out -we'd go out to have coffee, for instance, and as soon as we came back, Jess wouldn't get out of the car. It was sort of like, you know, "Drive, drive, drive me, I want coffee". I'd say, "We've just finished", and she knows that. "We've just finished". But, you know, "We're home

now", and home just became this boring place. And it was the lack of cooperation that was going on that was really making it really hard for me. And I could see the frustration in her, that she just wants to be out. She just wants to be out with people all the time. and coming home to boring old mum and I was just – you know, "Oh, do I have to do this?" You know, the tight – you know, at an age of 31, 32, she sort of, "I'm a woman now, I need my own – I need my independence, thank you". So - - -

MS BERGIN: Was this period that you're talking about around mid-2013?

MS SPICER: No, it probably went on for maybe three years before that.

MS BERGIN: Okay.

MS SPICER: I was getting pretty worn down by it, yes.

MS BERGIN: And once you had had this realisation, what options did you look for for Jessie?

MS SPICER: Well, we weren't quite – we were well aware that there were other clients at the day centre who also lived – who lived in aged care. It's part of the hospital system there. They have three residents there. And we were aware that they were there, but I didn't really think that that would be right for Jess, but I wasn't quite sure, and there was no other community residential unit in our whole town for disabled people. So in the past, disabled people whose parents had died automatically went to the residences at the hospital. And there's been such a big shift about what's appropriate for young people and I was sort of a bit torn. I'm thinking, you know, everybody says this is a terrible thing to do and – and the Department of Human Services had nothing to offer, really, in our town at all.

And so – and the lucky thing was that my partner, Martin, who has worked in nursing for so many years within aged care, had also had a lot of experience with the aged care facility that Jessie now lives in. And he had said "I believe that she will be very safe and well cared for here. You shouldn't be this worried about it." And I'm thinking oh, maybe, maybe, maybe. Anyway, in the end, because nothing else was on offer and I didn't feel that she would be happy in a flat shared with some other disabled person with a carer, I thought this will be worse than being at home for her, we thought it's people that she wants and we could see that her real skill and her whole personality is about people. In the end we – we just talked about it and I said yes, I think this is right. I think that she will have a lot of people.

And we went up and visited one of the – one of the centres and I thought this will be right for her. But because there were people with really severe dementia there, the mix was not going to work for her. So the hospital then contacted us and said we'd like to try her in the – in the – in the facility that is really for high care, and Jess really does have very high care. She's not a low care person. And so that's when we entered this, and that was for – ostensibly for respite to trial her, and see how it all

went, but we had – the management was really on our side. They felt that it should be able to work. They should be able to – to make it work. And they have, yes.

MS BERGIN: Robyn, you mentioned that you looked around and there was really nothing else on offer, this is – are you talking about in the Central Victoria region now?

MS SPICER: Yes. No, I'm talking about the town that we live in, specifically.

MS BERGIN: And what criteria were important in that sense of looking around for something that might be suitable for Jessie? You've mentioned her care needs but you've also mentioned that had she's a very sociable person, so was retaining those local networks important?

MS SPICER: The local networks were absolutely imperative as far as we're concerned. We she needed to be close to us because we felt that it needed to be a shared care arrangement where we could be very much part of the care that she was getting. Sure, we wouldn't be looking after her – her hygiene and all those sorts of needs but we would be there for everything else, basically. And so that was imperative that she was within a five minute drive, which she is, from us. So if there's any point at which we need to come and interpret whatever's happening, like we did last night with a phone call, "Can you please come down". We come down, have a chat, work out what's going on. And then that's fine. But also in the aged care facility in town it just meant that she could maintain all her local networks.

And for a person who can't speak, this is incredibly important because Jess is unable to say "Where are we going now, who are we going to see, what's happening?" She's unable to say all that stuff, and that doesn't mean that she's not thinking it; I'm just saying that she's unable to speak it. And so she's working blind a lot of the time, unless people are constantly saying, okay, we're going here now, then we'll be going there, then we're doing this, then we'll be doing that. So it's very – it's actually imperative that she's in a place that she knows the people.

MS BERGIN: So it was imperative to keep Jessie connected with her local community.

MS SPICER: Absolutely.

MS BERGIN: She moved into the facility.

MS SPICER: Yes.

MS BERGIN: What did the facility do to ensure Jessie retained those connections? For example, Jessie couldn't take herself down to the cappuccino club which you mentioned by herself, so did you find that the facility was supportive of maintaining those local networks?

MS SPICER: Well, the facility has probably maintained the local – the networks indirectly in that Jessie is meeting so many people from town as they come up to see their elderly people and then when she's down in town she's running into all these relatives who she's met as well as all the staff members, who – you know, so many live in town anyway, "Hi Jess", supermarket, everybody, I can never get out of the supermarket but there's so many people there, you know, so that's sort of indirect. The thing is – the important thing is that Jess goes out every day to her day centre and they facilitate all that community – well, not all of it, we do a lot of it too but they do the community engagement.

MS BERGIN: You do a lot of it, too, so when you talk about Jessie being down in the town, that's with you and Martin - - -

MS SPICER: Yes, we're out and about a lot with Jess. Particularly both days on the weekend we're always about and we go swimming with her on the week – midweek and stuff like that.

MS BERGIN: Now, I want to ask you about the role of the day centre. Has Jessie been attending the day centre since you first moved to Central Victoria?

MS SPICER: She has, yes.

MS BERGIN: How long has she been attending now?

MS SPICER: We moved up in 2001, yes.

MS BERGIN: How many people attend at the day centre?

MS SPICER: I think they've got 60 on the books but there's probably no more than 12 people there at the time and then there are lots of staff so it's a busy place.

MS BERGIN: And is there continuity between the clients that attend the day centre?

MS SPICER: Absolutely. Jessie knows these people very well. It's like a big family, really. So every day when she goes off she has a very busy – Jessie has an extremely busy full life. She really – she's go, go, go all the time and that's what she loves. She's a young woman out on the town and, you know, going to the gym and - - -

MS BERGIN: What activities does she do at the day centre?

MS SPICER: Well, they go – they go bowling on Monday, Monday afternoon. In the morning they do craft activities at the centre. Tuesday, what does she do Tuesday? I've forgotten what she – she does art.

MS BERGIN: Does she go swimming?

MS SPICER: Yes. Wednesdays, she goes swimming with a group. We go with her, too, help with the group. And then she has a quieter afternoon, a music afternoon. Thursdays, she goes to a gym class if she's interested. And Friday, she has community access mornings where she's out to the library or having cappuccino, always having a cappuccino, it's non-negotiable, and yes, so she's really busy, and on the weekends she's out and about with us, markets and theatre or whatever's on, really. It's a busy place.

MS BERGIN: Robyn, on one of those weekdays when Jessie is planning to attend the day centre, could you walk the Commissioner through what a typical day looks like with that routine?

MS SPICER: Well, a typical day for Jess, she's a very early riser. She's the first to rise in the morning and so she's showered and dressed and any sort of toileting things have to happen that – at that time by the night staff, one of whom thinks it's the best thing about her nights, her shift is to get Jess up in the morning. And then they have a changeover time with staff and I don't know if this is still happening or not, but certainly for some time that the changeover meeting was happening between the new staff coming in and Jess would find her way into that meeting and sit down as a staff member and take notes, and that was the easiest way for everybody to just know where she was and understand what she was doing. So it was really an interesting time. Then they'd make her – her breakfast would arrive.

And somebody usually would set her up in the living room, in – in front of the fire, maybe to watch Bert and Ernie or Play School or something like that which she really lover. And then at 9 o'clock the bus would – the taxi would arrive and in a small country town we know the taxis, we know the taxi drivers and that, so it makes it – it makes it so much easier. In Melbourne I wouldn't have allowed her to go in a taxi, but in a country town people know us and they know her. And then she'd go off to a day centre where she'd meet up with all her friends. They'd probably have a cup of tea and start some activities for the day. It might be art work in the morning and then off to bowling in the afternoon for instance. Have lunch there. The cut lunch would go from her residential facility with her.

And then in the afternoon the taxi would come and get her and bring her back to the centre. And then she would have a couple of hours before tea where she would sit and watch telly for a while with other residents, often holding hands with other residents. Often she'd go for a little tour of inspection, knock on doors, anybody home, you know, what are you up to, you know, talk to people around the residence. And so she'd have a sort of interactive time or just a quiet time, just vegging out in front of the TV like most people, really. And then an early tea at five and then straight to bed because, really, for Jess with mobility and some visual problems and things like that, it's – it's pretty exhausting.

One physiotherapist said to me one day, "Even for Jess to sit at a table is exhausting". So, you know, the amount that she does is huge, really, for her. Then it's off to bed. So that's a full day for anybody, really.

MS BERGIN: A full day for anybody.

MS SPICER: Yes.

MS BERGIN: Robyn, you mention in your statement that you are – and you've mentioned today that you're very involved in Jessie's care and that you have a model of shared care.

MS SPICER: Yes.

MS BERGIN: Could you describe that for us.

MS SPICER: Well, we always felt that her physical care would be looked after by the facility, basically, and that we were there for the same love and family that we've always had and her emotional support and getting her out in the community, and in touch with all her friends and family. So we sort of saw that as the big thing for us. And then the day centre was going to offer other things, like interesting activities, in and out of the facility and her – keeping her friendship group going. As it turns out, the – the residential facility actually takes care of a lot of her social and emotional needs as well which we hadn't – I hadn't anticipated.

Now, Martin may have but I hadn't anticipated the love that she would get from a lot of the staff and the other residents, really, and the connections that she would make throughout the community with their families who are constantly visiting as well. So the networking is huge in a small country town, or it's a large country town, I guess, but yes, it's a very big network and that – so that was – that was how we saw it.

MS BERGIN: Robyn, just moving to the topic of sort of care coordination, have there been issues for Jessie because of her age in the facility?

MS SPICER: Well, I suppose some – to some degree it is because of her age, but the coordination has been difficult because there are two centres who are a major part of her life, her residence and her day centre. And most of the coordination that I have to do has been around probably relatively trivial things, like who washes her bathers and who puts them back in her bag so that she actually has them on the right day. I mean, they sound quite trivial but clothing and movement of – sorry, continence – continence things, all of that, it's just practical little things more than anything else.

MS BERGIN: Who deals with those practical things?

MS SPICER: Well, to some extent I do, yes. I'm still very involved in negotiating and reminding and sometimes insisting that these things are done. So it's – sometimes it's a bit of a fine line because the aged care and the – and the day facility, they run on very different lines, very, very different.

MS BERGIN: They run on different lines so they have a different client base.

MS SPICER: They have a different client base, different responsibilities, ethos, ways of running staff, bureaucracy. There are very few similarities, I think, really.

MS BERGIN: It sounds like from what you've said that you play the key coordination – Jessie is – I think, I mentioned at the start that Jessie was here today and she's here with Martin and we've been very grateful to have Jessie in the hearing room and Jessie is free to wander around as she would prefer to do, is the arrangement I've made, Commissioner

COMMISSIONER BRIGGS: Jessie, where would you feel – where do you want to sit; do you want to come and be with your mother?

MS SPICER: Jess, are you coming? Come on; you can stay with me.

COMMISSIONER BRIGGS: Thank you.

MS BERGIN: We have got a special chair for you. That's good. Thank you for joining us up here, Jessie. And I just want to introduce for the audience, also, there's a staff member sitting next to Jessie, Rebecca Abbott from our witness support team.

Robyn, in October 2017 you've lodged an application for Jessie to become a participant in the NDIS?

MS SPICER: That's right.

MS BERGIN: What assistance did you receive from this application, what was available for completing the paperwork?

MS SPICER: Well, we were very fortunate, I think, because her day centre was very good at preparing parents and carers for what was about to happen. We didn't quite understand until it did happen, but most of the services that Jess was getting have actually continued from how they were, even on the NDIS it has continued in much the same way. It's just a matter of how it's all financed and it's the whole different arrangement. That's all. It's more of a financial arrangement that's been very difficult, actually, for the day centres to manage. Because it's turned their financial services upside down in the way they deliver services.

But what has changed is that Jess has more one-to-one time so that it's more tailored to her individual needs, really. For instance, we felt that it would be useful for Jess to do cooking activities because she has all her meals cooked for her and she never has any chance to do those normal things. So how's our little cookie, hey? Talking about you, yes.

MS BERGIN: We really appreciate you joining us, Jessie, I'm so glad that you could be here today. Fantastic. Maybe afterwards. I'll give you a hug.

MS SPICER: Fickle.

MS BERGIN: That's all right. It won't be the first time I've misread social cues. I was wanting to ask you about that, so Robyn – I got a bit distracted there for a moment, I'm sorry, but I know that you say in your statement that you worked for 18 years as a special education teacher.

MS SPICER: Yes.

MS BERGIN: Working with children and families in early intervention.

MS SPICER: Yes.

MS BERGIN: So you've got a significant amount of experience in dealing with health-related applications.

MS SPICER: Yes.

MS BERGIN: How did you find completing the NDIS paperwork?

MS SPICER: We did get a lot of assistance but I think that it was tricky and I thought – I kept on thinking, look, this is tricky for me. It must be incredibly tricky for people who maybe can't read English or – or who are filling it out for themselves. Yes, I thought – I thought it was quite tricky. But I'm finding that the process, even in three years now, is changing a bit, not the actual forms or anything. Perhaps I'm just getting more used to it, but also I think that the coordinators are understanding their role is going to be a bit different to what they expected and I think the coordinators of the NDIS need to be extremely well trained and I think, initially they had a lot of people that didn't really know what they were doing and I think they misled a lot of people.

I know people who have been quite – quite confused by the process, and had found the coordinators to be, you know, really not well trained, and that was really unfortunate. I was – I was lucky in that I got a well-trained coordinator who'd been working in the disability sector for ages. So we – we were lucky but I think it was luck, really. I think that role is changing, too. Do you want me to talk about that?

MS BERGIN: Sure.

MS SPICER: I think, initially, the coordinators were trying to get a handle on what they were meant to be doing, and with various success. And now, particularly for people in aged care, like Jess, I think – and I'm hoping that that role will alter and I think if it does it will be a really good thing because at the moment, for instance, we have so many hours, and I can't tell you exact many hours, out of Jessie's NDIS allocated to the coordinator's role. And that's okay, and we have virtually minimal hours because I do a lot of it myself. But I think as I get older and for people who are not able to do all the liaison work for their kids or for people with a disability who are unable to do the liaison stuff themselves, that coordinator role will become more and more important as time goes on.

And I think that specialised coordinators who really look into young people in aged care, who have – who specialise in that, can have a terrific role in the future in looking after those needs, doing the liaison type and coordination work that I find myself doing. And I would hope that, you know, when I'm no longer able to do it that these will be the key people who will keep her programs going, who will coordinate between day centre and NDIS and – and the facility, really. And I think – I see that as a crucial link, not just for my girl, but for anybody who's in aged care, that a specialised person is doing that coordination and who is not trying to get them out of aged care – because this is the published perception, these poor people, you know, and they're – I'm not saying for one minute that there aren't lots of people who are in aged care who really, really shouldn't be there, and there are some facilities that just are appalling, so I'm not saying that at all.

But I'm saying the people who – for whom it is a great choice, I don't think there should be any stigma about it and that those coordinators, if they're there to help things work, that would be a wonderful – a wonderful thing to happen. And that's not impossible. It's not impossible at all.

MS BERGIN: This is one of the areas that you'd like to see some change?

MS SPICER: Absolutely.

MS BERGIN: Why was it important for you to come to the Royal Commission today and share Jessie's story?

MS SPICER: Well, I wrote the letter and I didn't actually expect to hear back from anybody at all. But I felt that there's so much hard work going on, particularly in – in aged care, with such dedicated wonderful staff who are doing a fabulous job and I felt that – that most of the stories that come out of aged care are so depressing and awful and there are actually some good things happening out there and I felt that the table needed to be balanced a bit more. That's not to say that there aren't awful things happening but I think, you know, to give credit to the hard work of some of these aged care facilities and the work that, you know, it's really hard work for these people, the staff. It's not highly paid. It's really hard work. And what they give is just – can just be amazing and I think, you know, we've been very lucky, really.

MS BERGIN: I think that might be right.

MS SPICER: Yes.

MS BERGIN: Robyn, I know that before I conclude your examination that there was something that you wanted to say to the Commission at the end of the story?

MS SPICER: I'll try to remember.

MS BERGIN: Maybe – that's all right.

MS SPICER: I had a few ideas.

MS BERGIN: We might have covered everything that you wanted to cover.

MS SPICER: I think maybe I have. Yes.

MS BERGIN: Okay. Thank you, Robyn, and thank you, Jessie and Martin, for attending today. It's much appreciated.

MS SPICER: Well, we feel privileged to be able to have our say. Thank you.

COMMISSIONER BRIGGS: Well, Ms Spicer, it's a privilege for, I think, this Royal Commission to listen to a happy story.

MS SPICER: Good.

COMMISSIONER BRIGGS: It's a great story and it's great to hear about the way the entire community envelopes Jessie. I'm really happy to see Jessie here today and I want to thank you. You've certainly brightened up our lives as well as the lives of the people in your local district. But by the same time, Ms Spicer, I'm very conscious of how much personal commitment and effort you put in to supporting Jessie in being the life of the community. And I think you relayed to us today very helpfully the contribution that parents such as yourselves make to support their families and to support the broader community and the range of government services in understanding what's needed to make a system work seamlessly. So thank you very much.

MS SPICER: Thank you.

COMMISSIONER BRIGGS: And you're excused from giving further evidence today.

MS SPICER: Thank you. I hope it's been helpful.

COMMISSIONER BRIGGS: Thank you both.

MS SPICER: Thanks.

<THE WITNESS WITHDREW [2.55 pm]

COMMISSIONER BRIGGS: I think we might take a short break.

MS BERGIN: Thank you, Commissioner.

COMMISSIONER BRIGGS: Thank you.

ADJOURNED **[2.55 pm]**

RESUMED **[3.07 pm]**

COMMISSIONER BRIGGS: You've swapped sides. Mr Rozen, you're having a very big day today.

MR ROZEN: I am, yes. And, more importantly, the witnesses are also appearing in a different location now, Commissioner. So I formally call Chris Carlile, Scott McNaughton and Peter Broadhead.

<CHRISTOPHER JOHN CARLILE, SWORN **[3.08 pm]**

<SCOTT IAN ALEXANDER McNAUGHTON, AFFIRMED **[3.08 pm]**

<PETER BROADHEAD, AFFIRMED **[3.08 pm]**

MR ROZEN: Perhaps we can start with you, Mr Carlile, can you state for the purposes of the transcript your full name, please.

MR CARLILE: Christopher John Carlile.

MR ROZEN: And Mr Carlile, you are branch manager, hearing and disability interface with the Department of Health.

MR CARLILE: That's correct.

MR ROZEN: And Mr McNaughton, can I ask you, please, to state full name for the transcript.

MR McNAUGHTON: Scott Ian Alexander McNaughton.

MR ROZEN: Mr McNaughton, you are the acting deputy CEO, government communications and stakeholder engagement with the National Disability Insurance Agency.

MR McNAUGHTON: That's correct.

MR ROZEN: Agency or authority?

MR McNAUGHTON: Agency.

MR ROZEN: Got it right the first time. You report to the CEO, Ms Rundle - - -

MR McNAUGHTON: That's correct.

MR ROZEN: - - - from whom we will be hearing tomorrow. Finally, Mr Broadhead, you are group manager NDIS transition oversight with the Department of Social Security.

MR BROADHEAD: Social Services.

MR ROZEN: Social Services, I'm sorry. And you answer to Mr Lye who was the last witness that we heard from.

MR BROADHEAD: I do.

MR ROZEN: Previous to the last witness. Gentlemen, we've called you to give evidence together because you are three members of the five member project board which has been established to give effect to the younger people in residential aged care action plan. I need one of you to say yes, I think, if that's right.

MR BROADHEAD: Yes.

MR ROZEN: And before I ask you some questions about your roles on the project board, I might just ask each of you a little bit about your backgrounds, perhaps starting again with you, Mr Carlile. I'll ask for tab 30 to be brought up, please, operator, from the general tender bundle, and that's going to be a challenge for you, Mr Carlile, from that distance, but it's probably a document that you have some familiarity with.

MR CARLILE: The organisational chart for the Department of Health.

MR ROZEN: Indeed it is, and if – if the pink boxes that are third from the right could just be blown up a little. That's the section. And do we see a box with your name in it in that line where there are four boxes?

MR CARLILE: That's correct.

MR ROZEN: And it's got the description "hearing and disability interface" there, and if we can just scroll up the one level, please. Now, I'm setting the operator a task here, but ultimately I just want to establish here that the part of the Department of Health that you're in is not the ageing and aged care part with whom – with which we are quite familiar in this Royal Commission.

MR CARLILE: That's correct.

MR ROZEN: Is that right? You're in that part headed Population, Health, Sport and Aged Care Royal Commission Task Force and presumably it's the last part of

that section that is relevant here, is it? Are you part of the Aged Care Royal Commission Task Force?

MR CARLILE: No, I am not.

MR ROZEN: Okay. So what's the connection between your substantive role and your position on the board in respect of the action plan.

MR CARLILE: In the branch that I have, the hearing and disability interface branch, they have a number of programs, one of which is the hearing services program. I also have the continuity of support program which is for people who are 65 years and over who were in state-administered disability care and as part of the transition to the NDIS, the Commonwealth agreed that they would look after these people. They would not transition to the NDIS because they were over 65.

MR ROZEN: Yes.

MR CARLILE: And with that responsibility when it came into the branch there was also a shift of the young people in residential aged care. So that in a sense is a subset of that – of that work.

MR ROZEN: All right. Thank you. That's very helpful. And the linkages that exist between your role and that part of the department that is responsible for aged care, how does that work?

MR CARLILE: They – we have direct linkages with them so as part of the continuity of support program we do have direct involvement with My Aged Care colleagues and there's referrals and information exchanged between the teams, the branches.

MR ROZEN: Yes.

MR CARLILE: And physically are located on the same floor as well.

MR ROZEN: I see. Okay. Thanks very much for that. If I could turn to you, Mr McNaughton, how long have you held your substantive – your current position with the NDIA?

MR McNAUGHTON: So I've been acting in this current role since May this year. I've been with the NDIA for five and a half years.

MR ROZEN: Right. And what were you doing prior to the current role that you're in?

MR McNAUGHTON: My nominal role is the general manager of government relations and previous to that I was in our operations area in different general

manager roles looking after operations, our pathway reforms and also some of the full scheme negotiations.

MR ROZEN: All right. And do you have a background in disability policy before coming to the NDIA?

MR McNAUGHTON: Prior to joining the NDIA I was in other Commonwealth Government departments mainly in social policy and human service delivery, both frontline as well as operational policy-type roles.

MR ROZEN: All right. Thank you. And finally, Mr Broadhead, how long have you been with the Department of Social Services?

MR BROADHEAD: Since January 2014.

MR ROZEN: Okay. And in your current position, how long have you held that role?

MR BROADHEAD: Substantively for about two weeks. Prior to that I began acting in the role on 20 May this year.

MR ROZEN: And prior to joining the department, what – what were you doing? Just in summary.

MR BROADHEAD: I was previously in the Department of Health and between 1995 and 2014 essentially, a couple of other stints outside.

MR ROZEN: Thank you. Now, none of you has made a statement for the purposes of this hearing; that is correct, isn't it? But you have been called as a panel as we've already indicated because you're members of the project board. I might just ask you a little bit about the board and its role, firstly, and we might do that by reference to tab 133 if that could be brought up on the screen. And you'll see that it sets out the terms of reference of the project board. Perhaps, Mr Broadhead, given that you are in the role of co-chair of the board, if I could just ask you a little bit about the terms of reference. When were they settled?

MR BROADHEAD: I think it was in June. I think they went to the first meeting of the project board on 27 June where they were discussed and then they were settled after that discussion.

MR ROZEN: Right. So they were put up as proposed terms of reference for the board.

MR BROADHEAD: Generally the practice is to draft what you think are going to be the good terms of reference but you then give the people involved a chance to discuss that to see if there's any particular tweaks that you might wish to make and they were discussed and then finalised.

MR ROZEN: Okay. And the document we have here is the finalised version of the terms of reference.

MR BROADHEAD: I believe so.

MR ROZEN: Okay. We see that there's a heading, Context, which explains that the board, I'll call it that for the moment, will oversee the implementation of the YPIRAC action plan, and it notes that the plan sets goals to reduce the number of younger people living in aged care. It contains a set of actions which focus on better access and planning, improving hospital discharge processes, and so on. And then the role of the board is then identified as:

A temporary governing body established for the life of the action plan project.

What do you understand the timeframe to be for the project? Does that take us through to 2025 which is the latest of the dates referred to in the goals?

MR BROADHEAD: I think there's been a reference somewhere to 2020 but my own view is it will continue as long as it needs to be doing what it does.

MR ROZEN: Right. Which means, what, as long as the action plan is in existence the board needs to be there to oversee its implementation.

MR BROADHEAD: I would expect that the board or something very like it will continue to be involved coordinating between departments for as long as is necessary to see through on the action plan.

MR ROZEN: Okay. And then there's a series of specific roles which I won't go through, and then some responsibilities are sent out. And if I could ask the operator to go to the second page of the document, .9829, please. We've got identification of representatives of DSS and NDIA, and the levels are identified. And the Department of Health will also be asked to nominate a representative. And then we've got co-chairs, yourself, Mr Broadhead, and Ms Faulkner from the NDIA. That's right, isn't it, it's Ms Faulkner?

MR BROADHEAD: Correct.

MR ROZEN: Yes. She's no longer in that role.

MR BROADHEAD: That's my – no, she's changed roles within the agency.

MR McNAUGHTON: Yes. that's correct. She's moved to a different role within the agency. So the person who has taken over her former role will be the co-chair with Mr Broadhead.

MR ROZEN: Okay. And are you able to identify the second chair for us.

MR McNAUGHTON: It's Mr David Coyne is the co-chair at this stage but we're just working through that at the moment, whether or not it may be Mr Verlin so we are just working through that with the department.

MR ROZEN: Okay. The fact that the co-chairs are respectively from the Department of Social Services and the NDIA reflects the action plan as being very much an NDIA/DSS project. Mr Broadhead, is that a fair observation?

MS BRIDGES: Yes, I think so.

MR ROZEN: Yes. Perhaps if I refer this to you, Mr Carlile, we've heard from Dr Hartland earlier today and yesterday that the health role – I think I suggested it was subsidiary and he preferred the notion of a supporting role. Is that a term that you think accurately describes the role of the Department of Health?

MR CARLILE: Yes, I do.

MR ROZEN: Okay. As you understand it, Mr Carlile, what does that encapsulate? What is the Department of Health's supporting role; what's the nature of that role here.

MR CARLILE: Part of that role has been to provide information to assist the project board in terms of the action plan as requested. There are action items that appear under the action plan so when some action is identified as needing help from the Department of Health, I'll facilitate whatever needs to be done, whatever information needs to be provided. And the linkage into the aged care system just generally is part of the strategy of the action plan.

MR ROZEN: Right. Now, I want to ask you a couple of general questions about the evidence that the Commission has heard over the last couple of days in relation to this matter. And I might give each of you an opportunity to respond to this, perhaps starting with you, Mr Carlile. Mr Lye of the DSS gave evidence earlier today that the Commonwealth Government had manifestly failed to make inroads into the numbers of younger people in residential aged care. Do you agree with that statement – general statement?

MR CARLILE: In general, yes.

MR ROZEN: And as I understood his evidence he said, you know, that's essentially an unarguable proposition from the figures which have sat pretty well around 6000 per year going back now probably at least 10 years and probably longer. Do you agree that those figures alone support the observation of manifest failure of Commonwealth Government policy?

MR CARLILE: In general, yes.

MR ROZEN: What about you, Mr McNaughton? Do you accept as a sort of foundational statement for the work of this board that it is addressing an area that has been manifestly a failure?

MR McNAUGHTON: My sense – and I agree with Mr Lye's statements that I think this is an absolute priority for the agency and it's a priority for government and whilst we have seen some improvements in the trend over the last two to three years in terms of the data comings through from the Department of Health there's a lot more work to be done and hence why there's an action plan and a commitment to focusing in this really important area.

MR ROZEN: Just while I'm asking you, Mr McNaughton, we've heard evidence about the previous initiative, the 2006 to 2011 initiative, and then it's been raised with the Commission that the major change that has occurred in the area of disability services in Australia is the advent of the NDIS and the rollout of the NDIS, which is largely complete now, is it not; the rollout?

MR McNAUGHTON: We're nearing – what we have is an NDIS that's fully available across the country. So that's fantastic. We have got just over 300,000 people into the scheme. We expect that number would grow to more than 460 to 500 hundred thousand over the next couple of years. So in terms of rolling out the scheme we're still maturing, we're still seeing other developments in terms of markets and – and some of our business practices are still refining. So I wouldn't say we've finished the job but certainly it's been incredible progress to date but I still say there's a bit more work to be done.

MR ROZEN: Mr Broadhead, given it was your boss that made that observation, I suspect you probably agree with it, is that a safe assumption, about manifest failure?

MR BROADHEAD: I didn't hear it the way you did. I heard him agree that it was a manifest failure of governments, plural.

MR ROZEN: You may be right, and if that's how it was put, you'd agree with that?

MR BROADHEAD: Yes.

MR ROZEN: Yes. And I take it by that that governments plural, you're obviously referring to the States and Territories as well as having a responsibility in this area.

MR BROADHEAD: Yes, I think over the period of time concerned all governments that have been involved had some involvement in this and I think it's reasonable to say that it has never got to where we would like it to be.

MR ROZEN: Just whilst we're talking about governments plural, you probably heard me, Mr Broadhead, asking Mr Lye about the role of the States and Territories in relation to consultation about the action plan. It's the case, isn't it, that they are

missing from the formal structures that we see around the action plan; there's no States and Territories representative on this board, for example?

MR BROADHEAD: Correct. I can't speak to what Michael addressed about the development of the plan because I wasn't around in that – in that part of it at the time. But I think – and it goes to your comment earlier about the role of the health department, I think the reason why it's co-chaired between the agency and my department is because we see much of the answer, not 100 per cent of the answer, but much of the answer for this longstanding problem to be in changes to the availability and provision of disability supports.

So I would describe the longstanding problem of people with disability particularly, but not only, ending up in aged care for want of anything else to be a problem of the lack of availability of appropriate supports. And so the new National Disability Insurance Scheme provides an opportunity and that's the focus of my – what I work on and certainly what Scott works on in terms of standing up and improving that scheme, and we see that as central to addressing this problem.

MR ROZEN: The other general observation made by Mr Lye that I'd like to ask each of you about was the reference he made to the existing default to aged care. You may have heard him saying that earlier, that the current system sees young people – younger people that end up in residential aged care almost inevitably, or perhaps that's overstating it, but defaulting to that rather than defaulting away from residential aged care. And he said that he considered that it was necessary to disrupt that process, that for this project to be successful, the action plan to be successful, there needed to be a fundamental shift in the thinking around the way people are assessed, younger people are assessed through the ACAT process and there needs to be, where they are eligible for the NDIS – and I'll talk about the cohort that's not – but for the moment the cohort that is eligible for the NDIS, that's where the system has got to steer them, rather than into aged care. Mr Broadhead, could I ask you for your observations about that.

MR BROADHEAD: I couple of observations. I certainly agree with him about the need to disrupt that particular pathway but I don't think that's the only place that we need to disrupt. So I do think at the moment there's – for many years, when it comes to people in hospital who are no longer requiring hospital treatment but need a place to go and there haven't been adequate supports and services available in the community that the – there's a worn path, if you like, from the hospital discharge people to the ACAT, the ACAT then establishes that they don't believe there's any other more appropriate form of care and under 6(1)(b) you've quoted earlier in the proceedings they're found eligible for aged care and so we go.

I think there is absolutely a need to disrupt that. I think the – you heard Scott mention that the scheme has grown massively in the last few years but it's not in its final form, it's not available to everybody we think it ought to be available to. So because it's grown quickly the culture – and this is something that Michael mentioned – the culture within hospitals and other service systems hasn't yet come to

grips with exactly how the NDIS works and exactly how to tap into that. This is a problem on both sides, I think, and I think one of the reasons why the agency is putting – and piloting hospital liaison officers is putting people in from the NDIS side of things to try and build bridges with the people working in the hospital setting to change those patterns and so on.

But the reason I say that it's not just about the hospital pathway, once the scheme is fully stood up in the sense that everybody who is eligible at a given point of time is in the scheme and may hopefully have been in the scheme for some time, I would expect that of itself to change the trajectory of people before they end up in hospital. So I think that it's the case that people can end up in this situation in aged care for a variety of reasons, but sometimes it's because your initial – you acquire a disability, you have an accident, you acquire, for example, a brain injury.

MR ROZEN: Yes.

MR BROADHEAD: That puts you in hospital and only then, you know, first time in your life you might have to deal with a notion that you have a significant disability and what happens now, and from that point forward there's a question about how you exit hospital and where you go. For other people it may be that they have already had a disability for some time, and what may precipitate the issue is the inability of their people who care for them now to continue to care for them. And so that's a different path whereby, because they're in the community, they're being cared for in the community, but the available care is no longer sufficient or able to cope, if it's their family, for example, then they find their way into alternative which might end up being aged care.

The NDIS holds the prospect for that latter one of actually changing the degree of availability of care to avoid somebody being precipitated into a crisis of care which then leads to the fallback of aged care. So it's both. It's about disrupting the process from hospital to aged care, but it's also about disrupting or changing the degree to which care is available in the community. And the other thing I'd like to comment on, forgive me, is that there has been a lot of focus on ACATs. If this system was working as well as we'd like some years from now, then people wouldn't be referred to the ACAT in the first place. So that really is – you know, in the case of shaking up that path, that's the desirable outcome.

MR ROZEN: Yes. Well, can I take you up on that because you won't hear any disagreement from me about that proposition, that 6 (1) (b) ought only to come into play – that is 6 (1) (b) in the - - -

MR BROADHEAD: Principles.

MR ROZEN: - - - principles, ought only come into play – or, rather 6 (1) (b) requires a proper consideration of alternatives, and that must necessarily obviously include the NDIS, mustn't it?

MR BROADHEAD: Yes, and one of the difficulties here is that as recently as 2018 there were parts of the country for which the NDIS was not yet available.

MR ROZEN: Yes.

MR BROADHEAD: That includes, for example, southern Melbourne. So it's not like it was only out in the sticks, as it were, that the scheme was not yet available. So we're in a period of transition where people are – the circumstances are changing, the availability is changing. There is learning on all sides about how best to do this and how to stand the scheme up and make it available, as we hope, for everybody eligible. But this means also that other service systems are lagging in their understanding and application of the way they work to the new environment where this scheme is now available.

MR ROZEN: Just before we leave section 6 (1) (b), were you both – sorry, were you present in the courtroom, Mr Broadhead, when we were hearing evidence about two particular examples earlier today about section 6 (1) (b)?

MR BROADHEAD: I heard some of that evidence.

MR ROZEN: Yes.

MR BROADHEAD: I don't think I heard all of it.

MR ROZEN: Perhaps if I can summarise it hopefully fairly. It's suggested that at least in the two cases that we were looking at, that there was little if any consideration of alternative facilities or care options as mandated by 6 (1) (b). That's got to be a concern, does it not?

MR BROADHEAD: Yes. I have to say though, and I don't know the particular circumstances of those assessments, ACATs are regionally organised. They often have, quite recently for other people, moved to establish the availability of services. And so when a new person turns up for an assessment, they may already have some appreciation of the availability of services before that particular assessment was done.

MR ROZEN: Yes.

MR BROADHEAD: So I don't want to judge the individuals involved, but I would suspect that part of what operated there was their own local knowledge about what was available.

MR ROZEN: Would you expect an ACAT assessment to reveal on its face – the documented record of the assessment to reveal on its face the consideration of alternative options as required by 6 (1) (b)?

MR BROADHEAD: I think that there is merit in having a more formal way of guiding and recording the assessment of the availability of other services. Is that – you're looking at me as if I haven't made myself clear.

MR ROZEN: No, I understand what you're saying, so don't read too much from my facial expression, Mr Broadhead. What the Commission is concerned about is that we've been provided with – and perhaps this is a question best directed to you, Mr Carlile. We've been provided with a very recently promulgated set of guidelines aimed at ACAT assessors, which clearly are intended to assist the ACAT assessors to carry out the function of carrying out the ACAT assessments, particularly applying section 6 (1) (b). Are you satisfied that the guidelines that have recently been promulgated appropriately guide the assessors in the way that would achieve the outcome that Mr Broadhead is talking about of steering people away from doing such assessments and, where eligible for the NDIS, that that's where they're steered.

MR CARLILE: Yes, I am. Those particular guidelines have just been released.

MR ROZEN: Yes.

MR CARLILE: And as part of that release there was information sessions or training conveyed with the ACAT teams to talk to the actual intent of those guidelines. So I'm confident that that is the case.

MR ROZEN: I want to just ask you about correspondence that we have received in relation to those guidelines. Perhaps if tab 119 could please be brought up on the screen. And just to give you a bit of context here, Mr Carlile, this is a letter that was sent to the solicitors assisting the Royal Commission from the solicitors representing the Commonwealth, Gilbert + Tobin, and the Commonwealth was asked some questions. I think a hard copy has been put in front of you. Thank you, Mr Thorpe. And you'll see that there was a request for further information which was sought, and part of the request related to the guidelines. And if I could ask you to look at page 2 of the letter, which is .0002. You'll see about a third of the way down the page a paragraph that starts with the word "additionally." Do you see that?

MR CARLILE: Yes, I do.

MR ROZEN:

> *Additionally on 14 August, the Department of Health published updated Aged Care Assessment Supplementary Guidelines for Younger People with Disability.*

And if I just pause there, they're the guidelines that we've just been talking about, are they not?

MR CARLILE: That's correct.

MR ROZEN: And then going back to the letter:

> *The updated guidelines now include a process whereby the Aged Care Assessment Teams will liaise with the NDIA prior to recommending that a younger person is assessed to enter residential aged care.*

And then it's the next sentence I want to ask you about:

> *This process only applies to a younger person experiencing urgent circumstances. Situations of urgent circumstances may include, but are not limited to –*

And then there are four dot points there. I just want to clarify with you, as I tried to do with Dr Hartland as well, whether that's an accurate statement of the operation of the guidelines. That is, the process of liaising with the NDIA before recommending a younger person is assessed to enter residential aged care only applies to younger people experiencing urgent circumstances. Is that your understanding of the guidelines?

MR CARLILE: No, in general the ACAT teams are expected to test with the NDIA the eligibility of a younger person. This is in specific response to urgent circumstances where it might become clear to the department that someone is at risk of not having somewhere to stay or not having somewhere to go to because of whatever circumstances they're in.

MR ROZEN: Yes.

MR CARLILE: And in such a case there is a formal rapid assessment that's undertaken by the NDIA, and there actually is a form that goes to the NDIA to test the eligibility within a very short period of time, is my understanding; 48 hours.

MR ROZEN: I understand. Thank you for that. It's the word "only" in that sentence that I'm interested in. Is your evidence to us that that is not an accurate description of, or an accurate interpretation of the guidelines? In other words, do you say that the requirement on an ACAT assessor to liaise with the NDIA prior to recommending that a younger person is assessed to enter residential aged care, applies across the board?

MR CARLILE: There is specific requirements for urgent circumstances.

MR ROZEN: Yes.

MR CARLILE: But, in general, there is a requirement for ACAT assessors to look to the NDIS, but they would not necessarily have the same prescriptions in terms of this urgent pathway. So this is a rapid assessment pathway that has been established for a small subset of the cohort that could be eligible for the NDIS that need to be looked at straightaway.

MR ROZEN: The solicitors for the Commonwealth, presumably on instructions, are writing to the Commission telling us that the guidelines only apply to younger people experiencing urgent circumstances. That is, that part of the guidelines requiring referral to the NDIA. Then we've got a problem, haven't we, Mr Carlile, if you're of a different view about the role of the guidelines?

MR CARLILE: Perhaps I'm not making myself clear or my – certainly my understanding is that the guidelines and the operation with the 48-hour turnaround consideration by the NDIA or NDIS for these young people, only applies to people who are in these particular sort of circumstances. That if someone, for instance, was in hospital, acquired brain injury, is there for a long period of time - - -

MR ROZEN: Yes.

MR CARLILE: - - - that it still would be, you know, the case that the ACAT assessors would be required to ensure that that person had considered or had been tested for eligibility for the NDIS before they were considered for residential aged care.

MR ROZEN: Okay. We're going to hear some evidence later in the week from the State insurance schemes, the Transport Accident Commission, New South Wales Workers Compensation Scheme and so on, and part of that evidence will be that, concentrating on the Transport Accident Commission Victoria for the moment, that they have a system of very early intervention. When someone is involved in a motor vehicle accident, suffers a serious brain injury, for example, and is in hospital, it becomes apparent that, to the Transport Accident Commission, that that has occurred, that they make very early contact with that person, and the process – perhaps the best question best directed to you, Mr McNaughton, the process of planning for their eventual discharge starts very early on.

The evidence we've heard is that it seems to be quite different, often with younger people with disabilities, who don't fall under such a scheme. So if we take Mr Radley who we heard evidence about earlier today who suffered a brain injury as a result of a diving accident, he obviously wouldn't fall under such a scheme. My question is, are we – is the NDIS doing enough to similarly start the planning process for discharge from hospital early on in a person's time during hospital, or is it the case that the NDIS may not become involved until very late in the piece when an ACAT assessment is being conducted?

MR McNAUGHTON: Yes. We too have closely looked at the TAC models around how they do that, and they are probably an exemplar around the country in that model. We're testing some of that with our hospital liaison program at the moment. We see there's a lot of support in doing that, we think - - -

MR ROZEN: Yes.

MR McNAUGHTON: - - - and it also goes to some of the work around. We're doing the expansion of that pilot program here in Victoria and looking at having stronger connections with the hospital where there's been a major trauma, how our planners, our hospital liaison officers need to be involved early. So even there might be a slow to recover or a rehabilitation program, we're talking to the families around the NDIS and then looking at the accommodation options very early. So we strongly support that principle. We're partially rolling it out and we'll be rolling it out nationally. Because at the moment, if we find out too late in the piece and the person has already gone into an aged care facility, we're sort of, you know, chasing our tail, pardon the pun, really to sort of catch up there.

And what we want to be able to do is get early advice and connect in early, especially in the hospital settings, and that's why the Commissioner's really important comment earlier in the day is this, to work, will take a collective effort across all layers of government. Health systems, hospital systems, accommodation systems, the NDIS and the aged care system and the department, and all connecting and having early identification so that we can have our planners in there working with those respective systems. And we can see that there would be better outcomes and the TAC has been able to demonstrate that. So that's certainly a principle that we are looking at embedding as part of this project.

MR ROZEN: Can I just take you up on that notion of involvement across all levels of government and all relevant government departments. Doesn't it really make the point that there needs to be some formal role for the States and Territories in the implementation of the plan? Isn't that a gap in the governance arrangements that have been explained to the Commission?

MR McNAUGHTON: Sitting alongside our project board is the hospital discharge project.

MR ROZEN: Yes.

MR McNAUGHTON: Which is a really key project State Government is actively involved in. Actually the crafting and framing of that went through the Health Minister's Advisory Council, and there's a suite of improvements and initiatives in there that we're working very closely with state governments on. If we don't have that, then, you know, so the two absolutely go hand in glove, because without the two working together we're not going to have that connection strongly in the hospital and health systems working well. So the States are involved in it because whilst they're not actually on the project board, and debate the merits of that, but absolutely if this other subsidiary piece is critically important because it helps with, as you used that language earlier in the day, disrupting that pipeline of people from hospital into aged care.

We're getting in early, getting early information, strong collaboration with the hospital systems, doing that early planning, avoiding even having an ACAT assessment in the first place and then we can look at suitable accommodation with

the right care and support, whether that's back in the person's home or in some other accommodation option. And then that, as you said, disrupts that pipeline, so that's – that related piece of work is clearly important.

MR ROZEN: I just want to ask you a little bit more about the hospital liaison program. There is some evidence about it before the Commission. This is the South Australian project that you're talking about?

MR McNAUGHTON: Yes, that's correct.

MR ROZEN: Okay. And can you tell us a little bit about the scale of that. How many NDIA liaison officers are part of that project?

MR McNAUGHTON: We currently have three in South Australia.

MR ROZEN: Yes.

MR McNAUGHTON: And we're about to expand and put in place five in Victoria and then we're just looking at the ramp up of that across the country at the moment.

MR ROZEN: So the three that are in South Australia, where are they located?

MR McNAUGHTON: So they work between the major hospitals throughout Adelaide. So they're not based physically in the same hospital. They will spend certain days in each hospital, and their role is really to connect with health care workers, the hospital social workers, when there's a new admittance, that we can go in there and help people navigate the pathway of the NDIS, as we would call it. We're also working with a group of people who have been in hospital for a longer period of time and looking at what are some of the accommodation, whether transitionary accommodation, longer term accommodation options. And there's also an education training piece working with the hospital occupational therapist to make sure we're getting the right reports early so we can get the home modifications done more quickly. So there's a real education communication piece as well. That was one of the early findings from that trial.

MR ROZEN: So three in South Australia, plan to put in five in Victoria. Is there some ultimate number that you have in mind of liaison officers when that has been rolled out nationally, and what's the timeframe for that?

MR McNAUGHTON: We're working through exactly how many that would be. We think it's between 40 and 50 nationally. And they would be – there would be a coverage across the main metropolitan hospitals, the regional hospitals. The model would be reasonably flexible in terms of working across multiple locations. You know, we may not in Victoria. If I use an example, we may not have a permanent liaison officer in Ballarat. They might serve as Ballarat, Bendigo, Ararat, but that – a type of sector like that if you will. So we're just working through our teams on the

ground about those numbers, and we hope to have those in place in the first quarter of next calendar year.

MR ROZEN: Can I ask you about the goals in the action plan, please, and if we could bring up the goals behind tab 9. And if I could start with you, Mr Broadhead, in relation to goal number 1. We can see there that the goal is:

> *Supporting those already living in aged care under 45 to find alternative age appropriate housing and supports by 2022 if this is their goal.*

How is the board which is charged with implementing this plan, how are you going to know in 2022 whether or not that goal has been realised? What are the measurables for success of that first goal?

MR BROADHEAD: The board receives information from our colleagues from the Department of Health about the number of people under 65 in residential aged care.

MR ROZEN: Yes.

MR BROADHEAD: And we can and do decompose that by age group, for example, and other factors. So we monitor that. I can tell you – I haven't got the numbers in my head for the under 45s, but I can tell you for the under 65s that since the last quarter of 2016, moving 10 quarters forward to the quarter ending 31 March this year, that the number of people was 6267 in residential aged care in the last quarter of 2016, and that at the end of March this year it was 5715. It has dropped each and every one of those 10 quarters during that period.

In addition, there's a line in that data which looks at the number of people entering residential aged care in that age group, and that was, from memory, about 537 in the first quarter I mentioned, and in the last quarter I mentioned it's down to 407. And we look at that because one of the key goals here is halving the number of people entering aged care in the age group.

MR ROZEN: Yes.

MR BROADHEAD: If you do a straight-line projection of that number entering, then it will have halved. It will be down to 250 by 2023. Now, I don't have a crystal ball, I can't tell the future, and trends can fluctuate. But we do look at that data to understand at that level whether there is an impact being made on the number of people going into residential care and the number of people in residential care. We've got about a nine per cent drop of people in residential care and a drop of about 90 per quarter in the number going into residential aged care.

MR ROZEN: So most of those quarters, of course, predate the plan, don't they?

MR BROADHEAD: Yes, and that reflects the fact that the thing that's having the impact here is the scheme, in my view, and what the plan is doing is sponsoring

actions that might improve the way in which the scheme has that effect. So there are opportunities, rather than sit back and say the plan will deliver everything, we just – for the best, the – there's things to be learned and things to be done to improve the effect of the scheme, the way the scheme operates for this particular group of people such as we've been discussing.

MR ROZEN: Now, please don't think I intend any disrespect by this, but, in my view, as a basis for an assessment of the reasons for the drop in numbers only helps us so much. Has there been any analysis conducted to determine what is driving the reduction in those numbers?

MR BROADHEAD: Well, it's not in a detailed sense, no. So - - -

MR ROZEN: Well, in any sense?

MR BROADHEAD: Yes, we do think that the reason for it is the – that the scheme is now providing alternative options for people and, therefore, the likelihood that people will enter into residential aged care is reducing over time. Not by much, I have to say. A nine per cent drop is only a nine per cent drop in the total number of people in that age group in care, but it suggests that the presence of the scheme is having an impact.

MR ROZEN: You might have heard me earlier asking Mr Lye about whether there had been any evaluation of what happened in the medium to longer term with the cohort that were assisted to leave residential aged care under the 2006 to 2011 initiative. And I asked him whether there had been any evaluation of what became of them. Did they stay? Did they remain in the community? How many of them returned to residential aged care at a later time? And as I understood his evidence, he was unaware of any such evaluation being done. Do you think that would be helpful information? In other words, would that assist to learn from the previous initiative in the implementation of the current one?

MR BROADHEAD: Like Michael, I'm not aware of any follow-up study - - -

MR ROZEN: Yes.

MR BROADHEAD: - - - done. So there were evaluations done at the time of the program, but I'm not aware of a follow-up study being done.

MR ROZEN: Yes.

MR BROADHEAD: And I'm not aware that data was captured in a way at the time that would enable you to follow-up – in other words, to find the people who – the small number of people who were successfully moved out to then later discover what became of those individuals, so I don't – I'm not aware that that – the capacity to do that was structured into the way the thing was done in the first place. And as to whether had such a study been done, well, perhaps yes, but it wasn't.

MR ROZEN: All right. What about with the – the numbers that you've just been talking about of people leaving residential aged care, is anything in place to try and, even at a high level, determine or track what happens to those people? Maybe, Mr McNaughton, might be a question for you.

MR McNAUGHTON: Yes, thank you. So since the inception of the NDIS, what we are able to do now is to track every individual NDIS participant.

MR ROZEN: Yes.

MR McNAUGHTON: So we obviously have an individual record for them in our ICT system. And we have a flag or an indicator if that person currently resides in residential aged care. We're continuing making some improvements to our business system, and one of the one assist to track if they've moved out of aged care and where they've gone to. So over time our scheme actually will be able to provide some better data that we're all looking for and I think would go to your question, counsel. So we've set up the foundation for that now, but at the moment, no, I don't have any data to give you other than the fact that we have made those improvements to the system recently.

MR ROZEN: I asked you, Mr Broadhead, about goal number 1 in relation to the action plan. Are you able to tell us why goal number 1 has such a limited focus? That is, the relatively small number of young people who are under 45.

MR BROADHEAD: I can't speak to those who were involved in the plan at the time, but goals 1 and 2 are essentially the same except for two differences. The first is for under 45s, the second for under 65s, and the other difference is the time frame. So probably taken together, I think that there is a – honestly think that there's in people's minds – and I don't necessarily think this is correct, but people's minds I think feel that when it's somebody who's particularly young, there may be greater urgency - - -

MR ROZEN: Yes.

MR BROADHEAD: - - - to address the situation. I think also there's a view that because there is a smaller number, there's a possibility of achieving this more quickly because the number of people you have to work with and discover, you know, what they want to do and where and how they want to live can be worked through more quickly. So to simply leave them in the general category, it may make no difference to practice, but highlighting the fact that you might be able to do – to get more done more quickly for a smaller group is part of the reason why the goal separately identifies those people, whereas the larger number, which includes the broader age group, I suspect there was a view at the time that this might take a little longer.

MR ROZEN: And the 2006 to 2011 plan similarly targeted those under 50. That seemed to be where a lot of the resources went, and that's where we saw some

results. I think a drop of about 35 per cent. I see Mr Carlile, you're nodding. The data seems to suggest that even though within that relatively small group there were significant reduction in numbers, overall there was barely any impact on the cohort of under 65. That figure of around about 6000 remained constant throughout the five years of the program. Is there a concern here with this action plan that the focus on those under 45 might have a similar outcome? That is, we might achieve considerable success with that group but not make much of a dent on the overall figure?

MR CARLILE: That's a possibility. Certainly without alternative options of care and support for this cohort, I don't know what will happen. So - - -

MR ROZEN: Yes. Look, in fairness to you, I keep referring you to the earlier plan but, of course, no doubt each of you would draw the Commission's attention to the presence of the NDIS now as being the sort of fundamental game changer. Mr McNaughton, I see you're nodding. Is that – is it right, is it?

MR McNAUGHTON: Yes, that's correct, and it goes to Mr Broadhead's comment earlier that, you know, this isn't necessarily just about the action plan, it's about the NDIS because the NDIS provides a whole range of supports for people with disability to realise their goals and aspirations and including living – having alternate options for where they may choose to live.

Can I just add to the comments of Mr Broadhead about those actions. From an operational perspective, we aren't treating the under 45s or the over 45s any differently in terms of our priority for planning with those people. We are planning and doing the plan reviews and exploring housing options for that entire range of people, so it's not as if we've done anything different from a service delivery perspective. I just want to assure the Commission of that.

MR ROZEN: Mr Broadhead, we have – that is, the Commission – has asked the agencies involved in the project plan whether the board has developed projection for the numbers of younger people in aged care for each year up to 2025 and beyond. The answer appears to be that there are no projections over that time of what – the numbers that are expected. Is that correct?

MR BROADHEAD: Yes. I'm not aware that there's a formal projection as such of numbers by, say, half-year or year over that period of time.

MR ROZEN: Why not? Isn't that something one would expect to see so that you've got some way of measuring your project ever progress as the years tick by?

MR BROADHEAD: So I think we are measuring our progress, and hence the numbers I mentioned earlier. What I think we haven't done at this stage is feel like we know enough about the trajectory to know – you know, to put in place specific numbers for the future. I'm aware, and I – that the minister that I report to eventually is Stuart Robert, and he is quite clear that he would prefer us to exceed these goals as

opposed to meet them. And I don't think if there was any sense of – as we find our way through this and as the scheme and the arrangements that we're supporting have an effect, I don't think we'd want to limit ourselves to only what we'd projected forward if it turns out we could do better than that.

MR ROZEN: Well, I don't think projections necessarily have a limiting effect, do they? They might give you something to aspire to. They don't have to limit where you go. But I – and I do want to press you on this. It does seem curious from the outside that there are no projections. What do you say to that?

MR BROADHEAD: Look, I expect it's something we will do when we've got a bit more experience and data coming in. So I've already mentioned an informal calculation of the rate of decline of people entering – young people entering aged care, which, if you project it forward on what limited data we have over that period of time, 10 quarters, suggests that we will do better than the target here. But I think you'd want a few more data points and a bit more feel for how the initiatives being taken have changed the situation before you'd want to give precise numbers year by year. The precise number that we are aiming for and hoping to exceed is halving the number of people entering by 2025.

MR ROZEN: Those numbers that you referred us to, quarter on quarter figures from the end of 2016 through to the current day, is that data that's available to the Commission?

MR BROADHEAD: It could be made available to the Commission, yes.

MR ROZEN: I'd ask that it be made available to the Commission.

MR BROADHEAD: My pleasure.

MR ROZEN: We can formalise that request if need be. I've asked you about projections of younger people in residential aged care. Another issue that the Commission is interested in is projections about the availability of supported disability accommodation, which is obviously crucial to success of the plan. There are no such projections of those either. Perhaps, Mr McNaughton, that might be a question for you. Is that something that the NDIA is concerned with and focused on?

MR McNAUGHTON: Yes, it's certainly a major area of focus for us at the moment. We've seen the SDA market really start to grow significantly over the last couple of years, and it's one of our biggest growth areas in terms of provider registration as well. So we are doing a lot of modelling and mapping out of the expected number of SDA providers and properties over the coming few years.

The Productivity Commission estimated there would be around 28,000 participants who would be eligible for SDA at full scheme. We have around 13,000 at the moment who have SDA as part of their plan, so we do see there is obviously some growth there. I'll be honest – and it's not my actual strong suit within the agency –

my CEO is much stronger at the forecasting around SDA than I am, but it is certainly an area of focus for us.

MR ROZEN: You referred to modelling. Is that modelling that could be shared with the Commission?

MR McNAUGHTON: At this stage it's very, very early forecasting. We've been really focused on the demand side, because what we can capture is the participant lens versus the holistic supply side. So at this stage it's not as if we have a supply modelling map I could share with you at this stage, but it will be something into the future we are working hard on.

COMMISSIONER BRIGGS: If I might say, gentlemen, in my experience over the years, having a timeline and targets associated is a very fine thing to concentrate the mind of government officials. I've heard evidence today and yesterday, but today in particular, that this situation is manifestly a failure. I don't want to hear in 10 years time that this situation is still manifestly failing, so it would make a lot of sense, wouldn't you agree, to set some clear targets for how you're going to reduce those entry points down to zero and, indeed, where the numbers remaining in care are going to go, hopefully very much towards zero as well within a certain number of years.

MR BROADHEAD: Is that a question?

COMMISSIONER BRIGGS: Yes.

MR BROADHEAD: I'm certainly going to go away from today and think long and hard about that so, yes, I suspect that one of the things I'm going to look at doing is how we might do that.

COMMISSIONER BRIGGS: That would be good, Mr Broadhead. Thank you.

MR ROZEN: Can I just ask you a question about the role of the project manager in relation to the board. The roles referred to in the governance arrangements which I won't take you to, but our reading of the various iterations of the project plan that have been produced suggests that there have been three different project managers in the short life of this project. Russell Herald, Amanda Walsh and Ingrid Penberthy. Mr Broadhead, can you assist; is that a correct understanding of the project manager role?

MR BROADHEAD: It is a correct understanding of who has occupied that role, yes.

MR ROZEN: Is that telling us something about the stability of the project if in, what, three months there have been three project managers?

MR BROADHEAD: There has been a lot of things going on within the area and some people have had to move on to other tasks and so, yes, I have to say that all those people work closely together although Amanda is recently recruited. But they work closely together and there are other staff involved who provide continuity but it so happens that – I don't want to discuss people's personal circumstances, but Russell has had to move to another particular role in relation to the NDIS, Ingrid has gone to another job and Amanda is now the person in that role.

MR ROZEN: And a project manager role suggests that there are subordinates to the manager. Are there other employees who are working as part of the project team?

MR BROADHEAD: Yes.

MR ROZEN: And are you able to tell us in terms of FTE, full time equivalents, how many employees there are all together?

MR BROADHEAD: I – there's two, three – there's probably three people. It's not quite three FTE because they have other tasks. Two of them are largely dedicated to this task. There's also currently a grad recruit involved in the work as well so it's a graduate recruit who's temporarily assigned to us and we thought this would be a good project for her to be involved in. There's also a – some part of a branch manager's time involved in it as well.

MR ROZEN: Now - - -

MR BROADHEAD: That's only in the coordination, I should say, and in the management of the information and so on.

MR ROZEN: Thank you. I want to ask you about younger people in residential aged care who are not eligible for the NDIS because we've heard a lot from you about the expected role of the NDIS in providing support and alternative accommodation and supports for younger people who are eligible for it. But a matter that has been discussed in the meetings of the project plan is this cohort that fall outside NDIS eligibility and I want to ask you about them. If I can do it by reference to the 2019 report of the Australian Institute of Health and Welfare which is behind tab 28, if that could be brought up, please and if we could go to page .0015 – or .0014 firstly, please, there's a heading Specific Conditions of Interest.

There's a reference to the – and I think a hard copy is coming your way, thank you, Mr Thorpe. There is a reference there to the aged care assessment records of the health department which have been analysed by the institute as part of preparing this report. Without going into too much detail about that, if I can draw your attention to the next page, the table 4 on page 9 of the report; that's page 0015 of the document. We see that the table lists people who first entered permanent residential aged care aged under 65, the proportion with specific condition, and the first listed condition or any mention of the condition. And we see the most commonly mentioned condition is dementia and then the second most common is cancer where it's the first listed

condition for 12.5 per cent or one in eight of the assessments. And under the any mention column there's 19 per cent have mentioned that cancer is a condition that is identified in the assessment.

Dr Hartland in his evidence yesterday told us that as he understood it, the group of young people who are not eligible for the NDIS, that is, young people in residential aged care not eligible for the NDIS, he thought it was a small group and observed that it might be about five per cent in his evidence earlier today, so I just wanted to let you know that's the evidence. And I want to ask you about the discussion at the second meeting of the board, the minutes of which are in the materials behind tab 137 if we could go to that, please. On the first page of those minutes – thank you – if you look towards the bottom of the page, if I could address this question to you, Mr Carlile, you'll see under the heading Agenda Item 3, Status of Project Plan Report, the third black dot point there:

> *Discussion about the fact that not all YPIRAC will be eligible NDIS participants, for example, those going in primarily for palliative care.*

And one of the witnesses yesterday clearly fell into that category. And there's a reference to the IAHW report:

> *The board agreed that there is a need to have a formal and defensible process for decisions around who gets assessed for NDIS participation and who doesn't. DSS expressed concern that there might be a grey zone where people aren't being offered the opportunity to apply for NDIS supports. It was noted this could be appropriate in certain cases but a protocol needs to exist around these decisions.*

Mr Carlile, are you able to assist us with the reference to a formal and defensible process for decisions around who gets assessed for NDIS participation; what's being referred to there?

MR CARLILE: From recollection, it was discussion about the young people that would not be eligible for the NDIS and I think I might have actually raised it as part of the project board.

MR ROZEN: Yes.

MR CARLILE: I don't know that – defensible process is probably more a reflection of the need to have a transparent process, rather than defensible in the sense that it needed to be able to be scrutinised and understood. And I think it goes to the issue of the question of whether people who are – young people might have not necessarily even tested their eligibility for the NDIS because maybe their understanding of who would or would not be eligible, they haven't bothered to put their name, you know, forward or to test their eligibility for the scheme.

MR ROZEN: If I could ask that the third page of those minutes be brought up, that's .0056, there's a heading Agenda Item 4:

> *AIHW pathways of younger people entering permanent residential aged care report.*

Perhaps I could just address this question to you, Mr Broadhead. That's the report that I was just asking about a moment ago which identified cancer as the second-most mentioned condition. The minutes record:

> *DSS noted that the report shows that between 12 and 25 per cent of young people in residential aged care are going into aged care for end-of-life care, rather than disability. 12.5 per cent of admissions have cancer as their first listed condition, 80 per cent of whom die within 12 months of entry. Around 25 per cent of entrants in the report had cancer listed as a condition at all. It is possible some of these entrants also have a disability.*

And then the minutes go on:

> *This is a challenge for Health, because if entry to aged care is closed to all under 65 with the assumption that NDIS will care for them instead, there will be a substantial unmet need.*

And it goes on to refer to palliative care as being a responsibility of the states. And then, Mr Carlile, this is probably another one for you:

> *Health stated that they've recognised this complexity and are shaping the legislative amendment proposal to close aged care to under 65s with this in mind.*

You were the only Health representative at this meeting, I think, were you not? Or Mr Graham was there as an observer.

MR CARLILE: That's correct.

MR ROZEN: That comment there about the legislative proposal to close aged care to under 65s, is that a comment – does that accurately reflect what you said to the meeting?

MR CARLILE: That's a summary of what was discussed.

MR ROZEN: Yes. Is it an accurate summary?

MR CARLILE: It's accurate but incomplete.

MR ROZEN: In what way is it incomplete?

MR CARLILE: Well, we did also discuss the fact that we need exceptional circumstances always to be a consideration that, as is oven the case with these things, you can't do things in an absolute way.

MR ROZEN: I'm more interested in the legislative proposal to close aged care to under 65s. That's not something – and I'll be corrected if I'm wrong about this – but that's not something the Commission has been formally advised of by the Department of Health. What is the status of the legislative proposal development?

MR CARLILE: That's still a matter for consideration by the cabinet.

MR ROZEN: So there's a cabinet proposal?

MR BROADHEAD: If I can assist my colleague, I think the status of it is there's been discussion between departments about whether and how one might make some kinds of legislative amendments to change the Act in that regard.

MR ROZEN: Yes.

MR BROADHEAD: I think it's only got the status at this stage of discussions between officials. I don't think it's got beyond that, to my knowledge.

MR ROZEN: Now, the minutes record that the action arising from that discussion will be to place the discussion of the report on to the agenda for the SRG. Do you see that at the bottom of the screen there in bold? And the SRG is the Stakeholder Reference Group which has been established to provide input by various stakeholders into the process of the implementation of the action plan. Is that right, Mr Broadhead?

MR BROADHEAD: Yes.

MR ROZEN: And we see that happened. And I won't take you to the discussion by the Stakeholder Reference Group, but I just want to ask you about a change to the project plan that seems to reflect this discussion. There have been various iterations of the project plan. I think there might be about eight iterations that have been produced over the last six months or so, Mr Broadhead; is that right?

MR BROADHEAD: I don't have account for that, and some of them predate my involvement, I think.

MR ROZEN: Okay.

MR BROADHEAD: But I think the project plan is meant to be what they call a living document. In other words, it's meant to reflect the information and the way forward at any given point in time.

MR ROZEN: Yes.

MR BROADHEAD: So it does change as new things are discovered and perhaps priorities are rearranged.

MR ROZEN: If we could ask that the June version of the plan be brought up. It's behind tab 130. No, sorry, it's 124. My apologies. And so that – we can see on the cover there:

Version 0.4, June 2019.

And if we could go to page .9595, we see, right at the bottom of the page, a section out:

Out of Scope.

Do you see that, Mr Broadhead? There's two - - -

MR BROADHEAD: I do.

MR ROZEN: Two areas identified: children under the age of 18 and home care recipients. And are we to understand from that that they're two areas that are not part of the focus of the project board? Is that how we read that?

MR BROADHEAD: Yes, but if I can explain in relation to the first one - - -

MR ROZEN: Sure.

MR BROADHEAD: - - - because this might seem odd, and I have to admit that when I first saw it I asked about it. And there are a number of factors here. Firstly, it's – to my knowledge, there's nobody under 18 in residential aged care, and it's apparently a very rare, if ever, occurrence. I'm not saying never because one never should, but – and also that there are instances where children with disabilities are cared for other than in the family home, but they tend to be subject of different arrangements. For example, in New South Wales as a formal statutory arrangement for what's called voluntary out-of-home care where somebody may be cared for in another setting, and there are requirements around that. So for those reasons, it wasn't regarded as in scope for this particular project, for example.

MR ROZEN: So that's the – that's out of scope as described in the June project plan.

MS BRIDGES: Yes.

MR ROZEN: I now want to ask you about the – a later version of the project plan which, as we understand, is the current one from August 2019. It's behind tab 136. If that could be brought up, please. You'll see that it's "Version 3, August 2019" on the cover there. And if we can go to page .0037, and if we cast our focus to the bottom of the page:

The equivalent Out of Scope section has grown from the June version and now includes younger people not eligible for the NDIS.

Do you see that Mr Broadhead?

MR BROADHEAD: I do.

MR ROZEN: Yes. And is that a reflection of the discussion of the minutes that I've just drawn your attention to?

MR BROADHEAD: I expect so.

MR ROZEN: When you say you expect so, you are the chair of the board, are you not?

MR BROADHEAD: Yes, I am.

MR ROZEN: We don't see any discussion in the minutes reflecting a decision to take this group out of scope of the project, unless you can draw my attention to it. I haven't seen it.

MR BROADHEAD: No.

MR ROZEN: Was there a formal decision made by the board to expand the Out of Scope category so as to include younger people not eligible for the NDIS?

MR BROADHEAD: Not that I'm aware of, although there was a discussion about scope and – I think the AIHW report – which, by the way, I think was commissioned by the Summer Foundation, although it was done by the Institute – alerted us on the project board to the fact that there were people who might not be eligible for the scheme who were going into residential care for other reasons. I think the summary of the discussion in the minutes is a little bit compressed, but that was one of the things that was discussed. I'm not sure whether these – this change to the project plan has since been ratified by the board or whether it's just a change that's been made that's subject to ratification.

MR ROZEN: Well, can we clarify that, because it is an important matter for the Commission. Is there a later version of the project plan than version 3 of August 2019?

MR BROADHEAD: Not to - - -

MR ROZEN: Do you know?

MR BROADHEAD: Not to my knowledge.

MR ROZEN: Okay. And the board has, of course, met a third time, has it not? There was a meeting at the end of August.

MR BROADHEAD: Yes.

MR ROZEN: Now, minutes of that haven't been provided to the Commission. I take it that's because they haven't been finalised; is that right?

MR BROADHEAD: Correct.

MR ROZEN: But you were present at that meeting?

MR BROADHEAD: Yes.

MR ROZEN: Did it ratify the August 2019 version of the project plan?

MR BROADHEAD: I don't recall it ratifying it, no. But you're testing my memory.

MR ROZEN: It's not a memory test. It's really just for the Commission to understand whether or not this cohort, that is, younger people who are in residential aged care but are not eligible for the NDIS, whether they're within scope or not for the project.

MR BROADHEAD: So I think that the focus of the project is around the things that can be done through the NDIS and related things to take – to avoid people going into residential aged care.

MR ROZEN: Yes.

MR BROADHEAD: I think that where it's apparent that there may be people going into residential aged care while young for other reasons, that that may be taken up in another way. And so I've had some discussions about how we might seek to address people who are maybe going in for end of life care but who don't have a disability, because I don't think that the initiative of the NDIS will necessarily address the needs of that group.

MR ROZEN: Well, that - - -

MR BROADHEAD: But I don't think we have a clear way forward yet about how we would seek to address the needs of that group.

MR ROZEN: Well, on its face, the project plan from August 2019 would suggest that the board is not concerned with that group. They've been ruled out of scope.

MR BROADHEAD: There's – the scope is for that particular project. We have lots of engagement on issues around these sorts of things. So, for example, I've had

some initial discussions because end of life care is generally supported by State and Territory Governments about how we might raise, whether or not this group, what could be done about that with our colleagues in State and Territory departments.

MR ROZEN: If they're not part of this group, then they – the risk is they just become a forgotten group in residential aged care, isn't it?

MR BROADHEAD: No. I think we are interested in what happens for those people. I think we don't have – we have a very powerful mechanism I think to address the needs of people with disability through the NDIS. I think it's less clear, as I sit here, that we have a similar powerful mechanism to address the needs of people requiring end of life care and I think it's something we have to discuss with the level of government that has primary responsibility for that, which is State and Territory governments that fund palliative care and hospice services. So now, I don't think it would be up to this project board to simply take that on without that kind of a discussion happening because it's unclear how this project would influence that in the immediate sense.

MR ROZEN: Mr Carlile, are you able to assist the Commission at all in relation to this category, that is, younger people in residential aged care who are not eligible for the NDIS? Is your understanding that they are – they're out of scope in relation to this project or is it - - -

MR CARLILE: In relation to this project, yes, that's my understanding from discussions that we had.

MR ROZEN: Yes.

MR CARLILE: That the focus really is on the transition to the NDIS so it does, to my mind, sort of raise a question about what we are doing about this cohort and with the AIHW report I've actually started a discussion with other areas within the department about this cohort, in particular around sort of issues of palliative care, but I should say that it's not necessarily just palliative care, that it could be people with other issues that is are, you know, eligible for the NDIS are in residential aged care.

MR ROZEN: Can I move to a new topic and ask you about some questions concerning data and the access that the board has to relevant data to inform implementation of the action plan, and could I do it by reference to a discussion that took place at the first meeting of the stakeholder reference group. It's behind tab 131 if that could please be brought up. Just in relation to that, we see, Mr Broadhead, that you chair both the project board and the stakeholder reference group. That's the case, is it not?

MR BROADHEAD: It was, yes.

MR ROZEN: It was, you've lost - - -

MR BROADHEAD: No, no, I'm still the chair of it.

MR ROZEN: Right. Okay. You're still the chair, and we see the attendees and they are from various advocacy groups and then we see a representative of the Australian Healthcare and Hospitals Association, and that body represents public hospitals, does it not, in various States and Territories?

MR BROADHEAD: Yes.

MR ROZEN: Once again, no representatives of the States and Territories, if you're not going to have them on the governance board, why wouldn't you have them on the stakeholder reference group, Mr Broadhead?

MR BROADHEAD: We have a range of mechanisms for engaging with our State and Territory colleagues. The most senior of those is through the Disability Reform Council and that's the council, for example, that endorsed the changes to the health interface, things that were either – that would be covered by the scheme in relation to scheme participants that are of a health nature. And we have a range of working groups. There's a working group that deals with the health interface. There's a working group that deals with hospital discharge at one stage. And there's a senior officials working group to which they report which then reports to the DRC.

So we have quite a range of mechanisms for engaging with our State and Territory colleagues on the issues that is we're attempting to address here and that – there have been changes which are relevant to this topic, or issue, through those mechanisms, including the health interface, including the endorsement at DRC on 28 June of a national hospital discharge delay plan – action plan, and other measures as well.

MR ROZEN: It's not just me raising with you the question of State and Territory involvement on the stakeholder reference group. It was actually raised at this meeting by members of the group themselves, wasn't it, Mr Broadhead?

MR BROADHEAD: Yes, we discussed that and we discussed having an aged care representation as well.

MR ROZEN: Yes. We see that on page 2 of the document. If we could go to that, agenda item 3, Review Terms of Reference. The fourth dot point records:

> *SRG members discussed whether to include additional members in the SRG, especially aged care provider peaks and State and Territory, State health and housing representatives.*

And we see recorded an agreement that there would be one aged care peak representative invited. But there's nothing there about State or Territory involvement. Was there a resolution reached about that issue?

MR BROADHEAD: So can I caution that these are the draft minutes yet to go back to the next meeting of the reference group to be ratified so there may be members who yet seek changes to these.

MR ROZEN: Yes.

MR BROADHEAD: But yes, I – the discussion that was had, I think, settled particularly on the need to have aged care representation. I think there was acceptance that there are a range of mechanisms for engaging the State and Territories, and that one of the things that you juggle in these sorts of arrangements is the size of the group, the number of people who you're trying to convene into one place to discuss something, and so at this stage we decided to proceed with what you see there.

MR ROZEN: All right. The other aspect of these minutes I want to ask you about is on page 4, .9689, and it's the second dot point on that page and I think this is a matter for you too, Mr Broadhead. What's recorded there is:

> *Members indicated they could provide examples and case studies to illustrate the pathways into and issues facing younger people living in aged care subject to obtaining relevant consent.*

And then there's a reference to the chair which I take it is to you, Mr Broadhead:

> *Also indicated DSS would like to survey sufficient YPIRAC to gather as much information on as possible on all pathways by which younger people ended up in residential aged care and so ensure approaches to reducing the entry of younger people to aged care based on evidence rather than assumptions.*

Do you see that there?

MR BROADHEAD: I do.

MR ROZEN: I know these are draft minutes, you've pointed that out to me, but from your recollection, does that accurately record what you said at the meeting about this topic.

MR BROADHEAD: If you're talking about the second sentence, yes.

MR ROZEN: All right. So what seems to arise out of that for the Royal Commission's purposes is that what you seem to be addressing there is a lack of appropriate or reliable data concerning pathways younger people are following to end up in residential aged care; is that right?

MR BROADHEAD: I think what we have is a lot of administrative data from different systems that are set up to administer payments in relation to aged care, for example, there's data that's collected through aged care assessment program. What

we don't have much is to understand what people's experience was before they hit the system. And therefore, why they hit the system, if I can put it that way. So what was it that led somebody into hospital. What was it that led somebody into aged care. And what was the circumstances around that. So what we have is records of decisions of, you know, there's kinds of assessments and transactions that happen as people travel through but we don't know what happened to bring them to that point and we don't have much richness in the detail of what was going on for them when it happened. And I – I think it's exemplified by some of the direct evidence that the Commission has heard. You learn a lot from hearing from the people concerned about how it did or didn't work for them. And our administrative data sets are not terribly good at telling us that.

MR ROZEN: So you have in mind something involving actual interviews or a survey that - - -

MR BROADHEAD: Yes.

MR ROZEN: - - - would examined people's lived experience, I take it?

MR BROADHEAD: Yes. Say – but the thing here is that people in these circumstances have a lot of people asking them a lot of questions, and so you have to be, I think, a bit circumspect about, you know, feeling like you can go out and ask them a whole bunch more. But I think provided people are willing, provided we can come up with a succinct way of doing it and that people don't feel this is going to change their chances of how they travel through the systems, I think we have to be clear about that, but, yes, I think we need to try and gather some information from the people concerned.

MR ROZEN: What's troubling about that, Mr Broadhead, is that you've got the Department of Health there overseeing the aged care system. It's somewhat perplexing that that sort of information is not available from the department. Maybe that's a question more appropriately directed to you, Mr Carlile. I mean, why can't the Department of Health provide this board with that information?

MR CARLILE: The type of information that Mr Broadhead is looking for goes to very much personal, individual circumstances. The data set for the My Aged Care and the administration of the aged care is to do with administrative data, to do with transaction and payment data. It just wasn't designed or set up to capture the type of information that DSS need in order to look at entry points. It's designed for people who are in permanent residential aged care and to administer a payments system and transactions to do with permanent residential aged care.

MR ROZEN: Could I ask that tab 184 be brought up, please. And I just want to clarify, this is something that's just been very recently provided to us, and I think in fairness – Mr McNaughton, I think this is from the NDIA that we have received this. Is this something you're familiar with, this work that's been done by AlphaBeta Strategy & Economics?

MR McNAUGHTON: It came from the department.

MR ROZEN: Came from the department. Back to you, Mr Broadhead. Is this report a response to that concern that you – that we see raised in those minutes? Are we – is it the same thing?

MR BROADHEAD: I haven't had a proper chance to read this, to be honest but, yes, I am hoping that this would give us some of the information. I'm not sure that it will give us all of the information that we're interested in. Particularly, I think, if I can call it swimming upstream, knowing how – what happened in order for people to arrive is – we have a lot of information after they've arrived and what happened then, but we don't have a lot of information about what the lead-up to that was that, you know, landed them where they now are, and that's the thing that we're particularly keen to understand.

MR ROZEN: As I read this report – and I understand your position in not being familiar with it – it appears to be an analysis looking back at younger people who have left residential aged care to try and identify their characteristics - - -

MR BROADHEAD: Yes.

MR ROZEN: - - - so as to inform future planning. Is that broadly what you were seeking from this consultant?

MR BROADHEAD: Yes. So my understanding of this was that it was commissioned for two purposes. One is to look at the characteristics of people who've ended up in aged care, but also to try and understand what the characteristics of those people are vis-à-vis the characteristics of people not in aged care, and to look at also some understanding of who successfully leaves aged care and what the characteristics associated with that are. I think Michael Lye referred to this in his testimony. And this is trying to understand better what the factors affecting success in terms of assisting people out of aged care are.

MR ROZEN: Can I draw your attention to a page .0013, which is a figure that's been prepared by the authors of this report. You can see that it's data, so it's very recent data, 2018, Residents by Exit Status. And you'll see that of all the younger people that exited residential aged care in that calendar year, 40 per cent are exits to death or hospital. Do you see that's the grey part of the chart? Then we've got six per cent identified as exits to family or home, which are referred to as favourable exits. And then other exits, mostly transfers to new residential aged care, is that 16 per cent patched section. Do you see that?

MR BROADHEAD: Yes.

MR ROZEN: And then we've got 38 per cent who didn't leave residential aged care at all. I want to try and understand this chart in light of the evidence you gave us earlier about those reductions quarter on quarter for the 10 quarters between the end

of 2016 and this year. Are you suggesting in your evidence that those reductions in numbers were all favourable exits or - - -

MS BRIDGES: No.

MR ROZEN: How are we to understand?

MR BROADHEAD: No, I'm not.

MR ROZEN: So - - -

MR BROADHEAD: I was commenting on the number of people in care - - -

MR ROZEN: Yes.

MR BROADHEAD: - - - who are in the age group at the time that the data is run, and on the number of people entering aged care.

MR ROZEN: Yes.

MR BROADHEAD: But I didn't comment on the exits and, yes, the – my understanding is that most people leave the category of under 65 and in aged care because they get older.

MR ROZEN: Yes, they either get older - - -

MR BROADHEAD: Which is not – which is not, you know, what you would hope, but that's – that's – yes.

MR ROZEN: Yes.

MR BROADHEAD: And the second-largest category, as I understand it, is people dying.

MR ROZEN: Who pass away.

MR BROADHEAD: But that's from memory.

MR ROZEN: Can I ask you about that first category that's referred to sometimes in the literature as the ageing out category. It's important not to lose sight of the fact that there are probably considerable numbers of 66, 67, 68-year-olds who are in aged care only because they went in as younger people.

MR BROADHEAD: Yes, and, look, one of the good things I would say about the way the scheme operates is that if you apply when you're under 65 but then later turn 65 - - -

MR ROZEN: Yes.

MR BROADHEAD: - - - you can still be supported in – by the NDIS notwithstanding that you've now turned 65. But if you are older than 64, so you're 65 or older when you apply, then you aren't eligible as the scheme currently stands.

MR ROZEN: That first category, you've got to be assessed as eligible before you turn 65; is that right?

MR BROADHEAD: My understanding is that you have to apply for access or to be – anyway, to become part of the scheme. If you've applied, then an administrative delay, for example, in your assessment won't cause you to become ineligible.

MR ROZEN: Just excuse me for a moment. I just want to ask you if I can some questions clarifying the issue of funding. Mr Broadhead, probably best directed to you. Were you present in the hearing room when I was asking Mr Lye about questions of specific funding for the action plan?

MR BROADHEAD: Yes.

MR ROZEN: And just so that I – so, can I – so that I can understand it, is there – there's no specific funding allocation for the action plan. Is that correct?

MR BROADHEAD: Yes.

MR ROZEN: And Mr Lye explained to us that that does not mean that an absence of adequate funding for the plan, because the funding is – under the NDIS is demand-driven. Is that right?

MR BROADHEAD: Yes.

MR ROZEN: Okay. And maybe, Mr McNaughton, you jump in here if you're better placed to answer this. But can you explain to the Commission what that means in a practical sense? How it can – how those two statements sit together, that is, the absence of any specific funding and yet it doesn't convert into there being a lack of funding because of the demand-driven nature of the scheme.

MR McNAUGHTON: So because the NDIS is fully funded this year and into out years and then there's an NDIS reserve fund that's also there to support the scheme into out years, the funding isn't a driver, if you will, of us as individual planners from service delivery experience doing the plan with a participant. It's not a funding issue. It's about making sure that person's getting the reasonable necessary support. So it's not a cap, there's no upper ceiling, there's none of those considerations. It's making sure the reasonable necessary supports are provided. So that's – that's the – excuse me – the driver. It's not – there's not as if we have to operate through a cap is what Mr Lye was saying.

MR ROZEN: And is that because the way that the NDIS is funded takes into account the growth of the scheme year on year?

MR McNAUGHTON: Yes, that's right. The expected number of participants to phase in. Our scheme models the different categories of participants, the different cohorts that we'd expect, the level of functions across different cohorts. So it actuarial has done a lot of, you know, sustainability mapping, I guess, or forward estimates around the projected numbers, the projected impacts, the projected planning costs, and so all that goes into the mix in terms of how government then fund the scheme moving forward.

MR ROZEN: So given that those projections are so important to the actuarial calculations needed to come up with the figures, why then wouldn't you have projections for the numbers of younger people exiting residential aged care? Because, of course, that will have a significant financial impact by requiring a greater level of funding for them living in the community relative to them being in residential aged care.

MR McNAUGHTON: Yes, we would certainly expect that the majority of young – who are – majority of participants who are currently in residential aged care would qualify for specialist disability accommodation if they so choose – chose that.

MR ROZEN: Yes.

MR McNAUGHTON: So we would be factoring those into those estimates around forward estimates of specialist disability accommodation. Absolutely.

MR ROZEN: When you say you would be factoring, has that been factored into the calculation?

MR McNAUGHTON: Yes, so when the Productivity Commission initially did the specialist disability accommodation design, they did it based on the number of, essentially, the functionalist impact and the level of function of certain cohorts of people with disability. They would include the types of people who are in residential aged care and are under the age of 65, so the majority of those would be in that 28,000. But again, that's not a cap either. It's an estimate that the Productivity Commission did which was the best estimate at the time which we assume now, if that goes to 28 and a half, thousand or it's 27 and a half thousand – whatever the number is, yes, they were the forecasting done at that period of time.

MR ROZEN: And that category that we spoke of earlier which could be 12 and a half per cent or potentially higher of people – younger people who are in residential aged care but are not eligible for the NDIS, there is no funding from government in relation to that cohort, is there? No additional funding.

MR McNAUGHTON: Certainly not through the NDIS appropriations. Whether there is through other government appropriations, I would have to take advice from my colleagues.

MR ROZEN: Well, perhaps, Mr Carlile, are you able to assist us there?

MR CARLILE: There's no specific funding for that cohort that I know of.

MR ROZEN: No.

MR CARLILE: No.

MR ROZEN: Anything you can add to that, Mr Broadhead?

MR BROADHEAD: No. Again, the same as Mr Carlile. I'm not aware of any specific allocation for that group.

MR ROZEN: Commissioner, they're the questions that I have for the board.

COMMISSIONER BRIGGS: Okay. I don't have any questions, you'll be surprised to hear. Accordingly, might I thank Mr McNaughton, Mr Broadhead and Mr Carlile for the evidence you've given us this afternoon and the spirit with which you've provided that evidence and excuse you from further hearings before this Royal Commission. So thank you very much.

<THE WITNESSES WITHDREW [4.48 pm]

COMMISSIONER BRIGGS: And with that, I'm proposing that we adjourn until tomorrow morning at, I think, 9.15 am.

MATTER ADJOURNED at 4.48 pm UNTIL
WEDNESDAY, 11 SEPTEMBER 2019

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