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

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

MELBOURNE

9.15 AM, MONDAY, 14 OCTOBER 2019

Continued from 11.10.19

DAY 56

MR P. ROZEN QC, counsel assisting, appears with MR P. BOLSTER, MS Z. MAUD, MS E. HILL and MS E. BERGIN
MS K. MORGAN SC appears with MR B. DIGHTON for the Attorney-General's Department and the Department of Health

COMMISSIONER PAGONE: It is my duty this morning to mark the presence of a number of people in the hearing room today; in particular, the son of his Honour Richard Tracey – Commissioner Tracey; his partner Grace Turner-Mobbs; some members of the judiciary who I can see – the Chief Justice of the Family Court and other colleagues. I thank you for being here this morning. Commissioner Briggs.

COMMISSIONER BRIGGS: It is with a heavy heart that we mark the passing of the Honourable Richard Tracey, a fellow Royal Commissioner and our chair of this Royal Commission. Commissioner Tracey died in California on Friday where he was taking treatment for cancer, diagnosed only seven weeks earlier. Richard told a few of us that he had terminal cancer not long after the diagnosis. It came as a total shock, but, in true Richard style, he soldiered on and chaired a commissioners meeting that very same morning, and he spent much of the next month – in fact, five or six weeks – working on our interim report while taking treatment in the United States.

It gave us all hope that he would return fit and healthy in the New Year. The news of his death was, therefore, a complete shock and absolutely shattering. Few people ever have the privilege to be a Royal Commissioner, but Richard was made for it. He was experienced. He was wise. He was admired. He knew the law like the back of his hand. He was prepared to take a punt if it meant getting a better outcome for older Australians. He loved his country and he knew a lot about it. Many a time he would explain the history of the area we were visiting or the details of famous cases to me, past and present. I learnt a lot from him, even if I never quite mastered the courtly bow, despite his constant tutelage.

Richard was genuinely interested in people and their circumstances. He was such a nice man and everyone loved him. His kind words to our witnesses after their presentations gave them comfort and let them know that they had been heard. His gentle guidance and direction to the Royal Commission staff always helped and made our collective lives so much easier. He was a thoughtful and considerate man. I loved working with him. It was a genuine partnership. You could say that we bonded over morning teas, simple sandwiches, great fish meals and Iced VoVo biscuits which Richard lavishly shared with all the staff in the Royal Commission. We will all remember him very well.

It was Richard who labelled aspects of the aged care system cruel and unkind after two particularly gruelling days of evidence in Darwin, and it was Richard who encouraged me to drive our policy agenda beyond change at the margin to transformative change, given the degree of substandard care that was apparent to us. Our interim report will be his interim report. One of his many legacies.

Everyone at this Royal Commission extends their condolences to Richard's wife, Hilary, and their children Jack, who is with us here today, Fiona, Philip and Rosie, their families and grandchildren. Our deepest sympathies go out to them. Richard Tracey lived a full and rich life. He will be remembered for his work with the

military, as a lawyer, educator, as a Queen's Counsel, as a judge and as a Royal Commissioner. But he was also a great family man and a good friend. He was the kindest of men. He was a lovely man. May he rest in peace.

COMMISSIONER PAGONE: Thank you, Commissioner Briggs. Well, it has been our sad duty to begin this session of the Commission by informing the public that the Honourable Richard Tracey passed away on Friday, Los Angeles time, in Santa Monica where, as you have heard, he had gone for some medical treatment. Richard was a remarkable man as everybody who knows him testifies. He was a man who enjoyed life, including many or at least some wicked pleasures. He would enjoy a glass of red wine, and I can say that he even enjoyed the occasional wicked cigar.

I have known him, or known of him, for the whole of my involvement in the law. It was his book on administrative law that I recall reading as a student and which I then used when I was a lecturer at Monash University. Richard's career in the law has been – indeed, Richard's career generally has been remarkable. He was, for a time, an academic. He served in the Australian Army from 1975 to 2014 and achieved the rank of Major-General. He was appointed Queen's Counsel in 1991. He was Judge Advocate General of the Australian Defence Force from 2007 until 2014. He was president of the Defence Force Disciplinary Appeals Tribunal from 2009 until 2018. He was a judge of the Federal Court of Australia from 2006 to 2018. And as you know, he was appointed chair of this Royal Commission on 6 December 2018.

He had, by any measure, a distinguished career as a lawyer, as a jurist and, I must say, from my experiences of him, he was a remarkable friend. He had a selfless drive and energy which he blended with good humour and compassion. It is no small mark of the man's character that he worked solidly as a judge, despite at the time carrying an illness which might have crushed others until remission seemed to have lessened the danger. His work on this Commission has also been solid, selfless and significant. I will miss his wise counsel and his warm companionship and, like Commissioner Briggs, extend my deepest sympathy to his family. And for those purposes, I include as his family the whole of the members of the Commission. Mr Rozen.

MR ROZEN: Thank you, Commissioner Pagone. Richard Tracey was a leader at the Bar, on the Bench, and at our Royal Commission, a fundamentally decent human being whose passing is keenly felt by the counsel assisting and solicitors assisting teams and all staff at the Aged Care Royal Commission. It is on their behalf that I am privileged to make these remarks.

We take the opportunity to express our condolences to Richard's wife and family, and to his friends and colleagues, so many of whom are present this morning. Tragically, it is only a little more than one year since many of you gathered in this very building for the ceremonial sitting of the Full Court to farewell the Honourable Justice Tracey. Speakers on that day referred to Richard's remarkable career and his distinguished service to the Federal Court of Australia. They also speak of Richard's decency and compassion. For those of us who have been fortunate to work with

Richard during 2019 at this Royal Commission it was just these qualities that struck us.

His humanity shone most brightly on our site visits, at community forums, and with those whom we refer to as the direct experience witnesses. Some of these witnesses have travelled long distances to give evidence at the Royal Commission. Without fail, Richard, with his characteristic warmth and courtesy, engaged with these members of the public as they shared their often traumatic and distressing experiences with the Royal Commission. In so doing, he displayed the role of a true leader. By his example he demonstrated to us all how we should treat the members of the public with whom we were dealing, that is, with respect and kindness.

Richard was passionate about the work of this important Royal Commission and the need for change in the Australian aged care system. We will miss him. We will continue our work in his absence but we remain very grateful for the time we had with him. May he rest in peace.

COMMISSIONER PAGONE: Thank you, Mr Rozen. The Commission will, in a moment, adjourn momentarily to enable those who wish to leave to do so. We thought, though, it might be appropriate to have a minute of silence which we will do in a moment but just before, I do wish to thank, on behalf of everybody and Commissioner Briggs as well, those who are present here. I have been looking through the room. I wasn't aware of everybody who was attending. I now see more of you. It's a remarkable feature of his life and his dedication that so many of you have come. I thank you all for being here. I know that there are people watching on the webcast and thank you very much. I hope that gives some comfort to the members of the family. So we will have a minute of silence, and then I – we will adjourn the hearing. Please adjourn the hearing moment momentarily.

ADJOURNED **[9.27 am]**

RESUMED **[9.35 am]**

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Commissioners, I appear with Mr Paul Bolster, Ms Zoe Maud, Ms Erin Hill and Ms Eliza Bergin. Commissioners, the focus of this hearing is on the aged care workforce. During the five-day hearing we will call 41 witnesses who have made statements and we will tender a further 29 statements made by witnesses who will not be called. To date, Commissioners, the Royal Commission has received 6631 submissions. Over half of these raise concerns about workforce related issues. The Commission has had 55 days of hearings during which 296 witnesses have given evidence. Those witnesses are displayed in the image on the screens. 85 per cent of those witnesses gave evidence about workforce issues.

The older Australians and their family members who have given evidence to this Royal Commission have told you about their lack of confidence in the aged care workforce to deliver the safe and high-quality care that older people need and deserve. The Commission has heard evidence from people who work in aged care, personal care workers, assistants in nursing, enrolled and registered nurses, nurse practitioners, directors of nursing, allied health workers, general practitioners, clinical consultants, geriatricians, team leaders, residential managers and chief executive officers. To date, 113 witnesses, whose images are now displayed on the screen, have provided the Royal Commission with their perspective of working day-to-day in aged care.

Some of the key workforce challenges identified in their evidence includes inadequate numbers and continuity of staff, the adequacy and relevant of training and education and low pay and limited career paths. You have also heard evidence about difficulties attracting and retaining high quality people to work in aged care and the importance of selecting the right people to work in aged care. Commissioners, we would like to take this opportunity to revisit some of the evidence you have heard from a selection of our workforce witnesses so far. To do so, we ask the operator to play a video.

VIDEO SHOWN

MR ROZEN: Commissioners, the Department of Health has conducted a survey of the aged care workforce every four years since 2003. The most recent survey was published in March 2017. It described the aged care workforce in 2016. There were approximately 366,000 aged care workers, of whom 235,000 worked in residential facilities and 130,000 worked in home care and home support outlets. The workforce was predominantly female, that is 87 per cent, and the median age was 46 years. A comparison with earlier surveys revealed some important trends. Operator, please display the table from the Eagar report. You will see a table displayed, which compares the proportions of the workforce from the surveys conducted 2003 to 2017.

Commissioners, perhaps the most significant trend revealed by the table is the relative decline in the proportion of nurses in the residential aged care workforce and the corresponding increase who are personal care attendants. In 2003, as can be seen, 35.8 per cent of the workforce were nurses. By 2016, this had declined to 24.2 per cent. So from over a third to under a quarter. In the corresponding period, the proportion of workers who were personal care attendants had increased from 56.5 per cent to 71.5 per cent. There's also been a significant decline, as can be seen, in the proportion of the workforce who are allied health professionals, physiotherapists, occupational therapists and speech therapeutics. And, Commissioners, you heard from Ms Irwin, a physiotherapist in the video we have just shown about her concerns working as a physiotherapist in aged care.

There's every reason to think that these trends have continued since 2016, although we will have to wait until 2021 when the 2020 survey results will be released to be certain. This lack of up-to-date data is itself a concern that will we will be examining this week. What is also concerning about these trends is that they've occurred at the same time as the resident cohort have become frailer, older and in need of high levels of clinical care. Trends that, on the evidence before this Commission, are set to continue. The consequences of these trends have been revealed in some of the case studies in the Royal Commission. In the Avondrust MiCare case study – which was examined in the Darwin, Cairns and Brisbane hearings – the evidence revealed that a resident at the aged care facility, the late Ms Aalberts, received substandard care for a serious leg wound.

An investigation by the regulator found that much of that care was provided inappropriately by personal care attendants. The evidence was that despite there being in excess of 60 residents living in the home, on many shifts there was no registered nurse working. A consultant to MiCare calculated that residents were only receiving an average of seven minutes of care by a registered nurse per day. At that time, the former accreditation standard 1.6 of the Quality of Care Principles 2014 required a provider to ensure that it had appropriately skilled and qualified staff sufficient to ensure the delivery of the necessary care to the residents. The roster at MiCare had been earlier assessed by the Australian Aged Care Quality Agency as meeting outcome 1.6.

This requirement is now found in standard 7 of the standards that became operational on 1 July this year. We will, during this week, examine these standards and will note the often confusing manner in which they are enforced. We will ask whether the current standards are capable of ensuring that staffing levels in our aged care homes are appropriate. The vital importance of registered nurses being recovered to work in residential aged care facilities at all times was brought home by a recent coronial case in Victoria. John Reimers died on 17 December 2016 at the Mayflower Residential Aged Care facility in Reservoir. Mr Reimers had fallen from his wheelchair and his head had become trapped in the bottom drawer of his bedside drawers.

In her findings, dated 23 August 2019, the coroner found that the enrolled nurse and a personal care attendant on duty had not adequately cared for Mr Reimers between the time of his fall and the time the ambulance attended by which time Mr Reimers died. The quality of the first aid he received was inadequate. The coroner found that there was no registered nurse rostered on duty that night, although there was one on call. The coroner questioned both the training of the care worker and the leadership abilities of the enrolled nurse. In handing down her findings, Coroner Jamieson concluded that the circumstances of Mr Reimers' death, and I quote:

> *…have highlighted a concerning norm in aged care. Staffing to patient ratios administered at minimalistic levels which places the delivery of appropriate care at risk. Additionally –*

her Honour went on –

> *the delivery of appropriate care is being further compromised by an industry approach to employing enrolled nurses to act in charge of their shift. In many cases the enrolled nurses are supported only by a minimally trained group of care providers who by their mere dominance of presence in the sector give the impression that they have the status of a profession.*

And, Commissioners, all of these issues will be explored in the evidence called this week. You will hear more about these issues and, in particular, evidence will be led about the link between staffing settings and quality of care, changes that may be required to education and training frameworks to improve the quality and safety of aged care, remuneration, working conditions and career pathways, the possible role of registration in workforce reform, innovation and technology relevant for the aged care workforce, and workforce planning. We will ask the question of many of our witnesses who should be taking responsibility for and stewardship of the aged care workforce reforms.

Aged care workers often experience excessive work demands and time pressure to deliver care, as we heard from the witnesses recorded in the video. Other witnesses have told you of the impact of inadequate numbers of staff of people in aged care. Basic standards are often not met. Inadequate staffing levels mean that staff are overworked, rushed and generally under pressure. This impacts on their ability to provide high quality care and on their own health and safety. Later this week you will hear from Lavina Luboya, an assistant in nursing, about her experience working in a residential aged care facility. Ms Luboya will tell us that she does not have enough time to spend with residents and that she and her colleagues are constantly rushing. This, of course, is consistent with so much of the evidence we have heard, including that recorded in the video.

A number of witnesses before this Royal Commission have argued for the introduction of mandated staffing levels and a skill mix to guarantee a minimum level of care. Other witnesses have raised concerns that mandated staffing levels will not guarantee quality and that staffing stability and continuity are more important and that a more flexible means of ensuring adequate staffing levels is needed.

At the Perth hearing in in June of this year, Mr Chris Mamarelis of the Whiddon Group referred to the importance of stable staffing arrangements for the delivery of relationship-centred care. There can be no doubt, however, that staffing is a critical element in ensuring the quality and safety of those in care. Services must have the right number of staff and those staff must have the right skill mix. Workers must have compassion and empathy combined with knowledge of aged care and the illnesses and conditions of those in care.

Kathy Eagar, senior professor and director of the Australian Health Services Research Institute at the University of Wollongong, will give evidence this morning about how Australian residential aged care staffing levels compare with international

and national bench marks. Professor Eagar will refer to ground breaking work that she co-authored which was commissioned by the Royal Commission and is available on the Royal Commission website. The report co-authored by Professor Eagar and her colleagues uses a five-star rating system to define adequacy of care staffing levels. One or two stars is characterised by the report authors as denoting unacceptable levels of staffing, and five stars is best practice.

The report indicates that more than half of all Australian aged care residents are in homes that have one or two-star staffing levels. In other words, Professor Eagar's opinion is that more than half of Australia's residential aged care homes have unacceptably low numbers of staff by international standards. On Wednesday, you will hear from Emeritus Professor Eileen Willis of Flinders University, one of the authors of the National Aged Care Staffing and Skills Mix Project report 2016. That report was prepared for the Australian Nursing and Midwifery Federation. Mr Rob Bonner of the Federation will also give evidence. Dr Willis and Mr Bonner will describe the development of the ANMF Staffing and Skills Mix model. We will also hear from Ms Kym Peake, Secretary of the Victorian Department of Health and Human Services. She will tell the Commission that Victoria has had legislated mandatory staffing ratios in its public sector aged care services since 2015, although ratios have operated under public sector enterprise agreements since approximately 2000.

Ms Peake will describe the operation of the Victorian legislation and will explain how high levels of care are provided in Victoria's appropriately staffed homes. She will also explain that the Victorian Government subsidises these homes to the tune of nearly $100 million over and above the Commonwealth subsidies to pay for the additional nurses. During the week we will present two case studies. In the first of these, tomorrow, we will examine the circumstances of Menarock Aged Care Victoria Limited's Greenway Gardens facility which was sanctioned in February of this year. You will hear from family members of residents of Greenway Gardens who will tell you how their loved ones and they themselves were impacted by the failure of Menarock to meet the former accreditation standard 1.6 among other standards.

You will hear from current and former employees of Menarock about how rostering and staffing decisions were made at Greenway Gardens. We will ask the directors of Menarock how it is that a residential aged care facility can find itself in a position where it failed to meet standard 1.6 and why this happened. You will hear from Ann Wunsch of the Aged Care Quality and Safety Commission about how the Commission assessed compliance with standard 1.6 in that case. Turning then to training and education. Many workers are not sufficiently trained in how to care for older people with the complex conditions that are bound in aged care, such as the various forms of dementia or other age-related illnesses and conditions which affect physical and cognitive functioning.

This is particularly concerning given the evidence of the Sydney hearing that the 365,000 people in the population who are currently estimated to be living with

dementia will increase to around 900,000 by 2050. Evidence in the Perth hearing revealed that there is also a severe shortage of staff who are qualified and experienced in providing good quality palliative care. At the hearing in Adelaide in February, Mr Sean Rooney of Leading Aged Services Australia gave evidence of a need for subsidies for traineeships for aged care workers and an industry level capability framework that is linked to the Aged Care Quality Standards. He also said the industry should engage more with universities to refocus current nursing education to provide specific aged care educational streams.

Also, in the first Adelaide hearing, Ms Melissa Coad, a representative from United Voice, the union which represents many personal carers in the sector, gave evidence there should be a mandatory minimum qualification to work in aged care. This should be set as an industry standard. Ms Coad also called for more opportunities for workers to build and maintain their skills through continuous development in areas such as dementia, palliative care and mental health. At the Sydney hearing, we heard evidence that highlights how critical it is that aged care workers understand dementia and how to manage its symptoms. Professor Henry Brodaty from University of New South Wales spoke about the inadequacy of dementia knowledge and skills and said that this could be improved by changes to educational curriculum and on the job training provided by specially trained professionals.

Ms Jennifer Lawrence of Brightwater Care Group noted that good quality aged care, particularly for people with dementia, also requires careful consideration of workers' personal qualities and attributes during selection processes. At the Darwin hearing in July Ms Sandy Green, a nurse practitioner, said that undergraduate nursing courses often do not provide graduates with basic skills relevant to aged care, and this has been echoed by other witnesses, such as medical experts and health professionals, who have described specific skill and knowledge gaps in wound care, continence and nutrition. This week we intend to explore the reforms needed in the aged care vocational education and training and higher education sectors to provide aged care workers with the skills and knowledge to deliver person centred and specialised care.

This will include an exploration of how undergraduate and postgraduate programs for medical practitioners, nurses and allied health professionals can broaden their knowledge and capabilities to support those in aged care. Later today you will hear from the role of the vocational educational and training sector in relation to the aged care workforce and some of the challenges that that sector faces. We will receive evidence from Ms Mish Eastman from Swinburne University, Ms Jane Trewin of Box Hill Institute and Mr Bonner from the Nursing and Midwifery Federation. On Thursday you will hear from a panel of experts on aged care in the higher education sector. They will be asked what we need to do to ensure that our nurses, doctors, geriatricians and others are appropriately trained to respond to the needs of the growing older population.

You will hear from Ms Rachel Yates of Universities Australia, Professor James Vickers from the University of Tasmania, and Adjunct Professor Kylie Ward, the CEO of the Australian College of Nursing. Aged care workers are consistently less

well remunerated than their counterparts in related sectors. The 2017 Legislated Review on Aged Care identified that nurses earn up to 10 per cent less than their counterparts in the acute health sector and, similarly, analysis conducted for the 2018 Aged Care Workforce Taskforce identified that nurses and personal carers earn up to 15 per cent less than their counterparts in all other sectors. The uncompetitive wages and conditions in the aged care industry reflect how aged care work is valued. As Lyndall Fowler, whose mother was in aged care, observed in our Darwin hearing:

> *If the pay of people doing the important and challenging work of caring for the most vulnerable people in society like my mother is less than someone serving hamburgers, what does that say about our society?*

For nurses, there's a potential career pathway through enrolled nursing to registered nursing and, potentially, to nurse practitioner and other specialist roles. In contrast, career pathways for allied health workers and personal carers in aged care are limited or poorly defined. The issue was examined in depth by the 2018 Aged Care Workforce Taskforce which identified a new aged care job family structure, and this morning you will hear from the chair of this important taskforce, Professor John Pollaers. The taskforce proposed that the industry standardise its job classification, job designs, and definitions and career pathways. The ultimate intent of these proposals is to make the aged care industry a viable place to build a longer-term career.

On Wednesday, you will hear evidence about the challenges of improving wages and conditions for the aged care workforce. You'll hear from a panel of industrial officers and representatives from both unions and industry peak bodies. Professor Sara Charlesworth at RMIT University will provide evidence about the background and history to industrial issues in the aged care workforce. Professor Charlesworth will describe the gendered nature of aged care work undertaken by personal care attendants, and that our understanding of the work done by personal care attendants is premised on the notion that care work is work that women do innately and for free at home. Professor Charlesworth characterises the Commonwealth as effectively the lead employer of aged care, given its pivotal role in the funding of aged care services. And we will explore this observation with a number of witnesses this week.

Turning to the role of registration in workforce reform. We've heard evidence of serious misconduct by individual workers who've provided poor quality care or even callously assaulted those in their care with serious consequences for the residents and their families. This evidence raises the question whether adequate measures exist to ensure that people working in aged care not only have the relevant knowledge and skills but are people of good character. Ms Coad, from United Voice, has expressed support before this Commission for a registration scheme for personal care workers. She cautioned against any minimum qualification-based accreditation scheme, and said that it should be free or subsidised given the low pay of those working in the sector.

Also in our Adelaide hearing in February, Mrs Barbara Spriggs called for improved means of screening out people who are unsuited to working in aged care because of their character or lack of skills and knowledge. And we note, Commissioners, that the Commonwealth, in its post-hearing submissions after the Commission's Brisbane hearing acknowledged the merit in establishing a register of care workers to identify earlier and more accurately any patterns of reportable assaults committed by the same care worker.

On Thursday, in the second of our case studies, we will examine how approved aged care provider, Japara Healthcare Limited, managed an employee who it had found had engaged on several occasions in serious misconduct directed at several vulnerable residents over a considerable period of time. We have chosen not to name the employee in this hearing as he has not been the subject of any court findings. The misconduct concerned the employee's interaction with and handling of residents. After he left the employ of Japara, under the current law he remains free to work elsewhere in the aged care sector and, in fact, in other caring sectors and you will hear from witnesses that this is far from an isolated case. We will ask whether there should be a means by which such a person should be excluded from working in the aged care sector as a result of substantiated findings of misconduct and if so what form such a scheme should take.

We will explore current mechanisms to respond to concerning behaviour by health care workers namely the code of conduct for health workers. You will hear evidence from the Victorian and Queensland health complaints entities about how they are implementing that code of conduct. The Aged Care Quality and Safety Commission will explain the manner in which it works with the various health complaints entities to respond to concerns about health care workers in aged care. We anticipate that, ultimately, we will be submitting to you that the current arrangements are far from adequate to protect our elderly.

Turning to workforce planning, it's notable that in 2011 the Productivity Commission estimated that by 2050 the aged care workforce will need to have grown to around 980,000 workers; that is somewhere near triple our current workforce. Providers will need to adopt new models of care and scopes of practice to meet changing expectations. And they will need to be imaginative about how they use technology. Aged care is part of the health care and social assistance sector which has been the largest growing industry every year in Australia since 2015. According to 2017 government research, employment for personal care workers will increase by nearly 30 per cent in the five years to May 2023. In the same period the overall projected growth for all occupations is 7 per cent, 7.1 per cent.

The aged care sector is competing for its workforce with other parts of the health and social assistance sector, especially the disability sector. There are already staff shortages. We will tender a witness statement from Toni Hawkins of the Esperance Aged Care Facility in rural Western Australia. Ms Hawkins' evidence is that the Esperance Aged Care Facility constructed a new wing recently at a cost of $7.1

million to accommodate additional residents but it cannot recruit the additional 40 staff required to open the wing. Her evidence is that the wing remains closed.

A vital issue for consideration in this hearing is where does responsibility for workforce planning lie, what are the respective roles of industry and the government, and who is taking the lead on workforce planning to ensure that we have a capable workforce to meet the growing demand in aged care. We will explore these issues with witnesses from the Department of Health and with Kevin McCoy who is the acting chair of the Aged Care Workforce Industry Council. You will hear that that council is charged with implementing the 14 strategic actions identified in the June 2018 taskforce report. You will hear that the council is made up of highly motivated members but has concerns about the support that it is getting from the Commonwealth Government.

In addition, on Thursday you will hear from a panel of chief executive officers of aged care providers. We will ask those CEOs about how they are engaging in workforce planning within their organisations. We will also explore with them the challenges associated with attracting and retaining staff with the right skills and aptitude. You've heard evidence from witnesses previously that this is a challenge in many parts of the aged care sector. We will ask the question, "Why do we need to care about the people who themselves are providing care?" Commissioners, there can be no doubt that the quality of care that older people receive depends on the quality of the people who provide it.

What we expect of care providers and how we support them and those working in aged care reflects on how the Australian community views ageing and our elders, and the value we place on compassion, individual freedom, dignity and fairness. We need to inspire people to want to care for our elders and enable them to enhance their life through great quality care. Commissioners, we need more people like Sharai Johnson of the Larrakia Corporation who told us in the Darwin hearing of her love for working with the elders in her community and the joy working in the aged care, generally. She was, you may recall, the last person depicted in the video that we displayed earlier.

Australia needs a sufficient and stable supply of well-trained and motivated doctors, nurses, allied health professionals and personal care workers to deliver quality care and provide stability and certainty for our elderly. People in aged care should be confident about the skills and ability of those who are caring for them. They should feel secure and safe regardless of where they receive that care.

Commissioners, from the evidence to date, a picture is emerging of an aged care sector struggling to attract, train, retain and sustain its workforce. This is not a new issue, and you will hear that as with so many other aspects of aged care it has been the subject of numerous previous reports. As was observed in our first hearing in Adelaide, this Royal Commission is a once-in-a-generation opportunity to make substantial reforms for this vital sector. Nowhere is the need for reform more pressing than in relation to the aged care workforce.

Our final witnesses on Friday will be the Secretary of the Department of Health, Ms Glenys Beauchamp, together with Mr Charles Wann, also of the Department. In this evidence we will examine many of the issues canvassed in this opening and in the running of the hearing. We will examine the contribution, role, responsibilities and leadership of the department concerning the aged care workforce. Over the course of the week, in combination with what the Royal Commission has already heard about the state of the aged care sector, we will seek an answer to this question: who will take responsibility for and stewardship of aged care workforce reforms?

However, not only do we need responsibility and stewardship, in light of the raft of inquiries, reviews and recommendations in relation to aged care in recent years we need proper accountability for aged care workforce reform. As Professor Pollaers explained in his foreword to the taskforce report:

> *The way we care for our ageing is a reflection of who we are as a nation. How we care says who we are.*

Commissioners, what is abundantly clear from the video that you've seen earlier and the evidence that we have heard this year is that there are thousands of people working in aged care who display selfless devotion to those for whom they care every day. They are looking after the most intimate needs of some of our most vulnerable citizens. They do it for little money. They're often inadequately supported. At times they risk their own health and safety. They do all of this with love and dedication. We are all in their debt. They deserve appropriate remuneration, appropriate training and support and safe work places. Commissioners, before I call the first witness and tender the tender bundle, I understand there are parties who wish to announce their appearances. It may be an appropriate time for that to occur.

COMMISSIONER PAGONE: Yes. Thank you, Mr Rozen.

MS K. MORGAN SC: May it please the Commission. Morgan. I appear for the Commonwealth.

COMMISSIONER PAGONE: Thank you, Ms Morgan. That is it?

MR ROZEN: That's it. If it's suitable to the Commission, I will call the first witness at this time.

COMMISSIONER PAGONE: Yes, that's Professor Eagar, is it?

MR ROZEN: It is. I call Professor Kathy Eagar.

<KATHLEEN MARGARET EAGAR, AFFIRMED [10.16 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Professor Eagar, for the purposes of the transcript, can you please state your full name.

PROF EAGAR: Kathleen Margaret Eagar.

MR ROZEN: And you are professor and director of the Australian Health Services Research Institute at the University of Wollongong.

PROF EAGAR: That's correct.

MR ROZEN: And for the purposes of the Royal Commission, Professor Eagar, you have prepared a witness statement dated 4 October 2019.

PROF EAGAR: Correct.

MR ROZEN: And that is coded WIT.0459.0001.0001.

PROF EAGAR: Correct.

MR ROZEN: That's right. Have you had an opportunity to read through your statement before coming along and giving evidence this morning.

PROF EAGAR: I have.

MR ROZEN: Is there anything in the statement that you would like to change?

PROF EAGAR: No.

MR ROZEN: Are the contents of the statement true and correct?

PROF EAGAR: They are.

MR ROZEN: And where you express opinions in that statement, are they opinions that you honestly hold?

PROF EAGAR: They are.

MR ROZEN: Commissioners, I neglected to tender the general tender bundle. I think that should perhaps be the first exhibit.

COMMISSIONER PAGONE: Yes.

MR ROZEN: I can indicate for the record that it has 204 tabs.

COMMISSIONER PAGONE: Yes, I think we should, if we can, just indicate what it is with sufficient specificity so we don't get a mistake on the transcript. So the tender bundle.

MR ROZEN: We are calling it the general tender bundle to distinguish it from the case study tender bundles which will be separately tendered.

COMMISSIONER PAGONE: I follow that. I don't have it in front of me, but do we have a date or something we can - - -

MR ROZEN: It can bear today's date. It is an iterative document and it will probably be added to over the course of the week, Commissioner.

COMMISSIONER PAGONE: The general tender bundle then will be exhibit 11-1.

EXHIBIT #11-1 GENERAL TENDER BUNDLE DATED 14/10/2019

MR ROZEN: And I will tender the statement of Professor Eagar as 11-2. That is dated 4 October 2019, Commissioner.

COMMISSIONER PAGONE: Yes. Thank you. That will be exhibit 11-2.

EXHIBIT #11-2 STATEMENT OF PROFESSOR KATHLEEN EAGAR DATED 04/10/2019 (WIT.0459.0001.0001)

MR ROZEN: Thank you. Sorry about that, Professor Eagar, a bit of housekeeping which I should have attended to earlier. My apologies. If I can start, Professor, by asking you a little bit about the institute that you are the director of. You do set that out for us in your statement at paragraph 8 through to 11. Perhaps I can just ask you to very quickly just summarise the role of the institute, the work that it does.

PROF EAGAR: The institute was 25 years old last year and we're not a traditional medical research institute. We do health services research, so we do research into how the health and human services systems work and how to improve them. And the focus of our work is quite diverse reflecting key issues, really, at this Commission: safety, quality, access, efficiency and so on.

We have a very well-established group of about 60 researchers working across six research centres. Three of those are the national outcome centres, patient reported outcome centres in palliative care, rehabilitation and chronic and persistent pain as well as the National Casemix and Classification Centre, and the Centre for Health Service Development, which is the centre that has done the report we're talking about today.

MR ROZEN: And you indicate – and I will come to that report presently – and you indicate in your statement that the institute has considerable experience and expertise not just in health generally but in relation to aged care services.

PROF EAGAR: That's right. And I think we would be recognised as one of the national and international leaders more generally in subacute care and in non-acute care and we did our first related study in this area back in 1994.

MR ROZEN: Thank you. Now you've been the director of the institute since 1998 and if I could turn to your own personal and professional qualifications, which are also set out in detail in both your statement and an attachment to it. And I won't go to those in any detail, but I note from paragraph 4 that you hold various qualifications which we needn't go through, including a PhD in public health. At paragraph 5 of your statement, I note that you've been awarded a number of honours and I take it they're honours that you consider relevant to the work that you've done for us in the statement?

PROF EAGAR: I do.

MR ROZEN: Right. Once again, I don't think we need to read those out. For the sake of completion, if I could ask the operator to bring up tab 149 of exhibit 11-1, the general tender bundle. You've included for us there your CV; is that right, Professor?

PROF EAGAR: That's correct.

MR ROZEN: And if I may say so, it's a very extensive document and lists several hundred publications that you've either authored or co-authored in the period since 1990?

PROF EAGAR: That's correct.

MR ROZEN: Any reason why you chose 1990 as a cut-off date?

PROF EAGAR: We didn't have good computerisation before then.

MR ROZEN: So records are a bit sketchy.

PROF EAGAR: A bit sketchy before then.

COMMISSIONER PAGONE: The good old days, Professor.

PROF EAGAR: That's right.

MR ROZEN: Sadly, some of us remember them all too well. So I want to ask you a little bit more about your background, if I could. We have got your professional background set out at paragraph 6 of your statement and you note that prior to your

time working in academia, you worked in clinical and management roles in the New South Wales health system.

PROF EAGAR: That's right. I spent the first 10 years or so working in clinical roles. I trained as a psychologist. I then moved into management positions in both western Sydney and in the Illawarra and then I gradually got interested in those roles in what is the evidence about how to improve services, and it was really through the lens of having worked as a senior manager and an executive by that stage – a senior executive in the health system that I decided that I was really going to – if nobody else knew the evidence I was going to go and find it.

MR ROZEN: I will presently ask you about a report that you've prepared for the Royal Commission and reference has already been made to that in the opening statement. I think you were in the room when I made that statement. Before I do that, I need to ask you about some previous work that was carried out by the institute which goes by the title of the Resource Utilisation and Classification Study which is abbreviated as the RUCS work. You explain that study at paragraphs 12 to 20 of your statement and, as briefly as we can, I wonder if I could put some propositions to you which I suggest summarise the work that you did and you can tell us if you are satisfied that that is a sufficient and accurate summary of that work. So firstly, the work was done between 2017 and February of this year?

PROF EAGAR: Correct.

MR ROZEN: And the client was the Commonwealth Department of Health.

PROF EAGAR: Yes.

MR ROZEN: Before 2017 your institute had prepared a report which concluded that the Aged Care Funding Instrument was no longer fit for purpose.

PROF EAGAR: That's correct.

MR ROZEN: And the Aged Care Funding Instrument is abbreviated as ACFI, and there has been a lot of evidence in this Commission about ACFI and a number of deficiencies were identified with ACFI but at its heart was a concern that ACFI doesn't discriminate satisfactorily between residents, about what drives their care needs and what predicts the cost of that care.

PROF EAGAR: Yes, we had a number of concerns. One was about its inefficiency. The second set of concerns were about the perverse incentives that it creates in the system, and the third is that it's actually not a very good funding instrument in that funding should be aligned with care needs of residents, and people getting the same amount of funding had vastly different needs and we needed an instrument that resulted in people with the same needs getting the same level of funding.

MR ROZEN: The RUCS study was aimed at a number of things. Firstly, identifying the characteristics of aged care residents that influence the cost of their care; is that right?

PROF EAGAR: That's correct.

MR ROZEN: Secondly, identifying which of those costs were shared costs and which were individual costs.

PROF EAGAR: That's correct.

MR ROZEN: Could you give us an example in an aged care setting of a shared cost.

PROF EAGAR: Yes, roughly half of the costs of time are shared between all residents equally. So that's the night staff, the staff in the dining room supervising a meal, brief encounters in the corridor, social activities; only about 50 per cent of the costs are identified as being individual to individual residents. So the 50 per cent are shared equally and all residents benefit from them.

MR ROZEN: And those individual costs might be showering a particular resident for example.

PROF EAGAR: Absolutely, managing activities of daily living, cognitive problems, behaviour, medications and so on.

MR ROZEN: And then the third – this is a summary obviously, but the third task of the RUCS study was to develop a case mix classification system which could underpin a funding model addressing both shared and individual costs of care.

PROF EAGAR: That's correct.

MR ROZEN: This notion of a case mix classification system, I think well understood in the health sector, not necessarily so well understood outside, can you assist us, please, in understanding what that means? What does the expression case mix mean in that context?

PROF EAGAR: The ACFI is an – we call an additive model. You assess a person and you add up the scores, and the more scores the more money. A case mix classification uses a really different set of logic. It starts by saying what is it about this resident that drives their need for care and why does the resident A need more care than resident B. In the case mix classification we did in the residential aged care sector, the single best predictor of need for care is a resident's mobility. People who are independently mobile need very different volume and type of care than people who have assisted mobility versus those people who can't move around in bed at all.

We created a case mix classification so a classification where at the first level residents are classified according to their mobility and then it goes down different

branches of the classification based on the attributes for that type of resident that drives their need for care. For example, for the cohort who can't reposition in bed, the major determinants then are risk of pressure areas. Whereas for the assisted mobility group, the single best predictor for that cohort is their cognitive function.

MR ROZEN: Thank you. If you can just go back to the notion of case mix, it's literally a mix of cases, isn't it?

PROF EAGAR: It's a mix of cases where people are assigned to a case mix class based on their need for care and the cost of that care, and where the goal is that all the residents in a particular class need roughly the same care and the same cost of that care.

MR ROZEN: So we can just take a simple example, the class might be elderly people with dementia, for example. That could be a class.

PROF EAGAR: Well, dementia per se is not a cost driver. Dementia results in cognitive, behavioural decline and inability to manage activities of daily living and so the classes are defined that way. We do have one class for palliative care. There are 13 classes. The other 12 classes are defined by mobility, cognitive impairment, behavioural disturbance, pressure – skin problems and related. So a class might be people with assisted mobility who have poor cognitive function and with other compounding factors.

MR ROZEN: It might be of assistance if we can just, at the moment, leap forward to your – the report which I'm going to ask you about in a bit more detail, which is behind tab 148 in the general tender bundle of exhibit 11-1. And if we could go to page .0013 please, operator, and if we can highlight the third paragraph on that page, please. I hope that's visible on the screen in front of you, Professor.

PROF EAGAR: Yes.

MR ROZEN: What is noted there in the report is:

> *In the absence of a case mix adjusted funding model in aged care in Australia to date means there's currently no objective mechanism to identify the most appropriate staffing levels for different client cohorts or groups or to adjust for regional differences that may impact on staffing availability.*

If I could just pause there in the reading, that's a reference to ACFI not being a case mix funding mechanism; is that right?

PROF EAGAR: That's right. One of the criticisms of staff ratios has been it's too blunt an instrument. People have very different needs and you can't just have a one size fits all. With a case mix classification you can actually say people in this class need twice as much care as people in another class. So you start to create a way of better describing what individuals need. The technical performance for the

classification is assessed by looking at the coefficient variation; it's a statistic that looks at how homogenous the groups are. In the AN-ACC, the classification we developed, the coefficient variation of all the classes are really quite good. The groups are quite homogenous with respect to their staff time requirements.

MR ROZEN: We will come back to that in a moment, if we may, but if we can just go back to the RUCS project and probably the simplest thing is to go back to your statement exhibit 11-2, please, Operator, on page .0003, paragraph 16, and we can see at the bottom of the page that the RUCS study comprised four separate but closely related studies that are set out in your statement. Is that right, Professor?

PROF EAGAR: That's correct.

MR ROZEN: For our purposes we probably only need to focus in on studies 1 and 2. I see you are nodding, so I am pleased about that.

PROF EAGAR: Yes. Yes.

MR ROZEN: And if I can summarise those studies. Study 1 was a detailed time and motion study of the care needs of 1877 residents of 30 facilities.

PROF EAGAR: That's correct.

MR ROZEN: Is that right? And we can see on page 4 of your statement at the bottom of the page some data which emerged in a table format from study 1. And are there aspects of that, Professor, that you think are significant for present purposes?

PROF EAGAR: I think the most important point to make is that, overall, the split of time is about 50 per cent individual, 50 per cent shared but that does vary by professional group. The registered nurses who are the group that a lot of people have been concerned about, spending more of their time on shared activity versus individual, and a lot of the concerns raised at the Commission is about the inadequacy of individualised time from registered nurses. That reflects in part some of the dead weight of the paperwork systems in the aged care sector and other administrative tasks, particularly compliance with ACFI.

MR ROZEN: I see. We might come back to that as well but we see that the – if we look in the last column there, the percentage of total staff time, that is, personal care assistant time is 74 per cent.

PROF EAGAR: That's right, and this is time on the floor, not just the – this doesn't include the people back at the head office.

MR ROZEN: Yes. I note that that figure, in general terms, is very close to the figure I cited earlier in the opening about the proportion of the workforce that are personal care workers.

PROF EAGAR: That's correct.

MR ROZEN: That's also about three-quarters.

PROF EAGAR: That's right.

MR ROZEN: Whereas the proportion of the workforce that are nurses is a great deal more than 9 per cent, isn't it? And is that a reflection of the point you just made earlier that so much of the nurse's time is taken up by other activities?

PROF EAGAR: That's right.

MR ROZEN: Not direct care work.

PROF EAGAR: Yes. We are very confident about – this was a really resource intensive study. The staff in the study had a barcode scanner on a lanyard around their neck and they literally swiped time in minutes for each resident each day for each of the activities they did and they did that for 30 consecutive days.

MR ROZEN: How were the 30 facilities chosen for that study?

PROF EAGAR: That particular study was a cluster study. 10 facilities in Far North Queensland, 10 in the Hunter region in New South Wales and 10 in metropolitan Melbourne. They were chosen to be representative of the range of services across the country. So the North Queensland had a good representation of Aboriginal and Torres Strait Islander residents and, in fact, homes. The Hunter had a range of CALD residents, etcetera, so did the Melbourne one. We clustered them though because we needed to support them. We had our – members of our team in their every day with those homes. This was really resource intensive. They did a fantastic job. But they are representative of homes as a whole.

The other thing I would say about that is that having done a random selection to ensure that they were a representative section, we then eliminated any home that there were concerns about. So if a home was under sanction, they were not included in our study. If anybody had raised concerns about a home, they were not included. We were capturing current average practice but we were not wanting to reinforce bad practice by building that bad practice into the results of our study.

MR ROZEN: Thank you. So that is study 1. If we can go briefly to study 2 which is summarised at the top of page 4 of your statement, if the top paragraph could please be highlighted, Operator. Study 2 was a fixed and variable cost analysis study.

PROF EAGAR: That's correct.

MR ROZEN: And it looked at a sample of 89 facilities across Australia. How were those 89 chosen?

PROF EAGAR: They were a random selection to represent Australia. So we had a sampling framework with a strata in the framework with location, both State and Territory but also metropolitan, regional, remote, size, large, small, etcetera, ownership stream. So we had government, not for profit and for profit. And, again, the purpose was to be a representative sample where we could then draw conclusions about aged care as a whole. We did deliberately oversample the 20. We put in the 20 most remote services in Australia because they're very small volume. And so we deliberately oversampled them and then we weighted our results at the end to deal with that.

MR ROZEN: Now, that 89 was a representative sample out of, what, two and a half thousand - - -

PROF EAGAR: Two and a half thousand - - -

MR ROZEN: - - - facilities.

PROF EAGAR: That's right.

MR ROZEN: And, as you've explained, you developed strata. It's known as a stratified sample, isn't it?

PROF EAGAR: Yes, that's right.

MR ROZEN: That's a statistical term meaning there are layers with - - -

PROF EAGAR: There are layers.

MR ROZEN: Yes.

PROF EAGAR: So you are selecting a sample which has subpopulations so that you can draw conclusions about each of the subpopulations as well as the sector as a whole.

MR ROZEN: Now, importantly, we need to appreciate, don't we, that the data that was the subject of the analysis was financial activity and facility profile data that you were looking at.

PROF EAGAR: That's correct.

MR ROZEN: And it was for the 18-month period July 2016 to December 2017.

PROF EAGAR: That's right, and in the analysis of the results today, we included the last 12 months only.

MR ROZEN: Right. So that is, what December 2016 to December 2017?

PROF EAGAR: That's correct.

MR ROZEN: And it's important that we understand that because this is the data that you have relied upon in relation to the most recent report that you've done for us?

PROF EAGAR: That's correct.

MR ROZEN: Yes. Thank you. You mentioned earlier AN-ACC that we need to be familiar with, the Australian National Aged Care Classification System. That was the outcome of the RUCS project.

PROF EAGAR: Yes, the major outcome of the RUCS study was a new classification termed the Australian National Aged Care Classification and an associated set of recommendations about what the funding model should look like. There were 30 recommendations in total.

MR ROZEN: And that was the system that assigns a resident to a payment class based on their need for care and its cost?

PROF EAGAR: That's correct.

MR ROZEN: And they're the 13 categories that you spoke of a little earlier in your evidence.

PROF EAGAR: That's right. There's one class for palliative care, two classes for residents who are independently mobile, five classes for people requiring assistance with mobility and five for people who cannot mobilise.

MR ROZEN: If we can go to paragraph 20 of your statement, please, which appears on page 6. You inform the Commission there, that the RUCS study produced seven reports.

PROF EAGAR: That's correct.

MR ROZEN: And we see them identified. We don't need to go through each of them one at a time. At paragraph 21 you note what may seem an obvious proposition but no doubt is an important one, that the purpose of staffing a residential aged care facility is to meet the physical, social and emotional needs of residents and accordingly, you say, any consideration of staffing levels and mix must take into account the care needs of residents. What's the significance of those observations for the Royal Commission, Professor?

PROF EAGAR: I know it looks self-evident that the purpose of staffing is to meet the needs of residents, but I think often staffing has become an ideological debate about models of care and other sorts of considerations and making the dollar stretch rather than about meeting care needs. And I'm not proposing a total dependency

model, although this is a very dependent profile. I am also talking about people's strengths and their aspirations and their appetite for risk. And that's all part of meeting people's social and emotional needs as well as their physical care needs.

MR ROZEN: Now, if I could just go back to the RUCS studies. At their heart was an assessment by your team of the care needs of residents and you utilise the RUCS assessment tool.

PROF EAGAR: That's correct.

MR ROZEN: That was a tool that was designed by the team together with four national expert clinical panels.

PROF EAGAR: That's right. We convened four expert panels who were experts in nursing, pain, function cognition, behaviour and palliative care.

MR ROZEN: And as you explain in paragraph 23, the assessments provided strong independent evidence of the care needs of approximately 5000 residents who were assessed during 2018.

PROF EAGAR: That's correct.

MR ROZEN: And that number of 5000 we get if we add together the number that were examined in RUCS study 1 and RUCS study 3; is that right?

PROF EAGAR: That's correct.

MR ROZEN: And you say in paragraph 23 that that cohort is a representative sample of residents living in residential aged care across Australia in 2018. How can you be confident of its representative nature?

PROF EAGAR: Because of the way that we selected our sample and the stratification we had. The department provided us with a list of all residential aged care facilities in Australia and we used that list for sampling.

MR ROZEN: At paragraph 25, you note that the overall finding from the RUCS study is that residents are typically very frail with significant care needs. And you note some specific findings from study 1 and study 3 to illustrate this conclusion. And they're included in the following paragraphs of your statement. Can I just ask you to explain in general terms the various domains that were analysed to reach that conclusion? What is about the residents that you were examining?

PROF EAGAR: We assessed each resident independently by assessors that we selected and trained for that purpose and they were asked to assess what a resident is capable of doing, taking into account not just their physical conditions but also their behaviour, their cognitive status, mental health issues, motivation, etcetera. And the domains that were important were the ones identified by our international evidence

and by experts, and essentially that was mobility, ability to manage activities of daily living, cognitive and communication ability, frailty, palliative care, end of life needs, the risk of pressure injuries and mental health and behaviour.

MR ROZEN: Now, you have, and we're grateful for this, prepared a number of slides which depict some of these findings. Would it be convenient for those to be brought up at this pointed, Professor, and you may find it easier to give this part of your evidence by reference to these slides?

PROF EAGAR: Yes.

MR ROZEN: Yes. So the slides are behind tab 150 in the general tender bundle, exhibit 11-1. And it, I think, may be of assistance, Professor, if we had the slide, it's AHS.0001.0001.0111.

PROF EAGAR: Yes, I've got that.

MR ROZEN: It has appeared. Excellent. I should probably throw to you at this point. What's the frailty profile slide telling us?

PROF EAGAR: This slide, I really want to raise a number of issues. This is the overall frailty profile of residents using a very well established international measure, the Rockwood Clinical Frailty Scale. You will see that there are very few residents who are rated as fit and well, single digits only. The majority of residents are rated as very frail. That is directly linked to one of our major findings for the RUCS study; that the single best predictor of need for care is mobility, not because mobility per se is what you are caring for but because mobility is a good proxy for a lot ever other care needs that people have.

Only 15 per cent of people in residential aged care are independently mobile. 50 per cent need the support of another person in terms of being assisted mobility and 35 per cent cannot mobilise at all. And that is the group who are at greatest risk and who require the most resources. That is consistent with the frailty profile that we've provided in this graph.

I do want to make another point that frailty is directly linked to vulnerability. This is a very vulnerable population. They are lacking energy, increasingly having – struggling with activities of daily living. That is often causing cognitive problems, memory and agitation. Much of that is dismissed as "that person has got dementia, we can't do anything about it".

But a lot of the agitation and irritability we saw in the study we believe is due to frailty and pain rather than a medical diagnosis. I do want to make a point about point 9, terminally ill. It's not that there are no terminally ill in the aged care sector. Quite the reverse; there are very many. In our study, our protocol was that if a resident was identified as terminally ill, we stopped the assessment at that time and they went straight to one of our – to our palliative care class rather than us putting

them through the assessment which we thought was unethical to assess people at that point.

It does raise, though, a bigger issue about the care needs of this population. There's about 180,000 beds in the aged care sector occupied at any one time by people in permanent care. 60,000 residents living in aged care die each year and 60,000 new members arrive. And to put that into a sort of broader population context, last year there was 160,000 deaths in Australia, about 120,000 of those were reasonably predictable. Those people died of conditions within the last 12 months. Half of the people dying predictable deaths in Australia are living in residential aged care at the time of their deaths, although many of them don't die there; they're transferred to hospital to die.

MR ROZEN: That, of course, raises a whole separate question about the provision of palliative care in residential aged care facilities?

PROF EAGAR: Absolutely, but if you look at that population you are talking about a very frail population who are very vulnerable and that physical vulnerability then creates a lot of fear and distress.

MR ROZEN: It may be of assistance if we went to the next slide, the self-care slide at .0112.

PROF EAGAR: This slide is part of our assessment, looking at the help that people in residential aged care need in terms of basic self-care tasks, bathing, dressing, toileting, grooming and eating. For those basic activities of daily living, 80 per cent or more of residents need help. A bit over two-thirds need help with eating but it's 80 per cent in those other areas.

MR ROZEN: Yes. And without necessarily going to each of the slides, the key message here that emerges from the studies, as I am understanding your evidence, is that this is a typically very frail cohort with significant care needs across a range of daily living activities.

PROF EAGAR: Absolutely. And the other thing I would say about it is that this is a cohort who are so frail they need time with those activities; that when staff are rushed it increases the risk of injury, falls, pressure injuries, skin tears and it also increases the risk of distress.

MR ROZEN: If we can take a simple example we have heard many times during the Royal Commission, if a shower is rushed, the care worker providing the shower may miss the signs of an emerging pressure sore.

PROF EAGAR: That's right.

MR ROZEN: And it may be then some time before it is realised, by which time it becomes particularly difficult to treat.

PROF EAGAR: That's right. I think the other issue I would raise is that when staff are rushed they don't have the conversation with the resident about their appetite for risk and they don't document it. So that is, "It takes you a long time to get dressed, would you prefer me to help you or would you prefer to do it yourself? What is your choice?" And we should be having those conversations. That's part of the dignity of risk.

MR ROZEN: Commissioners, I'm about to go on to a new topic, I was wondering if it might be appropriate time to have a morning break.

COMMISSIONER PAGONE: Yes, I think that might be desirable. 10 minutes?

MR ROZEN: Yes.

COMMISSIONER PAGONE: Adjourn for 10 minutes.

ADJOURNED **[10.51 am]**

RESUMED **[11.02 am]**

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioner. Professor Eagar, we had reached a point before the break where you were explaining the outcome of the RUCS study, noting the high degree of frailty of the residential aged care cohort, and what I would like to do now is move to the work that we have asked you along today specifically to talk about, which is a more recent report that you have done for the Royal Commission. And that report, if it could be brought up, is behind tab 148 of the general tender bundle, exhibit 11-1. And that's the report that has recently been completed by the institute under your directorship.

PROF EAGAR: That's right.

MR ROZEN: As we can see from the title it's How Residential Aged Care Staffing Levels Compare with the International and National Benchmarks, a research study commissioned by the Royal Commission into Aged Care Quality and Safety and it is only very recently published; in fact, it's only published on the Commission's website at this point. Is that right?

PROF EAGAR: That's right.

MR ROZEN: Can you tell the Commissioners a little bit about the background to this, please?

PROF EAGAR: When we did the RUCS study we collected really good quality data on staffing levels and mix and that gave us, really, a very rich dataset which is – one of the problems in this sector is the absence of data. That allowed us then to do an international literature review, looking at the evidence on countries that had either ratios or standards for staffing and then to compare Australian data from our representative sample with the international evidence. We deliberately selected countries that had systems that are comparable to Australia and we did that work just over a couple of months.

MR ROZEN: Okay. We will come to the detail of that in a moment. Just to provide us with a bit of context, the report sets out, at page .0007. There is an introductory section and I want to ask you about the paragraph that appears at the bottom of that page, if that could be highlighted, please, The Changing Policy Context. We can see there that you are noting that with the introduction of the Aged Care Act 1997, there has been a philosophical repositioning of the sector. Can you expand on the significance of that for the report?

PROF EAGAR: I think it's a really important issue. There has been a philosophical repositioning to describe residential aged care as a person's home and none of us have a problem with that. And to describe a wellness approach and a social approach and none of us have a problem with that. I think the problem arises when those sorts of conceptual ideas and policies and philosophies have become a justification for inadequate care, and both in terms of the type of staff, the skill mix of the staff and the adequacy of staff numbers. And our contention, which I'm sure we'll get to, is that residents have a right and it is possible to provide both an environmentally friendly place for people to receive care, socially engaged and clinically competent care at the same time.

MR ROZEN: Yes, we will certainly come back to that. If we go to the top of the following page, please, which flows from the observations you've made that I just drew your attention to and if the top paragraph could please be highlighted. You say there:

> *This re-conceptualisation of residential aged care as a home has inadvertently encouraged the development of a workforce that is less clinically skilled and oriented with greater reliance on lower skilled personal care workers. Similarly, there has been limited incentive for either government or the sector to invest in systems that routinely capture and monitor resident needs or outcomes over time.*

If I could deal with the first sentence in that paragraph please, why do you say that the re-conceptualisation has inadvertently encouraged the development of a less skilled workforce?

PROF EAGAR: Because when people describe residential aged care as a person's home, it is somehow implying that it's a lifestyle choice rather than people are going into residential aged care now because they are so frail or have other significant care

needs that they can no longer be at home. The population currently in care needs more clinical skills, not less.

COMMISSIONER PAGONE: Can I just ask you about that. So it's a case of the homeliness aspect of it not being added to the services, but rather a taking away from the services that had previously been there. Is that how you see that?

PROF EAGAR: Yes, I think that's fair. I think prior to – if I go back 20 years, homes were criticised because they were institutional, and this was a whole policy shift to say let's move away from an institutional model and feel and make them more homely. But I don't think anyone ever intended that you would move away from a clinically competent model towards more of an unskilled model, but that is actually what's happened.

MR ROZEN: And the data which you summarise on the next page of the report, page 9, in table 1, at the bottom of the page, if that could be highlighted, this data makes that point, does it not, about the changing nature of the workforce?

PROF EAGAR: That's exactly right. The workforce has, over time, there are now less allied health professionals, there are less nurses, both nurse practitioners, registered nurses and enrolled nurses, all qualified nurses, and more staff with minimal training.

COMMISSIONER PAGONE: And that's not just a relative difference, that's an absolute difference.

PROF EAGAR: It's an absolute difference against a backdrop of the sector growing quite remarkably over that – if you worked it out as a ratio, it would be even worse.

COMMISSIONER PAGONE: So it's not that we are adding to the institutional care, the homeliness that we need, it's that we are actually reducing the professional staff and putting in people who may or may not be able to give the homeliness aspect of it?

PROF EAGAR: That's absolutely right.

MR ROZEN: You note in your examination of the relevant literature, and this is at page 10 of the report, .0010 - - -

COMMISSIONER PAGONE: Just before you do, sorry, Mr Rozen.

MR ROZEN: No, that's fine, Commissioner.

COMMISSIONER PAGONE: I do apologise to interrupt you. It may be something you were going to ask anyway. Is the driver for this a driver to provide homeliness, or is it an economic driver about returns on investments?

PROF EAGAR: I think the driver was actually economic, but it was also a driver from consumers that they wanted a more socially engaged, less institutional, a less patronising model of care.

COMMISSIONER PAGONE: Thank you.

PROF EAGAR: So I think it's a combination but I think it has been an unholy set of interests that have come together to have a deskilled workforce and I'm not sure that consumers would actually believe that the workforce has actually given them what they wanted when they wanted a less institutional feel.

COMMISSIONER PAGONE: Well, presumably the consumer didn't want a reduction in the other services; they presumably wanted something on top of.

PROF EAGAR: That's exactly right.

COMMISSIONER PAGONE: But it's the reduction of that, that I'm asking about. Is that economic or is it because there's some other driver that - - -

PROF EAGAR: I think the reduction in health professionals has been largely economic.

MR ROZEN: The evidence we've heard – and you can tell me if this is consistent with what you are now saying, Professor, the evidence that we have heard is that residential aged care facilities where there are few nurses may be more inclined to send out a resident to be treated in an emergency department of a public hospital. So, in a sense, there's the cost is shifted in those circumstances to the public health care system. Is that relevant to what we are talking about here?

PROF EAGAR: Absolutely. If a home does not have either the numbers or the skills to care for residents, the easiest thing to do is call an ambulance and transfer that person to an emergency department, and one of the major data failings in the system is that we do not have accurate records about the number of people who are transferred to hospital for basic care needs and also at end of life.

MR ROZEN: Yes, and we also heard evidence of that in this Commission. If I could turn – sorry, Commissioner Pagone. Does that adequately address that question?

COMMISSIONER PAGONE: Yes. It causes me to think of other things, but I will come back to that, perhaps.

MR ROZEN: That is your prerogative.

COMMISSIONER PAGONE: Well, if there's a need – if the shift results in it being easier to call an ambulance, does that mean that the decision to do that is based upon inadequate consideration; that is to say, if the person deciding "Oh dear, I'm not sure

what's happening here, I better call an ambulance", rather than, "I'm trained, I can deal with this internally. I don't need to call an ambulance because I can deal with it"; does that mean one is getting too many calls for ambulances where they're not needed?

PROF EAGAR: There are too many calls for ambulances where people are – could have been cared for within the home without going to hospital if better skills and better staffing had been available, including reports of people dying in the back of an ambulance because nobody recognised or had the skills to care for people literally in their last hours, days and weeks.

COMMISSIONER PAGONE: Thank you.

MR ROZEN: If we can skip forward in the report, then, to page 15, please, where you set out the methodology that you followed to reach the conclusions that you did. I might just ask you if you could, please, summarise the methodology that was followed.

PROF EAGAR: The methodology consisted of an international literature review looking at the evidence around staff ratios and essentially that evidence says there are two ways to deal with this issue. One is minimum staff ratios and the other is to define appropriate staff ratios. We then looked at comparable countries to Australia and we initially identified about a dozen.

MR ROZEN: Could we go to the table on page 17, please, operator. I'm sorry to interrupt, Professor.

PROF EAGAR: And they're the countries that we initially looked at, the US, Canada, UK, Germany, Netherlands, Japan, New Zealand, Australia. And we then went through and started to look at their care system and we eliminated those countries who had different systems where you couldn't draw meaningful comparisons. And the two obvious ones to highlight there are New Zealand and the UK, because, on most measures, we would compare to those two countries, but they have maintained the distinction between high care and low care. And so whilst they do have minimum staffing ratios and standards they're not directly applicable because we have merged those two sectors.

MR ROZEN: If I could just interrupt there, that's a distinction that existed in Australia prior to 2014.

PROF EAGAR: That's right.

MR ROZEN: And saw the sector divided, as you say, into two quite distinct groups which have now been brought together in Australia.

PROF EAGAR: That's right.

MR ROZEN: Sorry; I interrupted you. So that was the exclusion of New Zealand and the United Kingdom. The other exclusions, Japan, the Netherlands and the Canadian provinces, what was the basis for excluding them?

PROF EAGAR: That we were not confident that the people in those residential aged care facilities in those countries are representative of residents in Australia. And that's partly around the range of community services that are available in countries. The countries we selected had pretty well-developed community aged care facilities and also reporting that people now going to residential aged care are a lot frailer and a lot higher need than they were a few years ago.

MR ROZEN: Ultimately, you chose, as comparators, the USA, Germany, and the province of British Columbia in Canada.

PROF EAGAR: That's right.

MR ROZEN: And we note from that table that there's a reference at the top left-hand corner to United States, Medicare/Medicaid. Can you assist us there; is that a particular subset of the United States aged care sector, the Medicare/Medicaid sector?

PROF EAGAR: Medicaid and Medicare are the federal and state systems in the US and if a home wishes to receive government subsidies either through state or federal, that is pretty much every home, there are a very small number that are private, and then they will be part of that system. There are about 25,000 homes in the US who are eligible for – registered for payments under Medicaid and Medicare.

MR ROZEN: So for practical purposes, it's the US aged care system that you're looking at.

PROF EAGAR: Absolutely, it is. Yes.

MR ROZEN: Yes. I understand.

COMMISSIONER PAGONE: And the international review, were there constraints about language?

PROF EAGAR: We only reviewed papers in English and in German.

COMMISSIONER PAGONE: So the Japanese one was available in English.

PROF EAGAR: In English.

COMMISSIONER PAGONE: But presumably there would have been a number of European countries that didn't have material available in English.

PROF EAGAR: That's right, and there's also work on staff ratios done in other countries. We recently reviewed a paper from Korea, for example, but it was actually in English. A lot of academic papers internationally now are in English, irrespective of the primary language of the country.

MR ROZEN: And the reason you are able to look at German papers is you have a staff member who is German-speaking

PROF EAGAR: We have a health economist on our staff who is German.

MR ROZEN: Ultimately, the study focuses on the USA as the best comparator although you draw on aspects of the British Columbia system as we'll see in a moment

PROF EAGAR: Yes.

MR ROZEN: Why was that? Why was it the USA that was ultimately chosen? It's somewhat counterintuitive because one hears a lot of negative things about the USA health system.

PROF EAGAR: I've been a very loud critic of the American health care system but on this occasion, I think that we do have lessons we can learn from America. America started looking research, looking at the relationship between staff levels and resident outcomes back in 2001. It adopted a national system back then. It has maintained research every single year, and it updates the results of that research every year. So it's contemporary. There are 25,000 homes who are funded under those arrangements. It is so well-established in the States that nobody even questions it any more because the evidence is so strong.

The other thing that's really important is that it does adjust for the mix of residents and that for us was one of the essential criteria for selection. The other issue for me, which I thought was important is that it doesn't just address minimum staffing. It also addresses appropriate staffing.

MR ROZEN: I was wondering, Professor, if it might be of assistance to go back to your slides at this point of your presentation - - -

PROF EAGAR: Sure.

MR ROZEN: - - - and correct me if I am wrong but I think the slide at point 0117, this is tab 150, please, operator, at page .0117. Just back a little bit from there. So .0117, please. Perfect. What's the CMS star rating system. What's that an acronym for?

PROF EAGAR: So CMS is the Center for Medicare and Medicaid Services in the US. It's an overarching part, a very well-established part of the federal Department of Health and it does a lot of work regulating standards and services not just for the

federal systems but for all of the states in the US as well. It runs a public reporting system called Nursing Home Compare and any member of the public can log on to Nursing Home Compare and look at the homes that they're interested in and look at how they compare and rather than trying to work through screeds of text, those really complicated and very sophisticated rating systems are synthesised down into five star rating.

MR ROZEN: If we go to the next slide please on .0118.

PROF EAGAR: There are three domains that are reported publicly in Nursing Home Compare and one of those is staff hours. So it's a measure of inputs and it is adjusted for the mix of residents in each home. The next measure is a process measure, so for them that's inspections; it would be accreditation in the Australian context. And the third are quality indicators which are resident outcomes, adverse events but also some quality indicators, such as, for example, the percentage of residents who have been immunised or vaccinated for flu. That, again, is case mix adjusted.

MR ROZEN: If I could just ask you to pause there for a moment, Professor. So one can go on to the Nursing Home Compare website, any of us can do it, if we have got access to the internet and we can see a rating system that is based on data from each of those three domains.

PROF EAGAR: That's right. And you can limit your search and say I want to look at the nursing homes – the US nursing homes within a 10-kilometre radius of where I am, and it will just show you those homes or you can do it for the whole country, 25,000 homes, if you want. And that is updated every year.

MR ROZEN: Okay. And are the comparisons in the rating system state-based or are they national?

PROF EAGAR: They do both. So first of all, they calculate national rates and then they do some recalibration for public reporting because you if you are in Alaska or Hawaii, you actually want to know what the range is within the jurisdiction that you are likely to be wanting to select from for the consumer.

MR ROZEN: I understand.

PROF EAGAR: So there's two sort of purposes; one is public reporting to allow consumers to make choices, and the other is for accountability.

MR ROZEN: All right. Now, for the purposes of this report, you've primarily focused on the first of those inputs, that is, staff hours, first domain, staff hours.

PROF EAGAR: Yes, if I was to adopt this sort of system in Australia, the bit that is missing, and it's my last dot point, is if we were to really move towards a balanced score card I would also want to add measures of consumer and carer experience

because that is the missing element. But for the purposes of this analysis, we focused solely on staff hours.

MR ROZEN: All right. If we can then go to the next slide, please, .0119.

PROF EAGAR: The weakness of the American system – and we will come back to it in a while, is that allied health is missing, and I will come back to that. On the staffing side, though, it gives a 50 per cent weight to registered nurse minutes per resident day, and a 50 per cent weight to total staff hours per day.

MR ROZEN: Just so that we're clear about that. A calculation is made of the hours or proportion of hours of total care time whether it's provided by a nurse or a care worker, to use the language that we use in Australia.

PROF EAGAR: Yes. Total care staff hours in the American system, they will describe it as nursing hours, but they don't actually mean a registered nurse in the way we understand it, and that includes the registered nurses but is not limited to them. We mapped each of the professional categories in Australia to each of the professional categories that we were doing the international comparisons with.

MR ROZEN: So the nomenclature in other jurisdictions doesn't entirely line up with ours.

PROF EAGAR: That's right.

MR ROZEN: But the functions performed by the particular people in those descriptions can be compared to - - -

PROF EAGAR: Yes, in some cases we also had to go back and look at primary training and requirements, for example, how many years of training was required to say that a particular category of nurse was equivalent to a registered nurse in Australia.

MR ROZEN: Or an EN, for example.

PROF EAGAR: Or an EN.

MR ROZEN: Yes, I understand. Can we go to the next slide, Professor.

PROF EAGAR: This is the minutes per day, and this is what you see in an appropriate care system rather than a minimum staffing system. For each of the two main axes, registered nurses and all care staff, CMS defined one star according to the number of minutes, and I will just give you an example, right through to five stars, for registered nursing. Any home providing less than 19 minutes a day gets a one star. Between 19 and 30 minutes gets a two star, right through to 64 minutes plus gets a five star.

MR ROZEN: If I can just pause you there for a moment. So this is not a system that says a particular facility has to provide a certain number of minutes per day.

PROF EAGAR: No.

MR ROZEN: This is a system that measures what's actually provided and then allocates it a rating according to this matrix.

PROF EAGAR: That's right, and homes are required to submit their payroll data. It's not a separate report. Each month or quarter they're provided to actually submit their payroll data and their staff time is calculated from their payroll.

MR ROZEN: Right. And that's the source of the data that makes its way into the rating system?

PROF EAGAR: That's right. And the other thing to say about that is that whilst it's 19 minutes this year for registered nurses, it might not have been that last year. These thresholds are regularly updated in the light of the change in dependency profile of residents and industry standards.

MR ROZEN: Yes. You have, in fact, provided us with a document just yesterday which makes good that proposition, and I'm busily trying to find it. Just excuse me a moment, please, Professor. It's tab 201 in the general tender bundle, and I'll just ask that to be brought up. And perhaps if the top part of that could be highlighted, firstly, please, that is table 4, it might be simpler to go to table 5 first, and do it chronologically. Sorry, operator, if we go to the bottom one, staffing points and rating updated April 2018. What are we looking at here, Professor?

PROF EAGAR: So if I just give you an example, five star for registered nursing in a team, that was defined as being equal or greater to .88 of an hour, 88 per cent of an hour, just to be careful, it's not minutes, it's fractions of an hour.

MR ROZEN: I will just interrupt there, I'm sorry, and just so that we can all understand this because you and I have spent probably more time looking at this than perhaps others. On the left-hand side of the matrix we have got a heading RN Rating and Hours.

PROF EAGAR: That's right, and that's the rows.

MR ROZEN: If we go down there, we can see rating 1 is the equivalent of less than 0.246 of an hour. So it's slightly under quarter of an hour; in round figures, we are looking at about 14 minutes or somewhere in that vicinity.

PROF EAGAR: 19 – yes. Sorry. It was 14 or so last year. Yes.

MR ROZEN: Last year. Yes.

PROF EAGAR: Yes.

MR ROZEN: And so what that means is that if – focusing only on the registered nursing minutes for the moment, if you've got less than the 14 minutes or thereabouts, that's a one star rating.

PROF EAGAR: That's right.

MR ROZEN: But, of course, the American system is not only concerned with the time spent by registered nurses, it's also concerned with overall, the overall time of care that is provided.

PROF EAGAR: That's right.

MR ROZEN: So we need to look at the columns as well.

PROF EAGAR: The columns as well.

MR ROZEN: And we see the heading there, Total Nurse Staffing Rating and Hours, and that's a little bit confusing because it's not just nurse time, it's a combination of RN, LPN, what's LPN?

PROF EAGAR: Licensed practice nurses. And what the US are calling a nurse aid is what we would call a personal care assistant. So it's total care staff, but it is a bit confusing because they use the word "nursing", but it, really, reflects a culture that this is about providing nursing care.

MR ROZEN: Yes. Okay. And then the – without going through each of the columns, we can see that the star rating, be it 1, 2, 3, 4 or 5, is contingent on the amount of time, the total staff rating hours. So a rating of 1, if one is focusing only on the total number of hours, is anything less than 3.176 hours.

PROF EAGAR: That's right. And I think we will see that later in one of my slides, it might be clearer at illustrating that.

MR ROZEN: Let's do that. So I just wanted to make the point here, if I could, that picking up on your comment about the flexible nature of the ratings, that it's updated on a yearly basis. If we look at table 4 at the top of this page, we can see the figures for April of this year and these are, in fact, the figures you have used in your report, aren't they?

PROF EAGAR: That's right.

MR ROZEN: And we can see, if we just concentrate on RN rating and hours level, that that has gone up in that year from April 2018 to April 2019. So it's now 0.317 hours increased from what was previously 0.246 hours.

PROF EAGAR: That's right.

MR ROZEN: That's where the 19 minutes comes in.

PROF EAGAR: That's right.

COMMISSIONER BRIGGS: Can I ask why would that have gone up between years, just so we can understand it.

PROF EAGAR: Because they're also collecting data on the care needs of residents in a minimum – quite extensive minimum data set and also changing – so the care needs of residents go up, then the care hours go up. So even though their methodology was designed back in 2001, these thresholds are continually revised to reflect the changing needs of residents and if we adopted a system like that in Australia we would equally need to do that.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: And it's collecting the changing needs of residents by reference to what they are actually getting.

PROF EAGAR: But also what they need. The sort of assessment that we did in the RUCS study where you saw some of the figures, that sort of assessment is a mandated part of the reporting system.

COMMISSIONER PAGONE: Yes. Thank you.

MR ROZEN: And if I'm understanding this correctly, these figures are the product of a very large amount of data that comes in - - -

PROF EAGAR: That's right.

MR ROZEN: - - - about care needs and actual care provision and that data is crunched and produces these figures ultimately.

PROF EAGAR: That's right and it's regularly updated every year.

MR ROZEN: Yes. As you explained. Thank you. If we could leave that document and perhaps go back to the slides behind tab 150 and I think we had got to - - -

PROF EAGAR: 20.

MR ROZEN: - - - slide 012 – sorry; 120, 0.120. Here, we've got those same figures that we were just looking at for April 2019 but instead of being expressed in fractions of hours we have got them expressed as minutes. Why did you make that change?

PROF EAGAR: Because it's too confusing for everyone to look at fractions of hours. It's easier to convert, and we have done that all the way through the report. So we have converted everything to minutes.

MR ROZEN: I think you started to take us through this table and then I distracted you by dragging you back to the other one. So if we can go back to this one.

PROF EAGAR: The evidence out of the US is that each threshold, each step up has evidence for better outcomes. And the five-star threshold peters out because they could not demonstrate any better outcomes at another higher level, and that's really important and why I think it's a better system, although not incompatible with minimum staff levels. There are two statistics, I think, of interest on this slide that are really important. The bottom, the first is the bottom part of that – the bottom row for all care staff, you get a one-star rating if you provide less than 186 minutes of care. The Australian average is 180 minutes. So for all care staff, Australia rates one-star. For registered nursing, which is the other 50 per cent in the weighting system, the Australian average is 36 minutes of registered nurse time. And that rates as a three-star where the range for three-star is 30 to 44 minutes.

There is one caveat I would like to put on that: our study was necessarily quantitative. We were looking at the total time available rather than what is done in that time. We have ample anecdotal evidence that registered nurses are spending a disproportionate amount of time on paperwork for ACFI, for accreditation and for other administrative requirements. And if you took into account the amount of excessive dead weight time in administrative requirements, I suspect that the registered nurses wouldn't come anywhere near three-star.

MR ROZEN: I should have asked you this earlier, Professor, but the 50 per cent weighting that is given to registered nursing minutes within the overall score means that's given a disproportionate status in the assessment. Presumably that is because that recognises the disproportionate – in a positive sense – contribution made by nurses to the overall care of people that are looked after.

PROF EAGAR: That's right. 30 minutes of registered nursing time is not equal to 30 minutes of a personal care worker.

MR ROZEN: Yes. It's worth more, if I can use that colloquial expression.

PROF EAGAR: Absolutely worth more.

MR ROZEN: I understand.

PROF EAGAR: And it costs more but it's actually worth more too.

MR ROZEN: Yes. Going back to this comparison, am I understanding the point to be that on overall care minutes, by comparison to the United States we do

particularly badly in that we are one-star on average but if one focuses only on registered nursing minutes, we do better. We get to the three-star rating level.

PROF EAGAR: We do with my caveat - - -

MR ROZEN: With the caveat, yes.

PROF EAGAR: - - - about what people do with their time and with my observation that homes would need to spend more time on paperwork to be paid for a resident than a hospital needs to complete to be paid for a heart/lung transplant.

COMMISSIONER BRIGGS: When Commissioner Tracey and I visited residential care facilities they often say to us about two in every four RNs are spending their time on paperwork and that's what they do all day. Is that a common arrangement?

PROF EAGAR: Yes, I think that is exactly common. I gave a paper last year at the Adelaide conference for the Nurses Federation and I was overwhelmed by the number of nurses who said to me that they had left the sector because all they were required to do was paperwork for income, ACFI maximisation, that they loved working with older people and that they would come back into the sector if they were actually recruited back in to use their clinical skills to care for residents.

MR ROZEN: One hears the expression nursing the desk. Is that what we are talking about here, professor?

PROF EAGAR: I think so. I'm not a nurse but I have great admiration for them and I do know we are not using them as well as we could.

COMMISSIONER PAGONE: So just for me to be clear, of the 36 minutes that Australia has for registered nurses, some proportion of that 36 minutes dedicated to a resident is actually filling out forms?

PROF EAGAR: That's right. We don't actually know what it is. When we did the RUCS study, we had – the Department of Health had a stake holder, expert stake holder reference committee. They asked the representatives from homes what they estimated that to be. Their estimate of that was about 30 hours per resident per year on ACFI compliance.

MR ROZEN: Can we go to the next slide please operator, .0121 and can you take us through this please.

PROF EAGAR: So the American system puts those two components together. Registered nurses are the rows and you will see 1, 2, 3, 4, 5. 1 is less than 19 minutes; 5 is greater than 63. So it's exactly what you saw, this time it's a row rather than a column. And the columns are total care staff and the two of them are combined in the American system and you will see that one of those cells is in red and that is one-star for total staff and three-stars for registered staff gives Australia as

a whole a two-star rating. The other thing I would point out from this slide is that there are 25 cells because it's five by five and there's only five stars and there are different combinations to get you to each combination. We have said that three stars is the bare minimum for adequate care. There are actually nine combinations that get you to three-star and this is really important because one of the arguments against ratios has been that this is a blunt instrument with a one size fits all approach. This sort of system, which is more sophisticated, allows for homes to have a quite different mix of staff in each home, depending on the unique needs of their residents.

COMMISSIONER BRIGGS: You're saying that three-star is a bare minimum. So if you get to four star what's again the total staff rating required in minutes?

PROF EAGAR: Four star, and you can see – in fact it might be helpful to go to the next slide, I think.

MR ROZEN: It's - - -

PROF EAGAR: No, sorry.

MR ROZEN: It's slide .0125.

PROF EAGAR: Two-five.

MR ROZEN: I think?

PROF EAGAR: That's it.

MR ROZEN: That could perhaps be made a bit bigger on the right-hand side.

PROF EAGAR: This slide is a little bit hard to understand when you first look at it but it's the same idea. The registered nurse time are the rows. The total nursing or total staff time are the columns. The red cells are the one-star cells. The green stars over at five-star and the yellow is the big in the middle that is the three-stars and the percentages in that table are the percentage of residents in each of those cells. I would also - - -

MR ROZEN: If I could just interrupt you there. There are nine ways you can get to the three stars.

PROF EAGAR: That's right and that - - -

MR ROZEN: They are the ones in the light yellow, if we can call it that.

PROF EAGAR: That's right. You can get to three stars if you have for our five-star registered nursing but only one star for total care staff, etcetera, right through to the other extreme; five stars for total care staff, but only one star for registered nursing.

MR ROZEN: Presumably that's because if we look at the top right-hand where it says 0.0 per cent, that is five stars for total time and one star for nursing. Presumably the thinking is even if you have minimal nursing time provided you have lots of overall time, then that balances out to some extent and gets you to three stars.

PROF EAGAR: Yes, but I will go back to an earlier comment which is the Americans case mix adjust, so we calibrate this for the eye unique mix of residents in their homes. And so if you look at the homeless facilities, the facilities that specialise in homeless people, their staff mix needs to be different from a home that has a lot of physically frail people. So as long as you case mix adjust, this works.

MR ROZEN: Yes. Okay. I should have asked you this earlier, but you spoke about the amount of time our nurses are doing paperwork. Is that something that is taken into account in the American system? So when they talk about minutes, is it minutes of actual care time by nurses?

PROF EAGAR: No, it's also including clinical documentation, but I think our system for payment purposes is much more inefficient than the American system.

MR ROZEN: Right. Okay. So it's not – I understand you to be saying that there's some paperwork which is absolutely vital to the clinical tasks - - -

PROF EAGAR: Absolutely.

MR ROZEN: - - - such as making records of the administration of medications and so on. But you're talking about paperwork which is unrelated to the actual care task.

PROF EAGAR: Paperwork for clinical purposes to document a care and assessment of each resident, their care plan, the nature of the care that they've been delivered, any adverse events, quality problems, etcetera, etcetera, is absolutely essential and it is part and parcel of being a clinician. Every clinician does that and would not dispute the need to do that. I'm talking about the paperwork which is for administrative and funding purposes that doesn't add value on the floor.

MR ROZEN: I understand. And you were taking us through the table that appears on the screen.

PROF EAGAR: Yes.

MR ROZEN: And those percentage figures are your assessment of the percentage of Australian residents in the study that fitted into each of the 25 categories.

PROF EAGAR: That's right. And it's percentage of residents, not the percentage of homes, and this goes back to the questions you asked me earlier about sampling. 1.4 per cent of residents are in homes that rate five-star for both total staff and for registered nurses. The other comment I would raise, and I know the Nurses Federation is giving evidence on this, the Nurses Federation has developed a model

and when we mapped it to these standards, the Nurses Federation model is equivalent to five-star for registered nursing and one star for total care giving a three star rating.

MR ROZEN: Just so that is clear, that's the bottom left-hand figure; that is five-star, it's 0.0 % there, if that could be perhaps highlighted.

PROF EAGAR: That's right. Yes.

MR ROZEN: It's on the bottom-left hand corner of the chart.

PROF EAGAR: Yes, there's nobody in that cell.

MR ROZEN: As it turns out in Australia, on your assessment, there's nobody actually receiving that level of - - -

PROF EAGAR: There is actually no one in that cell. No one is receiving that level care recommended by the Nurses Federation.

MR ROZEN: Okay. So there's two things there; if the Nurses Federation model was to be adopted and this assessment tool was used to assess it, that's where it would be at three stars because it's five-star on nursing and one star on total minutes.

PROF EAGAR: But I'm sure the Nurses Association is not saying you could do better than that I would highlight the 1.4 per cent of people that are getting five star nursing and five star, total staff.

MR ROZEN: Yes.

PROF EAGAR: I would also point out that if you look at the totals for nursing, there are quite a lot of nurses – residents getting at least three-star compared to total staff. So the bottom that you're looking at, 73 per cent, 72.9 per cent of people are only getting one star for total time.

MR ROZEN: Yes.

PROF EAGAR: The spread for the registered nursing, which is the column that's now being highlighted, is actually much more even.

MR ROZEN: Yes. Thank you. Can we just go back two slides to .0122. My fault, I jumped ahead in the slides. Can you tell us what we are looking at here, please, Professor.

PROF EAGAR: Yes, what we are looking at here is the percentage of residents in Australia and in the US who meet each of the stars. The pink colour is the profile of Australian residents and the blue colour is the American profile. You will see that the Australian homes are clustered much more down into the 1, 2 and three-star compared to the Americans, which are much more evenly spread.

MR ROZEN: And this is where your figure of 57.6 per cent of Australian facilities being 1 or 2-stars come from. If we add together 11.9 and 45.7, that's where that figure of over half of our facilities - - -

PROF EAGAR: That's right so the first 1 and 2-stars together for Australia and that is quite different to the percentages in the US, pointing out that the US system is not a mandated minimum. It's appropriate.

MR ROZEN: Yes. If we go to the next slide please, .0123, this summarises the analysis that's included in your report. These terms, unacceptable and acceptable care, are they terms that are actually used in the CMS system?

PROF EAGAR: No, they're our judgment as a research team.

MR ROZEN: Yes.

PROF EAGAR: So a couple of things. We actually made a call, a judgment, that that is how we see the system, based on our really considerable experience doing this work now over 25 years, looking at the relationship between inputs, outputs and outcomes in subacute and non-acute care, but also on the American evidence. The other thing I would want to say about that is for simplicity, I've shown it on this slide as being 30 minutes of registered nurse time and 215 minutes of total staff time but note there's actually different sets of combinations to get there. That's for each of them. But you don't actually have to have both of those; it's the combinations. But to simplify it I've really used that as the proxy.

MR ROZEN: Yes. That's the nine ways of getting to three stars that we looked at earlier.

PROF EAGAR: That's right and I've just put one up here.

MR ROZEN: That slide is headed My Judgment and I should take you back now to your statement, if I could, at paragraph 43. So it's exhibit 11-2, paragraph 43, which is on page 11, .0011 and if we could just, if you can take us through, in summary, please, Professor, what you're saying here.

PROF EAGAR: My judgment is based on three factors. First, I do feel qualified to make this judgment. I've been working in this area, looking at the relationship between inputs, outputs and outcomes in subacute and non-acute care for more than two decades. My second piece of evidence around that is the significant care needs that I summarised before. This is a very fail, vulnerable population. 30 per cent turnover each year due to death.

The third is the evidence out of the CMS itself who now describe the evidence on staff ratios and staff thresholds as being both strong and compelling, and this really disputes the other issue that is commonly raised in Australia that there is no evidence for staff ratios. There is, according to the US, strong and compelling evidence for

not only staff ratios but for thresholds. And the threshold between two stars and three stars is defined as the point at which, under three stars you are more likely than not to have quality problems.

MR ROZEN: Paragraph 44 you make the point, I take it it's an important one, that this is not a set and forget system. Can you explain a little about what you mean there?

PROF EAGAR: Yes, one of the concerns we have, given the lack of historic R and D, research and development in this sector is that somebody adopts standards, sets and forgets them. The profile of residents continues to change and they're not updated. I pointed to the US where there is periodic revision. I've also given another example in this paragraph. Our expert nursing panel raised the point about a new cohort now starting to present in residential aged care requiring bariatric care due to morbid obesity.

This was defined in our study as people requiring three or more staff plus hoists and other assistive devices to move them. If the obesity epidemic that we are now describing at a population level turns out to be the case in Australia, we are going to need more and more staff to deal with that as resident dependency increases. The other thing I would say about that is that the more successful we are in providing genuine options for people to stay in their own home, the more the cohort who go to residential care will be extremely high need.

MR ROZEN: I understand that to be that this is only heading in one direction, in your experience.

PROF EAGAR: Yes. The thresholds won't ever come down whilst people in our community want to stay at home and whilst we provide systems of support which allow them to do so.

MR ROZEN: Now, just to conclude, and I don't – certainly don't want to rush you Professor and I will give you the opportunity to say anything else that you want to say but if I can go to page 12 of your statement, please, where, under the heading Concluding Remarks, you note that the work was commissioned – the work you have done has been commissioned by this Royal Commission. And you make reference to the evidence before the Commission in paragraph 53 to the effect there's a need for additional investment in care funding. The majority of which is required to improve the staffing mix and to increase staffing levels to an acceptable standard. It's the next sentence I want to ask you about, paragraph 54 you say:

> *I recommend that increased funding be provided as one element of an element of a comprehensive reform of the total aged care funding model.*

Now is probably not the opportunity to seek from you broader evidence about your ideas there, but are you able, in brief compass, to summarise them?

PROF EAGAR: I would make two remarks. The first is that the ACFI is no longer fit for purpose and so maintaining the current funding model but just throw a bit more money at the problem will not solve the problem. We need reform and – but it can be incremental over years. So that was my first point. The second issue is that one of the things that is missing in this sector is a policy on the relationship between cost and price. And by that, I mean if you think about the way residential aged care is funded, there's an accommodation stream and there's a hotel stream and there's a care stream.

It would be quite reasonable to argue that government funding for care should actually be invested in care, and that care is not a profit stream. And if we had a system that ensured that all care funding was actually invested in care, it would be a very different sector. And I'm not commenting on accommodation and hotel costs; they're separate. But care funding needs to be thought of as part of a broader aged care funding model that also gets rid of some of the perverse incentives in the current funding model.

MR ROZEN: I think it's no secret that the Commission next year will be examining funding in considerable detail and you may hear from us again at that time. Putting you on notice. Commissioners, they are the questions that I have for Professor Eagar at this time.

COMMISSIONER PAGONE: Yes, Professor Eagar. Thank you very, very much. It is quite an eye opener to see the material presented in this form. And you've certainly caused me, at any rate, and I am sure also Commissioner Briggs, to think about matters in a way that we might not have been thinking beforehand. I thank you for your efforts and for coming here today.

PROF EAGAR: Thank you.

MR ROZEN: May Professor Eagar be excused, please, Commissioner?

COMMISSIONER PAGONE: Yes, the good news is that you may go back to work.

PROF EAGAR: Thank you.

<THE WITNESS WITHDREW [11.56 am]

MR ROZEN: Our next witness is Professor Pollaers and I call John Pollaers.

<JOHN CARL POLLAERS, SWORN [11.56 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Professor Pollaers, can you please state your full name for the purposes of the transcript.

PROF POLLAERS: John Carl Pollaers.

MR ROZEN: And Pollaers is spelt P-o-l-l-a-e-r-s.

PROF POLLAERS: That's right.

MR ROZEN: All right. For the purposes of the Royal Commission, you've actually made a number of witness statements and perhaps I will just take you through those now to clarify the record. Firstly, there's a statement you made dated 20 September 2019 for the purposes of this hearing, it's WIT.0361.0001.0001. That should be on the screen in front of you, with your date of birth discreetly redacted. Can you confirm for us, Professor, that that is the statement that you have made dated 20 September 2019?

PROF POLLAERS: Yes, that is.

MR ROZEN: And have you had an opportunity to read through that statement before giving evidence today, Professor?

PROF POLLAERS: I have.

MR ROZEN: Is there anything in it that you want to change?

PROF POLLAERS: No.

MR ROZEN: Are the contents true and correct?

PROF POLLAERS: Yes.

MR ROZEN: I tender the statement of Professor Pollaers.

COMMISSIONER PAGONE: Yes, the statement of Professor Pollaers dated 20 September 2019 will be exhibit 11-3.

EXHIBIT #11-3 STATEMENT OF PROFESSOR POLLAERS DATED 20/09/2019

MR ROZEN: If the Commission pleases. Without needing to tender anything further but given that you are here, it's a good opportunity just to clarify the record.

Way back in February, it feels like a long time ago, you received a letter from the solicitors to the Royal Commission drawing your attention to some evidence that had been given by a witness, Mr Versteege.

PROF POLLAERS: That's right.

MR ROZEN: Do you recall that? And if tab 5 of the documents already tendered, a folder could just be displayed, please. This is exhibit – this has been received into evidence as exhibit 1-64. If I could just ask you to confirm, please, Professor, that this was the response that you provided when invited to respond to the evidence given by Mr Versteege.

PROF POLLAERS: Yes, that's correct.

MR ROZEN: And then finally, you've been good enough to provide us with a response to the report prepared by Professor Eagar which we sent to you a little while ago. If tab 166 could please be brought up from the general tender bundle, and if you are able to confirm for us, please, Professor, that that was a written report that you provided to us in response to our invitation to you to comment, if you wanted to, on the work of Professor Eagar.

PROF POLLAERS: Yes, that's correct.

MR ROZEN: All right. That housework taken care of, can I ask you a little bit about your professional background, please, Professor Pollaers. You are currently the chancellor of Swinburne University.

PROF POLLAERS: Yes.

MR ROZEN: We see this at paragraph 2 of your statement. I'm sorry, paragraph 4 of your statement, if that could be brought up, please, on page 2. You are also the chairman of the Australian Industry and Skills Committee.

PROF POLLAERS: That's correct.

MR ROZEN: You are a member of the Aged Care Sector Committee.

PROF POLLAERS: Yes.

MR ROZEN: That's a role you have held since 2018.

PROF POLLAERS: Yes.

MR ROZEN: Can you tell us what the Aged Care Sector Committee is, please?

PROF POLLAERS: It's essentially a group that was brought together, I think, under the Labor Government some years ago to provide advice to the Minister on issues associated with industry.

MR ROZEN: And you are a former member of the Aged Care Financing Committee.

PROF POLLAERS: Authority, yes.

MR ROZEN: Sorry; Authority. That was a three-year appointment which concluded last year.

PROF POLLAERS: That's correct.

MR ROZEN: In amongst all of that you run a business called Leef Independent Living Solutions, and what's the nature of that business?

PROF POLLAERS: Essentially, it's business built on an understanding of the order of functional decline, and then identifying product technologies and services that can help extend the independence of the elderly and the disabled.

MR ROZEN: And you've got an extensive business background, which I won't go into detail of now. But do you have any specific aged care experience that you are able to draw on?

PROF POLLAERS: Yes, I guess, at a personal level and at a professional level. At a personal level my wife and I lost each of our parents to mismanagement in the system due to medication mismanagement; one to misdiagnosis of dementia, and another to frequent transfers to acute care. I also have a disabled sister who has a more disabled son and I've been their guardian for the last 10 or so years. At a professional level, it's largely through the involvement in the government committees, obviously through the work of the taskforce but also through the work of Leef Independent Living Solutions.

MR ROZEN: All right. I want to turn, now, to the work you did on the Aged Care Workforce Strategy Taskforce. If the report of the taskforce could be displayed please; it's tab 1 of the documents already tendered folder, and it is part of the evidence before the Commission. It's part of exhibit 1-4. That's the front page, is it not, of the report of the taskforce, A Matter of Care.

PROF POLLAERS: Yes.

MR ROZEN: You chaired this taskforce. It's often referred to as the Pollaers taskforce but without asking you to be overly modest, it was the production of a committee, was it not?

PROF POLLAERS: Yes, it was.

MR ROZEN: Of which you were the chair and your appointment was on 14 September 2017 by the then Aged Care Minister, Mr Wyatt.

PROF POLLAERS: That's correct.

MR ROZEN: The taskforce itself was announced by the same minister on 1 November 2017. I think it's uncontroversial that the establishment of the taskforce arose out of an earlier Senate report, did it not?

PROF POLLAERS: Yes.

MR ROZEN: It was actually a recommendation of the Senate report, The Future of Australia's Aged Care Workforce; is that right?

PROF POLLAERS: That's correct, as I understand. Yes.

MR ROZEN: The terms of reference that the taskforce was given by the government are on page .0131 of the report, if that could be displayed, please. I think it's the next page, please. I think we've got two versions of that document, so the version I'm looking at might be easier. It's ACW.9999.0001.0131. They're the terms of reference of the taskforce?

PROF POLLAERS: Yes, they are.

MR ROZEN: Without going into them in minute detail, can you give us an overview of what the taskforce was asked to do?

PROF POLLAERS: Yes. Essentially, the taskforce was really attempting to deal with a substantial number of open issues resulting from very many previous reports that had touched upon workforce but hadn't actually addressed it. So the intention was to make sure that we looked at the current structure of the workforce, the changing nature of consumer expectations, and then the various models and responses to the issues that arose.

They went to the areas of workforce planning. They went to the areas of supply and retention, leadership capability within the sector, education and training. And the brief was wide enough, if you like, to also enable us to look at interface with other sectors of the care system, to understand the funding needs and requirements developing over time. And to look at this in both a short-term and a long-term context.

MR ROZEN: Yes. Thank you. Now, the members of the taskforce were determined by the Minister, as I understand the position, and if we can go to the next page, .0132, that, and on the following pages, the other members of the taskforce are identified. And they were essentially government representatives, industry representatives, including a peak body representative, and academics; is that sort of broadly the coverage?

PROF POLLAERS: It wasn't the way in which we looked at the taskforce. Essentially what we wanted was a mix of experience from research.

MR ROZEN: Yes.

PROF POLLAERS: From vocational training and higher education, government policy and organisational delivery.

MR ROZEN: Yes.

PROF POLLAERS: And the members of the taskforce were essentially chosen along those lines.

MR ROZEN: Yes. So it's not your classic pick the leaders of the industry taskforce. It's quite a different model that was settled upon; is that right?

PROF POLLAERS: Yes, absolutely. I think the first inclination of the Minister was a representative model and we said that – well, I said that I wasn't prepared to do it if it wasn't a more independent and capable group of thinkers, given the substantive issues that had to be addressed.

MR ROZEN: It was the relevant expertise that you were looking for to be drawn upon.

PROF POLLAERS: That's right.

MR ROZEN: Now, I need to ask you because it does jump out – well, I'm looking at the membership, that there's no representative of the workforce. There's no one from a union, for example, that was identified, and I know that was not your decision. You've told us the Minister chose the members of the taskforce. Is that a matter you can shed any light on for the Commission as to why that happened?

PROF POLLAERS: Yes. It was ultimately – obviously, the selection was a matter for the Minister, however, I made sure that through the process of forming this group that I made contact with the senior representatives of each of the unions, to discuss the approach and the framing of the taskforce with particular emphasis on how they could be involved in a way that would give them complete freedom to push and contribute to the agenda, including the establishment of dedicated working groups and the engagement of the employee representatives throughout the process.

MR ROZEN: If we can go to page .0137, please, I think there's some information there that is supportive of what you're telling us. The methodology that was used for the preparation of the report involved the identification of taskforce subject matter experts, as we can see on the left-hand column of page .0137, if that could be brought up, please. Thank you. So we see in the left-hand column there Taskforce Subject Matter Experts.

PROF POLLAERS: That's right.

MR ROZEN: And then on the right-hand side, about halfway down the right-hand column we see a heading Technical Advisory Group Chairs and Contributors; do you see that.

PROF POLLAERS: That's right.

MR ROZEN: And then we've got the first dot point "Employee needs and expectations" was chaired by Mr Rob Bonner of the Australian Nursing and Midwifery Federation. Is that an example of the way in which workforce representatives and trade unions were utilised by the committee?

PROF POLLAERS: Yes, that is an example. In addition, wherever we held employee consultations across the country, the various union representatives were involved and certainly as we started to form up the actions, they were also involved, the recommendations were also involved in discussions.

MR ROZEN: Yes. And the approach that was followed, the methodology that was utilised by the taskforce was a highly consultative one; is that fair to say?

PROF POLLAERS: Yes, it was.

MR ROZEN: And why was that important? It's probably obvious.

PROF POLLAERS: What became very clear at the very outset was this is a highly fragmented industry.

MR ROZEN: Yes.

PROF POLLAERS: With at one end sophisticated companies but dominated by largely small to medium enterprise. There are very many peak bodies that lay some claim to representing this sector. We often would – you know, so there's more peaks in this industry than there is in a small mountain range. So we had to find a way of bringing everybody together. At the outset, I could only characteristic it there was lots of different groups that didn't have a lot of time for each other, hadn't taken the time to listen to each other's opinions and points of view so – and in many ways locked into a contest between government, industry and the unions, without really involving the community or the residents and the consumers themselves.

So the intention in having a very wide-ranging engagement was to enable all groups to come together so that while we were exploring their point of view, they were also given the opportunity to start to build a greater understanding across the sector. I think I refer in the report to it being an adolescent industry. I think that is a feature of one where we needed to start to bring – to create an industry, if you like.

MR ROZEN: You've guessed my next question, Professor Pollaers, which is that you do refer to it as a fragmented industry in adolescence, and I would like to tease that out a little bit more, if I could, please. What leads you to use that description and what's the significance of it for the workforce issues that we're examining this week?

PROF POLLAERS: I think there were a couple of things that came through. Whether it be the experience on the financing authority or through the various other interactions, it became very clear that with the number of bodies representing the industry, there was often not an alignment of interests, quite often competition for membership. The same, I would say, is true in the employee representative space. And so there are lots of groups, if you like, trying to find a position within the industry. At the same time, I witnessed on very many occasions the way in which either the department or the Minister's office would almost take actions that would keep it fragmented and keep it divided because it seemed like it was easier to manage in those circumstances.

And so very often, you know, I would hear somebody putting forward a proposal and the response to that would be "Well, I'm hearing something different in other places". That would be the end of the discussion. So the adolescence is really represented by, I think, three factors: it's that lack of consolidated position; the fragmented way in which government engages it and, you know, the very, very many reports, you know, I think that haven't led to a decision is an example of the way in which this industry has not been big enough to resist that kind of oppression. It has been quite an oppressed set of circumstances. And then, finally, I think the way in which the industry is structured, we often do in Australia talk about small to medium enterprise.

Now, internationally, a small to medium enterprise is between 20 and 50 million dollars of revenue. In this industry it's between – we are seeing one to five million, you know, with employees of up to 20. So unless we start to talk about it as a micro-industry that needs to have policy settings to help it to build over time, then I think we are going to face continued issues. So that's another reason why I call it adolescent is that it's an industry that hasn't really found a way of properly representing itself.

MR ROZEN: There are a number of features of the industry or the sector, depending how one wants to describe it, that are, if not unique they're unusual, and perhaps if I can just identify a few of those. One is it's obviously highly dependent on government funding.

PROF POLLAERS: Yes.

MR ROZEN: And we will come back to that because that has significance for remuneration levels and some other areas that you examined in the report. Is that right?

PROF POLLAERS: Yes, absolutely.

MR ROZEN: It is also, in one sense, a highly regulated industry and others less so. Do you understand what I mean by that? There are – at least on the face of it, it's highly regulated because of the accreditation systems and the like. But the evidence we have heard in this Commission is that in practice that's not necessarily always the case. You're nodding; you need to say something for the transcript.

PROF POLLAERS: Right. It is but I think the way that I would position it is, it's heavily government-funded, with a funding instrument that is very non-specific in the way in which those funds should be deployed, in many instances leaving it for industry to determine how to make that investment. And in a context where the government took away at a point in time the case mix approach of high to low care, which has then also left them in a position to try and work out how to deploy those resources when that distinction isn't as clear in the system any more. And so to say that it's highly regulated but yet unregulated, in many respects there's a high level of regulation but not a lot of clarity over the execution that's creating that sense of not being regulated.

MR ROZEN: And not necessarily that much accountability for, for example, expenditure.

PROF POLLAERS: Yes.

COMMISSIONER PAGONE: Just before we lose that page that we have got on the screen, the technical advisory groups, you identified as the first of them there under employee needs and expectations chaired by Rob Bonner who is from the Australian Nursing and Midwifery Federation. I assume that that group would have had a number of others of a technical kind who were members. What is the relationship between that group of the nursing cohort that is dedicated to, or predominantly dedicated to, aged care services and the general nursing workforce, and also within that context to what extent are there specific enterprise bargaining arrangements for the aged care sector in relation to nursing that doesn't get swept up by the broader group?

PROF POLLAERS: If I understand the question you're asking, it helps to understand a little bit the way the unions are structured themselves. So generally speaking, there will be a part of the union that is very much involved in the industry structure skills and there will be a part of the union that's very much focused on the industrial relations framework and the local level negotiations around the awards or around that – those structures. Across all 66 industries in Australia, through my experience in chairing the industry and skills committee, they're all roughly structured in the same way.

In this instance, when looking at the ANMF and the other unions involved in this space, the ANMF is tilted more to nursing and some personal care workers and in the other unions may be a predominance of personal care worker and other sort of health

areas. In terms of a specific focus on the aged care sector, it seems to sit within the overall brief because they look at acute and subacute across the whole range of nursing. Aged care will fall within it but it's not a separate union in its own right.

MR ROZEN: Perhaps I can just jump in there, Commissioner. We will have witnesses later this week from the federation including Mr Bonner this afternoon who may be better placed, with respect, to Professor Pollaers to expand on those matters.

COMMISSIONER PAGONE: What I was really curious about was the extent to which there might have been individual people in the technical advisory group of this exercise, but I think we've had probably the answer that we're going to get out of that.

MR ROZEN: Yes. Thank you, Commissioner.

Before we turn to look at the specifics of the report, if I could just ask a couple more general questions, one of which relates to union involvement in the sector. It's actually a matter that is identified in the report itself, isn't it, that is, the historical enmity, if that's not too strong a word, between some of the providers and the unions and the point, as I understand it, from the report, is that the unions have a lot to offer to the sector in relation to many of the issues that are of concern in relation to workforce and it's a matter the taskforce is keen, as I read the report, for those relationships to be developed in future.

PROF POLLAERS: Yes. Again, it goes back to that adolescence point, is that the unions have an enormous amount to contribute to the skills agenda and to the, if you like, to industry broadly hearing more clearly what the employees are saying. I wouldn't necessarily say that there was enmity in the system. It was probably, in my experience the industry really had no contact with the senior members of the union movement because many of them are small to medium enterprises who are only facing up to the collective bargaining negotiations on a periodic basis. I think through the course of this work, relationships were built at a more senior level and I genuinely do hope that they go on and continue because through the course of that work, I think there was a recognition that many of their needs are very much aligned.

MR ROZEN: Yes. I take it from that, that you are referring to the more sort of strategic dimensions of – the ANMF is a good example, I suppose, of that without wanting to single one out, that the opportunities that are presented there for the sector to have discussions at those levels with the unions.

PROF POLLAERS: Yes, to look at – whether it to be to look at the total industrial relations framework, the funding mechanisms, the emergence of new job roles, certainly at that level they're best able to have that discussion.

MR ROZEN: It's important, is it not, to recognise, Professor, that just as the industry doesn't necessarily speak with one voice, neither do the unions. They don't have identical interests, one has to accept, acknowledge that.

PROF POLLAERS: Yes, that's true. I think it has been a concern through the course of the work that quite often we – because the nursing employee representatives are probably more developed and more vocal and have a clearer agenda, that often it sounds like nurses and then everybody else, and often a perception in the community that in order for the needs of nurses to advance, it's somehow at the cost or the enemy is the personal care worker. In fact, I think what the experience we had is that once we recognised it's an "and" not an "or", then we do need to do more for nurses and we need to do more for the other employee groups within the industry.

MR ROZEN: If I can take you to your statement at page .0011, please, and to orient you, it's page 11, in the bottom left-hand corner too, fortunately. You were asked a question:

> *What is the significance of structuring the report as a strategy with recommended strategic actions rather than a report with recommendations.*

Is that just semantics or is there an important distinction?

PROF POLLAERS: No, it is an important distinction. I think we – again, I was very clear with the Minister that this could not be just another review. I was very clear that we needed, if this was genuinely an industry strategy, to be able to have decisions taken up by industry and put into action as soon as they were clear, and that this report couldn't be held off by government before its findings were made available for industry to make progress. I think the other point, too, and in limiting ourselves to only 14 strategic action recommendations was to be very clear of the need to make progress and be very clear on the actions that we were looking to take in a very defined timeframe.

MR ROZEN: You say in your statement that the actions are interrelated and interdependent. Can I ask you to expand on that; what do you mean by that?

PROF POLLAERS: Well, there were two very important starting points to our work and that was to define who the consumer was and who the industry is. And if I touch on those and then explain interrelationships; is firstly, we said that, you know, the consumer really has to be the individual, their family, their community, their carers, because quite often they have a point of view and they don't always align but they do need to be heard.

And that's not fully represented in the current system. The second was to recognise that in a rapidly ageing population we needed to think about, and we wanted to be more consumer-focused, we need to think about consumers and we chose looking

from 65 through to death, and it was interesting that at the time there wasn't any recognition of death even in the industry's road map.

At the same time, if you look at those prematurely ageing groups, the homeless, the Indigenous and Torres Strait Islanders, the disabled, you really need to be looking from 50. If you take that journey, then you really have to consider an aged care workforce that starts with financial planning, primary care, home care, residential care, acute, subacute care, functional care. We avoided using the expression "allied health" because it implied nurses and everybody else and started to want to give more voice to occupational therapists, physiotherapists, etcetera, who play a role in frontline ageing. And then, of course, the government systems navigators and the carers.

So if you think about the needs of a rapidly ageing population we need to start thinking about the workforce more broadly because quite often issues that appear in that earlier journey land at the door of residential care, and then it's an employee who needs to work that through. If you take that point of view then the interrelated issues are then do go to the mindset of people when they're coming in, what their expectations are. It goes to the way the system interfaces with the other elements of the health system which is currently quite siloed. It goes to the training needs and job roles that are evolving based on those changing expectations.

So a simple example of why it's important to interrelate them is when we did the community and the employee consultations, interestingly, both groups independently were referencing that somewhere between 20 and 30 per cent of current employees didn't fit or they didn't think were the right people for the industry. Now, we took a view in our work that we wouldn't victim-bash because we're talking about people who are underpaid, under-recognised, in jobs that aren't properly graded, trying to do the very best they can. If you only solve one of the 14 issues that we identify are recommendation areas, then you will end up with the problem just moving into another area and that's really why we described it as being a high level of interrelationship and dependency that needed to be resolved by making sure each of those areas are addressed.

MR ROZEN: Now, in the time we have available, I don't think I can ask you about each of the strategic actions. They are obviously all set out in the report. There are a couple that I would like to ask you to focus on. The first of them is strategic action 7, which is set out in the report at page .0083 and it's headed Implementing New Attraction and Retention Strategies for the Workforce. And if I may say so, it seems to go to the heart of what the taskforce was all about, which is tackling attraction and retention as being an essential part of the exercise or a necessary part of the exercise. And there's a recognition on page .0083. Do you have a hard copy of the report in front of you?

PROF POLLAERS: I do.

MR ROZEN: It's page 54 of the report, if that assists. Do you see that strategic action 7?

PROF POLLAERS: Yes.

MR ROZEN: Yes, and then about halfway down the left-hand column there's a paragraph that starts:

> *Reinforcing a strong and respected industry reputation provides an essential foundation.*

And then it says:

> *The current reality is that the industry is not viewed as an employer or career of choice.*

And that's consistent with a great deal of the evidence that we have heard in the Royal Commission, and I couldn't help noticing that one of the witnesses in the video that we showed earlier, were you in the room when we showed that video earlier?

PROF POLLAERS: Yes, I was.

MR ROZEN: A witness who said there needs to be an industry that wants to attract people.

PROF POLLAERS: Yes.

MR ROZEN: We know the demands. We have all heard the figures, the numbers that need to be attracted over the next generation. So I suppose the question I have for you is what needs to be done, or perhaps another way of putting it is, who is responsible for making it a more attractive industry for young people and other workers to want to work in?

PROF POLLAERS: There's two parts answer to that question. Firstly, I think it is the responsibility of all – it's an all of government responsibility and all of community and all of industry. And I will say all of government because the thing that I found most challenging through the period of doing the report is the extent to which the department of ageing is so isolated even amongst all other government departments and the extent to which it's very, very difficult to get the government interested in having a COAG style council on ageing to make sure we are having the discussion across State boundaries also, because many of the issues could be addressed with an all of government approach.

At the same time, you can only get to the, really to the attraction and retention if you deal with, I think, six things beforehand, that really go to it. And they do happen to

map to the strategic actions. But the first one is there has to be a very proactive approach to a social change campaign around ageing in Australia.

MR ROZEN: That's strategic action one.

PROF POLLAERS: That's strategic action one. Secondly, we really need to look at job roles and the types of jobs that are available and the career opportunities within the industry. That goes to three and four. Because ultimately if young people in particular but also older people – you know, somebody is 45 still has 15 years of career ahead of them – they need to know that there is a job, what the job's role is, how it contributes to the organisation and what we did find in our attraction retention work is that if people understood their job role and how it contributed to the organisation, they were more inclined to score highly in their engagement.

The need for a code of practice is raised there also because it's an industry that hasn't defined itself. So it gets caught up in this clinical fight over a system, you know – over a system that's come out of – basically been borne out of a hospital system. Community expectations it will be a living well model and without a clear statement of what the industry stands for, it keeps being buffeted by that debate.

And the one thing that is absolutely clear is that any industry will not attract talent if its purpose isn't clear. If there's a strong sense of purpose, people want to belong to it and it will define the behaviours. So a lot of the work that we did when we started and asking the question why this industry matters is to establish that purpose because that will attract people.

The next one I think is that people will want to come into an environment where they are given access to lifelong learning, where they can seek career paths and ability to move across, and today the industry is largely defined by the personal care worker and we can argue that the word "worker" has to be lost to give more respect to the position as training quality increases, enrolled nurse and a registered nurse but there are many other roles that are emerging in this industry that are very exciting including starting to think about nurses as clinical specialists to enable them to do the job that they're being trained to do and not be part-time administrators or, as I think Professor Eagar mentioned in her evidence, around, you know, the burden of paperwork.

And then I think the next factor that came in very level is the extent to which you've got environments where you have open feedback and continuous improvement. And quite often when we talk about the Quality Standards, they're a minimum standard but you need the industry to be constantly looking to beat those standards, to stay in tune with community expectations. That does require a pre-employment screening to make sure you've got the right people to help them find the right careers but also much greater focus on development. We suggest a 360-degree development planning in our work.

So there's a whole series of things that you would need to do to make this an attractive industry. I think the last one that I would say is to make sure – now, the whole question of workforce planning I am sure we will come to. I am hoping we will come to that; we won't necessarily do that right now but we were very surprised to see in the employee survey that we did of just over 2800, the extent to which there is a mismatch between the view of management on how things are proceeding versus the employees. Very large mismatch.

And that goes down to understanding the enablement, do people have what they need to do their job, and the engagement issues in the businesses. That does require industry benchmarking, but it fundamentally requires each business to sit down and have that conversation with their own employees to work out what are the issues that are getting in the way. And that is a leadership issue within the industry. So you can see there are a number of factors that need to be addressed that get to the attraction and retention given the kinds of quality that we are going to need and the talent we want to retain.

MR ROZEN: There's a lot there to unpack, Professor. Can I start with engagement and enablement, two terms that you've used. I think we are very close to where we need to be. It's page .0085. There's a reference in the report to a survey that was conducted as part of the taskforce's report that surveyed some 2817 people, asking a range of questions about the employee's perspectives of the work that they were doing. You said there was a mismatch between the views of management, the views of the employees. What was the mismatch?

PROF POLLAERS: When we – in the study when we looked at each of the questions that were asked on the way through and we looked at management, we looked at direct care, indirect care and the very important roles that are involved in delivering, you know, living well model of care, whether that meal time, gardening, laundry, and so forth. Invariably what we found was that the management, the nurse unit leaders, the team leaders, were all feeling more enabled and more engaged than the personal care workers, the nurses or the other employees. And you will note from the graph that is showing there on that page that already by comparison to other norms within the health care industry or Australian norms, engagement, enablement are already very low.

So off a low benchmark you have got some groups feeling positive and some feeling very negative. And that mismatch suggests strongly that the time is not being taken at a local business level to really speak to the employees, find out what the issues are, engage in continuous employment. And many of the things that I'm sure you have heard, the focus on ACFI, the scheduling issues, very high levels of employee either absenteeism, churned or unfilled vacancies could create a circumstance where a business might say it doesn't have time to do those things. It's the most important thing they should be doing.

MR ROZEN: And that, of course, can become a self-fulfilling prophecy, can't it?

PROF POLLAERS: Absolutely.

MR ROZEN: It just perpetuates itself.

PROF POLLAERS: Yes.

COMMISSIONER BRIGGS: Can I just ask a simple question; do you think the people leading the aged care industry actually understand the importance of this question?

PROF POLLAERS: I think, Commissioner, that the – I think we have got to keep going back and reminding ourselves that many of these are very small companies that have grown over time and haven't necessarily developed those skillsets. So when we do start to think about the transition of this industry, it's not just about skilling people as they come in or personal care workers or nurses, there is a leadership growth requirement right across the board that needs to reflect the size – the small business, all the way through, if we're going to get the kind of shift that we need.

MR ROZEN: If I could just follow up – sorry, Commissioner, was that all that you - - -

COMMISSIONER BRIGGS: That's it. Thanks.

MR ROZEN: Can I just follow up on Commissioner Briggs' question, one of the themes that runs through a lot of evidence we've heard here is questions about adequacy of governance and governance arrangements within aged care providers. Do you have a view about that, linked, perhaps, to your earlier comments about immaturity and so on?

PROF POLLAERS: Yes, there's a couple of points that I would make on that one. Firstly, I think the role of the boards within this industry needs to be substantially lifted - - -

MR ROZEN: Yes.

PROF POLLAERS: - - - around their understanding and their commitment to doing better than the government regulated Quality Standards, which I would regard as minimum. And I often use an example of Sarbanes-Oxley when it came out as a model globally which was essentially saying that as a chief executive or as a board you have to self-assess each year to see where you are marginally deficient, deficient, meets, beats and hopefully exceeds and those companies who take it on just to get to the minimum will always be just focused on their compliance obligation. Those companies that want to be world class and want them to take themselves forward are always saying, "Well, how do we get to the exceeds on these dimensions" and will introduce areas that take them beyond. And I think boards need to have a greater – and, in fact, I think that even the Quality and Safety Commission could play a role in

continuous improvement, but boards need to be thinking about that mindset of how do you go beyond, not just meet.

Now, the second issue I think with boards is again, a symptom of being an adolescent industry and frankly, and I am quite pleased to hear you are going to spend so much time next year on the funding issues, but in an under-funded model, as I believe this is, then many of the boards are volunteers and that may not necessarily have the kind of training, the development themselves required to provide the governance to organisations like this, even though they give so much of their time and their commitment and we should be grateful for that but they certainly could do with some support also.

MR ROZEN: You mentioned workforce planning and I've taken my cue from your request that we address that. So if I could ask you to go to strategic 6 which is on page .0077, page 48 of the report, hard copy in front of you:

> *Strategic action 6 is establishing a new industry approach to workforce planning including skills mixed modelling.*

What's the central concern here, Professor?

PROF POLLAERS: I think it went – it goes to and I think it was also reflected in Professor Eagar's report is the absence of a capability around workforce planning in this industry. It's again if I draw on my experience in the aged care – sorry, in the Industry and Skills Committee, there aren't too many industries in Australia that are very strong on workforce planning. And, in fact, it's a program that's currently being rolled out across all 66 industries with respect to training to start to have them think more about it and the way in which jobs are changing and career paths are developing.

I think the critical nature of this industry, though, is that again having come out of a clinical and hospital-based system it has got a scheduling mindset, not a workforce planning and skillset mindset. And, again, take this comment in the context of the very many small to medium enterprises and the more sophisticated companies you would expect to be addressing this. So we looked in depth at about 30 businesses across home care, residential care and rural and remote to really understand the workforce organisational structure, job accountability, all those types of things and it became clear there wasn't a very sophisticated approach to workforce planning.

So in fact what we did is we looked at the ANMF model for workforce planning and it's a very good model in that it identifies the consumer profiles in, I think, in some ways Professor Eagar's work on case mix is a similar ideal, trying to understand what the kind theoretical case mix is, although I will comment on why I think the professor's work is a step up on that. Then they looked at what the clinical interventions were in the AM and the PM. They aggregated those. That then gives you the ratios. So we simply took that model and said what is different in this

industry? So what's different is that in this industry and looking at the case mix, we suggested that we need to think about holistic care planning.

So instead of just clinical needs, it's your clinical needs, your functional health needs, your cognitive health needs, your cultural and linguistic needs and your living well aspirations as the five elements of a care plan. And that rather than just looking at the AM and the PM you needed to look at the AM, the PM, the night-time and the weekend, aggregate those interventions and that then tells you the skills mix. Now, certainly, I think that there's often this question that's raised around ratios. Well, every business runs on ratios. It's just a question of when you apply them.

MR ROZEN: Yes.

PROF POLLAERS: And I think what we identified here that to reflect the differences in the different business models case mix was absolutely required as a model but, importantly, the case mix needs to take into consideration those five factors of a holistic care plan and then that then drives through on the skills mix. Now, you can't just expect that this is a way of planning that businesses can just adopt because it is a skillset in and of itself that needs to be brought into industry.

If I could just go one moment longer. The same issue applies in the home care industry. Because in home care, again, it's coming out of a scheduling mindset having somebody turn up for this amount of time, whereas when you look at businesses that are managing large field forces that are out doing their work in the field there's a very different set of skills that then would give you a stronger cultural consistency, career-pathing for those same roles, etcetera. So I think what we identified in strategic action 6 is to treat this as a skill deficiency of itself that we need to start to evolve within industry.

MR ROZEN: Thank you. Commissioners, I'm about to go on to a new topic, it might be an appropriate time.

COMMISSIONER PAGONE: We were wondering whether if we sat on until 1 o'clock whether you might - - -

MR ROZEN: I will conclude Professor Pollaers if we're able to do that.

COMMISSIONER PAGONE: I think that would be desirable.

MR ROZEN: I'm grateful. Thank you. Sorry, Professor. I wanted to move on to a broader question about the role of the government. We have talked a lot about the responsibility of the sector and you've already identified one of the difficulties with that, even conceptually, as the sector doesn't speak with one voice and necessarily CEOs come and CEOs go and boards change and so on. So it raises a question for the Commission as to what's the responsibility of the constant in all of this, and that's the government, of course.

And I note in your statement – this is at page 12, if we could go to this – you were asked a question about the progress of – in relation to each of the strategic actions. And, of course, a number of the strategic actions are directed at the government, are they not? Many are directed at industry but there's four or five, depending how you unpack it, I suppose, which are directed straight at government to implement. Is that the case?

PROF POLLAERS: That's correct.

MR ROZEN: And you've identified the five which fall into that category in the right-hand column of your statement there, and we note you say you are yet to hear the government's response in relation to those five and perhaps we could list them. One is the creation of the social change campaign you discussed earlier. Nine is strengthening the interface between aged care and primary and acute care.

10 is improved training and recruitment practices for the Australian Government's own aged care workforce. 12 is the establishment of an aged care centre for growth and translational research and, finally, 13 is current and future funding considerations including staff remuneration. You say you are yet to hear the government's response to those. Do you mean by that that there has been no formal announcement about the government's implementation of those strategic actions?

PROF POLLAERS: Yes, in fact, there has been no detailed response at all to each of those recommendations but for a pre-election commitment to fund the Aged Care Centre for Growth and Translational Research.

MR ROZEN: Yes, that is 12.

PROF POLLAERS: Which I haven't seen any progress on. But with all others, I wrote to the Minister asking for a point-by-point response to those and did not receive a response. I think they're important because strategic action 1 is a co-commitment, if you like, between industry and government. It's one that needs to be done together but essentially what we were focusing on is in – the philosophy of the taskforce was let's see how far industry can go on its own, and then what's left is the work of government. So we made sure that not everything was, if the government doesn't do it, we can't do it. And industry have been stepping up in this timeframe, they have responded in the main. But on these areas we haven't had a sufficient – or a response at all from government.

COMMISSIONER PAGONE: Professor, when you say that you haven't had a response to your letter, do you mean by that that there's not even been an acknowledgement of receipt of your letter?

PROF POLLAERS: So I got an email response that it was all of the past programs of government and I went back and said, "Look, that isn't sufficient. I'm asking for a step-by-step response." I didn't get a response to that email.

COMMISSIONER PAGONE: At all?

PROF POLLAERS: At all.

MR ROZEN: That has got to be profoundly disappointing, I suggest, Professor Pollaers?

PROF POLLAERS: It is, although I think I took the view at the time that I would then just really focus on working with industry to get the progress there. I think that the – you know, I made the observation at the very beginning of the evidence today that I felt that in any many ways the industry is undergoing a level of oppression, maybe not the right word, but I do believe that this is not a department that is resourced well enough, that has sufficient experience and/or weight within the current government department that it sits. Quite often the secretary, the deputy secretaries have other portfolios and not the focus.

I was very surprised through the course of the work, the extent to which PM&C, the Prime Minister and Cabinet, were sitting on top of the Minister with respect to these issues, and I was very surprised in many instances about how important it was for me to speak to the Minister to ensure that he got a full briefing, and that whenever I spoke to the Secretary of the Department, it was always in such a way that, you know, the number of people around it was almost impossible to give as frank a point of view as you would.

So, you know, my sense is that the way that government has positioned itself over the last few years is that, to the extent that this can be an industry issue and they can leave industry to deal with union, and then use the fragmentation as a reason to say, "Well, without one voice we don't know what you're asking", has been, you know, a reasonably successful approach, and if not a strategic approach then a real shame because the answers to many of these questions have been on the table for quite some time.

MR ROZEN: Strategic action 14 is the one that proposes a mechanism for implementation of the other 13. It proposes an industry-led body that is charged with giving effect to the recommendations that are focused on the aged care industry. And we will be hearing shortly, in fact after lunch, from Kevin McCoy who is the Acting Chair of that Council. What was the thinking behind having an industry body to pick up the strategic actions and run with them? Why was that important?

PROF POLLAERS: Because I guess, ultimately, the only way that a strategy is going to get executed if it's owned is if they wrote it themselves by the leaders of the industry. If you continue to push down a regulatory path then it will always be a question of what's the line, you know. It creates a notion of trying to just make sure that you hit the minimums and that you don't fall under. The line becomes focused, if you like, on target fixation kind of thinking. Whereas if you can get the industry to own and take responsibility for a living well model of care that is moving with

consumer expectation, then there will be less dependency upon government over time and you will start to see that maturity and strengthening.

The thinking around having a Workforce Council that was the responsibility of the CEOs of the industry, not delegated to any other level, that worked in collaboration with community representatives and with union representatives to steward this meant that we could also create a system whereby there would be – the interdependencies would be dealt with.

So part of the construct of the Workforce Council was to ensure that the Industry Reference Committee that's responsible for training is hooked into it, the remote accord was hooked into it. If the Research Translation and Growth Centre which hopefully will bring all of these small pots of money and give a much greater dedication to research in this sector, it would mean that all of the workforce issues would come together.

The other principle that I did discuss on many occasions with Minister Wyatt who I would say was, you know, a very proactive supporter of the work and kept pushing me to take the licence to open up the issues was that if you have the Quality and Safety Commission, if you've got a clear industry code of conduct, if you have the Centre for Research Translation that takes us forward, and you have got a very clear workforce strategy then you start to have the ecosystem that you need.

Then the only thing that is missing, frankly, and hopefully it's the work performed by Professor Eagar, is a funding system that recognises case mix and then many of the issues are addressed. So the Workforce Council, therefore, was really the start of creating that pillar in the ecosystem so that there was a group that had responsibility that you could look to, that had a single voice that could then deal with the government and the industry when it came to ensuring that the issues of workforce were addressed.

MR ROZEN: Two last matters, if I can deal with them briefly. The first is the strategic action number 12, the Centre for Growth and Translational Research which you have referred to a couple of times. It's dealt with at page .0133 of the report, page 84 of the one in front of you, Professor. Why was that considered to be important and what is it intended to do?

PROF POLLAERS: So I guess if all of the other recommendations are focused on resolving issues of today, you know, the backlog of issues to ensure that we set this industry right, then strategic action 12 is all about ensuring we do the research that we need going forward. Not just on new models of care but on the translation of those into practice. It's a great shame that we often refer to great examples around the world but if you go and have a look at all those great examples of the world they are also very subscale pilots that haven't been scaled up.

And if you consider that we are going to have 25 per cent of our population over 65, highest net contributor to the economy because we are talking about baby boomers

who do spend their money, then you are talking about an economic opportunity for this country, not just a social need today. That needs to be supported by good research and not the little doled out million here, five million there of research that doesn't go anywhere; substantial research.

Now you've got a Department that is sitting within the Health Department that has a billion dollar – I don't know exactly the amount of money but medical research translation fund that isn't focused on probably one of the greatest areas of need – you know, not at all to in any way undermine the validity of other medical research, but this is a very important area of social research.

If we want to get it right it does require investment and it does require an ability to translate to practice and scale up. And so 12 is really an attempt to say let's take the learning out of the other great centres that exist in other industries that the government is supporting and put it in place and have it then work to ensure that we get the right level and quality of research.

MR ROZEN: Of course, we have in Australia world class aged care research facilities like NARI, for example - - -

PROF POLLAERS: Absolutely.

MR ROZEN: - - - yet am I correct in understanding no real government response to strategic action 12 to your knowledge?

PROF POLLAERS: Other than a pre-election commitment, which I think was, you know, driven by the electoral timing, there has been no further detail. And we have – we had submitted a detailed recommendation as part of this report. We've since submitted a recommendation that was slightly less funding requirement to try and get it over the line but no response and that has been to the Minister and it has also been to the secretary of the Department of Health.

MR ROZEN: A final matter concerns timeframe. There's a suggestion in the report of a one to three-year timeframe for completion of – I hope I'm not overstating the position but that's identified as a realistic timeframe. Is it realistic, do you think?

PROF POLLAERS: So it needs a little bit more qualification. So in recommendation 14, I think there's six work streams. One of them – so all of the work streams are feasible within that timeframe but one of those work streams is the leadership development incubator which is about really looking at how you transition the leadership from the current standard to a different standard.

That does require a substantial level of funding support, I don't know if you would regard it as substantial but we did suggest to the Minister that would be around the $7 million investment. You know, put that in the context of our report finding, you know, funding gap of around three and a half billion when it came to workforce issues.

Then, investing in developing the leadership in a very clear program was required. The one to three is around setting things right and then I think you will see that we also referred to five to seven which is really premised off the work coming out of that recommendation 12. If we want to transition the workforce entirely to new sets of standards, so say, for example, we wanted to, when the new cert III is developed we want to bring all employees up into that standard, that probably is a three to five year exercise.

MR ROZEN: Thank you. They're my questions for Professor Pollaers.

COMMISSIONER PAGONE: Thank you. Thank you, Professor. I should not limit my thanks to you just from the point of view of the Commission. We've learnt a great deal from your work. But I think I might extend the thanks on behalf of the entire Australian community for the work that you have done in the past. Having heard you today and seen the details of your report by what you have had to say, I think we've been very greatly indebted to the work that you have done. It's an amazing amount of work. Counsel referred to the response or non-response as disappointing. I think probably discouraging might have been an even more apt word. I hope that's only a temporary position of the government, and that they might think about responding more appropriately. But thank you very much indeed. It's been very helpful.

PROF POLLAERS: Thank you.

MR ROZEN: Before Professor Pollaers is formally excused, I understand from my learned friend representing the Commonwealth that she would like to get some instructions over lunch about certain aspects of his evidence. I'm not quite sure where that will go but obviously we will have some discussions between ourselves about that, and it may be that some further brief evidence is necessary from Professor Pollaers after lunch.

COMMISSIONER PAGONE: All right. Subject to that, I think he can be excused subject to that so that he doesn't have to come back if it's not necessary.

MR ROZEN: Yes, we will deal with that ourselves. Thank you.

<THE WITNESS WITHDREW [1.02 pm]

COMMISSIONER PAGONE: Otherwise we will adjourn until 2 o'clock.

ADJOURNED [1.02 pm]

RESUMED [2.00 pm]

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: I call Kevin McCoy. The issue with Professor Pollaers resolved itself.

COMMISSIONER PAGONE: Thank you.

MR ROZEN: He has been excused in accordance with the conditional direction.

<KEVIN DAVID McCOY, SWORN [2.01 pm]

<EXAMINATION BY MR ROZEN

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Commissioner, I neglected to mention that Mr Heath is here and wanted to announce an appearance for Mr McCoy. Perhaps that should be done now.

COMMISSIONER PAGONE: Yes.

MR R. HEATH QC: Yes, I appear on behalf of Mr McCoy.

COMMISSIONER PAGONE: Yes, Mr Heath.

MR ROZEN: Thank you. Sorry about that, Mr McCoy. Can you please state your full name, please, for the purposes of the transcript?

MR McCOY: Kevin David McCoy.

MR ROZEN: Mr McCoy, you have made a witness statement for the purposes of the Royal Commission, WIT.0451.0001.0001. The first page of that should be on the screen in front of you, I hope.

MR McCOY: Yes.

MR ROZEN: Have you had a chance to read through your statement before coming along this afternoon?

MR McCOY: Yes.

MR ROZEN: Is there anything that you wish to change?

MR McCOY: No.

MR ROZEN: Are its contents true and correct.

MR McCOY: Yes.

MR ROZEN: I tender the witness statement of Mr McCoy dated 27 September 2019, Commissioner.

COMMISSIONER PAGONE: Yes, the statement of Mr McCoy dated 27 September 2019 will be exhibit 11-4.

EXHIBIT #11-4 STATEMENT OF MR McCOY DATED 27/09/2019 (WIT.0451.0001.0001)

MR ROZEN: If the Commission pleases. Mr McCoy, you are the chief executive officer of the Independent & Assisted Living platform of Australian Unity.

MR McCOY: Yes.

MR ROZEN: Excuse my ignorance, but what is the Independent & Assisted Living platform?

MR McCOY: So I represent about 65,000 customers across aged care and disability.

MR ROZEN: And the aged care business of Australian Unity, is it residential care, home care or a mixture of the two?

MR McCOY: It's a mixture of the two.

MR ROZEN: Are you able to indicate, at least in general terms, the proportion of each?

MR McCOY: We – in terms of residential aged care, we operate seven aged care facilities with about 1200 staff. In terms of home care, including – sorry, in terms of home care, we would do about 20,000 home visits a day and staff of around 4000.

MR ROZEN: Thank you. You were previously the group chief financial officer for Australian Unity.

MR McCOY: Yes.

MR ROZEN: By way of qualifications you have a Bachelor of Commerce in accounting and you are a chartered accountant?

MR McCOY: Yes.

MR ROZEN: Thank you. Your evidence today concerns the role you play as the acting chair of the Aged Care Workforce Industry Council. That's the case, is it not?

MR McCOY: Yes.

MR ROZEN: And that's why we have asked you to come along today. And, by way of explanation, the council is the body that has been established arising out of what's often called the Pollaers taskforce report?

MR McCOY: Yes.

MR ROZEN: So the witness prior to you, I'm not sure if you were in the room when Professor Pollaers was giving evidence - - -

MR McCOY: No, I wasn't.

MR ROZEN: Okay. He gave evidence that strategic action 14, that is the final action identified in the taskforce report, was a recommendation, in effect, to establish the council that you are now the interim chair of.

MR McCOY: Yes.

MR ROZEN: Or the acting chair, I should say. I might just clarify that title at the outset, if I could. You were originally appointed to that council as its deputy chair?

MR McCOY: Yes.

MR ROZEN: And that was earlier this year.

MR McCOY: That's correct.

MR ROZEN: 2019. And the interim chair was a gentleman called Ian Hardy.

MR McCOY: Yes.

MR ROZEN: Mr Hardy, unfortunately, is unwell and announced at the September meeting of the council that he was standing down; is that the case?

MR McCOY: That's correct.

MR ROZEN: And as the deputy chair, you became the acting chair?

MR McCOY: Yes.

MR ROZEN: Right. There is a search for a full-time independent chair at the moment but for the time being, it remains you.

MR McCOY: That's correct.

MR ROZEN: All right. I will ask you a little bit more about that search in a moment but that's the state of play. If I could start by just asking you a little bit about strategic action 14 by reference to the Pollaers taskforce report, and I would ask that that be brought up on the screen, please, at page .0130 of the version we were looking at earlier. Sorry; that's the other version. It's the one that starts ACW – my apologies. Just whilst that is coming up, I don't know if you have a copy of the Pollaers report, in front of you? You do. Terrific. If I could ask you to look please at page 101 and then that is the page, thank you to the operator.

This was the recommendation – if the first paragraph could please be highlighted, we will see that the Pollaers report recommended a taskforce – sorry, the taskforce recommended the establishment of an aged care services industry council to provide the necessary strategic leadership to accelerate the problematic implementation of the workforce strategy. And it went on and in the second column, there's a bit that I want to ask you about. It makes reference to – if the second column could be highlighted, it says:

> *To facilitate the implementation of the remaining strategic actions the Aged Services Industry Council would initiate the following: six cross-industry committees will be established to address each of the strategic actions in a coordinated and integrated manner, noting the dependencies between certain actions.*

That's a process that is still in progress, as I understand it?

MR McCOY: That's correct.

MR ROZEN: So far the council has taken a number of preparatory steps; is that fair to describe them as?

MR McCOY: Yes.

MR ROZEN: Perhaps if I can take you through those by reference to your witness statement. The first thing that has been done is the council has been put on a secure legal footing.

MR McCOY: Yes.

MR ROZEN: And it's actually a company limited by guarantee. That's the legal structure that has been settled upon.

MR McCOY: Yes.

MR ROZEN: Presumably that is to enable the body to be able engage staff, for example, and otherwise incur expenses.

MR McCOY: Yes, exactly.

MR ROZEN: Yes. And the various members of the council are directors of that company?

MR McCOY: Yes, they're directors.

MR ROZEN: Yes.

MR McCOY: Members are different in the structure.

MR ROZEN: Sorry, I might get you to expand on that, if you could.

MR McCOY: Legally. There's five members – there's directors within the structure of the company limited by guarantee but there's also members.

MR ROZEN: I see. So the directors are a subset of the members; is that right?

MR McCOY: Yes.

MR ROZEN: And you are one of the directors?

MR McCOY: Yes.

MR ROZEN: Okay. I might just perhaps bring up the constitution of the company at this point. It's in tab 43 of the general tender bundle. And if we could go to page .0010, clause 2.1. We see that the formal name is the Aged Care Workforce Industry Council Limited and the objects of what is referred to as "the company" in the constitution are:

> *To improve aged care in Australia by improving the workforce to ensure that, firstly, the workforce provides aged care services that can meet the care needs of older Australians now and into the future; and secondly older Australians have equitable access to aged care and the dignity to age well, irrespective of setting.*

So they're the principal objects of the company that is the legal manifestation of this council.

MR McCOY: Yes.

MR ROZEN: Is that right?

MR McCOY: Yes.

MR ROZEN: Okay. There has been an appointment made of a secretariat for the council.

MR McCOY: That's correct.

MR ROZEN: Is that right? And can you explain to the Commission, please, what the role, as you see it, is of the secretariat?

MR McCOY: The secretariat's role would be to make sure we operate within the bounds of the constitution and we comply with all the legal requirements we would need to in operating an organisation such as the one we do.

MR ROZEN: If I could draw your attention to paragraph 27 of your statement, exhibit 11-4. It's on page 5 of the statement.

MR McCOY: Yes.

MR ROZEN: You note firstly there Miles Morgan has been appointed as the secretariat function. That's not an individual, is it; that's a company?

MR McCOY: Yes.

MR ROZEN: And they are, what, a consulting firm, are they?

MR McCOY: Yes. My understanding is they're a policy type consulting firm.

MR ROZEN: Right. I think I'm right, aren't I, they were also involved in the taskforce report, at least in providing advice to the taskforce?

MR McCOY: That's correct.

MR ROZEN: Is that continuity of benefit to the council, do you think?

MR McCOY: Yes.

MR ROZEN: Okay. Because there are no members of the taskforce on the council, are there, it's an entirely different membership group.

MR McCOY: Yes.

MR ROZEN: And so, therefore, having that continuity via Miles Morgan, I take it, is of assistance.

MR McCOY: Yes.

MR ROZEN: I ask you about the membership of the council, which you address at paragraph 16 of your statement on page 3. Firstly, who determined the membership of the council, as far as you are aware?

MR McCOY: I wasn't involved in the determining of it.

MR ROZEN: I think you deal with this at paragraph 14 of your statement. Was this a process overseen by Miles Morgan.

MR McCOY: Yes.

MR ROZEN: Okay. And as you say at 14, "The peak bodies", that is, the industry peak bodies were:

> *...approached to nominate suitable candidates ... 10 industry members of the council were selected based on their capacity and capability, and recognising this role will require a significant commitment of time and resources for a period of no less than three years.*

MR McCOY: Yes.

MR ROZEN: Then we see the current members of the council are set out in paragraph 16 and there's a number of CEOs of providers. You will need to say something so the transcript picks it up.

MR McCOY: Yes.

MR ROZEN: Ms Hills, for example, from Benetas, is a witness that is going to be giving evidence for us later this week. The people on the council that are not CEOs of providers, if I'm right, are Melissa Coad, firstly, from United Voice.

MR McCOY: Yes.

MR ROZEN: You may not know the answer to this, Mr McCoy, but why was that particular union chosen to have a representative on the council?

MR McCOY: I don't – don't know the answer.

MR ROZEN: You don't know. Okay. Do you know from your dealings with Ms Coad whether she liaises in any formal way with other unions in her role on the council?

MR McCOY: Not directly, no.

MR ROZEN: Sorry. You don't directly know, or she doesn't directly - - -

MR McCOY: I don't know if she has a formal arrangement in place with them for that.

MR ROZEN: Okay. From her input at council meetings - - -

MR McCOY: My understanding - - -

MR ROZEN: Is it apparent she has some liaison?

MR McCOY: Yes.

MR ROZEN: Yes. That is pretty important, I imagine?

MR McCOY: Crucial.

MR ROZEN: And other than her, the other non-CEOs are Mr McCallum who represents National Seniors Australia. It's a consumer organisation.

MR McCOY: That's correct. Yes.

MR ROZEN: What from your perspective, if any, is the benefit of having a representative of that organisation at the council?

MR McCOY: In the work we've got to do, keeping consumers front and centre of that work is really important. So having a voice of the consumer on the council always, I think, will be extremely beneficial.

MR ROZEN: As I read the Pollaers report, it was envisaged that this process of implementation of the 14 strategic actions would essentially be driven by the aged care sector itself.

MR McCOY: Yes.

MR ROZEN: Would you agree with that?

MR McCOY: Yes.

MR ROZEN: And the report was quite prescriptive that it was to be the CEOs of various organisations that were to be involved. The CEOs that are on it are mainly of large provider organisations; is that a fair observation?

MR McCOY: Broadly. There is Glenview, CEO of Glenview which is a small organisation in Tasmania.

MR ROZEN: Small? It's certainly smaller than the bigger ones.

MR McCOY: A lot smaller.

MR ROZEN: Do you think from the workings of the council that you've observed that's an adequate representation of the small to medium patients of the sector?

MR McCOY: I would where we are at the moment. There's many ways you could slice the industry by affiliation, by faith, by size. But I think from where we are right now I think it's a good representation.

MR ROZEN: You've got what you would consider to be an appropriate representation of the for-profit and the not-for-profit sectors?

MR McCOY: Yes.

MR ROZEN: If I could just ask you some general questions about the council. You've now been to, what – there's five meetings, I think, there have been of the council to date.

MR McCOY: Five.

MR ROZEN: Most recently last week was the most recent meeting.

MR McCOY: Yes, Thursday.

MR ROZEN: Can you indicate to the Commission your observations, firstly, of the level of engagement of the council members with the tasks that they have.

MR McCOY: The members are highly engaged with the task and very committed to the implementation of the recommendations.

MR ROZEN: That engagement and commitment manifests itself practically in some certain respects, doesn't it? The funding to date, both in kind and actual, has been from a number of the organisations that the CEOs represent.

MR McCOY: Yes.

MR ROZEN: Including Australian Unity.

MR McCOY: Yes, that's correct.

MR ROZEN: I want to ask you a bit about that. Particularly the extent to which that is a sustainable formula for the operation of the council. As I understand the position, the council is to operate – is envisaged to operate for a number of years, implementing the strategic actions; is that right?

MR McCOY: Yes.

MR ROZEN: And from your perspective, as the current chair, is the existing arrangements with funding, where the bulk of the funding seems to be coming with the blessing essentially of organisations who have the CEOs on the council, is that sustainable?

MR McCOY: I don't believe so at this point, where we are at this stage of the implementation.

MR ROZEN: Right. And what is the range of funding sources that is available beyond what you are getting at the moment? Government is one obvious source.

MR McCOY: Government is one.

MR ROZEN: Yes.

MR McCOY: The industry itself.

MR ROZEN: There could be a levy, for example, imposed on the industry in some way; is that right?

MR McCOY: There could be. There are organisations who are prepared to, you know, put in funds just at the start to get momentum and then there's other organisations that may provide sponsorship from time to time. So you are right, there are other funding options.

MR ROZEN: And are they being actively considered by the council, the various options?

MR McCOY: They've been discussed and, you know, we're exploring them.

MR ROZEN: The work of the council, if we could just take one example, there's a suggestion in the minutes which I will take you to in a moment of the meetings of industry surveys being conducted. There's necessarily quite an expensive exercise, is it not?

MR McCOY: Yes.

MR ROZEN: And not to put too fine a point on it, for the council to do the work that it is charged with doing to implement the strategic actions, it needs resources to do that work.

MR McCOY: Yes.

MR ROZEN: Is it part of the thinking to have some form of – to have staff, for example, doing the work? Is that part of the thinking?

MR McCOY: Yes, that's correct.

MR ROZEN: And what have you got in mind?

MR McCOY: Well, across the 60 recommendations which – the breakdown of those 14 strategic actions, there is a lot of work involved in that.

MR ROZEN: Yes.

MR McCOY: I would imagine we would need some sort of operational function with a CEO, so to speak, and some program and project management capability. It ties back to your opening point, I think, on the mobilising and strategic action 14 mobilising across the five areas.

MR ROZEN: Yes. And that necessarily, as I think you've already agreed with me, requires some funding.

MR McCOY: Yes.

MR ROZEN: We can see from both your statement and the minutes that there is a monthly meeting planned that has been set in place for the council?

MR McCOY: Yes.

MR ROZEN: I think currently that runs through until the end of next year.

MR McCOY: Yes.

MR ROZEN: Which just coincides with our reporting date, as it turns out. I think liaison between the council at least – sorry; I withdraw that. The council is obviously following the proceedings in the Royal Commission?

MR McCOY: Yes.

MR ROZEN: And, similarly, I can indicate to you the Commission is obviously interested in the work of the council.

MR McCOY: That's great.

MR ROZEN: The description you gave before of the membership being motivated and engaged, presumably there's a challenge turning that into action, as with any organisation?

MR McCOY: Yes.

MR ROZEN: Is there anything in your background that equips you personally for the chairmanship role that you currently have, other than your involvement in the sector, obviously?

MR McCOY: Yes. So I have – by way of background, I'm also a qualified project manager. I have significant experience in transformation programs, integrations and acquisitions and significant change programs.

MR ROZEN: What are the particular challenges here, you think, that are front and centre in your mind in carrying out this work?

MR McCOY: The biggest challenge initially in any program is to get momentum, and to get the body tasked with doing it to get them into some sort of rhythm and cadence. That's what you need to achieve initially.

MR ROZEN: And presumably that's a function, at least in part, of leadership of whatever the body is?

MR McCOY: Yes.

MR ROZEN: And also relies on the commitment and enthusiasm of those involved, as you've told us.

MR McCOY: Absolutely.

MR ROZEN: I want to ask you a little bit about the government and how you see the Federal Government's role working in relation to the council. If I could start by just reading to you, without necessarily having it brought up on the screen, part of strategic action 14 in the Pollaers report. The report's authors wrote:

> *The council will take –*

that is your council:

> *…will take ownership of the implementation of the recommendations. It will shape and oversee the delivery of the outcomes working with industry and government throughout the process.*

And the word "throughout" is highlighted in that. I take it you recognise the importance of engagement with the government in the work that you are doing?

MR McCOY: Yes, very important.

MR ROZEN: Why is that? What is it about engagement with the government that is so important to achieving implementing the strategic actions?

MR McCOY: They're one of significant stakeholders in the aged care industry. So, you know, they set the standards and provide most of the funding at the moment. So it's really important that they're a big part of the work we do and, you know, their input – to my earlier point of momentum, their input will – and their backing will give us tremendous momentum.

MR ROZEN: Is there also a practical dimension to this? The CEOs will come and go, and the one – and even the industry changes significantly over time but the Federal Government is obviously going to remain a constant in relation to workforce issues. You agree with that?

MR McCOY: Yes. Yes.

MR ROZEN: In your statement there are a few references to the limited success that you've had in engaging with the government. Is that a fair description of the track record?

MR McCOY: In my four weeks or so of being the chair, yes.

MR ROZEN: But even before that you were at meetings where your predecessor was reporting on his dealings with government.

MR McCOY: Yes.

MR ROZEN: I will take you to what the minutes record about that at the moment. But, firstly, if I could note a couple of things in your statement and see if we can tease them out. Firstly, at paragraph 27 on page 5 which I asked you about a moment ago. This is the reference to Miles Morgan and the role of secretariat, and you suggest there that that appointment might assist to ensure the government has visibility of the council's operations, firstly. I will just read a few of these to you and then I will ask you to make a comment, if I could, please, Mr McCoy. At paragraph 28 you say:

> *The council itself does not have explicitly defined reporting lines to the Minister for Aged Care nor the Department of Health or the industry more broadly.*

Then you go on to make reference to the stake holder engagement plan which you have kindly provided to the Commission. Paragraph 29 you go on to say:

> *The council is also looking to engage directly with the Minister for Senior Australians and Aged Care so as to ensure the Minister has visibility of the implementation of the strategy. To support this the council is seeking to establish a memorandum of understanding with the Department of Health to ensure strategic actions that are to be led by government are actioned in a collaborative way with the council supporting the Department of Health.*

Do you see that there in paragraph 29?

MR McCOY: Yes.

MR ROZEN: I want to ask you a little bit about that memorandum of understanding. Firstly, was that the council's idea or the government's?

MR McCOY: The council's idea.

MR ROZEN: Okay. And what is the thinking behind formalising the relationship in an MOU in that way?

MR McCOY: I think a memorandum of understanding is a very good tool to smoke out exactly what both parties, you know, want out of something. So it just gives you clarity on roles and responsibilities and accountability.

MR ROZEN: And are you able to indicate, from the council's perspective, where you are up to with the MOU. What's the status of those discussions?

MR McCOY: We haven't had a discussion yet on the MOU. I haven't personally.

MR ROZEN: Okay.

MR McCOY: My understanding is Miles Morgan has had one meeting with the department where they've raised the subject of an MOU.

MR ROZEN: A draft MOU has been provided to the Commission. I take it you haven't seen that?

MR McCOY: No. No.

MR ROZEN: Okay. Paragraph 47 of your statement on page 7, you say:

> *The council has sought engagement with the Department of Health since its formal establishment in May.*

MR McCOY: Yes.

MR ROZEN: It's now the middle of October. There's a Royal Commission into Aged Care that has been running in the interim. Firstly, have you had a phone conversation with any senior officers of the Department of Health about the work of the council?

MR McCOY: Yes.

MR ROZEN: And who have you spoken to, Mr McCoy?

MR McCOY: Just bear with me, I will look at my notes.

MR ROZEN: I might be able to help you. Is it Ms McCauley or Mr Wann?

MR McCOY: Yes, yes.

MR ROZEN: Ms McCauley.

MR McCOY: I was looking for the title.

MR ROZEN: Yes. Okay.

MR McCOY: So I've spoken – Kate McCauley is dialled into two council meetings, so meeting 4 and 5.

MR ROZEN: Yes.

MR McCOY: And then I've had a 10 or 15-minute conversation with Kate, which was a, you know, very convivial conversation, no warning signs for me.

MR ROZEN: Okay. And you refer to the dial-in at paragraph 48 and I take it that she also dialled into the more recent meeting that has been held since you made the statement; is that right?

MR McCOY: Yes.

MR ROZEN: Okay. It might just be me, but dialling into a meeting from Canberra seems to show less of a commitment than actually turning up, being physically present at the meeting or is that a distinction that you don't think is so important?

MR McCOY: I mean it's hard to comment on that. I – you know, hopefully in time we can get to a point where we can have more face-to-face interaction.

MR ROZEN: Yes. I take it your schedule of meetings have been provided to the Department of Health?

MR McCOY: My understanding is it has.

MR ROZEN: I want to ask you some questions about the minutes of the council meetings and the first of those that I want to ask you about is at tab 136 in the general tender bundle, and just to give you a bit of context here, Mr McCoy, this is a meeting on 20 June 2019. So would that be the second meeting of the council? Does that sound right?

MR McCOY: Yes.

MR ROZEN: One where Mr Pollaers gave a presentation and I won't ask you about that presentation but I want to ask you something about the second page of the minutes which is .0039. Right down towards the bottom of that page, the second last black dot point says:

> *Consideration to be given to having someone from the Quality and Safety Commission to be an ex officio member of the council.*

Do you recall that discussion?

MR McCOY: I wasn't at that meeting.

MR ROZEN: Okay. I see you were an apology. Do you have any knowledge of that from subsequent discussions?

MR McCOY: We have had a few discussions on various stakeholders across the industry and, you know, we are exploring ways of how – how we engage everyone, either through participation in the council, structural changes to the constitution or ex officio or reporting.

MR ROZEN: Okay. So it's possible that that might still occur?

MR McCOY: It's possible.

MR ROZEN: You are not aware of any further developments by way of an approach to the Commission?

MR McCOY: No, I'm not.

MR ROZEN: Thank you. If I can take you to, in the same minutes, two pages further on, .0041 there's a heading Agreeing Implementation Priorities. And you will see there, and I'm conscious that you weren't, of course, at this meeting but you will see there the reference to the chair. That would have been Mr Hardy at that time; is that right?

MR McCOY: Yes.

MR ROZEN: Had a telephone conversation with Charles Wann, the First Assistant Secretary in the Department of Health in charge of Aged Care reform. Charles informed the chair that 1.2 million was to be allocated to the council to further its aims in the financial year 2019-20. A further 600,000 was going to be made available for training. This funding may be available to the council subject to its work program. No funding has been committed by the department to the council beyond 2019-20. Just pausing there in the reading, as I read your statement, the arrangements for funding other than for Miles Morgan as the secretariat service are really up in the air at the moment, are they not?

MR McCOY: That's correct.

MR ROZEN: So despite that reference back in June, Commonwealth funding has not been forthcoming to the council.

MR McCOY: No.

MR ROZEN: Okay. And I take it that's not for lack of trying, on the part of the council?

MR McCOY: No.

MR ROZEN: Is it a disappointment to you that that matter has not been able to be resolved in the time since May when the council was established?

MR McCOY: I mean there's a matter of care and the recommendations, it's a lot of work and it takes some time to get a piece of work like this mobilised and, you know, agreement with all stakeholders and buy in. So, look, I understand your point but, you know, in the scheme of what we've got to achieve and the complexity of the industry, I think we've just got to work harder to embrace all the stakeholders.

MR ROZEN: It's relatively early days, it is fair to say?

MR McCOY: Yes.

COMMISSIONER BRIGGS: It's relatively early days but there's a three-year plan, as I understand it.

MR McCOY: Yes.

COMMISSIONER BRIGGS: Working with, as we heard from Mr Pollaers before lunch, a very fragmented sector, in order to get those, all those action items with all those sub-elements adding up to 60 done, it suggests there's a need for some pretty strong and concerted action, as you say, Mr McCoy. Is this possible without more government support than is evident to date?

MR McCOY: It won't be possible without strong government support.

COMMISSIONER PAGONE: Who established you? Who gave the instructions to the lawyers to create the constitution?

MR McCOY: I wasn't involved in creating the constitution. My understanding is Miles Morgan were instructed.

COMMISSIONER PAGONE: And it was created – to what extent is it your understanding that government had been involved in the giving of the instructions for the creation of the constitution?

MR McCOY: I don't know what involvement the government has had in the - - -

COMMISSIONER PAGONE: All right. Let me rephrase it. Do you know whether it had any involvement?

MR McCOY: I don't know the answer to that.

COMMISSIONER PAGONE: And the selection of the five members, did the government have any involvement in the selection of the five members?

MR McCOY: I don't know the answer.

COMMISSIONER PAGONE: You don't know the answer. Do you have any basis for assuming that government did have any involvement in the selection of the five members?

MR McCOY: No.

COMMISSIONER PAGONE: Is it a fair assumption to assume that the constitution was essentially created by the five initial members because they thought it would be a good idea to link into action plan 14?

MR McCOY: I think – my understanding is it was a way – we had to mobilise – they had to mobilise quickly, form a corporate body.

COMMISSIONER PAGONE: So is the answer to my question that you think that's a fair inference to draw?

MR McCOY: I'm not really clear on the inference.

COMMISSIONER PAGONE: That the five initial members were the ones who thought it would be a good idea to create this body in order to capture the advantages or to come within the terms of action plan 14?

MR McCOY: Sorry, Commissioner, I may have misled you on the five members. The constitution allows for five members; there aren't actually appointed five members.

COMMISSIONER PAGONE: I see. All right. Forget the number 5. If I substitute the number 5 with initial members which I think is the term identified in the constitution, would what I said be right? Is that a yes?

MR McCOY: I don't think that's correct.

COMMISSIONER PAGONE: So the initial members – my proposition to you is, is it a fair assumption to make that those people who were the initial members were the ones who thought it would be a good idea to create this body for the purposes of furthering action plan 14?

MR McCOY: The appointment of the directors was a - - -

COMMISSIONER PAGONE: I'm not asking you about the directors. You quite correctly corrected Mr Rozen earlier on in drawing a distinction between the members and the directors. There is a distinction, isn't there?

MR McCOY: Yes.

COMMISSIONER PAGONE: Yes, and the members are the people identified as the initial members; correct?

MR McCOY: Yes.

COMMISSIONER PAGONE: And they are limited in number.

MR McCOY: To three, yes.

COMMISSIONER PAGONE: They are now only three.

MR McCOY: There is three members.

COMMISSIONER PAGONE: Whereas the directors may be as many as 11.

MR McCOY: Yes.

COMMISSIONER PAGONE: And they are intended to be skills based.

MR McCOY: Yes.

COMMISSIONER PAGONE: Whereas the members are different. What I'm asking you about is whether it's a fair inference to draw that the initial members were the ones who thought it would be a good idea to create this body to come within the objectives of action plan 14?

MR McCOY: I don't know the answer to that.

COMMISSIONER PAGONE: You don't know the answer, okay.

MR ROZEN: Commissioner, can I approach it this way because I think I may have introduced some confusion in this and I apologise for that. If we go back to paragraph 12 of your statement, Mr McCoy, on page 2, before there was any suggestion of creating a corporate entity, there was a council established, was there not, by the Commonwealth via Miles Morgan? People were identified to be members of an aged care industry workforce council; is that right?

MR McCOY: So before 12 February was there a council?

MR ROZEN: Yes, no, not before 12 February. The entity was incorporated in May, registered on 17 May.

MR McCOY: Yes.

MR ROZEN: Before that there had been a workshop in February.

MR McCOY: That's correct.

MR ROZEN: The workshop was attended by council members who at that time were operating on a council that had no corporate status but had been established by the Commonwealth.

MR McCOY: I don't believe so. The workshop was attended by approximately 40 leaders from across the industry.

MR ROZEN: Right.

MR McCOY: And the point of the workshop was to talk about what would be the sort of make-up of the council.

MR ROZEN: I see.

MR McCOY: So, for example, would it be just providers or not? Would it have employee nominee representation or not? And - - -

MR ROZEN: Okay. But I'm just trying to understand the process and the link to the Commonwealth. You understand that is what I'm trying to explore here?

MR McCOY: I understand but I was not involved in the establishment of - - -

MR ROZEN: But you do say at paragraph 12 that you understand the Commonwealth Department of Health engaged Miles Morgan on 5 September 2014 to support the establishment of the council.

MR McCOY: Yes.

MR ROZEN: And then the process of the workshop and everything else that you have described flowed.

MR McCOY: That's correct.

MR ROZEN: But it was always your intention, was it not, that the body that emerged from this, the council, whether it had corporate status or not, would be the body envisaged by strategic action 14.

MR McCOY: That's correct.

MR ROZEN: That's what this is all about.

MR McCOY: Yes.

COMMISSIONER PAGONE: But my confusion which stemmed from paragraph 12 was that the implication from paragraph 12 was what has emerged had been caused by the Commonwealth, whereas, in fact, the answers that I am getting seemed to indicate the Commonwealth was not the cause of the body that has been created.

The body that has been created is essentially three industry participants thinking it would be a good idea to create it.

MR ROZEN: Are you able to - - -

MR McCOY: Commissioner, I don't believe that's the – I think the Commonwealth engaged Miles Morgan to create a council. Miles Morgan have come up with what they think the entity structure should be, which is a company limited by guarantee. In parallel, they've reached out to the industry for suggested members of the council and because a company limited by guarantee needs members, they have then gone and sought membership for the workforce council. That's my understanding of how – how it came about.

COMMISSIONER PAGONE: But it does sound, from what you have said, though, that the body having been created with the very particular structure that was adopted – and it's not really right to say that because you've got a company limited by guarantee, you must have members. I mean, of course, you must have members if you are a company limited by guarantee. But that doesn't really explain who the individual members are that had been chosen. And it does look as though, once this body has been created, it has more or less been these members deciding which direction these members want to take, with the Commonwealth not being, as it were, taking ownership of what has emerged. Is that a fair statement?

MR McCOY: I – that's not my understanding. But I accept your point.

COMMISSIONER PAGONE: All right. Thank you, Mr Rozen.

MR ROZEN: Thank you, Commissioner. I wonder if I could just try and bring closure to that, this issue, put this proposition to you. The corporate arrangement, the corporate status that was settled upon, the company limited by a guarantee, is merely that. It's giving effect to the advice from Miles Morgan about the most appropriate legal structure for the council but it doesn't alter the initial intention which was the council established to give effect to strategic action 14.

MR McCOY: That's correct.

MR ROZEN: Thank you. Now, I was asking you about some discussions recorded in the minutes and I want to just conclude that by asking you about the minutes that appear behind tab 140 in the general tender bundle, at page .0019. I had better just clarify this was a meeting you were present at. Yes. We can see that you were there. This is the meeting on 15 August 2019. And we see under the heading "Matters for Decision" a series of dot points, the first one of which records:

Recent discussions between the department and the chair –

at that time that was still Mr Hardy; is that right, Mr McCoy?

MR McCOY: Yes.

MR ROZEN: And LG, is that Mr Gunaratnam of Miles Morgan?

MR McCOY: Yes.

MR ROZEN: Discussions between those two and the department indicated that:

> *...the department was not going to allocate the Minister's pre-election announcement of funding the council for $2.6 million.*

Do you see that recorded there?

MR McCOY: Yes.

MR ROZEN: Do you recall that being raised at the meeting in August?

MR McCOY: Yes.

MR ROZEN: And just for a bit of context here, "the Minister's pre-election announcement" is, of course, a reference to the previous Minister, Mr Wyatt.

MR McCOY: Yes.

MR ROZEN: And, of course, post-election we by this time we had a new Minister, Mr Colbeck; is that right?

MR McCOY: Yes.

MR ROZEN: Yes. And what was the response of the council to being informed that the new Minister – sorry, that the department was not going to allocate Mr Wyatt's pre-election announcement of funding of $2.6 million?

MR McCOY: My recollection of the discussion was the council – some were minded to approach the Minister directly.

MR ROZEN: Yes.

MR McCOY: Others were more we should keep working with the Department of Health and seek clarity on exactly what the position is.

MR ROZEN: And what was the ultimate decision?

MR McCOY: To seek clarity from the department. The – yes.

MR ROZEN: And has clarity been sought from the department since that time?

MR McCOY: Well, that's an ongoing process.

MR ROZEN: Just remaining in that list of matters for decision, if I could ask you about the fifth dot point, the one that starts:

> *There was discussion about whether to engage –*

if that could just be highlighted:

> *There was discussion about whether to engage with the Minister on the funding issue. A number of directors had already met with the Minister in relation to their specific aged care issues. Feedback from those meeting was that the Minister did not necessarily agree with the commitments on aged care from the previous Minister. The Minister was aware of the council but thought it had started in January 2019 and had not done much. This misinformation was apparently supplied by the department.*

Whose characterisation was it that that was misinformation?

MR McCOY: I can't recall who specifically said that.

MR ROZEN: It's quite strong – sorry.

MR McCOY: I personally haven't met the Minister.

MR ROZEN: Sorry. You - - -

MR McCOY: I personally haven't met the Minister.

MR ROZEN: No. I'm more interested in the goings on at the council, though. I mean, the use of "misinformation" is quite strong language, isn't it, Mr McCoy?

MR McCOY: Yes.

MR ROZEN: Does it reflect a concern in the council that the department is not properly briefing the Minister, the new Minister?

MR McCOY: Yes.

MR ROZEN: The minutes then go on to record that it's critical to have the Minister on side, and I take it you would agree with that proposition?

MR McCOY: Yes.

MR ROZEN: And then if we can go over to page .0023, there's an item 4.6.2 at the bottom of the page. I will just see if I can understand this; the item is listed as Department of Health First Assistant Secretaries, Charles Wann and Jaye Smith.

What does that mean, having that as an item in the minutes? Can you help us with that?

MR McCOY: Whoever is standing – when we established the council we set up a standing item for the department to dial in or to participate in the meeting.

MR ROZEN: I see. And then the details that are recorded there is:

The departmental representatives declined the invitation to attend the council meeting.

MR McCOY: Yes.

MR ROZEN: Was a reason given for declining?

MR McCOY: Not that I'm aware of.

MR ROZEN: So the references to misinformation and the Minister not being committed to the previous Minister's financial commitments, the department declining to attend a meeting, I suggest to you that taken together, they would suggest a lack of commitment by the Commonwealth to this process. Do you have a comment to make about that?

MR McCOY: I understand your point. I think I'm a bit more optimistic. I think it's part just the – you know, the formation of the council, getting organised, reaching out to the various stakeholders, and starting to build cadence and momentum around the work we're doing.

MR ROZEN: Since you've become chair of the council, have you had a telephone conversation with Mr Wann from the department?

MR McCOY: No.

MR ROZEN: I ask you that because Mr Wann is the representative of the department who has been identified to come and give evidence to us on Friday - - -

MR McCOY: Yes.

MR ROZEN: - - - about the relationship between the department and the council.

MR McCOY: Yes.

MR ROZEN: You understand that?

MR McCOY: I understand that, and I haven't – I have a meeting scheduled with Mr Wann, I understand, for 8 November.

MR ROZEN: Okay. Can I ask when that arrangement was made?

MR McCOY: It would have been on Thursday or Friday last week.

MR ROZEN: We, of course, don't have the benefit of the minutes from your last meeting last week. I take it they're probably still being prepared, are they?

MR McCOY: Yes.

MR ROZEN: Are you able to shed any further light on the relationship with the Commonwealth based on the discussions at that meeting?

MR McCOY: Kate McCauley dialled into the meeting and, you know, we had a discussion around her on the job of work and the prioritisation of the recommendations, and we said that we almost had those in order and we would be approaching Charles with the schedule of work for the next three years, with a recommendation on the level of sort of operational support we think the council needs.

MR ROZEN: Just before leaving this topic of the Commonwealth and funding, I just want to draw your attention to what you say at paragraph 68 of your statement at the top of page 11. You say:

> *Otherwise the council is acting with no funding and, other than as set out above, and it does not have any insight into when funding is expected. The council will need government funding support particularly in the early years to drive the changes recommended in the taskforce report with the speed required by the sector.*

Returning to the question you were asked by Commissioner Briggs earlier, it's the case, isn't it, that without that injection of funding soon there's going to be a real practical difficulty with achieving the pretty ambitious timeframes that are set out in the Pollaers report?

MR McCOY: That's correct.

MR ROZEN: From your dealings with Ms McCauley, do you think the government is of like mind in relation to that? In other words do you think there's a sense of urgency on the part of the Commonwealth?

MR McCOY: That's a difficult question to answer.

MR ROZEN: All right. Now, I just want to ask you about a couple of the strategic actions and if I could refer you to paragraph 58 of your statement on page 9. You note the grouping of the strategic actions into those five subgroups and then at 59 you say:

The following strategic actions have begun to be implemented since the release of the strategy in September 2018.

If we can just take three for the moment which is going to be the subject of some evidence later this afternoon:

Reframing the qualification and skills framework – addressing current and future competencies –

and, four –

Defining new career pathways.

Can you just briefly indicate to us what work has been done in relation to those?

MR McCOY: So, for example, under 3, my understanding is the IRC is looking at getting dementia as mandatory as part of the accreditation program.

MR ROZEN: The IRC, that's the Industry Reference Committee.

MR McCOY: Yes.

MR ROZEN: That's the other body that emerges from the Pollaers report which we are going to be hearing about this afternoon.

MR McCOY: Yes.

MR ROZEN: What sort of liaison arrangements are there between you and the IRC?

MR McCOY: So I personally haven't had any dealings with the IRC previously. Ian Hardy was both chair of the IRC and interim chair of the workforce council. So under the new arrangements I will have to connect with the deputy chair of the IRC and work out how we work going forward.

MR ROZEN: Yes. I should say, in fairness to you, Mr McCoy, we accept that you have only very recently taken over as chairman of the council. The last matter I want to ask you about is strategic action number 1, which is the one about the social change campaign around ageing and aged care.

MR McCOY: Yes.

MR ROZEN: And Mr Pollaers gave some evidence about that earlier as being a very important overarching piece of work that needs to be done. It is obviously an ambitious action, and I'm just wondering what the present thinking is at the council, as far as you are aware, of giving effect to strategic action 1? Or, alternatively you

may say that's a role for the government or – I don't want to leave that open-ended for you.

MR McCOY: So in the way the taskforce put together the recommendations strategic action 1, we would see as predominantly government-led. It's a country-wide program we need to do to lift the perception of aged care and what it's like working in aged care.

MR ROZEN: Yes. And at the risk of becoming a repetitive questioner, what indication have you had from the Commonwealth, if any, about its attitude to strategic action number 1?

MR McCOY: I've had no feedback from them on progress with strategic action 1.

MR ROZEN: Or for that matter any of the other actions that are the responsibility of the Commonwealth, I take it.

MR McCOY: No.

MR ROZEN: Commissioners, they're the questions that I have for Mr McCoy.

COMMISSIONER PAGONE: Yes. Thank you, Mr Rozen. You are free to go.

MR McCOY: Thank you.

MR ROZEN: Sorry. Just before Mr McCoy departs - - -

COMMISSIONER PAGONE: Yes, Mr McCoy. Just one moment.

MR ROZEN: Commissioner, my learned friend wishes briefly to put some factual matters to the witness. I have no opposition to that. The most efficient way might be if it's just - - -

COMMISSIONER PAGONE: Yes. The Commission is content with that.

MS MORGAN: Thank you, Commissioners. Mr McCoy, I understand you've been in this role for one month; is that correct?

MR McCOY: That's correct.

MS MORGAN: And so to the extent that Mr Wann or anyone else from the Department of Health has had conversations with your predecessor, the interim chair, you may not be aware of those conversations; is that right?

MR McCOY: That's correct.

MS MORGAN: Including organising the meeting for 8 November; is that correct?

MR McCOY: Yes.

MS MORGAN: In your statement at paragraph 52, you refer to your understanding of the government's lack of action on several of the action items. Do you recall that paragraph?

MR McCOY: I recall – sorry; was it 52?

MS MORGAN: It's on the screen, if you would like to look at the screen.

MR McCOY: Yes. Yes.

MS MORGAN: Is it right that one of those strategic actions is strategic action 10 which relates to the improved training and recruitment practices for the Australian Government Aged Care Workforce?

MR McCOY: Yes.

MS MORGAN: And are you aware of the announcement in the 2018-2019 budget of $14.8 million to fund training for part of the government workforce?

MR McCOY: Yes, I was aware of that.

MS MORGAN: Would you agree that that does appear to be some action in relation to strategic action 10?

MR McCOY: Yes.

MS MORGAN: And would you agree that given your position as external to the government, you have a limited visibility to decisions within government that are occurring in relation to any strategic action – any of the strategic actions the government is taking action on?

MR McCOY: That's correct.

MS MORGAN: No further questions, Commissioners.

COMMISSIONER PAGONE: Thank you, Ms Morgan. You may go now, thank you very much.

MR McCOY: Thank you.

<THE WITNESS WITHDREW [3.00 pm]

MR BOLSTER: Thank you, Commissioners.

COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: I appear in relation to the VET panel, and there are three witnesses in that panel. The first of those, if I could call – yes, there is an appearance.

MR E. WHITE: If the Commission please, I announce an appearance for the Australian Nursing and Midwifery Foundation, Mr Robert Bonner who is giving evidence today and Wednesday, and Mr Paul Gilbert, who will be giving evidence on Wednesday. And with the Commission's permission, I don't intend to remain at the bar table at all times but only for particular periods.

COMMISSIONER PAGONE: We can cope with your absence.

MR WHITE: Thank you. If the Commission please.

MR BOLSTER: Commissioners, I call firstly, Jane Leanne Williams who is known professionally as Jane Trewin, who is seated on the right-hand side of the panel.

<JANE LEANNE TREWIN, SWORN [3.01 pm]

MR BOLSTER: The next witness immediately to Ms Trewin's right is Mr Robert Bonner.

<ROBERT BONNER, AFFIRMED [3.02 pm]

MR BOLSTER: And the final witness is Michelle Eastman.

<MICHELLE EASTMAN, AFFIRMED [3.02 pm]

MR BOLSTER: If you could please have a seat. We might deal, firstly, with Ms Trewin's statement. If you have a look at the screen in front of you, there'll be a document that will appear; it's WIT.0482.0001.0001. Can you see that?

MS TREWIN: Yes.

MR BOLSTER: That's your statement?

MS TREWIN: Yes, that is.

MR BOLSTER: Do you wish to make any amendments to the statement?

MS TREWIN: No.

MR BOLSTER: Are its contents true to the best of your knowledge and belief.

MS TREWIN: Yes, it is.

MR BOLSTER: Thank you. I tender Ms Trewin's statement, Commissioners.

COMMISSIONER PAGONE: Yes. The statement of Ms Trewin dated 9 October 2019 will be exhibit 11-5.

EXHIBIT #11-5 STATEMENT OF MS TREWIN DATED 09/10/2019 (WIT.0482.0001.0001)

MR BOLSTER: Mr Bonner, your statement should appear in front of you. Is that your statement?

MR BONNER: It is.

MR BOLSTER: Do you wish to make any amendments to it.

MR BONNER: No.

MR BOLSTER: Are its contents true to the best of your knowledge and belief?

MR BONNER: They are.

MR BOLSTER: I tender Mr Bonner's statement, Commissioners.

COMMISSIONER PAGONE: The statement of Mr Robert Bonner dated 24 September 2019, exhibit 11-6.

EXHIBIT #11-6 STATEMENT OF MR ROBERT BONNER DATED 24/09/2019 (WIT.0488.0001.0001)

MR BOLSTER: Finally, Ms Eastman you should see your statement on that screen.

MS EASTMAN: Yes.

MR BOLSTER: And that's your statement?

MS EASTMAN: Yes, it is.

MR BOLSTER: And do you wish to make any amendments to it?

MS EASTMAN: No, thank you.

MR BOLSTER: And are its contents true and correct to the best of your knowledge and belief?

MS EASTMAN: Yes, they are.

MR BOLSTER: I tender Ms Eastman's statement, Commissioners.

COMMISSIONER PAGONE: Yes. Statement by Michelle Eastman dated 8 October 2019 is exhibit 11-7.

EXHIBIT #11-7 STATEMENT BY MICHELLE EASTMAN DATED 08/10/2019 (WIT.0460.0001.0001)

MR BOLSTER: I might start with a question to you, Mr Bonner, in light of the evidence we just heard from Mr McCoy who chairs a fairly similar panel or committee to the Aged Services Industry Reference Committee that you are the acting chair of. What has been your experience of dealing with the Commonwealth whilst you have been the acting chair of that committee?

MR BONNER: The Commonwealth has sent a representative from the skills area to each of the meetings of the Industry Reference Committee and remains engaged with us in terms of receiving reports from SkillsIQ, the skill service organisation that supports the committee on a fairly regular basis. There has not been, until a few weeks ago, any request from the Department of Health and Ageing for a formal report from SkillsIQ or from the Industry Reference Committee for an update.

MR BOLSTER: All right. We will get to the work of the committee in due course. Are there any funding issues along the lines of those that we heard evidence about before you were sworn in, with your committee?

MR BONNER: No. Our committee is funded for a three-year program for the skills area, and we are negotiating for some additional money that I've heard informally has been approved for the work for the next 12 months.

MR BOLSTER: All right. We might turn to VET, and Ms Trewin, let's start with you, you are the executive director, educational delivery, of the Box Hill Institute.

MS TREWIN: That's correct.

MR BOLSTER: And Box Hill is a technical and further education institution in Victoria?

MS TREWIN: Yes.

MR BOLSTER: And could you give us an indication of the sorts of VET courses that are offered by Box Hill when it comes to the aged care sector?

MS TREWIN: The aged care sector, yes. We have a variety of courses from the health training package. We do certificate III in individual support. We have a certificate IV in ageing on scope as well, and we also – some aged care units in our Diploma of Nursing qualification.

MR BOLSTER: All right.

MS TREWIN: As well, we have the allied health courses, but they're sort of to the side a little bit.

MR BOLSTER: And on the allied health, are we talking about physiotherapy?

MS TREWIN: Yes, not to that level but the low-level certificate III and IV.

MR BOLSTER: Ms Eastman, you are the executive director for Pathways and Vocational Education or PAVE - - -

MS EASTMAN: Yes.

MR BOLSTER: - - - Swinburne University of Technology?

MS EASTMAN: Correct.

MR BOLSTER: Does Swinburne offer complementary courses to those that are offered at Box Hill?

MS EASTMAN: Yes. We would offer the certificate III in individual support work. We don't offer the certificate IV in aged care; we offer the certificate IV allied health assistant, Diploma of Nursing and then in our higher education component of the university we have physiotherapy, occupational therapy and Bachelor of Nursing.

MR BOLSTER: All right. Let me ask you about your Diploma of Nursing course; does that lead to someone becoming a registered nurse or does that lead them to becoming an enrolled nurse?

MS EASTMAN: An enrolled nurse.

MR BOLSTER: And how many hours of study are involved in that course?

MS EASTMAN: In the Diploma of Nursing course?

MR BOLSTER: Yes.

MS EASTMAN: I can't answer that off the top of my head, I'm sorry. That would be – my specialists would be answer to that.

MR BOLSTER: Okay.

MS EASTMAN: It's about - - -

MR BONNER: 1700 normal hours.

MS EASTMAN: Yes.

MR BOLSTER: Now, Mr Bonner, your organisation is slightly different, the work that you do in the training sense, you are involved with the Australian Nurses and Midwives Association, South Australian branch, and they run an RTO that delivers VET in South Australia?

MR BONNER: Yes. And we're just taking on responsibility for delivery in Tasmania. So we offer programs from certificate III in individual aged care specialisation at both VET in schools programs, for adult learners through traineeship modalities and then into the Diploma of Nursing and the advanced Diploma of Nursing.

MR BOLSTER: Could you give us a description of the way in which the course that operates via the school system works; at what age do people come into that course, and what sort of engagement do they have on a practical level, in residential or in home care?

MR BONNER: So the students enter the program usually in year 11 as part of their SACE program in the state, so their higher school certificate, and spend two years enrolled in the program. They spend a day a week, either attending the registered training organisation and completing the academic learning or one of our educators visits the school and delivers it within the school environment. As part of that they also have a direct work placement over the two years where they complete the practical work in a workplace environment in aged care facilities.

MR BOLSTER: All right. Could I ask a philosophical question to start the discussion. The consumers of VET in aged care, who are they? Is it the student who is funded by the government to study at your institution? Is it their future employer or is it the person who is in aged care is going to receive at the end of the day safe, quality care from them?

MS TREWIN: All of the above really.

MS EASTMAN: All of those and some other stakeholders, I would suggest, as well but in particular for this context it would be the clients receiving aged care, ensuring

the graduates have the outcomes that they need to provide that care, the students themselves that we're delivering on the promise of quality vocational education, and the employers and industry stakeholders who employ those graduates.

MR BOLSTER: Mr Bonner, do you have a perspective about that?

MR BONNER: I think that at training delivery level that I'd agree with the assessment. There are student stakeholders, there are employer stakeholders, and funding stakeholders that we are seeking to – but there's also the VET system development level of the qualification design, training package work which is predominantly then what does industry need to meet future workforce requirements; industry people broadly defined as both employees and employers. So they're the primary stakeholders at that level of the process.

MR BOLSTER: And one of the outcomes of the Pollaers report has been the establishment of your Industry Reference Committee. Both you and Ms Eastman are on that committee, correct?

MR BONNER: Yes, that's right.

MS EASTMAN: Yes.

MR BOLSTER: Just in a broad sense, what are you focusing on in addressing those sorts of issues, on the committee side?

MR BONNER: Well, as I think I set out in my statement, the first part of this year or really up until now we have been largely focused on what was given to us as our priority piece of work which was looking at the adequacy of the existing certificate III in individual support work for cert III performance in the industry. So we have been engaged in a rewrite of that qualification, testing it in its first phase with industry, getting feedback and just last week issued to the Industry Reference Committee a stage 2 qualification design for signoff to go back out for validation.

We're now turning our minds to the next stages of work which is the broader adequacy of training and qualifications in the sector, and so we have set up some work in terms of pathways that both Mish and I are involved in, so looking at future work pathways, education pathways, and also establishing the nutrition and meal time experience group in addressing that area that has already been ventilated before the Commission in the past.

MR BOLSTER: Why has there been a priority for cert III; why is that a priority?

MR BONNER: The feedback from industry was that it was not adequately preparing workers for job-ready roles in the sector. And so that was the kind of feedback that came through the taskforce and so we were given – that is our priority piece of work because if that wasn't successful, then there was a fundamental breakdown in terms of work capacity in the sector.

MR BOLSTER: Well, let's talk about the course, then, and then we will talk about the future of it. What does cert III attempt to do? From the perspective of a trainer, what are you trying to achieve when you offer cert III to the hundreds of young Australians who come and study it every year?

MS EASTMAN: So understanding there's the Australian qualification framework which clearly articulates outcomes against qualification levels, cert III would be a base level worker, and in this context to work in providing components of care, under supervision, to stakeholders within the aged care industry. Some of that care might be in a residential care aged care setting. Others would be in a community-based or home-based care environment. And they are not – they have very strict scope of practice requirements for graduates at that certificate III level around decision-making and identification and troubleshooting and problem solving.

MR BOLSTER: Isn't cert III a much broader certificate that can be applied in child care, in hospital care and in other contexts?

MS EASTMAN: Not the certificate III individual support worker qualification. So there are a range of certificate IIIs in vocational education but specifically for this industry it's a certificate III individual support worker, and then there are components of that, that are disability sector, home support and aged care. There is three possible specialisation streams.

MR BOLSTER: All right.

MS TREWIN: It is mainly as a support role in the environment rather than making decisions themselves, so it's actually seen as support.

MR BOLSTER: You may have seen some of the evidence that the Commission has heard over the course of this year about how personal care workers are becoming the largest component of the delivery of care and they're doing it to an ever-increasing number of people with greater acuity. Is the Certificate 3 that's in place today keeping up with those needs?

MS TREWIN: No.

MR BONNER: I would argue that it's not and nor is it possible for it to do that given the kinds of changes in complexity and demand that we are seeing in the resident profiles in our facilities. So I think we are preparing workers at a cert 3 level for roles that are requiring skills, knowledge and competence that are far beyond that.

MS EASTMAN: Sorry. Certificate 3 was never intended nor could it be intended to provide solutions to all of those complex problems. It's to be part of a multidisciplinary team working with certificate 4 level graduates, with diploma graduates, with degree and masters qualified graduates and I think some of the evidence that you referred to, and I haven't kept up with everything, but the nature of

that expanding role and expectations of a Certificate 3-level worker is incongruent with what a Certificate 3-level worker can do.

MS TREWIN: If I can add to that, I think the Certificate 3 students when they're on placement, they're involved more with patients that are people in aged care facilities with dementia or palliative care, that type of role, and they don't have those skills to deal with it in some stages so they have got more exposure to that so they need to be skilled up a bit higher to cope with that better.

MR BOLSTER: The question I think that is a little unclear is the degree to which they are upskilled. Can we turn people who do cert 3 into nurses?

MS EASTMAN: We can't turn a Certificate 3 into a nurse if you don't invest in the qualification and pay them accordingly and give them the skills, knowledge and experience to be able to do that. So Certificate 3 workers operate within the framework of what they are prepared for, and are employed on Certificate 3 level pay.

MR BONNER: I think the problem with the way that the question takes us is you can keep on adding more and more content into a Certificate 3 level program. So you can add Certificate 3 level knowledge in relation to palliation or dementia or behavioural care. But it doesn't add to the capacity of the worker to assess independently of other people, to have the knowledge and skills to make the decisions about whether or not it's appropriate to medicate or not medicate a client. So that's the levelling issue that Mish was talking about at Certificate 3. So that's why we need to build pathways that take people up that knowledge tree and capacity tree as well as broadening skills across the workforce.

MR BOLSTER: I think verticality and horizontality. Can you explain to us what you mean by those things. So, horizontally, the worker - - -

MR BONNER: So, horizontally, the – you can add on more and more units. So someone who has got a support worker role qualification based grade is now going to work in dementia care specifically and they can add other elective units on to their base qualification that add to their capacity to work in dementia care. But it doesn't increase their decision-making capacity, their degree to work autonomously because their knowledge set is expanded by further what I describe as horizontal skill level. By vertical I'm talking about someone who is entering the workforce as support worker Certificate 3, going into allied health assistance at certificate 4 or enrolled nursing in the diploma stream or into the diversional therapy stream. So what they're doing is building on their base skills but also learning how to take more of a high level competency set, a knowledge set, into that work. And I think that there's a tension between what you can do with a cert 3 in not addressing the fundamentals of the skills mix in the workplace.

MR BOLSTER: Well, the statistics would seem to suggest that a nursing role is being forced on these people.

MR BONNER: Yes.

MR BOLSTER: That will never have the skills and there's never any scope for them to be skilled as nurses. Is that a fair summary?

MS TREWIN: Yes.

MR BONNER: Yes. The classic of that one is medications.

MS EASTMAN: Yes.

MR BONNER: So let's medication credential people in support worker roles but let's not give them the knowledge in anatomy and physiology, the interaction of the pharmacy with the body systems, why you might withhold on the way through. So you can teach medication but if you don't broaden the overall capacity of the individual, it's still not safe.

MR BOLSTER: What about, for example – it may be topical with some evidence we will hear this week, what about wound care?

MS EASTMAN: A Certificate 3-level worker hasn't got the deep understanding of physiology assessment and impact to be able to make decisions about whether wound care is improving or not improving.

MR BOLSTER: Well, are they trained to carry it out?

MR BONNER: No.

MS EASTMAN: No.

MR BONNER: They're trained to notice changes in skin condition and skin breakdown.

MS EASTMAN: Yes.

MR BONNER: That should then be reported to the registered nurse for investigation and for care planning when that occurs, but you couldn't possibly talk the level of knowledge and skills you need to, in terms of selecting the appropriate treatment for a wound at that level.

COMMISSIONER BRIGGS: Is it possible for you to sit a little closer to the microphone. It's quite hard to hear.

MR BONNER: Sorry.

COMMISSIONER BRIGGS: But fundamentally, you are saying you can pick up basically entry level skills that you need as a support worker to other more

professional staff, but you need to be trained at a higher level to bring the knowledge that's needed at that level to apply particular higher level skills? Is that right?

MS EASTMAN: Yes.

MR BONNER: That's correct, Commissioner.

COMMISSIONER BRIGGS: Good.

MR BONNER: If you don't have assessment planning skills, the kind of technical knowledge and skills, then it can be dangerous to ask workers with a Certificate 3 level qualification to cast their practice into those areas without supervision and support.

COMMISSIONER BRIGGS: Yes. Yes.

MR BOLSTER: Now, you mentioned that you've been – in your statement, Mr Bonner, that you've been involved in a consultation process with industry about the development or the changes to the curriculum for cert 3. Can you tell us what that has involved?

MR BONNER: Yes, the Industry Reference Committee looked at the design of the individual support worker qualification as it applies to the aged care specialisation and we were concerned really about the degree to which it was possible for RTOs to select – registered training organisations, I should say, to select from a pretty vast menu of electives and the advice we were having was that sometimes those elective choices were being driven by cost and delivery modality rather than by what the best needs of the student and industry were. So we recast the qualification. The biggest single change we made was to reduce the electives to a much shorter list that were directly applicable to working with the aged.

MR BOLSTER: And how many electives are we talking about?

MR BONNER: There are three in that group and there are three that are required for aged care specialisation.

MR BOLSTER: And they are?

MR BONNER: Here's my carefully prepared note for the Commission. Yes, so the core units are still provide individual support, support independence and wellbeing, communicate and work in health and community services working with diverse people, work ethically and legally, recognise healthy body systems, follow safe work practices for direct client care. So they're the core units that cut across all three areas. The ageing specialisation facilitating the empowerment of older people, providing support to people living with dementia and meeting personal support roles.

MR BOLSTER: All right.

MR BONNER: So they were the – so they're unchanged fundamentally in terms of the revamped qualification.

MR BOLSTER: Where did the direction in your consultation process come from? Did it come from the employers of these people or did it come from other RTOs or did it come from industry generally?

MR BONNER: The draft qualification went out to industry broadly. So we sent it out. It was on the website. We held workshops with industry and training providers across the country. And we cast the net far and wide in terms of going through the industry peak organisations, writing to all the stakeholders, seeking their consideration and feedback.

MR BOLSTER: And what was the response from industry, from the actual employers? How useful was that?

MR BONNER: In the end we had, I think it was 280 is the approximate number of responses to the draft qualification, and over 200 of those came from training providers rather than from employers.

MR BOLSTER: So only 80 employers.

MR BONNER: Less than 80.

MR BOLSTER: What about the peaks in the industry, so LASA and ACSA?

MR BONNER: I can't remember whether or not they wrote a separate submission but certainly their members and, of course, Industry Reference Committee has representatives from each of those peaks on it and so they gave direct feedback in relation to their members.

MR BOLSTER: Professor Pollaers said a couple of things this morning in his evidence. He talked about the aged care industry as yet to define itself and needing to establish a purpose. Do you see that issue resonating in industry involvement, engagement with the development of training programs for its workers?

MS EASTMAN: Yes, in – that's a very broad kind of question, I guess. The – we have experiences at Swinburne and also of the IRC of working with particular stakeholders who are actively involved in trying to shape what their workforce of the future looks like. However, the sector as a whole has, you know, a broad ranging remit as to how we support an ageing Australian population and I think has landed on a model to date that is now a hotel experience model and has precipitated things, including 40 per cent of residents of aged care facilities having markers, you know, acute markers of depression, loneliness, isolation.

So if the industry is to define itself, then the proposition around that is actually as a society and as a community how do we value people in an ageing process and how

does that then become part of the narrative for our graduates. Specifically, in VET we are being driven to produce graduates who are focused on tasks and doing things as Certificate 3 level workers. In its purest form it should be under guidance and direction, and then once they're reaching employment status it's becoming an ever increasing scope of what is expected of an entry level worker.

MS TREWIN: And I think it's like most industries really. You have your really good RTOs, you have you're really good industry that are very proactive, in their thinking doing the right things. The ones that have got it right are doing – making great progress and doing some things but it's not across the sector as a whole. So from our perspective with our students when we're sending them out on practical placement, we want to make sure that they are very highly skilled to begin, like, skilled up to know what they're going to be facing and then very tightly monitored but that relationship with our partners in the sector and knowing what they're doing in their space is really important and we try to align with the ones that are really proactive and then try and influence the ones that aren't so proactive.

MR BOLSTER: To what extent are people proactive and not proactive?

MS TREWIN: I think the standard of care.

MR BONNER: I think that our experiences at IRC and certainly our experience as a training provider is that industry has to be engaged by us rather than industry seeking to engage with us.

MS EASTMAN: Yes .....

MR BONNER: I think that the language of the VET system and the training system is alien to most industries and the aged care as an industry that's still, in many ways, sort of suffering from cottage industry features, is even more isolated than some others. So I think some of the engagement tends to be even when they do engage from training managers and workforce managers rather than directors of care or CEOs that you might get in other industries. So you tend to get pretty transactional conversations rather than meaningful stuff about what they would be seeking to get from workers into the future.

MR BOLSTER: Ms Eastman, what is Swinburne's experience?

MS EASTMAN: I would say there's also an overlay of economic drivers. So the partners of choice who we would partner with are interested in understanding quality experience for their clients and quality graduates contributing to that. Those who we then may have a transactional conversation with but not a deeper relationship as a training partner are – appear to have their decision-making driven by economics around what's going to be the cheapest and most beneficial way for them to employ people and/or to provide care.

MR BOLSTER: There must be another level of provider out there that doesn't take any of your students or any students at all.

MR BONNER: Absolutely.

MS TREWIN: Absolutely.

MR BOLSTER: How do you engage with them on your IRC? What's your message to them?

MR BONNER: We do that by our skill service organisation going out into some of those areas and seeking to actively interview and engage directly with them. But it can be difficult. So we do as much as we can but, I mean, it's part of the challenge of developing qualifications in a sector that has got, you know, two or three thousand providers spread across the length and breadth of the country as opposed to developing a qualification for submarine design where you have to deal with one or two providers all located in Adelaide. So it raises challenges.

MR BOLSTER: You mentioned diversity as being a real problem for industry engagement - - -

MR BONNER: Absolutely.

MR BOLSTER: - - - both in terms of the size, the small, the very many small as opposed – as well as their geographical.

MR BONNER: Rural remote areas have quite different capacities in terms attraction and retention, and also availability of training providers closer to their locations.

MS EASTMAN: And employment surety of graduates as well. So many Certificate 3 level workers will be employed as casual workers for a variety of providers and they will cross between the aged care industry and the disability sector often, and the more geographically disbursed that is, so as soon as you start to move away from metro areas into regional areas or institute-based care into community and home care, then that mix of worker changes.

MR BOLSTER: Do you have remote placements for any of your students?

MS TREWIN: Yes.

MS EASTMAN: Yes.

MR BOLSTER: Where do you - - -

MS TREWIN: We are based in Box Hill and our placements can be as far away as the western districts, down Warrnambool way.

MR BONNER: We have country hospital placement and country healthcare placements for our students.

MR BOLSTER: Are they regular placements year on year out - - -

MR BONNER: Yes.

MR BOLSTER: - - - with existing providers.

MS TREWIN: Yes. Yes, we have agreements.

MR BONNER: In a course that we are about to commence targeting Indigenous students in the cert 3 program, we are looking at having work placements in the APY Lands in the north of the State, in the Riverland and the like so that we can actually reach out to placements in country.

MR BOLSTER: Mr Bonner, at paragraph 6 of your statement, you say in the last sentence:

> *Apart from brief periods of relatively small co-investment through mechanisms such as the productivity places program and its successes, the aged care sector has used public funding without significant investment of its own.*

MR BONNER: Yes.

MR BOLSTER: Could you explain what was the productivity places program; why was it a good idea?

MR BONNER: The Commonwealth in those programs made available training money targeted to particular industry, based on cases that were put up by industry for skills in demand. As part of that, there needed to be industry contributions to the training and they needed to be cash, not just in kind investments for the first time. And in that way, the Commonwealth and State funding that was made available was spread further because of leveraging off of the industry investments. In some industries, like mining, that reached as high a leverage as 150 per cent. In aged care we were able to get up to about 30 per cent co-funding through those programs. Since those programs have gone back to traditional allocation, that money or investment from the providers has virtually evaporated.

MR BOLSTER: So in terms of the courses that you run, the cert 3 courses that provide the vast bulk of the employees of industry, what's your experience of industry investment in that process?

MS EASTMAN: None.

MS TREWIN: None.

MS EASTMAN: As far as financial investment, none.

MR BONNER: Ours is State funded.

MR BOLSTER: And - - -

MS EASTMAN: State – State funded.

MR BONNER: State and Commonwealth funding.

MS EASTMAN: And Commonwealth.

MR BONNER: And any gaps in there are met by the students.

MR BOLSTER: Looking forward to the replacement of cert 3, whatever that may be in five years time, that is fit for purpose, what would a best-case approach to funding of that sort of course? And included in that engagement with industry. What does that look like? What does the Apollo 11 design look like?

MS EASTMAN: Yes, so certainly from my lens it would be about a workforce that is far more interprofessional and connected so that the cert 3 worker alone is not bearing much of the burden of care provision in a decreasing cycle of supervision and guidance and that there is a greater blend of Certificate 3, 4 and diploma level workers across – and I'm not trying to make a nursing workforce as a non-practising nurse; it needs to include allied health and a range of leisure and lifestyle and stimulating activities. I think there is room for us to look at the introduction to this sector of things like an apprenticeship model but for that to occur it requires a radically different funding and economic leavers and buy in and participation financially from providers themselves, and a rethinking around what that experience looks like.

MR BOLSTER: Why apprenticeships?

MS EASTMAN: Why apprenticeships? Because there's status and recognition from employers and from government around apprenticeship versus traineeship. There's a social value on the premise of an apprenticeship model as opposed to a traineeship model. I think traineeships at scale have suffered from poor reputation and from being exploited in some of, you know, the known experiences nationally.

MR BONNER: Traineeships are fundamentally a funding vehicle. There is no learning model associated with traineeships. Apprenticeships have a specific learning model which applies both workplace learning alongside institutional learning leading to a vocational outcome. So I think that's - - -

MS EASTMAN: Yes.

MR BONNER: - - - what I would argue to be the fundamental difference between the two and we need more of an apprenticeship focused model than just funnelling money for training.

MS TREWIN: And from our perspective, when you look at the Certificate 3, it is a support role.

MR BONNER: Yes.

MS TREWIN: If you look at classic 3 apprenticeships in other industries, it's not a support role. They're actually a qualified practitioner. So we're actually – and they can give direction as well, rather than just having to support people.

MR BOLSTER: Can you give an example to bear that out.

MS TREWIN: Well, if you look at a hairdresser or a plumber or something, they can actually do the work themselves without being supervised once they have completed the apprenticeship. So with a traineeship it's generally in the workplace a lot of times. With apprenticeships it's a mix like you said before. But also it does hold a lot more credibility than traineeships within the view of industry's eyes. And I agree, I think, you know, I mentioned slightly before palliative care and dementia is becoming more and more visible and stronger where they've got accessible. So we would really look to see those sorts of skills involved.

We've had the situation where, ideally, we would like to have our students coming in at cert 3 and pathway and up into to the cert 4 in ageing but actually they've been employed straightaway in cert 3 and stopped from that further education. But a lot of the skills in the cert 4 ageing is actually what they almost need in the cert 3. So it's sort of a little bit of a – got it backward, and so it's levelling and straightening it out to make the skills relevant to a real cert 3. So even dropping the word "support" could end up – if you put the right skill base in that quote.

MR BONNER: The other part of the vision that I would add for the five years time is the modular approach, so actually making it easy for people to enter at a cert 3 level. Grow their skills into the diploma of nursing, into the cert 4 in allied health into diversional support and the like in a way that doesn't force them to restudy, get RPL, go through all those complicated processes that cost time and money and put people off doing them.

MS TREWIN: And there is, sorry, there is the opportunity to that – to upskilling and reskilling the existing workers. And if the businesses actually have the opportunity with skill sets, microcredentials, whatever you like to call it, they are all very similar, is there is an opportunity to get the diversity. You know, when we are talking about the leisure and health and activities, you know, get the patients out of bed and into the room and more active and things like that. But it's actually giving these cert 3 students opportunities to add to their portfolio skills.

MR BONNER: The difference I would have with that was that caveat I said at the beginning about broadening rather deepening skills. So skillsets are useful to supplement and broaden capacity for knowledge at a particular level. They're not a substitute for improving the qualification base for the broader role.

COMMISSIONER BRIGGS: Might I ask a series of dummies questions because I don't have a background in education and I do try to understand it. How often does the IRC update skills and qualifications in each of these things? Is it five-yearly, 10-yearly?

MR BONNER: Not any longer, Commissioner. So there was an expectation under the previous system that all qualifications would be reviewed on a five-year cycle.

COMMISSIONER BRIGGS: Yes, that's what I thought.

MR BONNER: Now there's an annual rolling process for industry reference committees to submit cases for change to the Australian industry and skills committee to approve funding.

COMMISSIONER BRIGGS: That's good. So in your evidence earlier on, I might have misheard you or misunderstood the lead-in but I checked the running write up of it, it sounded like even though you had said dementia should be a core unit that it wasn't actually still a core unit.

MR BONNER: It is.

MS EASTMAN: No, it is.

COMMISSIONER BRIGGS: It is now.

MR BONNER: It is absolutely.

COMMISSIONER BRIGGS: When did that start?

MR BONNER: It has been a core unit for a few years.

COMMISSIONER BRIGGS: But I thought it was an elective unit.

MR BONNER: It's called an elective but it's mandatory if the person is to qualify for individual support specialising in aged care. So there are two levels.

COMMISSIONER BRIGGS: So there are three electives that you mentioned. Are they all mandatory?

MR BONNER: Yes, the three electives I mentioned if the aged care specialisation, so facilitating empowerment, dementia, and educational support are all compulsory for the aged care specialisation.

COMMISSIONER BRIGGS: Okay. That's helpful. The next point that I think you made, Ms Trewin, is that in other sectors or other industries, cert 3 certification, traineeships, whatever, is more than an entry level grading. It enables people to operate independently to some extent.

MS TREWIN: Yes, that's correct.

COMMISSIONER BRIGGS: Now, why is a cert 3 in aged care less adequate than a cert 3 in another industry?

MS TREWIN: Good question. And, yes, and that's when if you look at the apprenticeship level cert 3s, they do end up when they get their qualification, they are a stand-alone qualified practitioner for that industry and they can work on their own. When you have a Certificate 3 in individual support you will always be a support person.

COMMISSIONER BRIGGS: So it's the difference between a cert 3 where there is apprenticeship involved at the end? No, it's not? Can you explain that. I can see - - -

MR BONNER: Both Mish and I are, sort of, sitting here saying have we got the AQF in our pocket and neither of us do. The Australian qualifications framework specify features of vocational performance at each level of the qualification, Certificate 3 diploma, etcetera.

COMMISSIONER BRIGGS: Right. Right.

MR BONNER: And they are constant across all qualifications regardless of which industry they're - - -

COMMISSIONER BRIGGS: That's what I would've thought.

MR BONNER: - - - in or how they're delivered.

COMMISSIONER BRIGGS: Good.

MR BONNER: So the issue is about the degree to which the worker is required or enabled through their training to make autonomous decisions to act independently or whether or not there is a degree of oversight supervision and the like in there. So they're constantly applied.

COMMISSIONER BRIGGS: So in order to have a cert 3 become more capable of acquiring the knowledge and applying it - - -

MR BONNER: Correct.

COMMISSIONER BRIGGS: - - - as you were suggesting earlier on, does that mean, Ms Eastman, that there should be more on the job training, more classroom training or what?

MS EASTMAN: Why I specifically used the apprenticeship word was because that's a tripartite relationship between the participant themselves, they're directly employed by the employing organisation and the training provider as well. So it builds a co-investment in the successful outcome and it blends the learning. So there is on the job component. There is then structured learning for practice in a training organisation environment where you can fail safely, you can learn from that.

And then you can be deemed competent to apply those skills back in your workplace. Whether that is in aged care or plumbing and bricklaying. So some of the anomalies that you referred to about why the difference exactly some of the work that the AQF review with Peter Noonan in particular are looking at, it has been an evolution of time and different industry sectors and also that many of the traditional trades still have licensed organisations in particular thresholds of demonstration of outcomes at year 1, year 2 and year 3 that need to be met at a State and/or national level.

COMMISSIONER BRIGGS: So an apprenticeship in aged care would take longer.

MS EASTMAN: Yes.

COMMISSIONER BRIGGS: It would take two to three years on average?

MS EASTMAN: It may do.

COMMISSIONER BRIGGS: And would involve both more time in the classroom and more time supervised in the workplace.

MS EASTMAN: And, Commissioner, the word you used was supervised in the workplace, so that is also part of the ingredient as far as adequate staff mix and adequate staff skill to provide guided supervision and development of those skills on the job.

COMMISSIONER BRIGGS: Now, to create an apprenticeship environment compared with the range of providers now that provide training cert III level for personal care workers, I'm assuming that the volumes don't match; that there would be many more people who are getting cert III qualifications in aged care as it stands now versus the challenge of providing an apprenticeship type model for equal numbers of people. Am I right or wrong about that or is that just a crazy observation?

MS EASTMAN: I think it's an observation of the state at the moment but I think if I was imagining a five-year difference then that would – I think you could get a like for like – you know, organisations need to employ care workers. So it's then about the value of the care worker and whether you change the model to be an

apprenticeship as an inherent requirement, as opposed to someone who may have achieved their certificate III through a historic delivery.

COMMISSIONER BRIGGS: Okay.

MR BONNER: The challenge would be in areas like home care where, typically, one worker goes out on their own, and if you were using an apprenticeship model that would necessarily mean accompaniment and direct supervision. So those things would add to cost and would need to be met, and there are some times of the day during low shift periods or on weekends in even residential care where those factors would come into play. So the point that has been made about adequacy of supervision and support and practice experience is really important because the apprentice is there fundamentally as a learner rather than someone who is independently productive during all of that cycle.

COMMISSIONER BRIGGS: That would require considerable change to the aged care industry. I'm sorry I've interrupted your train of questions, counsel.

MR BOLSTER: Not at all, Commissioner. Not at all. Certificate IV, has that fallen by the wayside?

MS TREWIN: Yes.

MS EASTMAN: Yes.

MR BONNER: Yes.

MR BOLSTER: Why?

MS EASTMAN: Financial imperative, so the drivers for having cohorts of students is that they will achieve outcomes that are meaningful at the end of that and there is a very slim employment demand within the sector itself for certificate level IV graduates. That's changed over about a 15-year cycle.

MR BONNER: I mean, the origins of the cert IV were to short-circuit the regulation of the Nurses Board at the time who was trying to restrict the use of people without appropriate systems of supervision. So the industry set up the cert IV as a way of sort of putting enrolled nurse level skills into an aged care qualification but not have licensing rules apply to the group, and so that's now run its race. So I would argue that time has caught up with the cert IV and instead of reinvesting in that we actually need to build pathways into full nursing roles rather than re-create that level.

MR BOLSTER: Is a person with a cert IV more expensive for a nursing home?

MS TREWIN: Yes, yes.

MR BONNER: Yes.

MS EASTMAN: Yes.

MR BOLSTER: How much more?

MR BONNER: It's not vast but it's a reclassification within the award system and employers have traditionally wriggled to avoid it.

MR BOLSTER: Is the skill useful?

MS TREWIN: There's different skills in the cert IV to the cert III.

COMMISSIONER BRIGGS: Is the cert IV the diploma level?

MS EASTMAN: No.

MR BONNER: No, certificate IV – the diploma is a cert V equivalent qualification AQF.

COMMISSIONER BRIGGS: Okay. So there's a clear progression through them, and what you are telling us is what we have heard in the evidence before us, that the focus in the industry tends to be on cert III and then the workers in the sector aren't necessarily encouraged or feel disinclined to go further.

MR BONNER: Correct.

COMMISSIONER BRIGGS: And the excuse we've heard for that is they didn't necessarily do very well at school so they don't necessarily go much further or they've got other interests and so on. Now, we've heard that in some places but not every place, I'd hasten to add. You are looking very sceptical about that so - - -

MS TREWIN: No, no.

COMMISSIONER BRIGGS: - - - let's talk about the aspirations of people in the sector because that is really important to making this workforce engaged.

MS TREWIN: No, I do agree. But there is also a lot of people that are returning to work or are retrenched workers that go into that. So what we find with our students when they're out doing their placement, we've got some of our partners give our students guaranteed employment when they're finished the cert III so that doesn't encourage them to go on to the cert IV because then they've been employed and the whole idea for them is to get a job outcome at the end of their course.

COMMISSIONER BRIGGS: Yes, that's a better way of saying it, I think, to get a job outcome rather than to sit there. Okay.

MS EASTMAN: The other piece of the puzzle in this complex land of vocational education is there is a funding disincentive for people to retrain into this industry

area if they do have a higher-level qualification. So you might be a mother returning to work who might happen to have been a physiotherapist or anything else that has a diploma or higher qualification. If you are wanting to do a personal care worker qualification you will not be eligible for State Government funding in the main to do that. You will have to pay a fee for service.

MR BONNER: If you have had a traineeship in one qualification stream then you won't get a traineeship to migrate that qualification into another stream. So the funding mechanisms actually get in the way of career progression and people building qualifications. The other thing I would say, Commissioner, in response to your question is that there is no single pathway. So some people who might have a certificate III in support work might find themselves moving into a certificate IV in diversional therapy rather than a Diploma of Nursing or in some other role within the organisation. So it's about matching the skills and aspirations of the worker and their capability with the jobs that need to be done as a balance and then giving them additional assistance in terms of numeracy and literacy and some of those issues to get them through. It can be done.

COMMISSIONER BRIGGS: Thank you. Sorry.

MR BOLSTER: Can I ask you about a witness we heard in Sydney who was a personal care worker who did the Bachelor of Dementia course at the University of Tasmania. And extraordinary evidence was that when she graduated, she came back to her facility, no extra responsibility, no role in management, no decision-making. It was just the same job although she had put a considerable period of time and a lot of effort into getting that course. Why isn't that sort of knowledge and that sort of approach valued?

MS EASTMAN: Well, you would need to ask the employers that question, I would suspect. Certainly within an education environment it's valued but there's not a proportionate match with the framework of employment within the sector.

MR BONNER: And that is what is different to our sector because the question we always start with is what's the vocational outcome that comes from the program we are seeking to develop and deliver, and in some of those higher ed sector programs there is no vocational specific outcome. It can just be additional knowledge for interest's sake as the outcome or product from the course.

MR BOLSTER: But the vocational outcomes come from a history of industry engagement and practice.

MR BONNER: Precisely.

MS TREWIN: And hands-on skills.

MR BOLSTER: Embedded roles. Why can't industry get involved and embrace that sort of outcome and give that person a role?

MS TREWIN: Sometimes it's a lack of understanding. The employer – like, a lot of the vocational sector courses are very much about the hands-on skills and a lot see the university qualifications as a research-based.

MR BONNER: It's also with the cart and the horse argument here.

MS EASTMAN: Yes.

MR BONNER: If a university – and I'll leave the specific example to one side, but if a university goes off and devises a course of its own right without engaging with industry as to what the demand is, we can't then expect industry to create jobs just to match the qualification outcomes that a university might do to earn money as a training provider. So it's about how do we make sure that whether it's in VET or the higher ed sector that there is engagement between industry and the education providers about the demand so that the graduates can have some assurance that when they do the course there will be some reward and benefit from doing it.

MR BOLSTER: Could I turn to the – unless you wanted to say something?

MS EASTMAN: No, that's fine.

MR BOLSTER: Could I turn to the Joyce Review, and what the implications are for this part of the VET sector. What does the Joyce Review say to aged care VET providers?

MR BONNER: So I would characterise the Joyce Review as yet another example of rearranging the deck chairs of the system. So reframing the governance, reframing who commissions the work, reframing who does the quality assurance, without addressing the fundamental problem, which is about what does a qualification look like. Is it compliant with the needs of industry broadly stated now and immediately into the future, and is it producing good quality graduates. So I think that's the fundamental problem I would have with it.

The second thing I would say is that the proposal to pilot industry training organisations in the aged care sector and disability sector is just an horrendous thought. We are one year into a three-year change process for qualifications for this sector, and government is proposing we start again by a new parallel training organisation taking responsibility for the same area. Why would we continue our work? So we would be saying to government, if you want to pilot this model, do it somewhere else rather than crossing over into an area that has a critical workforce need that we are only just into addressing.

MR BOLSTER: Was your committee consulted about the decision to pilot aged care?

MR BONNER: No.

MR BOLSTER: And presumably if they had asked you would have given the answer you have just given.

MR BONNER: Yes. The discussion we have had at the committee was, as I've outlined, that why would you do this because it means that the resources we have available be stripped away in terms of technical skills available. Look at the small market in terms of writing qualifications for this industry. Those people would be poached by the incoming skills organisation who would have a contract for a longer period. So why would the staff remain with our skills service organisation and complete our work? So we have great trepidation about the overlap. If you want to do it, do it at the end of our period of tenure and after we have had a chance at fixing up the issues that we have been given a job to do.

MR BOLSTER: Ms Eastman?

MS EASTMAN: Yes. Similarly, I think perplexing that they have identified this area as a pilot model. There are a range of other industry areas that this could be tested with as far as a service organisation model goes. It's taken establishment of the IRC to build understanding of our purpose, our priorities, get all the stakeholders on board, which are from a board range of providers of aged care as well as providers of training and consumers. So it would be a drastic duplication and would derail work that is really just getting going with reimagining what the aged care workforce needs.

MR BOLSTER: Is there a dialogue in place to reconsider that decision?

MR BONNER: The Commonwealth is currently going through a consultation process, but we need to see whether they're listening as well as having conversations with us about that. They have not sought to meet with the IRC about the issue. So individual stakeholders have been invited to roundtables but there has been no direct communication between the federal department involved and the IRC about their proposition.

MR BOLSTER: Who, on the part of the department, attends your board meetings?

MR BONNER: It has been someone from the skills directorate, so typically one of the director-level people from within the skills directorate. I can't remember the name of the directorate now that it has been remapped in the new government department.

MR BOLSTER: Has this issue been raised as a matter of concern to the - - -

MR BONNER: We raised it with them at the last IRC meeting and they took our concerns on board and they tried to reassure us that we would still have a role but couldn't explain how the two organisations would work alongside one another for the next two years and not get in each other's way.

MR BOLSTER: Where does that fit in with the Pollaers inquiry action plan? Does it dovetail within any of the action - - -

MS EASTMAN: The Joyce Review findings?

MR BOLSTER: Yes.

MS EASTMAN: No. I think they're two separate frameworks.

MS TREWIN: Yes.

MR BONNER: We have mapped our role against three or four of the taskforce recommendations and other people have got other parts of the taskforce recommendations to deal with but it's not clear at all how many of those would go to the skills organisation as well.

MR BOLSTER: Just while we are on that, in terms of the Pollaers recommendations, you mention that the committee has effectively been given the opportunity to deal with a number but not all of the recommendations. To the extent that the committee doesn't engage in that process, who else will take on the responsibility for implementation?

MR BONNER: I guess we were lucky for the first six months that Ian, who was our chair was also chair of the Workforce Council so that we had the same person going between both bodies. That is now being tested because we no longer have that and so we actually have to establish now formal discussions between our groups to keep things tracked down. But he would advise us that the Workforce Council was dealing with certain things, the Department was dealing with others and we would – so he was our road map. So now that he is no longer in play, we will have to put formal processes in to make sure that we can keep track of who is doing what to whom.

MS EASTMAN: We were very – so for my interpretation as a committee member we were clearly focused on recommendation 3 and 4 ,and then secondary to that, looking at recommendation 7 and - - -

MR BONNER: Yes. And we have narrowed it even then in the last couple of weeks in terms of the career pathways by making it clear that our role in the world is about the education pathways, not about the occupational pathways because that's effectively an industrial matter to be sorted out between employers and the employees in terms of job roles and what people do and how they're rewarded.

MR BOLSTER: So what's the direction for the education pathways? What is the process that's going to happen in the next 18 months? Where is the direction?

MR BONNER: So our special advisory group was just constituted about a month ago. We had our first meeting two weeks ago. We expect to have our first

discussion paper formulated and ready to get out to industry is the hope by the end of November this year. That starts talking about issues of how can we create that kind of building block approach to skills. How do we make sure that we have the right kind of match between training and job outcomes.

MR BOLSTER: All right. Another report, the ASQA report from 2014 which dealt with quality issues in your industry. It came up with a whole list of recommendations. Could you give the Commission a summary of the key findings of the ASQA review?

MR BONNER: The ASQA review was really looking at unduly short courses. So they were looking at the sort of just add water over the weekend courses in aged care that was leading to really poor results in terms of training and capacity outcomes. The result of that was that just tackling duration of its own, which is one of the recommendations of Joyce, wasn't enough. So we need to look at mode of delivery, so there were some providers doing aged care in remote areas in particular, entirely over the net. So no requirement at the time for exposure in the workplace. And clearly that's not an acceptable way forward. Teacher qualifications and capacity, current industry knowledge, those were all input.

So the outcome of that review was that committees like ours would have the capacity to make a risk assessment based on what we know the risk to consumers, risk to students and workers, risks to industry reputation about what additional measures would we put in the training package that would become regulatory in nature so that ASQA when they go out and measure the quality of training provided by an RTO could give attention to those. Presently those measures are all in the companion volumes of the training package and they're not enforceable standards. So they can look at them but they can't require RTOs to comply to those levels.

MR BOLSTER: What has been the Commonwealth's response to that raft of recommendations?

MR BONNER: There was a further committee formed to look at training package reform, that was a collaborative exercise between the senior officials network in the state and federal departments of education and some of the industry peaks, that created models for how that could be implemented, and it has gone nowhere.

MR BOLSTER: You identify a problem in course development and updating that it involves an ante-process which means states and territories get involved, have their say and that process – how does that impact on the ability of industry to get action in this area, even now?

MS EASTMAN: It's very slow, even now with our new requirements as the IRC, for example, and having made some recommended changes to what the certificate III level individual support qual will look like, that now has to then go back out around with consultation with all of the state and territory committees and seek advice and

validation or not from all of those before it can then go up to the AISC committee, is that right?

MR BONNER: Yes.

MR ROZEN: That's the Australian Industry Skills - - -

MR BONNER: And Skills Committee.

MS TREWIN: Skills council.

MR BONNER: Committee.

MS EASTMAN: Committee.

MR BONNER: And the problem from there is that if any of those state or territory, state training authorities run interference against the change at the ministerial council meeting that follows that actually gives final approval, if any of those withhold consent then it goes down. So you actually – you have to go through a process of negotiating with industry nationally about what the training qualification package looks like and then any of the states or territories can effectively run a right of veto over that content and you have to try then and moderate it down to get rid of their complaints or the ministerial council ultimately won't sign off.

MS EASTMAN: So it's months and years, not weeks, to get changes made.

MR BONNER: Which is also one of the faults of Joyce because Joyce doesn't contemplate working in a federal system in the way that we do here. It's using a model from New Zealand. It doesn't have the kinds of complexities that a federated environment brings.

MR BOLSTER: Just before I ask you to give your perspectives about how things should change, there's one other topic, a discrete topic – a slightly different topic that I would like to address. Registration of the personal care workforce; what benefits do you see as providers who work with students and people coming into the industry, what benefits could such a scheme have for that career pathway?

MS EASTMAN: I think if you look at the sectors that have introduced registration, what it does do is provide a level of oversight and governance that protects the consumers of that service.

MR BONNER: Yes.

MS EASTMAN: So I have a history of understanding the registration with regard to the nursing model but also with regard to licensed builders, licensed plumbers, etcetera. And I think what it does do is then creates a regulatory environment that, at

its peak, protects the most vulnerable consumers of whatever it might be and in this case of aged care services.

MS TREWIN: And it's good to have visibility of currency so you can actually see when they were last trained, how current their skills are. But in saying that, we tried to get regulations into some industries. It's the person who is going to be monitoring those; that's where it falls down a lot of times.

MR BOLSTER: That was my next question.

MS TREWIN: Sorry.

MR BOLSTER: How would you – Ms Eastman has mentioned through – would the health professionals registration authority be the way to do this or should it be done in any other way?

MS EASTMAN: I think there's a model through the AHPRA model, the Australian Health Professions Association model that could look at it but I'm very mindful – aged care is not a medicalised model. So we need to be consumer driven and listen to what the stakeholders from a consumer lens are really looking for because aged care provision is very broad and not institution-based.

MR BONNER: I would argue that the fundamental tenet of the professional regulation under the health practitioners scheme is protection of the public, regardless of the domain. We are dealing in this environment with some of the most vulnerable people in care anywhere in the country.

So we need a scheme that is fundamentally modelled on the health practitioners law that is in the interests of protecting the public. And, as part of that, you then deal with conduct, you deal with competence and you deal with qualifications approval. I think what it brings to training delivery is the translation of a training package and competency set into curriculum and we don't, in training package world, deal with curriculum.

So when we turn the Diploma of Nursing training package into a course, we then had to go to ANMAC, the regulatory authority in nursing and show them how we had interpreted the contents of the training package, the pedagogy and how we were proposing to deliver that program, that we had the resources and the staff and the capability to deliver it to the appropriate level. And that's missing in the aged care qualification. So regulation in that sort of way would bring that rigour both to the work of the workers but also to their preparation.

MR BOLSTER: Ms Trewin, did you want to add anything to that?

MS TREWIN: They've covered that quite well there, but yes, I really do think it does come back to, you know, the currency and the skills, making sure they have got the right skills to do the job, putting the patient first at every stage, and looking at,

you know, from my perspective, who is doing it well and what are they doing that's different to who is not. And that's from an education perspective to a business and aged care facility perspective in everything if the council is working with home care and all that type of thing so it's quite broad.

MR BOLSTER: Other holders of cert III qualifications would have registration requirements, would they?

MS TREWIN: Yes, there is, like electricians, building and nursing.

MR BONNER: Child care.

MR BOLSTER: And complaints mechanisms for the holders of those qualifications?

MS TREWIN: Yes.

MR BOLSTER: And accountability - - -

MR BONNER: Yes.

MR BOLSTER: - - - for their qualification and continuing to hold it?

MS EASTMAN: Correct.

MR BOLSTER: That leads me to the last three questions, one for each of you. What is your vision for this sector? Who wants to go first?

MS EASTMAN: I've got a philosophical vision; I don't know how practical that is but I think many Australians have watched with joy and sadness the Old People's Home For 4-Year Olds model, which is an ABC documentary. And what that exposes is the core tenets of what great aged care looks like and how you can have a multi-layered approach that is intergenerational and interdisciplinary and that would be my desire for aged care as we revisit, actually, it's not just about certificate III level workers being supervised by registered nurses; there needs to be a whole workforce but also an outreach and models of care that are based on true connection with the community, with breaking down isolation and visibility, and then a whole range of factors around elder abuse and depression and isolation get removed because of the physical activities that can be brought into that experience.

MS TREWIN: I would like to see, in a lot of the facilities where they've had a duty nurse and they've got a lot of support workers that are mainly certificate III students that actually build up a big percentage of the workforce, actually look at the skill level of what's required for the business and making sure that we're pitching at the right levels of what we are delivering in the education to what the right skills are required for the job outcomes. So at the moment, it seems to be that ..... that we need

to have a really natural progression where, you know, we're skilling up to suit all the different diverse types of aged care requirements that there is for the sector.

MR BOLSTER: Mr Bonner?

MR BONNER: I guess that I would be arguing that we need to be blending the needs for competent individual workers with a capable overall workforce that blends the various skills and attributes, professional disciplines to meet consumer needs that are ever-growing and so we need more people with more capabilities and knowledge, with greater skills at the point of care. To do that we need to make our qualifications easier to navigate and easier to progress, and we need co-investment and co-responsibility between industry, students and training providers to get there.

MR BOLSTER: I have no further questions, Commissioners.

COMMISSIONER PAGONE: Well, what a task you have set. I have sat there quietly bemused and thank you very much. The educational training component of aged care really is very important and we have learnt a great deal this evening and it has been terrific to hear from three people who are so intimately involved in training at the coal face. Thank you very much.

MS TREWIN: Thank you.

MR BONNER: Thank you.

MR BOLSTER: Might the witnesses be excused with the exception of Mr Bonner who has to come back later in the week to talk about ratios.

COMMISSIONER PAGONE: Mr Bonner, you are not excused for ever; you are only excused for today, but I think you should be allowed to go home tonight.

<THE WITNESSES WITHDREW [4.14 pm]

MR BOLSTER: That's the evidence for today, Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Mr Bolster. We will adjourn until tomorrow morning at 9.15 am.

MATTER ADJOURNED at 4.15 pm UNTIL TUESDAY, 15 OCTOBER 2019

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