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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

HOBART

9.48 AM, FRIDAY, 15 NOVEMBER 2019

Continued from 14.11.19

DAY 68

MR P. ROZEN QC, counsel assisting, appears with MS E. BERGIN
MS J. NEEDHAM SC and MS J. BUNCLE appear for Bupa ANZ Healthcare Holdings Pty Ltd and Bupa Aged Care Australia Pty Ltd and Carolyn Joan Cooper
MR T. HACKETT appears for Ms Davida Webb

MS BERGIN: Good morning, Commissioners. I call UQ and US. Just while they come up to the witness box, by way of explanation, both of this morning's witnesses have been given pseudonyms.

COMMISSIONER PAGONE: Yes.

MS BERGIN: And their identities won't be revealed on the webcam.

COMMISSIONER PAGONE: Yes. Thank you.

<UQ, AFFIRMED [9.48 am]

<US, AFFIRMED [9.48 am]

MS BERGIN: Firstly to you, UQ, have you prepared a statement for the Royal Commission?

UQ: Yes, I have.

MS BERGIN: Is there a copy of it there in front of you?

UQ: Yes.

MS BERGIN: I understood you had a change to paragraph 20.

UQ: Yes. We do. In paragraph 20 could we strike out the word "back" so it should read:

Dad was settling into the Court.

MS BERGIN: Thank you. Are there any further amendments?

UQ: No.

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

UQ: Yes.

MS BERGIN: I tender the statement of UQ dated 29 October 2019.

COMMISSIONER PAGONE: Yes. Thank you. The statement of the witness identified with the pseudonym UQ will be exhibit 13-35.

EXHIBIT #13-35 STATEMENT OF UQ DATED 29/10/2019 (WIT.0584.0001.0001)

MS BERGIN: Secondly to you, US, have you prepared a statement for the Royal Commission?

US: Yes, I have.

MS BERGIN: Is there a copy there in front of you?

US: Yes.

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

US: No.

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

US: Yes.

MS BERGIN: I tender the statement of US.

COMMISSIONER PAGONE: The statement of the witness identified with the pseudonym US will be exhibit 13-36.

EXHIBIT #13-36 STATMENT OF US DATED 01/11/2019 (WIT.0585.0001.0001)

MS BERGIN: Thank you, UQ and US. I'm going to ask both of you questions and you should answer as you feel most appropriate. If there's something that you wish to add just let me know or feel free to chime in. Your parents – where did your parents meet?

UQ: Sorry, what was that?

MS BERGIN: Where did your parents first meet?

UQ: My parents have been – they were childhood sweethearts, really, back in the US – so – because their parents were friends, so they met in the mid-west, probably in the 20 – in the 1920s, 1930s.

MS BERGIN: And they had four children.

UQ: Yes.

MS BERGIN: What were their hobbies or interests?

UQ: They were very much believers in peace and they had found Quakers and they were very passionate about making the world a better place. That's why they moved to Australia. They didn't want to bring up four children in the US during the sixties and the Cold War.

MS BERGIN: When did they move to Australia?

UQ: 1963.

MS BERGIN: And when did they move to Tasmania?

UQ: Nineteen - - -

US: '82.

UQ: '82.

MS BERGIN: You both moved to Tasmania with your parents.

UQ: No, I moved first in 1978.

US: And I moved here in 1980.

MS BERGIN: Okay. Now, in 2014 you say in your statement that your parents brought a unit in Vaucluse Gardens Residential Village.

UQ: Yes.

MS BERGIN: They wanted the option to transition to the high-care unit next door to the retirement village at the appropriate time or if needed.

UQ: Mmm.

MS BERGIN: What did your parents know about Vaucluse Gardens in making the choice to move there in 2004?

US: I think they knew that it was a – quite a well-run institution. They liked the physical layout of the place. It was by the Hobart Rivulet, and it was closer to their activities. They were quite active in various – as [REDACTED] mentioned – or sorry, as my sister mentioned, many – they were involved in a lot of social justice and peace activities that happened around the inner city, so South Hobart was a good location for them.

MS BERGIN: What expectations did they have for the quality of care they'd receive?

UQ: I – what they liked was that it was going to be a transition, so they initially went into the part of Vaucluse where they could look after – it was independent living.

MS BERGIN: Yes.

UQ: But across the road they thought in the future if one of us gets disabled and we need higher care we can move across there and we wouldn't be a physical burden to the children.

MS BERGIN: What did they know about the facility across the road at the time they decided to move to Vaucluse Gardens?

UQ: Probably - - -

US: Not very much I would think.

UQ: - - - not very much, yes, I agree. I don't think they – they probably would have had a tour through it and a look through. I think at that stage it was still Vaucluse Gardens and they – they never mentioned that they were concerned about it or anything. So we – I assumed that they were quite happy with the facilities at that stage.

MS BERGIN: Now, in August 2011 your mum moved into Bupa South Hobart? And she had spent eight days there.

US: Yes.

UQ: Yes.

MS BERGIN: She was 89 years old.

UQ: Yes.

MS BERGIN: And she died of bowel cancer after her short stay.

UQ: That's correct.

MS BERGIN: How did your father respond to your mum passing away?

UQ: He was devastated, as we all were. Yes, it was a slow decline over two years but, you know, her – she was made comfortable and, you know, our GP was wonderful in looking after her but after she died he was so lonely and within, you know, six months we put a lot more care into looking after him, he had said to me,

"Look, I – I believe I'm suffering from a broken heart syndrome", and he had some falls and, you know, he wasn't eating well. So, you know, I think he was really grieving a lot.

US: They had been married for 67 years and we always thought they were joined at the hip, really. So when she died, he – he actually did some research into something called broken heart syndrome and found there was some papers had been written about it and so on. Did you say the pacemaker that - - -

UQ: No.

US: He had a pacemaker put in shortly thereafter and that actually changed – gave him a lot more energy physically, and he didn't fall quite as much then.

MS BERGIN: So after your mum passed away your dad remained living in Vaucluse Gardens Retirement Village for another couple of years until November 2013.

UQ: Yes. Correct.

MS BERGIN: What were his care needs at this time?

US: We spent a lot of time with him. So toward the end before an incident that occurred in November 2013 he was starting to get a bit confused and we had trouble using a Webster-pak, like his medication pack. He couldn't quite work out how it worked because the sides were different and I was just in the process of having a nurse come in, a community nurse call in every morning to help him with his morning meds, and I would come after work and help him with his evening meds. And at the same time I had him assessed by a geriatrician and I was present when he was, and he showed signs, early signs of dementia there, not being able to work out spatial things and I think there are a series of questions that are generally asked to assess how people's brain function is. He didn't do too well on that at that stage.

MS BERGIN: Sure. And which part of Bupa South Hobart did he move to?

US: He moved to The Court but first he was in the hospital and rehabilitation before.

UQ: He had a small stroke, they believe.

US: We think. Yes.

MS BERGIN: And that affected his mobility?

US: Yes, he was no longer able to walk.

MS BERGIN: And at this time he was about 92 years old.

US: Yes.

MS BERGIN: After your dad moved into Bupa South Hobart what were your initial impressions of the facility?

US: It was very attractive. He had a very nice room. He was quite comfortable to begin with, but we soon realised that there were some deficiencies, we thought. Because he was immobile he needed, I think, a two-person hoist to get anywhere, into a wheelchair or into the bathroom or whatever. The carers seemed to take quite a long time to come, longer than we thought was appropriate, actually.

MS BERGIN: I see. So you had some early concerns about the level of staffing at the facility.

UQ: Yes.

MS BERGIN: And what were the indicators that there was a problem in this regard?

US: The time it took to respond to a call bell, and I guess the amount of attention that he was given by the staff.

MS BERGIN: What implications were there for your dad, for example, in his room and the way that was maintained?

UQ: We noticed even early on at The Court that there were – incontinence pads were left around the room in, you know, full view of visitors and people coming in. His clothes often went missing or they were shrunk or, you know, just thrown into the room so there were – always seems to be those – they may seem insignificant but they were difficulties that we found. We were often having to re-organise all his cupboards and his clothing, because it was always – often seemed to be in disarray.

US: And there were often other people's clothing put in his wardrobe, including clothing that was clearly women's clothing. Although all his clothing was labelled, lots and lots of things went missing. Small indignities, I'd say. Yes.

MS BERGIN: That was an indicator there was problems with staff levels in the laundry for example?

UQ: Yes.

US: Yes.

MS BERGIN: You had a family conference in February 2014?

UQ: Yes.

MS BERGIN: And what concerns did you raise? If you can recall - - -

UQ: I've got – I think I had tendered this as evidence.

MS BERGIN: There's your handwritten note dated the 24th of – there's a handwritten note dated the 24th of February 2014?

UQ: Yes. Yes; that's true. And I had written out our concerns, hip-protectors, night-time issues, how he was distressed in the morning, how staff seemed to be very rushed and very busy, they had minimal contact with him, there was little regard for him, that he was living in his home, that they would burst in and sometimes leave the toilet door open, leaving incontinence pads, as I've mentioned, yes, not being quick in repairing jobs that we had asked to be done and - - -

US: Maintenance jobs.

UQ: Maintenance jobs. Sorry; yes. And the other thing was that we had been told that an RN or somebody would give him massages, and we found that wasn't happening. So there were numerous issues that seemed to be pretty continuous and consistent in the different family conferences we had with the BUPA staff.

MS BERGIN: After this February 2014 conference – firstly what response were you given by BUPA at the conference?

UQ: Well, they said that they'd put for example, a toileting-schedule into effect and that they would wake him at certain times and take him to the toilet. It was often hard, for us to find out if that was actually happening. Our father wasn't able to say "yes" or "no" about that; so some of the things – we weren't really sure. The night protectors – we said "Look; don't bother with them, the ones" – hip-protectors; they were too small, and they were very uncomfortable for him. So there were a lot of issues, I think – I don't believe – I don't know that the RN ever did the massages. I, certainly, never witnessed that happening. There was a physio at the – in the early stages, that was seeing him, but she left, and there was nobody to replace her. So a lot of the things, I think we just felt, weren't really being fixed up or attended to.

MS BERGIN: Yes. You had a further family conference in July 2014?

UQ: Yes.

MS BERGIN: And do you recall whether the issues were the same or different at that time?

US: Pretty much the same, I think.

UQ: They were fairly much the same; yes.

MS BERGIN: Your dad stayed at the facility for a further three years. In that time – just to take an example – did the problem you mentioned with continence pads being left around his room resolve?

US: No.

UQ: No.

MS BERGIN: So your dad was encouraged to move from the Court to the lodge, and this was partly because of the higher staff ratio in the higher-care facility, you say. How many staff were you promised per resident in the lodge?

UQ: Five staff altogether.

MS BERGIN: And how many residents were there approximately?

UQ: I believe we were told 29. I think that might be in the upstairs, because he was put into the upstairs locked facility.

MS BERGIN: So was it your understanding, that there was a ratio of one staff member to up to five residents in the lodge?

UQ: Yes; that's – yes. And I think I was led to believe that there would be five upstairs, and once he was there, I realised that were – the five staff may be between the two floors, because there was a – quite a big downstairs facility also that was called "the lodge".

MS BERGIN: Yes. Did you ever see five staff present at the one time in the lodge?

UQ: Not upstairs; no.

MS BERGIN: And what observations did you make about the level of training that the staff at the lodge had?

US: We were disappointed in that as well. They didn't seem to have specific dementia-related training. For instance: communication – they would often talk to people with the – behind their backs so that they couldn't see their faces, and my father would get a bit confused about a voice coming from somewhere. So – just basic training, and when you're talking with someone with dementia, you face them and you make sure they know you're there and so on. Just that kind of really basic stuff we didn't see happening. They didn't seem to also – many of them didn't use – try to use sort of behavioural-related methods to get our father to do something or comply .....

UQ: Yes. I was disappointed; they didn't relate to him as a person. It was more just – attend to the personal needs.

US: You'd have to say some of them did, obviously, but – yes.

UQ: There were two or three that were excellent; we do say that, and I was very pleased to have those staff members there. But by and large the majority of staff – I felt it was just a job, and they wanted to get into his room, do the job and get out as quick as possible, because they had many other things to do.

MS BERGIN: Now, turning to paragraph 37 of your statement – you say in about 2017 one of the care-managers at the lodge suggested that your dad be prescribed risperidone.

US: Yes.

MS BERGIN: What is your understanding of the reasons why the suggestion was made?

UQ: Not on the screen. We were told that he was becoming a concern to the staff, that he was wandering, and when we questioned the care-manager on this point, she indicated that he was taking himself off for a walk and he would go down to the lodge when he was still living in the Court and he would do one of two things, he would either go and sit near the room where my mother died because he did remember that or he would go and visit another resident there who was of a similar profession as my father and they would sit there and be very companionable and they liked each other's company. So – but he wouldn't, necessarily, take himself back, he would just stay down there and enjoy the company.

US: This was more the reason that they wanted to move him to the lodge.

UQ: To move him; yes.

US: But in relation to the risperidone, your question – they felt he was getting harder to manage by the staff.

UQ: Yes.

US: He was resistant at times to getting up in the morning, like many of us, but often that would relate to the nature of his sleep the night before, but he also would resist those efforts to get him up and to have a shower and to get dressed and so on. They did use the word – that he was showing aggression, and we really questioned that. That was not in our experience at all. Resistance is a different thing, I think, altogether than aggression, but that was the reason, the main reason, I think, that risperidone was recommended.

MS BERGIN: And what signs of resistance did your dad show that you're aware of?

US: I think he – well, when he was verbally encouraged to get up, he would verbally resist. But – and if he was physically – that is lifted or grabbed or whatever – he would physically resist, and he would kick his legs and flail his arms and so on.

MS BERGIN: And did you understand your dad didn't like to get up early in the morning?

US: It depended entirely on how he slept the night before, I think, like us all. I think sometimes he didn't mind getting up early and getting dressed, having a shower. He in fact quite liked having showers, but at other times he just really didn't want to get up, and he didn't want to be hassled into doing something he didn't want to do.

UQ: He had a chronic shoulder problem, and I think a lot of the carers didn't realise that, when they went to pull him up, it would cause him a great deal of pain, and he may have reacted to that situation. So - - -

US: Yes. Think his resistance may've had something to do with that.

UQ: Yes.

MS BERGIN: Did the care-manager explain the pros and cons of risperidone – so for example: any risk of side effects – to you?

US: No.

MS BERGIN: How did you get information about the side effects of risperidone?

US: We asked our brother, to begin with, who's a consultant psycho-geriatrician, and he gave us chapter and verse on risperidone and the uses of it and the indications for use, and he thought it was pretty inappropriate in our father's case. We also talked to our father's GP.

UQ: GP.

MS BERGIN: Just on that: you mentioned your brother was a – is a psycho-geriatrician. What concerns did he raise with you about your father being prescribed risperidone?

US: Well, later on he raised – he used the term – well, it was recommended by a psychiatrist from the dementia-behaviour unit. It was also with – the older persons' mental-health unit in the department of health and human services, Tasmania, had recommended quite a high dose of risperidone for my father. My brother saw this as - - -

UQ: Behavioural euthanasia.

MS BERGIN: And what does "behavioural euthanasia" mean?

US: Well, my understanding of it - - -

UQ: We did ask him at the time.

US: Yes. We did ask him, and he waffled on. No. He did tell us, but – basically, that it would kill off his current behaviours. So – both the challenging behaviours and the loving behaviours, the whole thing, by rendering our father sort-of semi-conscious, I suppose, and, possibly, immobile. So he would no longer enjoy the things he had continued to enjoy.

MS BERGIN: Yes. At this time your dad was seeing the family GP in Tasmania; is that right?

UQ: Yes.

MS BERGIN: Which was also your GP?

UQ: Yes.

MS BERGIN: What decision as a family did you make about the prescription of risperidone to your dad?

UQ: We said "no"; on numerous occasions we had to say, "No, we do not want him to be put on risperidone".

MS BERGIN: And when you say "on numerous occasions" – is that because the facility was encouraging the prescription of risperidone?

US: Yes.

UQ: Yes.

MS BERGIN: And what's your understanding of the reason the facility wanted your dad to take risperidone?

UQ: I believe it would make him easier to manage for the care staff and that's what they were seeking.

US: More compliant.

UQ: Yes.

MS BERGIN: In your view is there a connection – and tell me, if it's not your view, but is there a connection between that concept of compliant residents and the encouragement to prescribe risperidone?

UQ: Yes.

US: Yes.

UQ: Definitely.

MS BERGIN: Ultimately your dad had some success with a product called Calmology. How did he come across this product?

US: Well, one of the things that was suggested by the care-manager was that – we called in an organisation called the dementia-behaviour unit; also I think it might've been in the process of being restructured, and it was also called, I think, Dementia Services Australia.

MS BERGIN: Was that a state-government body?

US: Yes, it was. Well, the former was, and I think the latter was – may be private. I'm not sure. And eventually they came and did an assessment on my father, and they recommended various behavioural techniques to deal with what – the perceived problems. And they included massage and so on, and it was – I think it was BUPA, the BUPA staff, who actually purchased the Calmology – aromatherapies, basically, is what they were, and I think Calmology was specifically dementia – for dementia-related purposes.

UQ: They also recommended staff training, and I believe they did come in and do some work with the carers, to work with our father.

MS BERGIN: Okay.

US: And they also suggested not forcing him to do things he didn't want to.

UQ: Yes.

MS BERGIN: It seems pretty wise. So you also mentioned at the start of your evidence that the physio who was present when he first moved in left, and I think you say in your statement that there was then a transition to a fly-in fly-out physio who would attend from the mainland to treat residents.

US: Yes.

MS BERGIN: But you ultimately, or you early on, in fact, engaged the services of a private physio. How many times a week did your dad go to the private physio?

UQ: Once a week.

US: She came to him once a week.

UQ: Once a week, yes, for, like, four years.

MS BERGIN: For four years.

UQ: And we paid for that because we just didn't have confidence that Bupa were going to provide a consistent physio to keep him walking and mobile.

MS BERGIN: So, again, you engaged through your own resources, a – the care that you thought your dad needed.

US: Yes.

UQ: Yes.

MS BERGIN: What were your reflections on that sort of need to resist the recommendations and need to engage private services to supplement your dad's care?

UQ: I mean, I was disappointed. I was disappointed that we had to bring in our own care in terms of physio. And also disappointed that if we said no to, you know, the chemical restraint, then we weren't going to change our mind and we were asked on several occasions to reconsider.

MS BERGIN: Now, unfortunately in September 2018 your dad contracted pneumonia.

UQ: Correct.

MS BERGIN: He then had some palliative care at the facility. Could you describe the experience of receiving palliative care at the facility for your dad and through your own observations?

US: The palliative care was managed by his GP, the medication-related palliative care. I'd say the Bupa staff treated us very well at that time. It's obviously something they deal with every day, every week at least, possibly, maybe even not that often, but for instance they offered to bring a bed in – another bed into the room so we could stay with our father overnight. They offered us meals and so on. But that's about the extent of it, I think. So - - -

MS BERGIN: So the oversight of the palliative care treatment was by the family GP?

US: Initially, yes, although I think she had left some medications for the facility nurses to administer when needed.

UQ: Yes, yes.

MS BERGIN: So the facility nurses had the task of administering the palliative care treatment?

US: Yes.

UQ: Yes.

MS BERGIN: How did that go into?

UQ: Well, that brings me to the first night of his illness. I stayed the whole evening on the mattress on the floor. And I found he was starting to get very agitated at about half past 8 that evening. And I pushed the call button for assistance and no one came. I waited 15-20 minutes. I was walking around the facility looking for someone. I couldn't find a carer anywhere. I didn't have phone numbers of an RN or anyone to ring. So I just kept pressing the button and continued looking for somebody. I couldn't find anyone. I eventually did but it was – I would say 30 to 45 minutes before I could find someone.

MS BERGIN: And why were you looking for someone?

UQ: Because my father was very agitated. He was groaning, he was thrashing around, moving around and to me it looked like he was in a lot of pain.

MS BERGIN: And were you aware that he needed to be administered medications under the plan prepared by the family GP?

UQ: Yes. Yes, definitely.

MS BERGIN: You were looking for assistance because you wanted the nursing staff to administer the palliative care to your dad.

UQ: Yes. Yes.

MS BERGIN: How did this – on this night I think you mentioned that this started at 8 o'clock; how did you resolve the problem with your dad experiencing, apparently, pain?

UQ: I finally found a carer walking down the corridor and I stopped her and I said "My father is in a lot of pain, he needs for medication. Could you do that?" and she said "No, no, I can't do that. I'm not allowed to. Only an RN can do that". And I said, "Well, please call the RN. He needs help now". And she said "Well, I don't know where she is. I think she's in another building", and I said "Well, phone her, get her to come as soon as possible." "Yes, I will try", she said. So I waited about another 15 minutes and this would have been about – now, we're talking about half past 9 perhaps. I got a phone call between half past 9 and quarter to 10 from his GP. She rang me on my mobile while I was in my father's room, and she said, "I'm just ringing to check in before I go to bed", and I just burst into tears. I said he's in a

great deal of distress and I can't get anyone to help him. And she said, "Leave it with me, I will ring the RN straightaway".

MS BERGIN: Take your time, UQ.

UQ: And about 10 minutes later, the RN turned up and she put a driver or - - -

US: A syringe driver, I think it's called.

UQ: A syringe driver into his stomach, and was able to give him continuous medication then. And he calmed down and he was feeling much – well, I was then feeling better and he was feeling better but it was a very, very difficult traumatic time for me.

MS BERGIN: Yes. The syringe driver gave him some relief?

UQ: Yes.

MS BERGIN: And how did you go about organising that relief for him? Did you contact – I think in your statement you say you contacted the family GP.

UQ: She rang me. She rang me. But it was just – I think – I don't know what I would have done if she hadn't have rung. It was a coincidence, I believe, but she knew he was in palliative care and she wanted to check on him and I was just so upset that there wasn't more careful attention to his needs. Bupa knew that he was in a palliative situation and they weren't checking on him, and that was very upsetting to me.

MS BERGIN: Yes. Was there something you wanted to add, US?

US: No, only that the GP then got in touch with the nurse and the nurse came immediately after. I think [REDACTED] said that before, yes.

MS BERGIN: Now, I just needed to clarify that when your mother first moved into Bupa South Hobart in 2011, I said, it wasn't owned by Bupa at the time your mum first moved in.

US: I thought it was, actually, but I might be wrong. I did the sort of money business and I thought I paid Bupa but I did hear the other day that they took over in 2012.

MS BERGIN: 2012. Yes, Commissioners, I just need to correct the record in this regard. Thanks to my friend for passing me a note about that. Now, why was it important for you both to give evidence to the Royal Commission today?

US: I guess we were motivated by our parents' example of activism. That if you want to change something, that you have to do all you can do and so in, I guess, the

memory of our father, we thought we would contribute to the Royal Commission to try to bring about that change, so that older people are treated with more dignity and compassion and care, and skill, I might add.

UQ: Yes. Yes. I think things need to change and I thought this is a very good vehicle and way to do it. What small part we can make, hopefully will be helpful for many others, including ourselves in the future.

MS BERGIN: Thank you both. Thank you, Commissioners, that concludes my examination of these witnesses.

COMMISSIONER PAGONE: Thank you to each of you for coming and I'm sure that both of your parents would be very proud of you to have taken these steps. It's important that we hear what you have to say and it's important that the public generally hears what you have to say so that what flows from whatever recommendations we end up making will be hopefully a great improvement. Thank you to both of you. You're formally excused from further attendance.

US: Thank you.

UQ: Thank you.

<THE WITNESSES WITHDREW [10.24 am]

MS BERGIN: Commissioners, I call Beth Wilson and Dr Penelope Janet Webster.

COMMISSIONER PAGONE: Yes. Thank you, Ms Bergin.

<BETHIA ALICE WILSON, AFFIRMED [10.25 am]

<PENELOPE JANET WEBSTER, AFFIRMED [10.25 am]

MS BERGIN: Good morning, Dr Webster and Ms Wilson.

MS WILSON: Good morning.

MS BERGIN: Ms Wilson, firstly to you, could you state your full name for the Commission.

MS WILSON: My full name is Bethia Alice Wilson.

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

MS WILSON: Yes, we have.

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

MS WILSON: There is.

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

MS WILSON: Yes, we have three amendments: page 2, paragraph 4(f), if the date 2019 could be deleted and replaced with 2018.

MS BERGIN: Yes, so then the date will read 3 November 2019?

MS WILSON: '18. That was the mistake we made.

MS BERGIN: Thank you. And what was the second amendment, please, Ms Wilson?

MS WILSON: Page 3, paragraph 6(a), sorry, paragraph 1, delete again 2019 and replace it with 2018.

MS BERGIN: So then the date will read 10 November 2018?

MS WILSON: Yes. Are there two in that one, Penny?

DR WEBSTER: Yes.

MS WILSON: And in paragraph 2, page 3, again, delete 2019 and replace with 2018.

MS BERGIN: Yes, that's paragraph 2 under the heading 6(a) will read 5 November 2018.

MS WILSON: Thank you.

MS BERGIN: Now, included with your statement there was a report attached as appendix 4.

MS WILSON: Yes. We'd ask for that to be deleted and we would ask the Royal Commission to rely on the report that we presented to Bupa and which they have presented to the Royal Commission.

MS BERGIN: And that report, Commissioners, is tender bundle 75 which is being substituted for the signed or initialled copy at tender bundle 102. So just to clarify, tender bundle 75, the clean copy produced by Bupa has been included as the new appendix 4. Now, apart from those changes, Ms Wilson, is your statement true and correct on the basis of your information, knowledge and belief?

MS WILSON: Yes, it is.

MS BERGIN: I tender the statement of Bethia Wilson.

COMMISSIONER PAGONE: That statement will be exhibit 13-37.

EXHIBIT #13-37 STATEMENT OF BETHIA WILSON DATED 29/10/2019 (WIT.0586.0001.0001)

MS BERGIN: Thank you, Commissioner. The date on that statement is 29 October 2019.

COMMISSIONER PAGONE: Yes.

MS BERGIN: Now, Dr Webster, you've read the statement prepared by Ms Wilson.

DR WEBSTER: That's correct.

MS BERGIN: Do you agree with its contents?

DR WEBSTER: I do.

MS BERGIN: Could you state your full name for the transcript.

DR WEBSTER: Penelope Janet Webster.

MS BERGIN: Now, firstly, to you, Ms Wilson, you have expertise advising government, industry and consumer groups.

MS WILSON: Yes.

MS BERGIN: In fact, you were formerly the Health Services Commissioner of Victoria in 1997 to 2002.

MS WILSON: That's correct.

MS BERGIN: And you're also qualified as a lawyer.

MS WILSON: I beg your pardon, 1997 until 2012.

MS BERGIN: Thank you, Ms Wilson; 1997 to 2012 was the period you were Health Services Commissioner. And you're qualified as a lawyer?

MS WILSON: Yes.

MS BERGIN: Dr Webster, you have a PhD in applied conflict theory.

DR WEBSTER: That's correct.

MS BERGIN: You're a member of the Mental Health Tribunal.

DR WEBSTER: That's correct.

MS BERGIN: And the professional standards division of the Police Registration and Services Board.

DR WEBSTER: That's correct.

MS BERGIN: You have a Master of Commerce in industrial relations and human resources management.

DR WEBSTER: That's correct.

MS BERGIN: Now, together you formed Wilson Webster Consulting in 2015; is that right?

MS WILSON: Yes.

MS BERGIN: Now, I'll direct questions to the both of you. You have complementary but different expertise, and I would ask you to answer the questions as you see fit.

MS WILSON: Thank you.

DR WEBSTER: Thank you.

MS BERGIN: In relation to Bupa you advised them in a consultancy role in your partnership under the banner of Wilson and Webster Consultancy during the period September 2018 until March 2019.

MS WILSON: That's correct.

MS BERGIN: And you provided reports including on Bupa South Hobart.

MS WILSON: We provided eight reports in all and, yes, one was on Bupa South Hobart.

MS BERGIN: Yes. So I think Bupa South Hobart was the fourth of the eight sanctioned facilities owned by Bupa that you reviewed.

MS WILSON: That's right.

MS BERGIN: Your understanding of the reasons for your engagement is set out in part in appendix 1 to your statement.

MS WILSON: Yes.

MS BERGIN: What was your understanding of the reasons you were engaged by Bupa?

MS WILSON: Okay. We were approached by Bupa when sanctions were placed on, first of all, Traralgon in Victoria and we were asked to go along and hold a meeting with residents and their families and carers to find out what their concerns were. So it was a consumer engagement meeting, if you like.

MS BERGIN: Yes. And how did you come to review Bupa South Hobart?

MS WILSON: Sanctions were being applied on several facilities one after the other and we were being asked to go there pretty soon after the sanctions were placed. It was a quite busy time.

MS BERGIN: Yes. And what issues did Bupa brief you about?

MS WILSON: We were told about the sanctions, what they meant. Bupa were very unhappy about the sanctions. They complained that their facilities had been reviewed previously and were found to be fine. So they were saying, "Well, why have we got sanctions now?" and people were saying to us, "Well, why weren't they sanctioned a long time ago?"

MS BERGIN: Yes.

DR WEBSTER: Could I just clarify; we weren't given anything written about the sanctions and which of the sanctions had actually been placed on Bupa South Hobart.

MS BERGIN: Yes.

DR WEBSTER: So we had one email from James Howe and that referred to an ABC report that was just about to come out. But other than that, we were only given verbal information that sanctions had been applied so there was nothing in writing about the actual details.

MS BERGIN: I see. So you attended at Bupa South Hobart in November 2018 and by this time sanctions had been imposed on Bupa South Hobart, but is it your evidence that you weren't given a copy of the sanctions decision?

DR WEBSTER: That's correct.

MS BERGIN: Was it your understanding that the purpose of your engagement was so that you could advise Bupa on the results of your engagement with families and carers so that Bupa could consider and respond to your recommendations.

MS WILSON: Absolutely. And we believed that Bupa was genuine, that they would take our recommendations and our information into account to make things better for people.

MS BERGIN: Now, turning to your report, you've included a copy of your report as an appendix to your statement, Ms Wilson, and you note at 4(g) of your statement that Wilson and Webster Consulting had two concerns about the process of providing Bupa a report about Bupa South Hobart. The first concern in your note relates to being put under pressure to make changes to your report. What changes were you asked to make to your report?

DR WEBSTER: On March 19 – March, sorry, 9 March 2019, there was a meeting that only I was able to attend. Ms Wilson wasn't able to attend and I was asked to remove the word "systemic" from the front part of all the reports that we made.

MS BERGIN: And in what context was the word "systemic" used?

DR WEBSTER: The context was at the introduction of each of the reports. There was a general comment that we considered that most of the failures that we were seeing were systemic, and that was based on the evidence that we received so – sorry, go on.

MS BERGIN: I was going to ask who requested that you change the word "systemic problems" in your report?

DR WEBSTER: I have to apologise because I don't have her second name but I understand it was Emma, who was at the time the general counsel of Bupa Australia.

MS BERGIN: Yes. And what response – what change did Emma request? What did she want the words "systemic problems" substituted with?

DR WEBSTER: She wanted it to be "emerging themes".

MS BERGIN: Did you change your report in relation to Bupa South Hobart?

DR WEBSTER: I consulted with Beth and we decided that the evidence would speak for itself and the words that we used to describe it weren't that material, so we were happy to change it to "emerging themes".

MS BERGIN: And did you change the report relating to Bupa South Hobart?

DR WEBSTER: No, I don't think we did because I think it – we considered it had already been distributed, to a degree. Look, I'm not entirely sure about that.

MS BERGIN: Were you given any reasons for removing the words "systemic problems"?

DR WEBSTER: No.

MS WILSON: Bupa just didn't seem to like it.

MS BERGIN: And how did you resolve the requests – I withdraw that. What changes did you make to the Bupa South Hobart report, if any?

DR WEBSTER: I don't think we – we didn't make any because to our knowledge it had already been distributed to some of the residents.

MS BERGIN: So it remains your view today that there were systemic problems at Bupa South Hobart?

DR WEBSTER: Yes.

MS WILSON: Yes.

DR WEBSTER: Definitely.

MS BERGIN: What did the fact of this request to delete the words "systemic problems" tell you about management of Bupa South Hobart?

MS NEEDHAM: Well, I object, Commissioner. The evidence is that corporate counsel requested a change of wording, not management of Bupa South Hobart, and if there is a link it should be properly established in fairness.

COMMISSIONER PAGONE: Yes. Thank you. Ms Bergin, I must say I think that sounds right, doesn't it?

MS BERGIN: Thank you, Commissioner. I'm happy to establish the link.

What observations did you make about management of Bupa South Hobart during your time reviewing this facility?

DR WEBSTER: We were in Bupa South Hobart for about two and a half hours. The contact that we had with the management was very short, but we found a degree of hostility, quite open hostility towards us and reluctance to assist us with basic things like finding a whiteboard for us which we had requested.

MS WILSON: And also the meetings were intended for the residents, their families and personal carers, not for Bupa staff. That was very deliberate because we wanted people to feel free to speak about the concerns that they had because often when people are in residential care, it's difficult for them to make complaints. So Bupa staff, one person stood in the room and was taking names of people who attended.

The meeting was conducted with me engaging with the participants and Penny being the scribe on a whiteboard. I had to ask Penny could she please go and ask the person who was taking notes to leave the room.

DR WEBSTER: And the response was quite hostile, and the person said that they were there to take the names of people, to which I replied words to the effect that our understanding was that management at South Hobart had been advised that no staff should be present. And it took quite some persuading from me for that staff member to leave. Throughout the meeting other staff members turned up and each time I had to go – walk to that staff member and ask them to leave. Some did immediately. Others resisted, and I had to explain that they weren't permitted to remain. So in all, that – those sorts of incidents indicated a degree of hostility, and a lack of understanding of what a consumer engagement meeting would be and a lack of understanding about how complaints need to come forward and be addressed.

There was one other incident that raised our concerns about the degree of hostility that we experienced. At one stage I realised that there were a number of windows to the left of the meeting room. All those windows had been covered in paper and when I went around the corner I found that that was actually the staff room and the windows between the staff room and what was a common area had been blocked off by paper. I knocked on the door of the staff room because I needed some assistance, it was something to do with the whiteboard or something similar. At first there was no response. I kept knocking. Eventually somebody came out and before I could speak told me to go away. I nearly put my foot in the door. I did figuratively put my foot in the door and say, "Well, I do need to speak to you and you do need to address my concern". Sorry.

And again, that hostility to me as a guest was very troubling, and indicated that that kind of defensiveness and hostility was very strongly inculcated in the staff, that they considered it was permissible to behave this way to guests, let alone the residents and the families.

MS WILSON: We gained the impression that it was a closed place, that was not open to scrutiny.

MS BERGIN: Yes. Now, the second issue you mention in your statement relates to the distribution of your report after you provided it to Bupa and you note that you promised residents that the report would be circulated and you requested that Bupa do so.

MS WILSON: We didn't promise them it would be distributed. We promised to recommend strongly to Bupa that they make it freely available.

MS BERGIN: Yes. Why was this particularly important?

MS WILSON: People give us their information. They were very open and frank, and we wanted that to lead to quality changes. We wanted them to have a record of

what had happened so that they could see that we had fairly and honestly recorded their concerns and a record that they could use to negotiate with Bupa to improve the services.

MS BERGIN: And what is your understanding of whether the report was circulated to residents by Bupa?

MS WILSON: We got told it was distributed by Bupa but we also got told by families we haven't got the report. So we were never really sure.

MS BERGIN: Is this an indicator – taking a step back, is this an indicator of an issue with transparency?

MS WILSON: I think it is, yes.

MS BERGIN: And why is that?

MS WILSON: I think it relates back to the use of that word "systemic" that Bupa didn't really want people collectively to know how bad things were.

MS BERGIN: So this is one of the systemic problems that you mention in your report.

MS WILSON: Yes, I believe so. Also one of the other facilities that we visited, I was instructed by one of the managers who appeared before the Commission this week – Davida is her first name – that I was not to mention that there were sanctions on any other facility, and I said if I'm asked I will tell them.

MS BERGIN: And was she asking you not to tell residents at Bupa South Hobart that there were sanctions on other Bupa facilities in Australia?

MS WILSON: No, this happened at Woodend.

MS BERGIN: At Woodend. Thank you, Ms Wilson. Now, was this an indicator of a reluctance to be transparent by Bupa?

MS WILSON: Yes, I believe it was.

MS BERGIN: Why is that?

MS WILSON: I think perhaps they didn't want to look bad. They're running a business, of course, in my opinion not particularly well, but I can really only guess.

MS BERGIN: What would be your recommendation to a provider in these circumstances such as at Bupa South Hobart?

MS WILSON: Be open, be transparent, listen to what people are telling you. We believe that Bupa missed a great opportunity to improve things for their residents and their families by not being open to complaints. In fact, there seemed to be a culture that didn't welcome complaints. I've been a complaints commissioner for many years and I believe that a little complaint is a wonderful thing in terms of quality improvement. Consumer complaints are a window of opportunity to improve your practices.

MS BERGIN: So are you saying that this is a cultural issue at Bupa South Hobart?

MS WILSON: Yes, I think it is a cultural issue.

MS BERGIN: Now, turning to the topic of corporate governance, what did you observe about information flows between the Bupa facility and Bupa office in Melbourne that you were dealing with?

MS WILSON: Look, it was like they were galaxies apart, and it was very difficult for us to try and understand the management structures of Bupa. We've heard a lot through the Royal Commission in the last couple of days that left Dr Webster and I saying "That's what – that's why this happened."

DR WEBSTER: Overall you could say it was inconsistent.

MS WILSON: Yes.

DR WEBSTER: So it seemed like some information was getting through some of the time but there was not a consistency of information.

MS BERGIN: Yes.

DR WEBSTER: And, certainly, people in the meeting said when they contacted head office in Melbourne, information wasn't flowing back, and there was also indications that when they made complaints or raised concerns with South Bupa – sorry, South Hobart management, it wasn't flowing up.

MS BERGIN: Yes.

DR WEBSTER: So both from our own experience of that small engagement with South Hobart management and the engagement, the intermittent engagement we had with Melbourne head office and from the information that we got from consumers, it was intermittent, patchy, very difficult to kind of get an overall picture of what was going on, even about what our engagement was supposed to mean.

MS WILSON: For example, we had asked BUPA to draw up a contract for us, which they never did. And we heard from people at the meeting and afterwards that, when they made formal complaints to head office because they weren't getting

satisfactory response locally, their letters were either ignored, or the responses were unsatisfactory.

MS BERGIN: Yes. Now, commissioners, I'd ask the operator to bring up general tender bundle number 2 and turn to page 4. This is a document prepared by Ms Catherine Maxwell, who will give evidence later today; it's her insights into governance issues arising from the financial-services royal Commission in relation to culture dated April 2019. Now, Dr Webster and Ms Wilson, you've read this document?

DR WEBSTER: We have.

MS WILSON: We have read this document.

MS BERGIN: Did you make an assessment of BUPA South Hobart culture as part of your work there?

MS WILSON: Yes, we did.

MS BERGIN: And apart from what you've mentioned already, what was your assessment?

MS WILSON: As I said, it was like a closed shop. "We run things here; we don't want outside scrutiny."

DR WEBSTER: There was a level of defensiveness, frustration.

MS WILSON: Yes.

DR WEBSTER: And at times that spilled over into hostility.

MS BERGIN: And what was the implication for care-recipients of this – these cultural deficiencies.

MS WILSON: People weren't listened to; complaints weren't responded to. Things didn't get any better.

MS BERGIN: As you say, a lost opportunity.

MS WILSON: A lost opportunity, a lot of lost opportunities.

MS BERGIN: Now, you've mentioned the concept of staff hostility a number of times, and you note in your report that participants appeared to have concluded that BUPA was an organisation unable to run an aged-care facility. What were the reasons that participants provided you with – that is participants in your meeting in November 2018 – to leave you with this impression?

MS WILSON: Well, they told us in no uncertain terms that they believed BUPA wasn't fit to run the nursing-facilities, they looked back to a time when Vaucluse owned it, when, they thought, things were much better, they were really concerned about poor communication which led to loss of trust, they were very concerned about staffing levels. They said that some of the staff were really nice but they were overworked and underqualified for the jobs that they were expected to do, they were deeply concerned about medication errors, issues to do with continence-management, dignity, lack of dignity, lack of respect, people being brought to the dinner table in soiled nappies for example. Anything further, Penny?

DR WEBSTER: And I think our report details – goes into some detail of what Ms Wilson's just said, and it came to the point where several of the family members actually then summed it up by saying, on reflection and in comparison to the previous operators, that BUPA wasn't able to manage a nursing-home; sorry.

MS BERGIN: Again what recommendations would you make to a provider, in these circumstances, seeking to address staff hostility?

MS WILSON: Well, you – sorry; you go.

DR WEBSTER: Staff hostility doesn't just occur overnight; so if you're going to address staff hostility, you would need, as a manager, as a competent manager, to understand how that occurred. One reason it might occur is because the staff are being frustrated in their efforts to perform their professional duties. And we've already heard about the staffing-cuts, and that leads to – so if somebody's trained and committed, which you would expect, when they take on a job like this, committed to performing at their best and then they're frustrated in performing at their best, initially that frustration will turn into defensiveness, because they don't have – and defensiveness would occur, if you don't have the capacity to overcome those frustrations.

So if there directives from senior Management that cause you to be overworked or not have the skills that you're required to do, to be required to provide services that you're not skilled to do, then you become defensive to criticism, and if pushed and challenged, that defensiveness will then turn into hostility, and that hostility then becomes embedded, if there is no management support. So if Management doesn't turn around and say "I'm hearing and seeing hostility" and ask the staff to tell them what the concerns are and listen to the staff and understand the staff's concerns – and then work with the staff to address their concerns.

So there are – management is a well-developed area of expertise; there are many techniques of supporting staff, but the first thing you have to do is listen to your staff, understand what they want and what they need to perform their functions professionally and competently. I.e., you need to allow them to have meaning and dignity in their work, and that then translates into giving respect and good service and loyalty to the organisation and to the people that they're providing care to.

MS WILSON: And you've got to do what you say you're doing. BUPA has written values, but from what we saw those values were not being lived at the facilities.

MS BERGIN: Yes. You mentioned that you heard some of the evidence yesterday?

MS WILSON: Yes; we did.

MS BERGIN: And did you hear evidence about Save a Shift, the targets to save one, two or three shifts per day as a cost-cutting measure?

DR WEBSTER: Yes, we did.

MS WILSON: I didn't hear that in person, but my husband listened carefully and conveyed that information to me, and our response was "Oh dear, that's what was going on". That so fitted with what, the people were telling us, was their experience.

MS BERGIN: Yes; thank you, Ms Wilson, and, Dr Webster, did you hear that evidence?

DR WEBSTER: Yes, I did and had very much the same response. It was the other side of the coin from what we were hearing from residents and carers; yes.

MS BERGIN: And in your view is there any connection between your observations about staff hostility and a project like Save a Shift?

DR WEBSTER: Absolutely; it's one of the few examples in management where you've got a clear line of sight between a management directive and an outcome.

MS BERGIN: Do you have a view about any connection between that sort of focus on financial profitability that underlies a strategy like Save a Shift and the sanctions which BUPA was placed under in October 2018, shortly prior to the residents' meeting you attended?

DR WEBSTER: We formed a very clear view very early on that many or most of the drivers for management and senior Management decisions at BUPA were financial and that that was placed as the central aim for decision-making and that it seemed – if I can use an example from Seaforth, where we had the acting chief financial officer in the room, and one of the carers – sorry; when I say "carers", I mean "family members" – asked a question about why was it, that BUPA paid the minimum wage to their personal-care assistants when down the road there was a similar facility who paid above minimum wage who didn't have these problems. And the acting chief financial officer said straight off that would be a race to the bottom.

Now, as a human-resource professional, I actually struggled to understand what that meant; took me a while, to realise that what he was doing was assuming that you would pay more and get less service, and that is, of course, completely contrary to

the years and years of empirical research on people-management that says that, if you pay people better, if you give them better working-conditions, if you take your needs and interests of your workers, your staff into account, when you design your working-life, then you get better workers, you get better service delivery and you get better performance.

So it seemed to me, that the financial people who – have demonstrated in that one comment not just limited knowledge of people management but upside-down knowledge, the reverse of knowledge. So that was actually to me, if that was followed through – that would be a way of reducing service, of getting the least-experienced, the least-committed workers and, therefore, the worst care, and you would, in fact, create a downward spiral in your organisation of performance and delivery of service.

MS WILSON: And Dr Webster has put that beautifully and very intelligently, and also intelligent were the observations of people at BUPA South Hobart, who talked about BUPA penny-pinching.

MS BERGIN: So was this another example of the basis on which you formed a view that most of the drivers were financial, this reference to penny-pinching?

MS WILSON: Yes.

DR WEBSTER: Yes.

MS BERGIN: And were there other observations that you made?

MS WILSON: Well, there were many about the lack of care.

MS BERGIN: Thank you; that's sufficient, Ms Wilson. Now, I took you to the document prepared by Catherine Maxwell a moment ago; if the operator could, bring it back on the – up on the screen. Part of the discussion relates to how culture can be shaped, and I wanted to ask you, "Is this appropriate?", and if so, how could culture be shaped at a facility like BUPA South Hobart?

MS WILSON: I think Catherine Maxwell's put it brilliantly, and she quotes from Commissioner Haynes, who with his usual concise, to-the-point approach says:

> *Obey the law. Don't mislead or deceive. Be fair. Provide services that are fit for purpose; deliver services with reasonable care and skill, and if you're acting for other people, act in the best interests of other people.*

So she recommends an ethical frame-work for a corporation from which values may be derived and cascaded throughout the organisation.

MS BERGIN: How can an ethical frame-work be cascaded throughout an organisation? What does that mean?

DR WEBSTER: Well, an ethical frame-work needs to start at the top, with the Board. And then in – so if I was asked to give advice on this, I would then say that it needs to be then localised so each – a local facility would need to engage with the broader wording of that ethical frame-work and have staff, consumers, family and Management together to then recreate that ethical frame-work using words and phrases that have meaning to them. So that way it would cascade down; the people at the facility would have ownership and would see their concerns being reflected there.

MS BERGIN: So then in the evidence which you might've heard yesterday, Mr Engeler – just to paraphrase – Mr Engeler and Ms Payne from Anchor Excellence referred to the importance of engagement with residents. Is that part of this cascading through the organisation?

DR WEBSTER: Yes.

MS BERGIN: It's also about engagement with residents and their families; is that right?

DR WEBSTER: Yes. And look. The cascading-down and the engagement with residents and their families or representatives, I think, operates in the three streams that Catherine Maxwell – and if I may mention those – so the three streams are the ethical frame-work, the accountability and then the external scrutiny. And I think, in each of those streams, there are – you must have engagement all the way through – so that includes the residents, their representatives, the staff and Management – because each of those different cohorts of stake-holders has a different perspective. So they have a different understanding of what is needed and how to address the needs and interests of all the parties – so that you actually create the home and community to which – into which services can be provided that people expect and that – and that's what they've – that's the exchange of value that they've made at the beginning, when they've signed the contracts. We could talk about accountability and external scrutiny.

MS BERGIN: Yes. Let's talk about accountability and transparency. What – was there – you mentioned hostility. Was there a hostility in response to residents' complaints? And if you can, in answering that question give examples.

MS WILSON: It was more that they felt their complaints were just ignored, not taken notice of it, but there was also, I think, a culture too of – if you complain, that might mean your relative doesn't get good care.

DR WEBSTER: So there was an element of fear attached to it, and part of that was – we strongly got the impression that trouble – that people who complained were labelled as trouble-makers, as deviant, as not to be respected but to be discounted. In our professional experience, that's exactly the opposite of what, we would say, is best practice and exactly the opposite of how you would approach complainants in order to improve your service and best match your service with what people expect.

MS BERGIN: What are the consequences for residents of such a culture of fear and being labelled – fear of being labelled a trouble-maker or a deviant? What are the – what does that mean on the ground for residents?

MS WILSON: The consequences are dire for people who are living in the facility where they should be cared for, comforted. They are – they're treated in a way that – they feel they can't trust the people who care for them. They find people in their room, not knowing who they are, why they're in the room. And sometimes the residents wouldn't even tell their relatives what was going on, because they were afraid, that their relatives would complain and that would rebound on them.

MS BERGIN: And is this what residents told you during the meeting in November 2018?

MS WILSON: Yes.

DR WEBSTER: Yes; if I could just go on - - -

MS WILSON: Thank you - - -

DR WEBSTER: What tends to happen, if people can't make complaints, is that the behaviours that give rise to those complaints become entrenched and escalate. And the care-givers – so the staff in this case – don't know that what they're doing is causing problems, and therefore, they think that what they're doing is okay. So then if a complaint does arise later on, they're surprised and taken back. So if it's not addressed early and not addressed in a way that's constructive and embraced positively, it becomes something that becomes adversarial and frightening for both parts. So the frontline staff then get blamed. They haven't got the power to make the changes, because the service provision at that level has become entrenched through the financial system, and you get a kind of polarising of the different stake-holders.

MS BERGIN: How could a provider address problems such as this problem with fear?

MS WILSON: By being open, to listen to people, training their staff, communicating with their staff, having the right policies in place, reviewing those policies continually, where they do make changes, go back and have a look and evaluate. Did those changes make things better or not. There's a raft of things that can be done.

MS BERGIN: Is it – would a register of complaints be appropriate?

MS WILSON: There should always be a register of complaint, what the complaint is, what action was taken and, hopefully, a review of whether those improvements were sustained six months later.

MS BERGIN: Yes, and should a register of that nature be able to be inspected at a facility like BUPA South Hobart?

MS WILSON: Yes.

DR WEBSTER: We would think accountability means openness at all levels; so – right through from the books of an organisation to knowing who's on duty each day. So there should be a white board at the front of the facility so that, when you walk in as a representative, you know who the RN is, you know who the EN is, you know who the PCAs are and you've got contact details for them.

MS BERGIN: Yes. You mentioned the transparency over the books of an organisation. What would that look like?

DR WEBSTER: Well, I would say that, if I was paying for something, I would want to know what I'm getting for my money. So if I'm the Government, I would want to know what I'm getting for my money on an annual basis, I would want to see the books, I would want to see line-by-line how many staff, what residents, the care needs of those residents, what money is going to the cost of the facility, just like any other transaction. I think it should be completely open.

MS WILSON: And people were saying to us "Where is the money going? My parents paid a fortune to come to this place; where is it going? Is it going off shore? We don't know".

MS BERGIN: Is it your view then on the basis of your observations, that the eight BUPA facilities and at BUPA South Hobart – that there should be more transparency over how providers finance aged-care facilities and provide aged-care services?

MS WILSON: Absolutely.

DR WEBSTER: Absolutely.

MS BERGIN: Is that because it would benefit residents and the quality of care?

DR WEBSTER: Yes. It would benefit everybody.

MS WILSON: Yes.

MS BERGIN: What did you perceive to be the influence of financial governance in – on operations or function at BUPA South Hobart?

MS WILSON: Well, staff issues obviously. The cutting-back of shifts: that makes sense to us; we don't like it, but it makes – we can understand how it was happening, that staff numbers were dwindling. They were overworked, weren't necessarily qualified, and that had a kind of spiralling-effect on services and residents.

DR WEBSTER: Yes. I think the financial approach led to a very transactional approach. So it formulated the organisation in the end or located the organisation in the industrial area; so that – the view was that, if you're giving a service that takes five minutes – "Well, let's see if we can make it more efficient and make it take three and a half minutes, and therefore we can save money. We can get it done more efficiently". So rather than thinking "We are creating a home and a community into which services are provided" as your central aim, the aim – if the aim is about finances, then you think of everything you do as a transaction, and the services just become a transaction.

Time and time again we heard "People don't even say 'hello'; people don't engage with my parent or my loved one. And therefore, that – my parent or loved one becomes more and more depressed, less motivated", and that – they become unwell, and that hastens the end of their life. So that shift from thinking about the whole service or organisation as a profit-making service – if it shifted to something more like – "It's a home and a community into which we provide a whole lot of services, depending on what is needed" – then finances and legals just become the enablers of that shift, rather than the drivers.

MS BERGIN: Dr Webster, when you talk about the transactional approach versus the approach where it's treated more like a home and a community into which we provide a whole lot of services, is that a commentary on values and behaviours of the company?

DR WEBSTER: It's – yes; from what we viewed on the ground and then – I had no indication that that was not coming down from the top. So what we saw over and over again – that's what we saw, and there were certainly disconnects, and there were some organisations – sorry – some facilities that would say "Our general manager is absolutely fantastic and responds really well when we come and raise a concern or an issue, and it gets addressed". And then there were others like South Hobart, where the blanked-out staff windows were an absolute indication of how voice was responded to.

MS BERGIN: Yes. You just mentioned then the importance of the general manager, and you were engaged by BUPA between September 2018 and March 2019 and only involved, as I understand it – correct me, if I'm wrong – at BUPA South Hobart in November 2018?

DR WEBSTER: That's correct.

MS BERGIN: For a 10-day period?

DR WEBSTER: No; we were involved for a two-hour period. So we came down that morning; we had the meeting in the afternoon. The meeting was for an hour and a half, and we would've been on site for a bit over two hours.

MS BERGIN: Yes, and on that day that you attended at BUPA South Hobart – do you know who the general manager was at that time?

DR WEBSTER: We were not introduced. We were not given anything in writing; so we just walked in, and that's when I had to start looking for somebody to help me.

MS BERGIN: Yes. So you dealt with people at BUPA in Melbourne, BUPA Aged-care Services Australia. Is that right?

DR WEBSTER: We did, and even that was a – it was changing almost every time we had exchanges, email or telephone exchanges; we would have someone different.

MS WILSON: And we were told at South Hobart – I don't know if this is correct, but we were told there were 14 changes of managers in a 12-month period.

MS BERGIN: Yes. And the observation you're sharing today are based upon your observations during that period, September 2018 to March 2019.

DR WEBSTER: That's correct.

MS BERGIN: Yes. Now, you mentioned the Commonwealth as a stake-holder a moment ago. Should the Commonwealth have more oversight over how providers spend the rebates and subsidies paid to providers for the purposes of monitoring whether it's spent on care delivery?

MS WILSON: Absolutely. We're taxpayers; it's our money. We need to know where it goes. That's accountability.

MS BERGIN: Yes. And what does that look like for a private-equity multinational company with an office in - - -

DR WEBSTER: It shouldn't make any difference, whether it's a small standalone not-for-profit or a multinational private-equity company. The same rules should apply.

MS BERGIN: Yes. And is that because it's not a problem in itself, that BUPA has a profit motive?

DR WEBSTER: No; it's not a problem in itself. It may become a problem, if the culture of BUPA is profit-motive and that culture is difficult to shift, but it's not a problem in itself. It's how that organisation manages the culture of the entity within it that runs the aged-care facilities and then each aged-care facility themselves.

MS BERGIN: Yes. And is it your view, that – you mentioned earlier about being able to see the books. Is it your view, that the Commonwealth should be able to inspect the books for the purposes of assessing what subsidies and rebates are spent on?

DR WEBSTER: Absolutely. If I was paying that kind of money, I'd want to see the books.

MS BERGIN: Now, I just want to go back to that question about the request to delete the words "systemic problems". What did the fact of that request tell you about management at BUPA South Hobart?

MS NEEDHAM: I object on the same basis.

MS WILSON: Well, it wasn't South Hobart Management.

COMMISSIONER PAGONE: Just wait a moment. Ms Bergin, I must say I think the objection is well made. The request was by the lawyers. You're really asking - - -

MS BERGIN: Commissioner, I'm sorry. I can't quite hear you.

COMMISSIONER PAGONE: An objection is made on the basis that you're asking an inference to be drawn about what the Management may have – about what inferences you can draw about the management from a statement conveyed to the witnesses on the part – by a lawyer. And such inferences as can be drawn are inferences that we can draw if inferences are appropriate to be drawn.

MS BERGIN: Thank you, commissioner. Dr Webster and Ms Wilson, returning to the purpose of your engagement and the purpose of making recommendations so that BUPA could act upon your recommendations – what did BUPA do on the basis of your knowledge and response to the recommendations you made about BUPA South Hobart?

MS WILSON: We had very little feedback. We came to the conclusion that our recommendations hadn't been put into place when sanctions were replaced on some of the facilities.

MS BERGIN: How would you expect a diligent aged-care provider to respond to the advice that you gave?

MS WILSON: We thought our advice was excellent and it should've been acted on.

MS BERGIN: And how influential is a general manager in implementing recommendations such as the one you made, the recommendations you made about BUPA South Hobart?

DR WEBSTER: A lot of the recommendations we made didn't cost any money at all. They were just a change in attitude and, simply, doing things like – a communication board at the front of the organisation. And they were designed like that. They – none of the recommendations said "Put in double the number of staff" or anything like that. It did point to things like "Consider your staff qualifications"

and things like that, but there was a lot in those recommendations that the general manager at South Hobart could've implemented straightaway, particularly around communication and food, that would've really uplifted the place very quickly.

MS WILSON: But we were told and we did convey back to BUPA that, if the staffing issues were attended to, then a whole lot of the other problems would be fixed up as well.

MS BERGIN: One of the recommendations you made was in relation to a provider meeting with representatives of residents regularly to obtain feedback. Is there value in this even for those who are not sanctioned?

DR WEBSTER: Absolutely. I think it's demonstrated by the amount of information we got in an hour and a half, that regular meetings mean that you address problems and concerns really quickly. And also you would create a positive environment and ideas for improvement that not necessarily based on a problem but are just – ideas for improvement would come forward very quickly.

MS WILSON: And as – residents and their families said, "We have a lot to offer. We can help to make this a much happier place".

MS BERGIN: Yes. Just turning to that phrase "systemic problems" – what did you mean by the word "systemic"?

DR WEBSTER: I put the word "systemic" in because I kept seeing it over and over again, and I – sorry – because I kept seeing the same problems over and over again, and a lot of the problems were based on or, sorry, arose out of the same kinds of issues, which was a lack of accountability, lack of people management skills, lack of placing the resident as central to the decision-making. So – and that focus on finances. To me that indicated that there was a systemic problem that was sitting underneath some of the smaller things that we saw.

MS BERGIN: Yes. Ms Wilson, was there anything you wanted to add about why you thought there were systemic problems?

MS WILSON: I agree with what Dr Webster has said.

MS BERGIN: Thank you, Ms Wilson. Commissioners, I have no further questions.

COMMISSIONER PAGONE: You were asked a rather general question earlier on about whether you thought there might have been a role for the Commonwealth and you answered the question – a general question with a general answer, understandably. Is there anything that you want to say by way of being a bit more specific about how you see the role of the Commonwealth?

MS WILSON: I think that the regulators in these – in the cases that we've seen were a bit slow to act. It wasn't until the Royal Commission was announced that the

sanctions began to be placed on the facilities that we visited, and that all happened very, very quickly once it started. So I guess I'm going back to that question of why weren't they sanctioned earlier rather than why are we being sanctioned now. So I think there needs to be much more scrutiny of the regulator who should be, I think, the window to Commonwealth accountability.

DR WEBSTER: And I can only speak very generally because I don't have expert knowledge about this industry and the Commonwealth arrangements, but it seems to me that a regulator that is very distant and has limited powers doesn't have the flexibility that would really engage the facilities at the local level, and there's been some talk about random visits, and look, there are other industries, you know, so, for example, prisons have prison visitors who are independent people who don't have powers except to report. So I think there are other examples around of how you can make that external regulatory framework and scrutiny more effective.

So you really want to have a situation where only a very small percentage of your facilities are actually being pulled up because the facilities get so used to being observed and having people come in and looking very closely, coming in for mealtime, sitting down with the residents at mealtime, experiencing the meals. When you have the organisations at the local level comfortable with that kind of observation and review mechanism, they will automatically lift their services so that you only very occasionally have breaches and failures. So I think that whole system of external regulation and scrutiny needs to be tailored so that it fits the industry more closely and I would suggest that some of the experts in the industry could give you a lot of good advice on that.

COMMISSIONER PAGONE: I see. Well, it sounds like that you think that there is scope but you're not at this stage able to give us, as it were, a blue print of the scope of the Commonwealth's additional involvement. That's not a criticism. That might just be because the matter was really only sprung on you, as it were, earlier on, and now by me. So perhaps I should leave it on the basis that if you do have any further thoughts about the detail about how one might go forward, we would be delighted to hear from you.

MS WILSON: Thank you.

DR WEBSTER: Thank you very much.

COMMISSIONER PAGONE: Thank you. I think I can formally release you from further attendance. Thank you for sharing your experiences with us.

DR WEBSTER: Thank you very much.

<THE WITNESSES WITHDREW [11.19 am]

MS BERGIN: Thank you, Commissioners. I think it's now time for a morning tea break.

COMMISSIONER PAGONE: Well, it's a bit earlier than intended but I'm happy to do it now, so let's adjourn for 15 minutes.

MS BERGIN: Thank you.

ADJOURNED [11.19 am]

RESUMED [11.38 am]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioners. I call Carolyn Cooper.

<CAROLYN JOAN COOPER, AFFIRMED [11.38 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Ms Cooper, is your full name Carolyn Joan Cooper?

MS COOPER: Yes, it is.

MR ROZEN: And you have prepared two witness statements for the Royal Commission; is that right?

MS COOPER: Yes, it is.

MR ROZEN: The first witness statement, WIT.0444.0002.0001, I think I'm right in saying it's not dated. That's no criticism of you, but I just want to clarify that that's the case but it's a statement of some 60 pages with attachments. Do you have a copy of that in front of you, Ms Cooper?

MS COOPER: Yes, I do.

MR ROZEN: Did you have an opportunity to read through that before coming and giving evidence today?

MS COOPER: Yes.

MR ROZEN: There is one matter which I meant to raise with your counsel, I'm sorry, but it would appear to be a very minor typo. If I could draw your attention to page 51 in the bottom right-hand corner and it's .0051, which will appear on the screen. You will see that there – this is paragraph 187 subparagraph (a), sub-subparagraph (6), there's a reference to 36(f); do you see that at the end of 187(a)?

MS COOPER: Yes, I do.

MR ROZEN: Because it's a reference to the new head of risk, I think it should be to 36(g) rather than 36(f). Perhaps I will ask you to look at page 9, paragraph 36(g); do you see there's a reference there to the new role of the head of risk?

MS COOPER: Yes, I do.

MR ROZEN: That's the correct cross-reference, isn't it, to (g) rather than (f)?

MS COOPER: Yes, thank you.

MR ROZEN: Okay. So you're happy to change (f) to (g) in 187(a)(6). Otherwise, are the contents of the statement true and correct?

MS COOPER: Yes, they are.

MR ROZEN: I tender the first statement of Carolyn Cooper, Commissioners.

COMMISSIONER PAGONE: Yes, well, the first statement with the reference number that counsel has indicated is exhibit 13-38.

EXHIBIT #13-38 FIRST STATEMENT OF CAROLYN COOPER (WIT.0444.0002.0001)

MR ROZEN: More recently, Ms Cooper, have you provided the Commission with a second statement dated 12 November 2019?

MS COOPER: Yes, I have.

MR ROZEN: And that's WIT.1292.0001.0001. And in that statement you responded to a more recent notice to give information that had been provided – served on you.

MS COOPER: Yes, I did. Thank you.

MR ROZEN: Have you had an opportunity to read through your statement of 12 November before giving evidence today?

MS COOPER: Yes, I have.

MR ROZEN: And are the contents of that true and correct?

MS COOPER: Yes, they are.

MR ROZEN: I tender the statement dated 12 November 2019.

COMMISSIONER PAGONE: That will be exhibit 13-39.

EXHIBIT #13-39 STATEMENT OF CAROLYN COOPER DATED 12/11/2019 (WIT.1292.0001.0001)

MR ROZEN: Ms Cooper, I think I'm correct, aren't I, you've been present in the hearing room for the entire Bupa South Hobart case study.

MS COOPER: Yes, I have.

MR ROZEN: So that's Wednesday, Thursday and today of this week.

MS COOPER: That's correct.

MR ROZEN: And were you present earlier in the week when the Southern Cross case study was the subject of some evidence?

MS COOPER: I watched the final session.

MR ROZEN: Okay.

MS COOPER: I can't remember the two gentlemen's names, the chairmans - - -

MR ROZEN: Yes, Mr Groom and Mr Shirley.

MS COOPER: Correct.

MR ROZEN: Yes. Okay. Now, I will just ask you a little bit about your personal background if I could, please, Ms Cooper; you are a registered nurse, professionally.

MS COOPER: Yes, that's correct.

MR ROZEN: Since 1982.

MS COOPER: In the scope of management only, yes.

MR ROZEN: I understand, but your registration is current.

MS COOPER: Yes, that's correct.

MR ROZEN: You list a number of other qualifications in paragraph 5 of your first statement, exhibit 13-38. I won't go through those in detail but I note that you have some 40 years experience in the health sector, including the aged care sector in New Zealand.

MS COOPER: That's correct.

MR ROZEN: You're currently the managing director of Bupa Villages and Aged Care New Zealand.

MS COOPER: Yes.

MR ROZEN: In that role you have responsibility for 48 aged care homes in New Zealand.

MS COOPER: Along with some other areas as well but, yes, 48 - - -

MR ROZEN: Yes. As well as some retirement villages and other - - -

MS COOPER: Rehab services, yes.

MR ROZEN: Are you able to tell us, of the 48 aged care homes do the aged care homes in New Zealand broadly correspond to what we refer to as residential aged care facilities in Australia?

MS COOPER: They're very similar, yes.

MR ROZEN: Do you know what the total number of residents would be at those 48 aged care homes in New Zealand?

MS COOPER: There's about three and a half thousand for New Zealand.

MR ROZEN: Do we take it from that that the average size of an aged care home is slightly smaller in New Zealand than it is here?

MS COOPER: It is definitely smaller. It is, yes.

MR ROZEN: For the purposes of this inquiry, it's relevant, isn't it, that you were seconded by Ms Jan Adams from November 2018 to July 2019 to Bupa Aged Care Proprietary Limited as the interim chief operating officer?

MS COOPER: That's correct.

MR ROZEN: Is that right? And that was in respect of the aged care business in Australia which is referred to as BVAC Aus or BVAC Australia; is that right?

MS COOPER: That's correct, yes.

MR ROZEN: And during that time you had oversight of matters relating to the reaccreditation of Bupa South Hobart; is that right?

MS COOPER: I did.

MR ROZEN: So in a sense, you've come into the picture post the sanctions being imposed as far as South Hobart is concerned?

MS COOPER: Yes, I had. Yes.

MR ROZEN: You were asked to respond to a significant number of questions that were directed to your employer, and I note that in your first statement you make the observation that many of the individuals that would be expected to know what took place at Bupa South Hobart in the period that we're inquiring about, so 2016 through to late 2018, many of those people were no longer employed by Bupa.

MS COOPER: That's correct.

MR ROZEN: I might just ask you from the point of view of someone as experienced as you in managerial positions in health and aged care, what that significant departure of staff, including many senior managerial staff, what does that tell the Commission about the business, about Bupa?

MS COOPER: I think it tells us a few things. One is that it's a challenging business to be involved in aged care. It's very rewarding but it's also very challenging. I think there's a lot of people that move around in aged care businesses and that's happened a little bit for Bupa South Hobart, but also for Bupa generally.

MR ROZEN: Yes.

MS COOPER: They move from role to role and you saw some examples of that yesterday. And I think there were a few people that perhaps were not suited for the aged care industry that may have moved on.

MR ROZEN: I see. Is there a broader point – and if you don't accept this then obviously you're not required to agree with me, but is there a broader point that there's a relationship between the difficulties, if I can use that term, experienced at Bupa South Hobart and that turnover of staff, because it hasn't just been since the sanctions were imposed. We also see considerable turnover in the lead-up to the sanctions being imposed.

MS COOPER: I think stable leadership and stable clinical leadership as well is really important, and that was something that we saw as being a major issue for South Hobart, particularly.

MR ROZEN: And can I just tease that out a little bit. Why is that an issue? What's the problem with unstable leadership? Perhaps it's obvious but I would like to hear what you say about it.

MS COOPER: Obviously, you need a good leader to engage residents and relatives and staff to actually make sure that the environment and the facilities that people are living in, it's the residents' home. I'm really clear, and you would have seen from my statement, that we have to think about the quality of care but also the quality of life.

MR ROZEN: Yes.

MS COOPER: So it's residents' homes. Families need to be happy about that as well and they need to get a bond and a relationship with the staff that they are working with. So if you are constantly changing those people that's very hard to get, that relationship. For our staff it's also very hard to have a relationship if they have a person changing all the time; they're not sure what their focus is and what they might want them to be doing and so it's really important to have stable leadership.

MR ROZEN: One of the issues that's emerged from the evidence that the Commissioners have heard about Bupa South Hobart is that at the end of 2016 where there had been two mock audits, both of which indicated significant problems in relation to the facility, the manager of the facility's employment came to an end, and a new facility manager began in 2017.

MS COOPER: That's right.

MR ROZEN: Early 2017 but by the end of 2018 when new problems emerged, greater problems, as a result of external auditing, the response was to change the general manager again. He resigned - - -

MS COOPER: He did.

MR ROZEN: - - - but the evidence would suggest that that was in the face of a likely termination of his employment. I would ask you to accept that. Is there a risk that if you just change the facility manager when problems like this arise, that you miss an opportunity to identify the real structural systemic problems that might have caused the problem?

MS COOPER: Absolutely, there is a risk, yes. And I think we need to be making sure that there's other people there involved in reviewing things like the audits that can actually provide that continuity that's required.

MR ROZEN: Yes.

MS COOPER: Yes.

MR ROZEN: You've sort of anticipated my next question which is something I was going to ask you about a moment ago. One of the other risks of turnover, particularly at that sort of middle management level or lower middle management level in a large organisation like Bupa, is the loss of corporate memory, isn't it, about previous audit problems that have occurred, for example?

MS COOPER: It could well be, yes.

MR ROZEN: And how, as an organisation, can a business like Bupa guard against that? Obviously, you can't force people to stay if they don't want to but what can you do, from a governance point of view, to ensure that that corporate memory doesn't disappear, if you like?

MS COOPER: I think there's a number of things that you could do around making sure the information was trended and available over a period of time for anyone that was coming into the organisation, that other areas of the organisation such as the clinical services improvement team or the operations teams, generally, actually have that information available to give. And also through induction of a care home manager, you could make sure that that information was provided over a period of time so that the picture was clear as to what had happened and what – what they should be expecting and I would see that as being a good thing to actually talk to people about when they were actually applying for the role as well.

MR ROZEN: A theme that's run through both of the case studies this week has been something you touched on a moment ago and that is the suitability of people to work in aged care and related to that the suitability of people to work in managerial positions within aged care. If I can take the first of that – the first one of those, given your vast experience, what sort of qualities do you think are important for someone, firstly, to be working in aged care and, secondly, if they're different, to be working in a managerial position in aged care?

MS COOPER: Well, those that know me know that we should be recruiting for attitude and not just skills. We can support people to develop skills but if they've not got the right attitude to work with older people and to have that passion and also to understand things like it's their home; they have rights, and how important families are as well. I think that's a number 1 thing for me; it always has been. And I know we've done quite a lot, now that we can test for attitude when people are actually applying for roles. So that is an absolute number 1. Also, the values of people that might want to apply for us, their experience, not necessarily their skills – as I said, I think you can teach people – but their experience and whether it's relevant, including whether they have had family members who have been involved in aged care.

I always find that's really important because you get that degree of empathy and understanding if you've actually had some interaction in reality with aged care. And I think from a manager perspective it's very similar, actually. Obviously, you want those skills and business skills and the ability to actually lead teams and, you know, undertake the requirements of any manager that might be there, but having the right

attitude, having the experience that you need and having empathy for working – and passion for working in aged care is really important. And if you don't have it, you shouldn't be working there.

MR ROZEN: You mentioned a moment ago the ability to test for attitude. Is that something that is a relatively recent initiative within Bupa? When did you start testing for attitude in prospective applicants for roles?

MS COOPER: So if I could just explain that; I actually brought that into New Zealand in 2017. In order to, again, live by my, you know, attract for attitude and not just skills. It's been very successful over there, and when I came over to Australia, we had already been talking about whether the system would be good over here or not. And I pushed it quite heavily when I came over, and it's working – working over here now. It's not a psychometric test. It's basically – it's literally an attitude test. It tests, you know, whether people are going to actually engage well, the empathy and trust and integrity that people might have. And that's what we need in aged care; we need those sorts of people.

MR ROZEN: You're not the first witness here to tell us that. When you say it's not a psychometric test, what is the nature of the test; how is it administered?

MS COOPER: So there's a number of different modules. They take around five or six minutes each to complete and it's actually – it is an online test. Generally, what we do is – and I can speak more for the New Zealand experience – is we actually have that as a, if you like, entry test. Because you can have – in New Zealand you could have up to 1000 applicants of a caregiver a month, and so you want to know that those people actually mean their applications, they're not just applying to a lot of people, and so it's a, if you like, an entry. So if people take the time to actually take the test, two or three tests for six minutes, then they will end up obviously moving through to the next phase.

It comes up with a range of different things. It will red flag if there are some attitudes that we don't believe fit the business, but it will also develop interview questionnaires, or questions, and it will also develop things like what you might want to motivate the person with if they are successful in the role so that you've got some guidance about that person and their, you know, special interests or things that need to be motivated.

MR ROZEN: Tell me if you're not, but are you in a position to be able to share any of that information with this Royal Commission or is it commercial material that's confidential to - - -

MS COOPER: So in terms of the style of provider and things, I mean, I'm sure we would be – in submission, we could easily provide that.

MR ROZEN: Yes.

MS COOPER: Other than that, I would have to talk with the business about how best to do that.

MR ROZEN: Okay.

MS COOPER: And also the provider of that. It's used in the UK, and a number of places in Australia as well.

COMMISSIONER PAGONE: I've got a couple of questions about that, if I may. I must say it sounds very interesting although I shudder to think how I would score on one of those.

MS COOPER: I make no comment.

COMMISSIONER PAGONE: No, no.

MR ROZEN: That's very wise, Ms Cooper.

COMMISSIONER PAGONE: And it's probably a good idea if counsel doesn't assist in that regard. How – who did develop it? How was it developed?

MS COOPER: I'm sure the firm won't mind me actually talking about them. It's a group called Care Advantage and I don't know their long – their history but they are in the UK and in Australia. They specialise in aged care, and I think it's come through very similar things to my desire when I moved to New Zealand to take up the aged care business. I found, sadly, that there were some people that perhaps were not suited for aged care and I asked our organisational development people to help me work out how to gauge that better. And so they did some market research and they came up with this group called Care Advantage.

COMMISSIONER PAGONE: And is there follow-up testing of the model to see whether the model actually works long term?

MS COOPER: There is, and there's been a number of – I'm not sure what the correct term is, but reliability-type questions as a follow-up, sorry, with the company and they've got a strong history of ensuring that, you know, they are a reliable source in the market. But I'm sure we can provide the Commission with substantial detail about this.

COMMISSIONER PAGONE: What I mean is you – somebody does a test six months ago. Is there likely to be any follow-up that that person in four years time was predictably chosen – correctly chosen. I'm putting it badly. What I'm saying is is there evidence that it's a good long-term predictor of the kinds of attitudes that you need?

MS COOPER: I think us as an organisation would need to follow that up but my understanding is that they have got longitudinal data from other providers. We're

quite new to this, late 2017 for New Zealand and I'm not sure of the exact start date for Australia. So we haven't got longitudinal data.

COMMISSIONER PAGONE: And when you were looking for something like this, so you went to the UK, but now that I think about it there's likely to be similar kinds of research done all over the planet. Are there?

MS COOPER: Yes. Yes, there is. Our – and I wasn't intimately involved in the research that our organisational development team did. I had to rely upon them and their expertise. But they researched a number of places. This is used in Australian aged care other providers, and in the UK aged care, which Bupa actually uses it as well in the UK. And I engaged with the business. I've seen – I haven't actually done it myself either, which probably is also wise, but I engaged and had gone through an entire session with the people that run the company, and I was very comfortable with what it might show me.

COMMISSIONER PAGONE: Yes. Thank you.

MS COOPER: Thank you.

MR ROZEN: Thank you, Ms Cooper. Can I just end the series. We went on a tangent there but I'll just end the series of introductory questions I wanted to ask you and that is to clarify that even though you weren't involved in the events at Bupa South Hobart before 2018 – that you have, to respond to the royal Commission's questions, examined a large number of documents to inform yourself about events.

MS COOPER: A very large number of documents. Yes.

MR ROZEN: Yes. And that was – that became particularly important, given the people you might've wanted to speak to were not generally available, a number weren't available to give you that information.

MS COOPER: Correct.

MR ROZEN: Now, in your statement you range across a wide number of areas which are of assistance and interest to the Commission. I want to ask you about a selection of those, and then I'll ask you some specific questions about the evidence that we've heard this week. I want to start with a sort of a big topic of corporate governance, which you deal with in your statement at page 5, and paragraph 25, which will appear on the screen near you - - -

MS COOPER: Can I just check; it's my first statement?

MR ROZEN: Sorry; your first statement. Yes. You talk to us about some changes that've been made at the board level to BUPA Aged-care Proprietary Limited.

MS COOPER: Correct.

MR ROZEN: It's quite a complicated corporate set-up. Isn't it. Within BUPA and its aged-care business, but that's the one that you're talking about here, BUPA Aged-care Proprietary Limited. Before looking at the specific changes, you say that they are informed – they were informed by at least two things, one, the need to comply with the new standard 8 for governance - - -

MS COOPER: Yes.

MR ROZEN: And the second was the learned experience of the sanctions process at BUPA South Hobart and other locations; is that right?

MS COOPER: Correct.

MR ROZEN: And you tell us there that, until very recently, until August of this year, all the members of the BUPA Aged-care Proprietary Limited board were executives; that right?

MS COOPER: Yes; they were.

MR ROZEN: Executives of the business, and you now have independent nonexecutive members of the board.

MS COOPER: That's correct.

MR ROZEN: Can you explain to the commissioners firstly why that change was made. What is it about the experience that we've been looking at, that led to that change?

MS COOPER: I think it was clear from the situation that BUPA ended up in, that there was a need for greater governance at the aged-care-board level, and it became clear, that those people that were executives as well as on the board actually had – as part of their roles had, actually, knowledge of what was going on anyway. So the board meetings were not as robust as they could've been, and that's why there's been a review and a very clear direction from our chairman and our CEO, that they want to see robust governance. And I think that what they've put in place is actually going to bring that about significantly.

MR ROZEN: I take you to be saying that, because the executives knew about the issues that were being discussed at the board level – that by definition they wouldn't challenge themselves about those matters. Is that what you mean by "a lack of robust discussion at board level"?

MS COOPER: That is one way you could look at it; yes.

MR ROZEN: The reason I ask that is because evidence that's to be given immediately after you, by Catherine Maxwell from the governance institute of Australia, includes evidence that it's of vital importance, that Boards do challenge, in

appropriate cases, managerial assumptions, managerial proposals and so on. So is that what you're talking about here, the need to have people who will provide that level of challenge and oversight?

MS COOPER: Absolutely. Yes.

MR ROZEN: If that's right – have you considered taking it to its logical conclusion of only having independent nonexecutive board members rather than having a mixture?

MS COOPER: So that decision wouldn't be mine.

MR ROZEN: No. I understand. I don't mean you personally but the organisation.

MS COOPER: Yes. I think the organisation will continue to evaluate the effectiveness of the board and particularly the aged-care board and looking at skill mix and how the board's operating and making sure that they are following good governance guide-lines.

MR ROZEN: Yes.

MS COOPER: So I'm sure it will evolve over time.

MR ROZEN: And how have the – you may not know this, but if you are able to tell us – how have the nonexecutive members of the board been chosen? What's – not so much how the individuals have been chosen, but have particular skills been – sorry; have particular skills searches informed the people that've been selected to perform those roles?

MS COOPER: Yes. There's, definitely, a desire to have people with aged-care experience and to have – one of the non-BVAC Australian executives is both a doctor and a very experienced aged-care executive. And I think those considerations have been very strongly thought about by people looking at the governance.

MR ROZEN: We heard some evidence yesterday from Ms Payne – I think you were present in the hearing-room – from Anchor Excellence; she was explaining to the commissioners the role that she'd personally been playing in providing training for board members.

MS COOPER: Yes.

MR ROZEN: Is that – I, probably, should've clarified it with her, but is that in relation to this board that we're talking about now?

MS COOPER: Yes; that's correct, and they've been involved in the training – but also many of the senior managers and all the people that had leadership roles in the organisation basically.

MR ROZEN: Yes. And I understand you to be saying that that in a sense is a work in progress because there will be an ongoing review to see if that ultimately is of benefit to the organisation.

MS COOPER: Absolutely. As I said, our chairman and CEO are very determined to improve things in that area.

MR ROZEN: Another change that I want to ask you about is at paragraph 45 of your statement, where you summarise – page 12 – you summarise the changes that've been made to the CSI team, the clinical-services-improvement team. We, of course, heard yesterday from Ms Hudec, who was the leader of that team in 2018, 2019. You tell us that the name of the team has been changed to "the clinical-safety-and-compliance team"; is that right?

MS COOPER: That's correct.

MR ROZEN: Does it, essentially, perform the same role?

MS COOPER: It's more of a focus across the compliance as well; so – not just improvement but deliberately adding the compliance function, first-line compliance, in there.

MR ROZEN: There is a risk, isn't there? With such changes, that it's, essentially, old wine in new bottles, you give something a new name and you therefore assume that it's going to be a different outcome.

MS COOPER: I would say that that's, definitely, not the case for this. What's actually happened is that there's also many other changes, as you would've seen in the statement, under the clinical-service-and-compliance team.

MR ROZEN: Yes.

MS COOPER: And Maryann Curry is the director of that team. Ms Curry has extensive experience and has formed a very strong team under her and is still recruiting to that team, but it also includes things like the quality partners, which are absolutely critical to work with the care homes, which is a missing thing from the past, and that's something that Ms Curry and I worked on together to make sure it was in place, and I think there are 13 regions now, and so there are 13 quality partners. There's also an increase in educators, which is also – as you know from the history of BUPA, the training and education for care homes is really critical. And so those two areas, along with many others, are absolutely critical. So I don't believe it's as you described it – with respect.

MR ROZEN: Thank you. Can you just expand a little on the role of quality partners, what that initiative involves? And perhaps, if you can, relate it to the evidence that we've been looking at here and how a quality partner might've made a

difference, particularly to the inadequate responses to the audits that we have examined.

MS COOPER: So a quality partner has a clinical background, and they work closely with a small group of care homes; so – around five. And they are the person that actually works with the clinical team as well as with the general manager. They will work on a – projects, but they also make sure that there's – history in the trends and things that have been an issue in the past are being addressed. And so they are absolutely critical for close management of quality-improvement initiatives in the care home and continuous improvement.

MR ROZEN: You were asked as part of the request for the statement to inform the Commission what the – what's been learnt from this experience by BUPA. I can draw your attention to page 56 of the statement; question 16 that you were asked was –

> *Provide a summary of what BUPA has learnt from the experience of BUPA South Hobart being under sanction and subsequent remediation efforts.*

And if I'm counting correctly, I think there are 13 lessons that you've identified, and you'll be pleased to know that I'm not going to take you through each of them. But I do need to ask you a broad general question about them. A number of the – if I may say so and –without being disrespectful – a number of the lessons seem obvious in a way. Take for example D, your need to take the home's layout into consideration when determining rostering and arrangements and so on. From your perspective, why did it take the imposition of sanctions for a number of these lessons to be learned? What was lacking there before, do you think?

MS COOPER: That's, probably, a fairly hard one to answer, but I think there's a number of things. So - - -

MR ROZEN: Got to ask hard questions.

MS COOPER: Yes; of course. There's a number of things, if I take that example of the layout of facility; as you know – commissioners and yourself have visited the facility – it's not like many care homes. It's a lovely facility, but it is quite rangy and across many floors and many buildings. So whilst it might look obvious, to actually say you need to take that into account, I don't believe that it was fully taken into account with some of the changes that were made before. And so with the new roster systems, which you may or may not come to in terms of questioning, but – we have, definitely, taken into account things like environmental influence, and that can get signed off with a warranted variation. And so whilst they look very logical, I actually believe in many cases they weren't taken into account fully.

MR ROZEN: I need to pursue that. It's evident to us, they weren't taken into account fully. The question – perhaps the more difficult one is "Why?" Is it a function of there being only the one BUPA home in Tasmania? And it was a bit

peripheral to general thinking? Or is there some other explanation that you can identify?

MS COOPER: No. I don't think it's just about South Hobart. I think it is very challenging, to have a care home by itself at a distance, and I think that does play a part definitely. I think it's also very difficult, to get the right leaders in an area such as – not just that it's South Hobart but in a distant area – and to support them well. It's also quite hard, to recruit staff that we need; so registered nurses are quite hard to recruit for all aged-care providers, including South Hobart. And even carers are actually challenging too, to find the right people with the right attitude. So I think there's a number of those sorts of things that are factors in this.

MR ROZEN: Can I suggest three lessons that should be learnt from the experience and ask you to comment on them. The first lesson I suggest to you is that an aged-care provider like BUPA can't implement an across-the-board cost-saving initiative that involves reduction in nursing-hours without it impacting deleteriously on the level of clinical care as provided to the residents. Do you agree? That's one of the lessons to be learnt from the experience?

MS COOPER: I think, if you're reducing hours below what is appropriate for the residents that are in that care home, yes, I would agree, that that's an issue.

MR ROZEN: You've anticipated, I think, my next question, which is, "From your examination of the documents and the history here: was there enough consideration given to the particular circumstances of this home and by extension other individual homes amongst the 72 in Australia, through Project James and the implementation of BMOC2?". Was there enough consideration given to the individual circumstances of the homes?

MS COOPER: I don't believe there was.

MR ROZEN: And why was that?

MS COOPER: Obviously I've reviewed documents. It doesn't explain that in the documents; so it would be hard, to actually determine why people would've felt that was a way to go. I can only talk about what I found, and that is that rosters don't seem to have been reflective of the care needs of those residents in their care home by way of including acuity and environmental factors as two key influences if you like, to ensure that the right staff were there for those particular residents at the time.

COMMISSIONER PAGONE: I suppose, Ms Cooper, another way of asking the question that Mr Rozen is inquiring into that, I think, we'd be interested in your experience to inform us – so take the obvious thing, those matters that – the lessons that are obvious; it may be, that one of the reasons why they're overlooked is because, being obvious, it's assumed, that it's being looked at. The nature and layout of the facility being such that it is, one might make assumptions about it, and those assumptions may include, well, it's being taken care of. But where you've got that

disconnect between taking into account of the detail in a largish organisation, what processes should be put in place and at what level to ensure that, whether it's obvious or not obvious, the detail doesn't get missed?

MS COOPER: So I believe that the roster that I was – developed and implemented or commenced implementing when I came actually took into account each individual care home's requirements. There's a – and I'm not sure if you have them in evidence or not, but there is a spreadsheet that we go through which actually looks at the characteristics of the care home, including the environmental thing, and as – I think one of the witnesses yesterday referred to warranted variation, which is my own term, where from an environmental factor – and BUPA South Hobart is an example – there absolutely has to be consideration. I think, if you're developing rosters and a frame-work for rosters from an office base if you like, in a generic way, without considering the individual factors at a care home, including the acuity and including the environmental factors, you will miss that nuance.

COMMISSIONER PAGONE: So what's the broader lesson? I can understand some of the questions that get asked of you and of other BUPA witnesses in a sense put you in an awkward position because it's – they're quite pointed, but at a broader level, without the point – that's an example, that you've given us, about the rosters, but as a systemic question, how as a matter of system can we ensure that other organisations don't end up with the detail being missed in the implementation of a care-by-care basis?

MS COOPER: I think there could be an opportunity for more broad use of benchmarking, like the Stewart Brown benchmarking that I used, and that could be checked by the relevant Authority. I'm reluctant to say there should be more regulation than there is, but there are – there could be opportunities to actually look at how people were developing the rosters. I think it's very hard, to actually say one size fits all, because each care home has individual residents with individual needs, and we have to take that into account. And it is their home; so we also need to take into account quality-of-life factors and making sure that they have the ability and the access to actually live their lives to the full.

COMMISSIONER PAGONE: Thank you.

COMMISSIONER BRIGGS: Would you agree, that there's also a place in this for longstanding staff of an organisation with expertise and understanding of the organisation to be engaged in these discussions? And I ask this question, because time and time again in my experience those longstanding staff with knowledge are ignored in cost-cutting exercises because they're seen to be old-fashioned and slow and lamenting the change rather than actually having deep knowledge of the operations.

MS COOPER: Absolutely. And we actually made sure we talked to – at forums we talked to all the general managers, and, fortunately, some of them are longstanding. We also engaged with some of the clinical managers; as you know and have already

referred to, aged-care has quite a high turnover of people, but there, definitely, were some longstanding people. The feedback I got was that the style of roster implementation that we were looking at was much more logical and if you like, took into account the factors of acuity and environment which hadn't, potentially, been considered in the past. So I totally agree with what you're saying.

COMMISSIONER BRIGGS: So what that does in effect is say that you need to have someone with a good sense of the business to oversee these sorts of changes and give the subtlety and the nuancing to the changes?

MS COOPER: Yes. Correct.

MR ROZEN: Could I just explore an aspect of the question that you've just been asked by Commissioner Briggs. There was one constant at BUPA South Hobart right throughout the period that we've examined, from early 2016 to the present day, and that was the GP. She's the one position that hasn't changed during that time. You were, I think, in the hearing-room when she gave evidence two days ago.

MS COOPER: I was.

MR ROZEN: Her evidence was – I think I'm fairly summarising it – that her concerns which she was raising regularly and in some detail – but she said they fell on deaf ears. That was her perspective. I'm not asking you to comment on the *why*s or *wherefore*s of that but more at a systemic level; it seems counter-intuitive, that a doctor working wouldn't be listened to when they're raising concerns about clinical care. What's been done within BUPA to ensure that those voices are heard?

MS COOPER: Yes. So there's a range of different things that are happening; at the – if you like – the extreme level there's a speak-up policy that people can actually – if they feel they're not being heard – so that's if everything else fails – they can actually go through a process that will actually allow them to make a complaint or raise an issue through an independent part of the organisation, but I would like to think that we have set quite significant expectations, that there is better engagement at sites, there is better understanding of the needs of clinical people, including doctors and nurses, but also the care-givers.

We have hundreds and, in fact, thousands of care-givers and nurses and doctors, kitchenhands, cleaners who are fantastic people and work every day tirelessly to make the lives of aged-care people living in our facilities better. And their voice has to be heard, and we actually – as managers we have to make sure we do that. And so visiting care homes is really important. Sitting down with those people and engaging with them as well as the residents and their family is also extremely important. So the voice of those that work for you and the voice that you look after: critical.

MR ROZEN: I take it, you mean by that that it's important, for people in executive positions to visit the care homes; is that what you're saying?

MS COOPER: It is, but I also think it's every layer of – it's the business we run. If you're – with respect – and I'm not referring to anyone in particular, but if you are in an office and you're not in a care home regularly, then you're not doing your job well enough in my view.

MR ROZEN: If I can pick up on the questions you were asked by Commissioner Pagone a few minutes ago about what can be done at a sort of system level to ensure that the interests of individual homes and the care needs of residents are not missed, even though they might be obvious concerns, one area that I'd like to test with you is whether it would be of benefit – and I heard what you said about not wanting to encourage more regulation. I understand that, but would it be of benefit, to have a duty, whether it's a statutory duty or something more in the way of a regulatory norm that is taken into account by the regulator, imposing on the key decision-makers a duty to take into account the care needs of residents in all the decisions that they make about the business?

MS COOPER: Absolutely. That's what I do every day. The only reason I come to work is to improve the lives of residents and staff and by way of that, hopefully, provide some more comfort to the families – that their loved ones are being well looked after. So absolutely we'd encourage that.

MR ROZEN: You accept, don't you? In your statement that the initiatives which have been examined – and I'm talking about Project James and BUPA model of care 2 – inadequately took into account the care needs of residents? Is that a fair summation of your evidence?

MS COOPER: Yes.

MR ROZEN: And does it follow from that, that there was too much emphasis on the financial aspects of the business as compared to the care needs of the residents?

MS COOPER: I think the company found itself with a model that was unsustainable financially.

MR ROZEN: Yes.

MS COOPER: And there were some substantial changes to the funding nationally that impacted on the business.

MR ROZEN: Yes.

MS COOPER: And so I think that was quite a driver; yes.

MR ROZEN: Yes. Can I just tease that out, because it's very important, for the Commission to understand this. The model of care that was unsustainable was what's been referred to as BMOC1?

MS COOPER: Yes; that's correct.

MR ROZEN: And that was the model that saw Dr Monks and other GPs employed on an ongoing basis and was directed, on the evidence before the Commission, at ensuring a higher level of person-centred care for residents in residential care homes.

MS COOPER: That's correct.

MR ROZEN: Now just ask you a little bit about that model of care. Was that something that was imported into Australia? Was that based on the British model that BUPA uses? That is having in-house GPs and the other aspects of the model?

MS COOPER: Yes; as, I think, Dr Monks said, it didn't actually mean that every care home had its in-house GP, but, yes, it's based on a range of other models – my understanding.

MR ROZEN: Because the evidence that we've heard both from Dr Monks – but also we heard from Ms Hudec yesterday; she was saying that, when she was a regional director and had hands-on responsibility operationally for some homes – that at the time that that model of care was being implemented, it was showing quite positive results.

MS COOPER: That's correct.

MR ROZEN: The reason I ask you that is because, in the statement that Ms Hechenberger has provided to the Commission, she says that part of the reason for moving away from BMOC1 was that – not just that it was costly but that it wasn't improving clinical indicators. Are you able to assists us on that? You don't say as being ..... a problem with BMOC1 in your statement.

MS COOPER: No; it's not something that I – in my review of documents, I couldn't tell that it hadn't or had assisted, either way. So I'm not sure what reference she's referring to.

MR ROZEN: No; there's nothing in our research of the documents that tells us that. I suppose what flows from that is whether there was an adequate-enough assessment of whether BMOC1 was achieving the results that it was set out to achieve in the move away from it. Are you able to comment on that?

MS COOPER: From the review of my documents: there is some surveys undertaken, and there were – from the GMs and clinical managers, and there were – particularly, I think, they pointed to some duplication between the clinical-manager role and the care-manager roles as a key thing. It wasn't an evaluation in the formal sense, but it was a survey. I think that's – from memory that's a relevant review that might've been undertaken.

MR ROZEN: Yes. Want to ask you about one aspect of that which we've heard quite a bit of evidence about, and that's the Save a Shift initiative. And I think you're familiar with the evidence that we've heard about Save a Shift.

MS COOPER: I am.

MR ROZEN: The suggestion in the evidence we heard yesterday and in some of the documents is that the directive to save a shift, to not replace someone who went on sick leave for example, was to be implemented only if doing it wouldn't have a deleterious effect on care. Now, that seems to be a bit unrealistic in homes that are already stretched in terms of staffing. Would you agree with that?

MS COOPER: Yes, I do.

MR ROZEN: That notion of saving money by saving a shift, I suggest, was a misguided policy.

MS COOPER: It's not a policy that I would endorse.

MR ROZEN: And perhaps further to that, making saving shifts a key performance indicator for general managers is going to exacerbate any such problem, isn't it?

MS COOPER: It would, yes.

MR ROZEN: Yes. And that's what was done, wasn't it; it was made a KPI?

MS COOPER: Yes, it was.

MR ROZEN: Yes. Now, you say in your statement that the Project James was paused, I think you say – I will just find the reference to that – paragraph 161, Project James was paused on 21 September 2018. What do you mean by it being paused?

MS COOPER: So the implementation of Project James was stopped. Not all care homes had gone through the process for Project James and so it was paused on 21 September.

MR ROZEN: Does that mean it's been shelved or does it – paused sort of implies a temporary halt. I'm just trying to understand - - -

MS COOPER: It's gone.

MR ROZEN: It's gone?

MS COOPER: Yes. I think it was formally paused at that time and that's why I refer to it that way, from my perspective when I came in some, what, six weeks later.

MR ROZEN: Yes.

MS COOPER: In fact, until I've had to do the reading for the Commission, I hadn't actually reviewed those documents because I wanted to make sure we were actually getting skills mix and numbers right for the residents in the care homes at that time. And I didn't want to have an influence of what may have gone before. So I looked at what we could invest as a company and ensuring that the staffing was more appropriate for all Bupa care homes going forward than what it had been in the past.

MR ROZEN: Now, before leaving the – this period of Project James and asking you a little bit about the subsequent period of time where you've had a more hands-on role with rostering and so on, I want to ask you about a document which has been provided to us, and it's a board report that I think you co-authored. So tab 107 in the general tender bundle. Just to orient you, this is a document which, on its face, appears to have been prepared by yourself and Ms Hudec, and a Mr Forster, who was the chief of staff at the time; is that right?

MS COOPER: Yes. He had just finished being acting chief operating officer, and I had just started four days before that.

MR ROZEN: Yes. And so I take it your first task was to provide this report to the board about the sanctions that have been imposed at Bupa South Hobart; is that right?

MS COOPER: So I didn't write the report because I wasn't in post when it was required to be written.

MR ROZEN: I see.

MS COOPER: But I attended as it describes there.

MR ROZEN: All right. Just so that I can understand the corporate relations, this is a board meeting of Bupa ANZ Health Care Holdings Proprietary Limited.

MS COOPER: That's correct.

MR ROZEN: Is that the parent company; is that right?

MS COOPER: Yes, that's the market unit board, if you like. I can't recall how it's referred to in my statement but it's not the aged care board.

MR ROZEN: I understand.

MS COOPER: It's the next one up.

MR ROZEN: And the relationship between the aged care entity and this one is what?

MS COOPER: They are different companies.

MR ROZEN: Yes, I understand that. But obviously they're related companies.

MS COOPER: Sorry. With respect, sorry So there's four business units and they each have their respective boards or the aged care business has its respective board and then the Aged Care ANZ board is above that.

MR ROZEN: Yes. I see. That's what I was trying to clarify.

MS COOPER: All right.

MR ROZEN: We see there that the chair of the board was the former Federal Health Minister, Nicola Roxon.

MS COOPER: That's right.

MR ROZEN: Are you able to inform us how long Ms Roxon had been the chair as at November 2018?

MS COOPER: I'm sorry, I wouldn't be sure when – excuse me – she had been there for a wee while but – because I was aware of her from my New Zealand experience.

MR ROZEN: Okay.

MS COOPER: But I'm unsure, sorry.

MR ROZEN: Now, there were a number of issues that were addressed at this board meeting, one of which was the presentation of the report about the sanctions at Bupa South Hobart; is that right?

MS COOPER: Yes. Would somebody mind getting what you're looking at up for me.

MR ROZEN: Sorry, it's not in front of you.

MS COOPER: Yes, but it doesn't have any detail other than the - - -

MR ROZEN: No, you've just got the first page, I take it.

MS COOPER: Cool. I thought you were going to ask me a question about something on there and - - -

MR ROZEN: I am, but we will get the right page up before I do that. It's page .2778.

MS COOPER: Thank you.

MR ROZEN: Perhaps in fairness we should go to the previous page, .2777. And we can see there the paper that was presented to the board is identified at the top of the page there. The purpose of it is to:

> *...provide an update to the board on key activities, risks and outcomes impacting on the Aged Care Quality Agency decision to not reaccredit Bupa South Hobart.*

Do you see that?

MS COOPER: I do.

MR ROZEN: And then there's a reference to the audit report which was produced by the Quality Agency and that's attached to this paper and if we go to the next page, I want to ask you about the summary points for consideration at the bottom of the page. Do you see that heading at the bottom of page - - -

MS COOPER: Yes, I do.

MR ROZEN: - - - .2778. So there's five points that were identified. You told us a moment ago you weren't the author. Do we take it, then, that it was produced by Ms Hudec and Mr Forster?

MS COOPER: Yes, I think so. Yes.

MR ROZEN: Okay.

MS COOPER: As far as I'm aware.

MR ROZEN: Okay. Then we see the first point notes the:

> *...potential loss of accreditation and subsequent funding and brand damage.*

The second point is:

> *Process of submitting responses in a timely manner –*

that is, responses to the regulator going forward from that time. 3 is:

> *Review of systems and processes across Bupa work instructions to be reviewed immediately to ensure they are simplified, easy to implement and lead to sustainable quality and safety outcomes for residents.*

I just want to ask you a little bit about that. We heard some evidence earlier in the week from a former employee of Bupa, a Mr Anderson. He told the Commissioners that there is a work instruction at Bupa for everything, he said.

MS COOPER: There is.

MR ROZEN: He was drawing a contrast with his then current employer, a health provider. Ms Hudec yesterday also talked about the work instructions at Bupa and, as I understood the evidence she was giving, was making the point that whilst work instructions are obviously a good idea to ensure people do the right thing, they can be counterproductive if they are overly prescriptive. Do you have a view about that at a general level?

MS COOPER: Yes, I do. Yes, I think if you have too many work instructions or they are overly prescriptive, it's very challenging for staff on the ground to actually follow. All the clinical work instructions have been reviewed by Ms Maryann Curry, and those have been reviewed to ensure that clinical staff at the coalface can actually understand them better and follow them better.

MR ROZEN: If we go over to the next page there's two more points that were raised in the paper. The first, number 4 at the top of the page is:

> *Acknowledgement of consistent themes with compliance issues relating to rostering and human resource management continue, escalating urgency to endorse actions, review increased staffing hours in homes which have recently reduced staffing from the Project James model where need has been identified.*

Do you see that?

MS COOPER: I do.

MR ROZEN: I suggest that what's not clear there, or from point 5, is any acknowledgement that there was a fundamental failure of the clinical governance framework associated with the experience of Bupa South Hobart? Do you think that's adequately identified in the paper that was presented to the board?

MS COOPER: I'm not sure that was the purpose of that paper.

MR ROZEN: Okay.

MS COOPER: I think they are actually just providing an update on South Hobart. I don't think they were providing any sort of clinical governance framework or - - -

MR ROZEN: Okay. Well, then - - -

MS COOPER: And it was to the full board. It wasn't to the clinical governance board.

MR ROZEN: I understand. You accept, don't you, Ms Cooper, that the evidence that we've examined does strongly suggest that the clinical governance framework

did not operate as it should have in the lead-up to the sanctions being imposed in October 2018?

MS COOPER: Yes, I do.

MR ROZEN: And specifically that what looked – looks on paper to be quite a robust process of mock audits and clinical governance reviews and improvement plans to follow-up, despite the warnings being raised in the mock audits the problems weren't addressed. Do you agree with that?

MS COOPER: I do.

MR ROZEN: And has that been the subject of a proper examination within Bupa, do you think?

MS COOPER: Absolutely.

MR ROZEN: It has?

MS COOPER: It's been the subject of multiple focuses.

MR ROZEN: Yes.

MS COOPER: There's a range of different things which are in my statement but mock audits don't happen in the way they used to. Now, there's a team called the quality and safety team, I think it is, that undertake those audits as required, but also on a regular basis but also increasing as required. There's also a range of other reviews that have been done around how we actually support at the coalface so that that's why we've got – sorry, clinical quality partners and the increase in educators, etcetera. So I think there's absolutely, from my experience and ongoing understanding, that there's a lot learnt from the clinical governance side of things.

MR ROZEN: Moving from what's been learnt internally to what the Commissioners can learn for broader application to the sector, one of the aspects of the evidence that we've looked at is this: it's almost a paradox, really, between having what looks on paper to be a robust governance framework but then, when it's tested, not necessarily working as well as it could. What is it that is necessary within an aged care provider to ensure that you've got not only a good paper system, a good system of governance, but one that actually works when it has to, and achieves the outcomes that it sets out to achieve?

MS COOPER: So I think it was Commissioner Briggs yesterday referred to a health check.

MR ROZEN: Yes.

MS COOPER: And one of the things that I think is really critical is to look at – instead of actually just mock audits, look at a broader range of things around a health check. So in New Zealand we have a thing called a care home health check which we've had for a period of time, a quite substantial period of time actually, well before my time. We've been improving that constantly and in light of what has happened with Bupa Australia we've also had another deep dive look at that with our risk team for some independent view. I think both our businesses have now employed a head of risk to make sure that they oversee this type of work, and I'm in final interviews for that sort of role coming up. And I will make sure that the care home health check is sitting under the head of risk as a responsibility.

So I think a little bit of distance sometimes is quite good as well to make sure that those people that are working in the business all the time are being supported by fresh eyes, if you like, to make sure that the activities that they are undertaking are actually a true and accurate record of what's actually happening at a care home. The care home health check in New Zealand aligns with the standards and you heard from, I think it was Linda yesterday to say that the mock audits were related to the work instructions, initially. And I think that was a concern. And they've now moved to any sort of auditing they do are related to the standards and that is the same as what we do in New Zealand. That's critical because that's important for residents and relatives to get that right.

MR ROZEN: Lots we can learn from New Zealand, it sounds like, Ms Cooper.

COMMISSIONER BRIGGS: Might I ask, do you think the organisation just expanded too quickly? So that's the first question.

MS COOPER: It expanded before my time; so I came to New Zealand April 2017. And as far as I was aware Australia was quite a bigger organisation then. New Zealand had 62 care homes when I went there and we have actually subsequently sold some. But it is a large organisation; I absolutely am fully aware of that.

COMMISSIONER BRIGGS: Do you think the leadership of the organisation understood the business as well as one might expect Bupa would understand the business, given its foreign background?

MS COOPER: I think the leaders that were employed in the aged care business understood the business. I think that some of the changes that they were trying to make, perhaps they hadn't looked at the full implication of those. Yes.

COMMISSIONER BRIGGS: Why was the policy in Australia that was adopted different from the one that was adopted in New Zealand?

MS COOPER: So which policy - - -

COMMISSIONER BRIGGS: I suppose the cost-cutting policy, if I can call it that, with inverted commas.

MS COOPER: So are you referring potentially to the Bupa model of care?

COMMISSIONER BRIGGS: Yes.

MS COOPER: Yes. So the Bupa model of care, initially, I think was developed to improve things and – but it's hearsay and in writing around the place that it did. As has already been said, it wasn't evaluated in terms of its effectiveness but then it was unaffordable or was considered unaffordable. In New Zealand we didn't take the Bupa model of care. We actually have got a process called a Bupa care journey, which is actually about engaging the entire business from cleaners through to the – the residents and their families as well, about things like, you know, how we actually bring people into the organisation, how we do clinical reviews, how we actually decide on the menus.

I mean, I'm picking lots of little bits and pieces but – and I think we took quite a different approach, and I can't say why that is. I suppose it was under my leadership; I wanted that approach. I wasn't closely involved in – at all in what was happening in Australia. I have learnt of the four years of work through my review, but I hadn't been involved at all, really, during that time, so I chose a different path.

COMMISSIONER BRIGGS: What's the basis of the New Zealand funding model?

MS COOPER: It's very different to the Australian funding model. So we have three – sorry, four main care types in New Zealand, and they each have a day rate, so a bed day rate. So a large proportion of people are government-funded but not all. And we're in the process of a funding review nationally for the country which I've been heavily involved in. And we are – the Bupa Foundation has actually done some work on case mix and on whether there is a different way of looking at funding, more individually packaged care, but we will never move to 141 ways such as the ACFI model over here. We may move to around 12 to 15 case mix indicators, that would actually create some funding.

COMMISSIONER BRIGGS: Can I ask you one more question before I no longer interrupt counsel's stream of questions. You've now worked in both countries and you may have worked in other countries. Do you have any sense of what's an ideal home size? So in Australia there's been quite an emphasis over 20 to 30 years in increasing the home size for reasons of efficiency and so on. And I have no doubt that's yielded efficiencies, but the question is has it come at the expense of care? So in your experience in New Zealand what's the average resident per home size?

MS COOPER: My view would be that around 80 would probably be a manageable size, both for a – the leadership team but also for the residents and their families living there. It is a home. It's really hard to make it homely if you've got - - -

COMMISSIONER BRIGGS: Too many.

MS COOPER: - - - you know, too many people there. You can design as we are in New Zealand; we have quite an active building program over there. So we're designing in smaller communities; so – 10 to 12 residents living in a community, in amongst a bigger facility.

COMMISSIONER BRIGGS: Yes.

MS COOPER: So we've actually dropped our future building to around 56 to 60 beds per development. But in New Zealand we have villages and aged-care as a continuum of care, and we build the two together.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Just picking up on that last bit of evidence you're giving, Ms Cooper – do you have building-standards that you're building those newer homes to?

MS COOPER: Yes; very strict.

MR ROZEN: Are they internally developed, or are they externally imposed?

MS COOPER: No; there's government standards, and there's, obviously, the normal building-standards, but we have our own standards that we build to, and we also have to get approval, as you would expect, through our boards, and so we have to make sure that anything we're doing is – we're very accountable for all parts of it, including making sure that we're going to be able to deliver the care we need and also all the commercial aspects obviously.

MR ROZEN: Commissioners, I note the time. I've got, probably, 10 more minutes for Ms Cooper, and Ms Needham may have five minutes of questions, depending on what I do. Should we try and complete Ms Cooper before lunch?

COMMISSIONER PAGONE: Yes, we should.

MR ROZEN: That's what we'll do. Ms Cooper, last topic, which is the 2019 roster, where – you were involved in a hands-on way, as I understand it, together with Ms Davida Webb, in developing the 2019 roster; now, this was, obviously, a roster that was intended to replace the roster that was in place prior to this year. Firstly the 2019 roster was to be applied across the board, across the 72 BUPA homes?

MS COOPER: So the 2019 roster was developed as a minimum. So I want to be really clear about that.

MR ROZEN: Yes.

MS COOPER: It was also a substantial investment to be made by the company as well. So this was not a cost-cutting exercise. So I want to be really clear about that. I came into the business, and as I've outlined in my statement, I picked up on five or

six key things, and the skill mix and numbers was one of those six key areas. So it was really important, for me to actually make sure that I got a view fairly early on of where, I thought, people were going to be sitting in terms of whether their roster was appropriate, both for the residents that were in that care home on that day or that period – and also to consider acuity and environmental sectors. So we developed a roster. It took a bit longer than I had hoped, because I wanted to be able to bring it in quickly, but everything takes time, and it needed to be carefully developed. I used the benchmarking from Stewart Brown, as I've referred to before, which has over 900 facilities included, and it gave us a really good guide as to what we could use as average hours per resident per day.

MR ROZEN: Can I ask you to have a look at a document which has been provided to the royal Commission by BUPA. It's tab 185 of the tender bundle. That's the first page of it. Can we just go to the second page, please, operator, 8953, and the heading there is "2019 roster recommendation". Is this a document that you're familiar with - - -

MS COOPER: Yes. I am.

MR ROZEN: Without going back to the first page – it had the date February 2018 on it. That's an error, I take it.

MS COOPER: Yes. I hadn't noticed that. Thank you. Yes. It's an error.

MR ROZEN: Okay. It sounds like it, probably, is. So that's the first point. But more importantly, if we look at the page that's in front of you now – and we can see there that the three aims of the 2019 roster are listed. We don't need to go through each of those. Then we see:

> *The recommendation seeks to implement a minimum of 2.5 direct-care hours per resident per day, which is just above the top 25 per cent performing homes that were benchmarked by Stewart Brown.*

You've just referred to that benchmarking, and it's well understood by the royal Commission, that it's a process of looking at many residential-aged-care facilities throughout Australia. I just want to understand from you what you mean when you talk about the top 25 per cent performing homes; what criterion or criteria are you applying there?

MS COOPER: So that's from the Stewart Brown information.

MR ROZEN: Yes.

MS COOPER: That is how he – I'm sorry. With respect – the company describes – I didn't ask them how they define the top 25, but that is their analysis that – they show the top 25 separate to the average, separate to the - - -

MR ROZEN: It's not the top 25 in the sense that they're the top quarter in providing the most hours of care per resident per day. Is it. Doesn't mean "top" in that sense.

MS COOPER: Don't think so.

MR ROZEN: No. The figure that's cited in the Stewart Brown report is 2.48 hours.

MS COOPER: Correct.

MR ROZEN: Isn't it. And I suggest to you what they mean is top 25 per cent in terms of profitability.

MS COOPER: That's not anywhere that I'm aware of. That's, certainly, not the understanding I had.

MR ROZEN: Isn't it? What's the understanding you had?

MS COOPER: My understanding was that the top 25 was 2.48, that was clinical hours only and that we shouldn't, definitely, be below that. But – so that's why we went for 2.5, which was still quite an investment from the company's perspective.

MR ROZEN: I'm not making myself clear; top 25 per cent in what sense? What did you understand that to mean?

MS COOPER: We actually talked about this quite a lot, because we actually weren't sure what they meant either, but we felt that if we were actually above a lot of the people that were actually involved in the survey – that it would be a better place to be, and it was actually an increase in hours for about half of the care homes.

MR ROZEN: Yes. I suggest to you that that is what Stewart Brown means. It means top in terms of profitability. Do you say it means something else?

MS COOPER: I – actually I'm not sure; sorry. It's not my understanding.

MR ROZEN: Okay. All right. In any event, 2.48 hours is the figure that Stewart Brown attributes as the average for the top 25 per cent.

MS COOPER: That's right.

MR ROZEN: You've gone just above that by settling on 2.5 hours; isn't that a pretty arbitrary approach to .....

MS COOPER: It's a very arbitrary approach, but I also used my experience in New Zealand. With this, the four levels of care in New Zealand, there are not mandatory, but there are suggested minimum hours per residents per day, and I want to be really clear: this is a minimum. This is not a requirement. This is not – and, in fact, I can't

remember how many warranted variations I have signed, but I have signed several warranted variations, and it was a substantial investment from the – millions of dollars of investment from the company, to actually move to this model. So it was actually improving and meeting the recommended aims for many care homes.

MR ROZEN: Can I draw attention to the second last line on the page. Do you see it says:

Acuity levels may warrant a higher/lower roster and needs to be considered.

That doesn't read as being consistent with the evidence you've just given about this being a minimum number of hours. Would you like to comment on that?

MS COOPER: No; acuity is a factor. So this is the minimum hours, and then acuity or environmental factors might change that.

MR ROZEN: But what does the word "lower" – what do the words "lower roster" mean?

MS COOPER: And I can actually say one care home did ask for lower hours, and you might think that's curious, but in actual fact – and I questioned them quite significantly. They had low acuity in the care home. They had longstanding staff; their clinical managers had been there for many, many years. They had a stable registered-nurses workforce, and they had a stable GM. I actually didn't approve that. I said to them they should still have 2.5 and – but that is what they might've requested. That's an example of one care home.

MR ROZEN: Without wanting to repeat myself – the document clearly suggests doesn't it, that as part of the proposal you could go below the 2.5 hours if the acuity level warranted it.

MS COOPER: It potentially does, but my example that I've just given shows that I actually didn't approve that.

MR ROZEN: I understand. Now, in fairness to you, as the – as your evidence indicates in your second statement, the 2.5-hour roster was not implemented at BUPA South Hobart. Was it.

MS COOPER: That's right.

MR ROZEN: Three hours of care was the roster that has been implemented; is that right?

MS COOPER: So they've got the same rosters they had from November 2018. I think it's at least three hours per resident. In fact, I think it's over that.

MR ROZEN: Just finally can I ask you about the 80-20 split.

MS COOPER: Sure.

MR ROZEN: So we see there the proposal is to provide 20 per cent of direct-care hours to registered nurses and 80 per cent of hours to carer roles. What's the basis of that 80-20 split?

MS COOPER: So we had to work out how to actually consider the mix of staff, and with the ACFI funding – you'll be aware, that there's three elements with that. So – activities of daily living, the behaviour management and the clinical care or complex clinical care, and so in order to actually try and work out a system that would be fair and reasonable and would, hopefully, meet the needs of the resident, we actually applied – that the 20 per cent, which is what's allocated in ACFI for the clinical care, would have to be done by registered nurses and that the carer ADLs and behaviour management would often or could often be done by carers. It's a guide. And you'll note in many that it's actually not – there's lots of places it's not specific, and I think some examples we've given you might be 22 per cent registered nurses and the equivalent of carers.

MR ROZEN: 78.

MS COOPER: I suddenly think I'm going to say the wrong number.

MR ROZEN: That's all right. In fact, that is the split of BUPA South Hobart according to the evidence in your statement.

MS COOPER: Yes.

MR ROZEN: The Commission heard some evidence in a hearing in Melbourne a couple of months ago, one month ago perhaps, from Professor Kathy Eagar from the university of Wollongong; are you familiar with the evidence that she gave about a star-rating system that has been developed based on an American star-rating system?

MS COOPER: I'm not familiar with it, but I'm aware of it; yes.

MR ROZEN: I'd ask you to accept my maths – probably, risky proposition, but I'll ask you for the sake of the question to accept that, even if one takes the three-hour roster on the 78-22 split at BUPA South Hobart – that if one applies the Eagar star rating – that gives BUPA South Hobart a two-star rating. So it's a five-star rating, that she's developed. Her evidence was that anything under three stars was an unacceptably low level of staffing for Australian care homes. That was her evidence. How do you respond to that, if you accept that proposition that that roster that's been developed and implemented at BUPA South Hobart would leave – would result in a two-star rating on her - - -

MS COOPER: Well, clearly, I'm not very familiar with that rating, but I know Kathy Eagar and know that she has a lot of experience and the research such as this; so – obviously, as a sector, an aged-care sector in Australia, we need to make sure

that there is sufficient funding for us to be able to actually meet things like a star rating such as that. I would like to see there is an increase in staffing. I haven't been asked that, but since I've got the opportunity to say it – it would actually be absolutely ideal, if we could have more staff in the aged-care sector. And I think it's not just registered nurses; it is more carers as well. They are the people that look after the residents every day. And so if we could get more – that would be great.

MR ROZEN: That concludes my questions.

COMMISSIONER BRIGGS: Thank you, Mr Rozen.

MR ROZEN: I'm informed by my learned friend Ms Needham that she has about three minutes for Ms Cooper. I, certainly, have no objection to that.

COMMISSIONER PAGONE: Good.

MR ROZEN: Thank you.

COMMISSIONER PAGONE: Thank you. Yes, Ms Needham.

MS NEEDHAM: May it please the commissioners.

<EXAMINATION BY MS NEEDHAM [1.04 pm]

MS NEEDHAM: Ms Cooper, were you in the hearing room this morning when Dr Wilson and Ms Webster – or it could be the other way round – gave their evidence?

MS COOPER: Yes. Yes.

MS NEEDHAM: And you heard what they said about the issue of complaint management at BUPA South Hobart?

MS COOPER: Yes. I did.

MS NEEDHAM: Were you aware of their report?

MS COOPER: Yes, I was.

MS NEEDHAM: What was the views that you took of the usefulness of their report?

MS COOPER: I found their recommendations were useful, and they have been included, and I think in amongst all the remediation activities across the business they have been included. May not have been as quickly as, they suggested this morning, things could've happened, but they, absolutely, were useful.

MS NEEDHAM: And I think in your statement you give some evidence about what has been done in relation to an implementation of a targeted complaints-management frame-work.

MS COOPER: I do. Yes.

MS NEEDHAM: And that includes work done on ensuring that complaints are processed in a timely manner?

MS COOPER: Yes. In fact, the frame-work says "within one business day".

MS NEEDHAM: And can you give the commissioners some examples of the way in which the new complaint-management frame-work has been operating as far as you're aware.

MS COOPER: So the new management frame-work came in earlier this year, I think, around the middle of the year. It was designed and supported by an external company, and it's very much there to actually ensure that we have close resolution with families and relatives at early stage, hopefully, with their complaints, but if they're not comfortable with that, there's escalation process. There's also a way of recording and making sure that there's more transparency, and I know a lot of people have talked about transparency around complaints, and I support that with the regard to privacy for individuals as they need it. And there's also an assurance that this goes – the complaints go up through both the clinical governance – but up through the boards and to the main board of BUPA as part of the frame-work and as part of the policy.

MS NEEDHAM: And is there a position that has been created in order to oversee this?

MS COOPER: Yes, there is. There's a position – under the new role of customer director there's position called complaints-manager. It's a person who was a former consumer-adviser advocate, and that person's now moved into that role to concentrate on complaints management.

MS NEEDHAM: And are the – does the clinical-government-risk committee have any role in complaints management?

MS COOPER: Yes, they do; they review – through the risk process, they actually review complaints, trends and themes, and they provide a monitoring oversight to make sure that there is action being taken and support if it's needed.

MS NEEDHAM: And you mentioned that the Boards have a role in complaint oversight. Can you explain how that is managed.

MS COOPER: Yes. They do. So they received rolled-up reports on a regular basis to ensure that they have visibility of the complaints and the resolution, and there's a

dashboard that includes the trends, the types, the numbers, those that are outstanding, that've been resolved, and I'm aware from experience that the Boards are particularly interested in this and that they question people like myself quite heavily on these - - -

MS NEEDHAM: And just to tie that in – is the independent company you mentioned, Blackhall and Pearl and – their complaint behind tender bundle 155?

MS COOPER: Yes.

MS NEEDHAM: And the – and was that work undertaken with Blackhall and Pearl after the attendance at BUPA South Hobart by the witnesses you heard earlier?

MS COOPER: Yes; that's right. It was undertaken earlier this year.

MS NEEDHAM: Thank you. No further questions. Thank you, commissioners.

COMMISSIONER PAGONE: Thank you, Ms Needham. Thank you, Ms Cooper, for your evidence and for sharing a great range of experience and knowledge. I think we're better informed. You're formally excused from further attendance. Thank you.

MS COOPER: Thank you.

<THE WITNESS WITHDREW [1.08 pm]

COMMISSIONER PAGONE: Adjourn to 2.15.

ADJOURNED [1.08 pm]

RESUMED [2.16 pm]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioners. I call Ms Catherine Maxwell.

<CATHERINE MARGARET JOSEPHINE MAXWELL, SWORN [2.17 pm]

<EXAMINATION BY MR ROZEN

MR ROZEN: Please be seated, Ms Maxwell. Ms Maxwell, your full name is Catherine Margaret Josephine Maxwell.

MS MAXWELL: Yes.

MR ROZEN: And for the purposes of the Royal Commission you have made a witness statement dated 6 November 2019.

MS MAXWELL: Yes.

MR ROZEN: A copy of that should be available to you both in hard copy and shortly on the screen in front of you. The code is WIT.0620.0001.0001. Have you had a chance to read through that before giving your evidence today?

MS MAXWELL: Yes, I have.

MR ROZEN: And is there anything you would like to change?

MS MAXWELL: No.

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

MS MAXWELL: They are.

MR ROZEN: I tender the statement of Ms Maxwell dated 6 November 2019, Commissioners

COMMISSIONER PAGONE: Yes. That will be exhibit 13-40.

EXHIBIT #13-40 STATEMENT OF MS MAXWELL DATED 06/11/2019 (WIT.0620.0001.0001)

MR ROZEN: Ms Maxwell, can I ask a little bit about your personal background and a little bit about the Governance Institute that you work for, and then I will ask you some broader questions about questions of governance specifically as they apply to the aged care sector. So firstly, your position is the general manager of policy and advocacy of the Governance Institute of Australia.

MS MAXWELL: Yes, it is.

MR ROZEN: And you've held that position since 2017.

MS MAXWELL: I have.

MR ROZEN: In your statement at paragraph 5 you set out your formal qualifications, which I don't need to go through but you are legally trained.

MS MAXWELL: Yes.

MR ROZEN: In addition to other qualifications. And at paragraph 6 you set out a range of work roles that you've held which are relevant to the area of corporate governance.

MS MAXWELL: Yes.

MR ROZEN: And they consist of both regulatory agencies such as AHPRA, is that right, as well as private sector organisations like the Australian Institute of Company Directors; is that right?

MS MAXWELL: Yes, that's right.

MR ROZEN: And you've held the position as company secretary for – is it NPP Australia?

MS MAXWELL: NPP Australia, it's a – New Payments Platform Australia; it's a provider of a fast payments platform.

MR ROZEN: Okay. As well as the other roles which are – and I won't go through each of them there. You tell us in paragraph 7 of your statement on page 2 a bit about the Governance Institute. I might just ask you to summarise for us, if you would, the – what the Governance Institute is and what it does?

MS MAXWELL: It's a professional association. We have approximately 7400 members who are company secretaries, other governance professionals, risk managers and directors in a range of sectors. So they will work from the very largest listed companies, not for profits, charities, and also in the public sector. So across the whole range.

MR ROZEN: Yes. And you tell us that approximately 20 per cent of the membership work in the not-for-profit and charitable sector.

MS MAXWELL: That would be right. And a number of our members who have a paid role will also volunteer their services pro bono as a way of giving back to the community. So that's quite common amongst our membership.

MR ROZEN: Yes, I was about to say, it's quite common in the aged care seconder, too, I think to have - - -

MS MAXWELL: Yes, it is, very common.

MR ROZEN: - - - board members on a voluntary basis who perform similar or related roles on a professional basis elsewhere.

MS MAXWELL: That's very common in the charitable and the not-for-profit sector yes.

MR ROZEN: Yes. And just as a general proposition, I take it that you would agree that having that expertise available to the not-for-profit sector is, all else being equal, a good thing.

MS MAXWELL: It can be very beneficial. Certainly when I was the company secretary for Father Chris Riley's Youth Off the Streets, we were able to get access to some very skilled people who gave an enormous amount of time on a pro bono basis and it was a real benefit.

MR ROZEN: Yes. I might ask you to perhaps speak a little bit closer to the microphone.

MS MAXWELL: Yes, certainly.

MR ROZEN: Just so that we can – everything can be transcribed. The benefits probably don't need to be outlined of such people making their time available on a voluntary basis, but are there any downsides that, in your experience, arise in that context?

MS MAXWELL: One thing you sometimes see is a lot of those people are in quite senior management roles.

MR ROZEN: Yes.

MS MAXWELL: So it can sometimes be difficult for them to take the management hat off, and think at a more strategic, more oversight type role. So occasionally you will see that happen, because they are used to – to being in control of an organisation in their day job. So it can be sometimes difficult for them to sort of step back and think about contributing in a more strategic manner.

MR ROZEN: All right. That's a topic we will come back to.

MS MAXWELL: Certainly.

MR ROZEN: So I will just ask you to hold your thought about that. But that managerial broad oversight distinction is an important one.

MS MAXWELL: Yes.

MR ROZEN: Just sticking though with the not-for-profit sector, the evidence before the Commission, and I think it's repeated in your statement at paragraph 13, is that

the majority of aged care providers are not-for-profits; 60 per cent, I think, is the evidence.

MS MAXWELL: Based on the statistics I've seen, yes, that's right.

MR ROZEN: Yes. Can I ask you at a high sort of conceptual level, what you would see as the principal differences from a governance point of view between a not-for-profit and a for-profit organisation, particularly in the aged care setting?

MS MAXWELL: I think you actually have to think about – and when I was teaching corporate governance, one of the things I used to say was you have to remember that your duties and your responsibilities and your liability is the same whether you are paid or unpaid. So you have to see it as a serious responsibility. So I think that's one thing I think people need to think about in the sector - - -

MR ROZEN: Yes.

MS MAXWELL: - - - and need to have a really good appreciation of that, that it is just as serious, whether it's a paid or unpaid role. So I think that's a comment. I think the other thing in the not-for-profit sector is that it can be difficult to get access to appropriately qualified people and skilled people.

MR ROZEN: Yes.

MS MAXWELL: Particularly, you are seeing a much greater move towards skills-based boards in the not-for-profit sector and looking at, you know, what is the skill set of the board is certainly – if you look in the sort of – having worked with the listed sector in terms of the governance principles for the listed sector, investors have a very big focus on, you know, what is the board's skills matrix, what skills do they have. And you are beginning to see that translate across into the not-for-profit sector. And also particularly, I think, in the aged care sector there is a lot of regulation, there are a lot of responsibilities, there are a number of risks. You are dealing with vulnerable people so you need to have a skilled board, and it can be very difficult to get access to those people.

MR ROZEN: Yes. And we've heard evidence of that, both this week and as recently as the hearings in Mudgee where we heard from a relatively small regional provider who was informing the Commission about those challenges. Is one of the challenges that the not-for-profit sector faces relative to the for-profit sector the access to the sort of information that is needed by board members to make soundly based decisions, and by that I mean that in a larger better resourced organisation, you're more likely to have professionals who can convey information about risk and so on to the board?

MS MAXWELL: That's an interesting question. I was actually canvassing where I was having a discussion with some members recently, and in theory in a smaller organisation there is a chance for a board to actually have a better understanding of

what's going on because you're not as removed. Particularly if you have a good quality board they will be able to pick up on things and watch things. But look, yes, that could – that can be the case, that can be difficult to get – to get people who understand what a board might need by way of information.

MR ROZEN: All right. Now, I want to ask you a little bit about the relationship between the Governance Institute and the aged care sector, generally - - -

MS MAXWELL: Yes, certainly.

MR ROZEN: - - - because that's been an area that over the last three or four years the Governance Institute has done quite a bit of work, both in terms of publications and training. I want to just get a sense from you, firstly, what was the genesis of that work?

MS MAXWELL: I think my predecessor in my role, whom I've known for a number of years, had a strong personal interest in the sector so I think that was part of it. But I think also we try and produce material that's going to be helpful for people and practical. I think that's a big focus at Governance Institute, giving people practical guidance, how do I actually do this on the ground. So we also – the organisation also thought that given the changes in the sector following some changes in government policy that there would be challenges in the sector. So that it felt that there was a place for some good practical guidance, not legal advice but practical guidance about governance in the sector. So it was started as a project and they got some members from the aged care sector together and came up with the document.

MR ROZEN: And I think in your statement you tell us that the members from the aged care sector were quite a disparate group.

MS MAXWELL: Definitely, yes.

MR ROZEN: Representing both the for-profit and not-for-profit aspects of the sector.

MS MAXWELL: And small and large, and then city and regional. I think we had somebody from Rockhampton, so quite disparate and across the country.

MR ROZEN: And I take it that you would say that that adds to the practical strength of the document that was ultimately produced - - -

MS MAXWELL: I think so.

MR ROZEN: - - - through that working group.

MS MAXWELL: And I certainly have found working with our members that they're very generous with their time and they genuinely want to assist people, and

they're very conscious of producing something that's going to be useful, rather than motherhood statements. It's a big focus for them because this is their job.

MR ROZEN: Yes. Before asking you some questions about the guide that was produced, I just want to focus for a moment on some other work that the Governance Institute - - -

MS MAXWELL: Yes, certainly.

MR ROZEN: - - - has done and is doing in relation to governance in the aged care sector. You refer in your statement at paragraph 20 and onwards to other activities by way of training. Can you tell us a little bit about what that's consisted of and how it's been received by the aged care sector.

MS MAXWELL: Yes, certainly, so in late 2018 and then earlier year we developed the content and delivered in collaboration with Leading Age Services Australia three aged care specific workshops and, in fact, I delivered one of them in Sydney at the beginning of December last year; so they were governance in aged-care, business-continuity management for the aged-care sector and governing reputational risk for the aged-care sector, and then next year we're going to do some work with Leading Age-Services Australia to deliver the certificate in governance practice, and we also have a certificate in not-for-profit governance. I think – LASA or Laser – I'm not sure, how it's pronounced. It's in different states. They've got initiative in relation to training; so that's some work we're going to be doing next year. But we also have a certificate in not-for-profit governance, which is very popular in the aged-and-community sector. We have an annual not-for-profit-governance forum in New South Wales and Queensland, and we'll often have aged-care sessions in those forums. I also do some speaking at aged-care for conferences on governance, and I've, certainly, been to Albury Wodonga a couple of years to speak to people in the region; so - - -

MR ROZEN: Has those training initiatives and other activities of the institutes you've been involved in – would you say they've been well received by the sector?

MS MAXWELL: Yes; they have been actually very well received. And particularly the workshop we did in December last year was very popular, because it was before – it was in the run-up to the commencement of the aged-care-quality standards.

MR ROZEN: Yes.

MS MAXWELL: And there was quite a lot of work on standard 8; so – yes. It was very popular. People were very interested.

MR ROZEN: It's, probably, an opportune time to ask you a little about standard 8, which is one of the topics that I want to ask about. Perhaps it could be brought up on

the screen. It's in the general tender bundle. Sorry. We're just following up on that. Just whilst that's being done, Ms Maxwell, if I could ask you - - -

MS MAXWELL: Yes.

MR ROZEN: And it's, probably, a difficult question, and tell me, if it's too broad, but through your dealings with the sector, both through the working-party at the governance institute and the other activities you've been engaged in, do you have an overall view about governance in the aged-care sector, quality of governance in the aged-care sector?

MS MAXWELL: I think it's variable. It's interesting, when I have talked to people in some of the – at some of the regional conferences – I did a session which had quite a number of attendees, and we were talking – we got on to the topic of board succession and tenure on boards, and a question I quite often like to ask is "How many years have your board members been on the board?".

MR ROZEN: Yes.

MS MAXWELL: And it can be quite surprising, that you would have directors on boards for 15 or 20 years, which is, probably, way too long.

MR ROZEN: Why is it too long? That's a little counter-intuitive in some ways, because they would have - - -

MS MAXWELL: They would have a very deep knowledge of the organisation, but I think they get too close and because – a very important quality that a director should bring to a board is independence of mind and independent thinking and the ability to exercise oversight and to think strategically. And if you've been with an organisation for 20 years, it's going to be much harder, to think in a fresh way about what's coming and about issues.

MR ROZEN: Yes.

MS MAXWELL: So, certainly, as a rule of thumb, in the listed sector, somewhere between – nine to 10 years or three times three-year terms is considered to be appropriate.

MR ROZEN: Thank you. Now, standard 8: it should be on the screen in front of you, and I think it was one of the – it's a document you're, obviously, quite familiar with. Before I ask you about it – there's one other matter I wanted to ask you about the sector generally, which is, probably, related to standard 8.

MS MAXWELL: Yes.

MR ROZEN: We've had evidence at least on one occasion in the Royal Commission where a person from outside the aged-care sector who was – found

themselves doing a lot of work within the sector – Professor Pollaers: I don't know if you know him.

MS MAXWELL: No. I don't.

MR ROZEN: But he's done some work particularly in the area of workforce development within the aged-care sector, and his evidence to the Commission was that it was an immature sector relative to other areas of the economy that he's been involved in, and the explanation he gave for that was that he meant that in a sense that it's a – because of the extent of Government funding to the sector, that it's not, necessarily, a sector that is able to stand on its own two feet, essentially, as I understood the evidence he was giving. Does that at all resonate with you from your exposure to the governance side of the aged-care sector?

MS MAXWELL: That's an interesting remark, because I think – certainly, one of the members of our working-group remarked to me that the aged-care sector and senior-management positions in the aged-care sector are not seen as – say for example – as prestigious as equivalent positions in the health sector so that it, possibly, suffers from being not quite a poor relation, but it's, certainly, considered less prestigious than working for example, in a mainstream large health organisation. So there would be, possibly, that perception, but nonetheless the people that I have encountered from the sector are incredibly passionate about what they do and very committed to doing a good job and doing it well. So that could be true, but I don't do enough direct work in the sector.

MR ROZEN: I understand. And, presumably, by definition, if they're members of the governance institute, then they've, probably, got a pretty significant interest in governance matters.

MS MAXWELL: Yes.

MR ROZEN: You would expect.

MS MAXWELL: They're interested in finding out what's – they're interested in keeping up-to-date and giving back; so – yes. They tend to be the people that are interested in those topics.

MR ROZEN: Now, if I could turn to standard 8, then, which you referred to earlier – and there's, obviously, been a great deal of interest in the sector about the standards that came into operation on the 1st of July of this year. Do you have any general views about the efficacy of standard 8 or the likelihood of standard 8 contributing to improvements in governance standards in the aged-care sector?

MS MAXWELL: Well, certainly, based – if you look at the areas that it covers and you say for example care – compare it to the corporate-governance principles and recommendations – it covers a lot of the same territory. So – the same sorts of concepts in different language.

MR ROZEN: Yes.

MS MAXWELL: But – yes; definitely. The concepts from the leading statement are incorporated to a greater or lesser extent in that, but for example: there are particular things in relation to 8(3)(e), which are particular, obviously, to the sector.

MR ROZEN: Yes; that's the clinical-care .....

MS MAXWELL: The clinical-care – that's right.

MR ROZEN: Yes. Yes. And, presumably, 8(3)(d)(ii) would be another example, talking about the neglect and abuse of consumers.

MS MAXWELL: Yes. Absolutely. So there are some specific – things specific to the sector, but it does cover a lot of the same territory.

MR ROZEN: Yes. Turning to the enforcement of a standard like that because – obviously, the way in which any legally enforceable standard is actually enforced is relevant to its practical effect.

MS MAXWELL: Yes; absolutely.

MR ROZEN: Do you see that as being a standard that is enforceable? Perhaps I'll just clarify that.

MS MAXWELL: Yes.

MR ROZEN: The language is fairly general, I would suggest. Is that a problem in relation to enforceability?

MS MAXWELL: I think there's quite a bit of material that sits below it in terms of what you do to meet the standards, and it's going to be a question of how the regulator deals with and enforces the standard and what – the sort of mechanisms that they – the quality agency has in place in terms of dealing with not meeting the standard.

MR ROZEN: If I could just expand on that a little – the evidence in some of the case studies we've looked at, particularly one we've looked at this week, has presented what appears on its face to be quite a robust governance frame-work, range of committees and mechanisms to ensure that care outcomes are ultimately achieved for residents. My question is from a regulatory point of view. Is there more a regulator can do than examining the paperwork? How can one ensure as a regulator that the on-the-ground governance if I can call it that – what is happening in practice matches the paper governance frame-work?

MS MAXWELL: It's – that's an interesting question, because there is a real-life example at the moment in the for-profit sector. The security – ASIC, the Australian

Securities and Investments Commission, has actually just done a project, looking at the four banks and AMP, who have very robust systems and governance processes in place, and they've, literally, just done a project where they've gone in to interrogate, well, how does this work on the ground; so, in fact, there is a real-life example, and they've just produced a report about what they found, including a report that – from an organisational psychologist who sat in at board meetings and observed.

MR ROZEN: Yes.

MS MAXWELL: So that's one way of doing it. So, certainly, we have a real-life example of a regulator doing just that.

MR ROZEN: Yes.

MS MAXWELL: It is always going to be difficult, and I think the other thing in this area is that leadership and culture are sort of the other ingredients to a robust governance frame-work. It's – "We have these policies, but what is our leadership like? What is the culture of the organisation? What's the attitude of my manager when I don't do something I need to do? Are there – is there accountability? Are there consequences?"

MR ROZEN: One of the areas that's identified in the guidance material is to ask what the key performance indicators are for senior executives. Does the answers to that question tell one something about the culture of an organisation?

MS MAXWELL: It can do. It can do; yes. What is rewarded is what the organisation values, although you're, obviously, dealing - - -

MR ROZEN: Yes.

MS MAXWELL: I've done a lot of thinking and a lot of work in the financial-services sector, because, obviously, there's been a huge amount of scrutiny on that very issue in the last sort of 12 to 18 months. You're – in this sector you are not going to see the same sorts of financial incentives that you see in the financial-service – so it's quite different, but nonetheless, what is valued in the organisation by way of behaviour, who gets promoted or who does the organisation – so there are other ways of promoting or valuing behaviours in an organisation apart from money, in sectors where salaries are not large.

MR ROZEN: So if I can just tease that out a little – so for example: in applying standard 8, could the regulator for example, examine the KPIs for senior executive leaders to see whether for example, one of the key performance indicators is good outcomes in audits for example, in care audits that are carried out in an area that is the responsibility of the – of that manager?

MS MAXWELL: And on its face that would be a legitimate key-fulfilments indicator, but if the culture of the organisation was such that it was more important,

to have a hundred per cent success on that KPI, than to admit that something had gone wrong and that we might need to look at what we were doing - - -

MR ROZEN: Yes; it could be counterproductive.

MS MAXWELL: It could be counterproductive.

MR ROZEN: I understand.

MS MAXWELL: Absolutely; so it's – that's, I think, where leadership and culture – it's the sort of – it's an intangible, but it's not, because it's so important in any organisation.

MR ROZEN: Can I turn then to the document which you've drawn to the Commission's attention, "Adding value to governance in aged-care", which is the product of that working-party that you told us about earlier.

MS MAXWELL: Absolutely.

MR ROZEN: I'll ask that that be brought up, please – it's RCD.9999.0200.0001 – document 1 of the general tender bundle, please. Just while that's being brought up – you're probably reasonably familiar with it, I suspect, Ms Maxwell.

MS MAXWELL: Yes.

MR ROZEN: At page 5 there is a heading What Is Governance and What is the Role of a Director, and there's a basic definition of governance and why it matters. And I want to ask you about this, five listed key components of governance on page 5.

MS MAXWELL: Yes.

MR ROZEN: Page 1 of the document but it's page 5 in our materials. That's it there. The five key components that are identified are transparency, accountability, stewardship, integrity and risk management. I would like to ask you about number 4 and number 5, integrity, firstly:

> *Developing and maintaining a culture committed to ethical behaviour and compliance with the law.*

Now, I know that the Hayne report into the financial sector which you've made some reference to, both in this document and in other guidance material published by the Institute, places considerable weight on the role of integrity and integrity starting at the top. My question for you is: from your experience how does the board of an aged care provider, if we can just stick with this sector for the moment, develop and maintain a culture committed to ethical behaviour and compliance with the law? What does that mean in practice? What do you look for - - -

MS MAXWELL: In practice what does it look like?

MR ROZEN: Yes.

MS MAXWELL: Well, it starts, I think, with modelling that behaviour. It starts with, you know, being respectful with staff when they come in to talk to the board. It starts with treating people properly. I think it starts with – a lot on a board is driven by the personal qualities of a chair. That's a very important key ingredient in a successful board.

MR ROZEN: Yes.

MS MAXWELL: Because it is as much a human system as anything else. So there need – need to be – there need to be good relationships between the board members where it's – you can ask challenging questions but you treat each other respectfully, so I think it actually starts with behaving well as a group.

MR ROZEN: Yes.

MS MAXWELL: And having high expectations of behaviour and high expectations of your senior manager and usually one of – it's said that one of the most important tasks of the board is to appoint the CEO. So looking where you recruit, not just for someone who is a good manager but who demonstrates that they are – they have the right characteristics to lead the organisation. So you will do that by good reference-checking, trying to understand. By taking a lot of care with your recruitment process.

MR ROZEN: Can I ask you a little bit about the relationship between a board and senior executive management of an organisation, both generally and in the aged care setting, particularly with small aged care providers but not necessarily as we've learnt this week. It's quite common to have a board that consists either wholly or largely of executive managers on the board. Now, you - - -

MS MAXWELL: Could I clarify that?

MR ROZEN: Sure.

MS MAXWELL: So do you mean a board where the board members are executives of the organisation of which they're overseeing?

MR ROZEN: Yes.

MS MAXWELL: Okay.

MR ROZEN: We've heard quite a bit of evidence that that's a relatively common situation in the aged care sector.

MS MAXWELL: It's really not considered good practice.

MR ROZEN: No. And why is that?

MS MAXWELL: Because you really need to have independence of judgment at the sort of apex of the decision-making body of the organisation and, certainly, contemporary good governance practice is to have, where possible, and it's not always going to be possible, a majority of independent directors.

MR ROZEN: Yes.

MS MAXWELL: By independent I mean that they are not executives of the organisation. So if you can avoid that situation, it's generally considered good governance to have a majority of independents.

MR ROZEN: That is presumably because one of the important roles of a board is to challenge management.

MS MAXWELL: Absolutely. Or to oversight management, yes. And they need to have that independence of mind so if you are – it is, to use the vernacular, you're marking your own homework.

MR ROZEN: Yes. And going back to standard 8, is that something that you would be, if they were contact you, if the Aged Care Quality and Safety Commission that's responsible for oversighting the implementation of standard 8 if they were to contact you, presumably your advice would be that that's one thing that they would be looking for.

MS MAXWELL: It's one thing they should be looking for. Absolutely.

MR ROZEN: Okay.

MS MAXWELL: And certainly if the look at – the Australian Institute of Company Directors have put out and we actually provided input into the document, they've got a very helpful document called NFP Governance Principles which are actually referenced on the aged care quality site. If you go into the aged care quality standards, it's one of the drop-down options. I mean, that whole discussion about the importance of independent directors is in that document also. So you don't have to go very far to find it.

MR ROZEN: And I take it – I mean, that's a good point, isn't it; there's no shortage of guidance material available to anyone who is interested in understanding the principles of good governance, both generally and as it applies to the aged care or service sector. Do you agree with that?

MS MAXWELL: I think that's right and having been a company secretary for a couple of charities, you get quite good at finding free stuff.

MR ROZEN: Yes.

MS MAXWELL: So you actually learn where you can get good quality resources at little or no cost. So, you know, that's one of the things you learn when you're working in the charitable or not for profit sector.

MR ROZEN: Is another matter that you would encourage the regulator to look at in the implementation of standard 8 be look at what training has been provided to board members?

MS MAXWELL: Look, I think training is really important and you don't – I mean, obviously, we do quite a lot of training. The Australian Institute of Company Directors deal with training but there are other organisations; some of the aged care organisations do training.

MR ROZEN: Yes.

MS MAXWELL: There's a great organisation in Victoria called NFP Law; they do training. There are a number of people around, but you can also – people's legal advisers are always – or accounting firms are always happy to give training. So as I said, when I worked in the charitable sector I did become quite good at finding resources. The other thing is that, you know, if you have a proper company secretary they can help you with that. So, you know, a good company secretary or governance professional will also help a board with these sorts of issues and we – a number of places – we in particular, we have a service whereby our members volunteer their time to act as company secretaries.

MR ROZEN: Yes.

MS MAXWELL: So, you know, there is – there are things you can do.

MR ROZEN: One of the themes that comes out of the Hayne Royal Commission, and is picked up in the document the Governance Institute has published summarising some of the recommendations in the Hayne report is the question – a simple one on its face – boards asking themselves not just can they do something but should they do something. Are you familiar with that discussion?

MS MAXWELL: When I think of all the material that came out of the review of Commonwealth Bank and the financial services royal commission, I think that's the phrase that resonated with me the most, and I think it's a very good rule of thumb. We can but should we, can we, should we. It's very simple but it's an excellent precept.

MR ROZEN: It goes directly to questions of ethics, doesn't it?

MS MAXWELL: Absolutely to the heart of it. It goes right to the centre of it.

MR ROZEN: Yes. Going back to your list of key concepts, the other one I wanted to ask you about was risk management – this is number 5 – you'll see on the left-hand column just over halfway down.

MS MAXWELL: Yes.

MR ROZEN:

> *Taking appropriate risks and avoiding unnecessary risk where the benefit is insufficient.*

There's a better discussion of that or a more fulsome discussion on page 22 of the document if that could please be brought up, please. And you will see on the left-hand side The Role of the Board in Risk Management. Perhaps if that first paragraph under that heading could be blown up, please. I was interested in this notion of the risk appetite for an aged care provider. Can you expand on that for us, please, that concept of a risk appetite.

MS MAXWELL: A risk appetite is really the board working out where its tolerance for risk sits so what it will – what it will do and what it won't do, really. You know, what risks it will accept and what risks it won't take on. So risk appetite is a relatively new term. It's probably the last 10 to 15 years but it's a well-established term. It's probably – I come from a legal background. I found it a slightly curious term when I first encountered it, but it's really what is the board's tolerance for risk.

MR ROZEN: Could you give us a practical example of that, either in aged care or generally. What – how that might work.

MS MAXWELL: How that might work. So tolerance for risk. We could – it would be something along the lines of we do this sort of activity, we are – we are – we are a dairy producer.

MR ROZEN: Yes.

MS MAXWELL: We have a very good product but it needs to be consumed within 72 hours to be at its peak. Our reputation is very important to us and there's a real risk that the product will deteriorate if it's not used within 72 hours. So what is our risk appetite in terms of the market risk we take on. We're not going to have this product more than 72 hours away from consumption. So, for example, without appropriate safeguards we won't export it to the other side of the world, for example. I mean, that's a pretty extreme example but it's just, you know, what the organisation will tolerate in terms of its activities. What risks it will and won't take on.

MR ROZEN: So maybe we can tease that out. The advice of the board might be that it has to be consumed within 72 hours but to be safe let's make sure we get it to places within 48 hours.

MS MAXWELL: Absolutely, to be at its peak.

MR ROZEN: Yes, to be at its peak. And then we're sure we're going to be – no one is going to be consuming after 72.

MS MAXWELL: And reputation – our reputation for this product is so important to us that, you know, that's what we're prepared to do.

MR ROZEN: Yes. And there might be costs associated with that because some product doesn't get consumed, for example - - -

MS MAXWELL: Absolutely, but - - -

MR ROZEN: - - - but that's better overall than - - -

MS MAXWELL: But such is the value of our reputation to us that we're not prepared to take that risk.

MR ROZEN: I understand.

MS MAXWELL: Does that explain it?

MR ROZEN: I think so. It does for me anyway. Thank you.

MS MAXWELL: Okay.

MR ROZEN: I want to ask you a little about an area that has been given a bit of air time in this Royal Commission and that is whether there's a place in the aged care regulatory framework for a duty, a type of due diligence duty being imposed on board members of aged care providers, a duty to ensure safety and quality of care provision. Something along the lines of the duty that is currently in, for example, workplace health and safety legislation which is referred to in the guidance material. And which could potentially, I suppose, focus the minds of decision-makers when it comes to having to trade-off, for example, between profitability and safety issues. So can I ask you to comment on that?

MS MAXWELL: Well, I suppose the preliminary comment would be that, in my experience, a due diligence – the due diligence has had a very salutary effect in relation to work health and safety. Boards are, in my experience, very aware of work health and safety and take it very seriously.

MR ROZEN: Yes.

MS MAXWELL: They will frequently get – most boards – most good boards will at least get training on work health and safety at least every two years, some annually. So it is something they take very seriously. I've also seen boards getting very focused on the data – the notifiable data breach. I've certainly seen a lot of

attention. So a due diligence – the due diligence concept does, in my experience, have the effect of concentrating people's minds on a particular issue. One thing someone did point out was that there is, I think, in the – and I'm not a work health and safety expert at all, I don't know the area in detail, but someone has commented to me that in the uniform rules there is a provision – I think it's section 23.

MR ROZEN: It might be 27.

MS MAXWELL: 27, the one that provides employers have a legal duty to make sure the health and safety of other people is not put at risk.

MR ROZEN: Yes.

MS MAXWELL: And the comment was made to me that they don't see that that is something that could be used in the context of aged care, and they don't see that that has been used.

MR ROZEN: Yes. Yes.

MS MAXWELL: And that that might be something that's currently available but it's not actually being used. Certainly, look, it would be worth looking at for the sector, provided it's appropriately tailored to the sector.

MR ROZEN: Yes.

MS MAXWELL: So it wouldn't be out of the question. Certainly – in terms of talking to people in the sector that I have spoken to – it would not be out of the question, but it would be – it would need to be tailored, because it's really more about safety.

MR ROZEN: Yes; so can I explore that. So the due-diligence duty under work-health-and-safety law, under the uniform law, imposes a positive obligation on - - -

MS MAXWELL: Board members.

MR ROZEN: Officers, board members to be informed about health and safety risks within their organisation, which – and then it's broken down – without going to the provision – it's broken down into receiving information about things like notifiable incidents, as you've said. So it wouldn't seem like such a stretch, to model that for the aged-care situation, because, of course, there are notifiable – incidents that have to be notified as well. And so that discipline of requiring regular reporting about such matters to board members could, potentially, have a positive effect, could it not? On governance?

MS MAXWELL: It could possibly, although, I suppose, arguably, if you've got good governance, this should be happening currently.

MR ROZEN: Yes. That's often what the law does, though, isn't it? It turns good practice into uniform practice or at least tries to?

MS MAXWELL: That's the ideal; yes.

MR ROZEN: Yes. Yes. Indeed. Can I ask you a little bit more about the question of culture, which is dealt with in another publication of the governance institute. This is in the general tender bundle, at tab 2, RCD.9999.0261.0010. And on page .0012, reproduced helpfully are recommendations 5.6 and 5.7 of the Hayne Royal Commission final report. I want to ask you about recommendation 5.6, which is a recommendation directed to financial-service entities to carry out something, I think, along the lines of the health check that you – that we've heard a little bit about. Commissioner Briggs was asking yesterday a witness, and we heard some more evidence about that this morning. Is that a notion that you're familiar with, that sort of stocktake, essentially, of governance arrangements within an organisation on a regular basis?

MS MAXWELL: Yes; absolutely. Well, certainly, the Australian prudential-regulation Authority produced quite a long report about the Commonwealth Bank of Australia. Was April last year, I think. Yes. I think it would've been April 2018. And a lot of large-company boards were doing self-assessments; one of the things they were doing was taking that report and doing a self-assessment of their practices against the findings of that report. So, yes, a health check or an assessment against a report is not a bad idea.

MR ROZEN: Yes, and – I'm sorry. I didn't mean to cut you off.

MS MAXWELL: No. Look. I was going to say – and if you've got someone in a governance role or a company secretary and they're good at what they do, it should be something that they're doing relatively regularly. "What are we doing" – because you really should be thinking about continually improving what you do, and, certainly, a lot of the discussion I hear at our policy committees from – particularly, from the larger listed companies is – they are all – well, there's a new edition of the ASX principles coming out. So everybody is looking at what they're currently doing. Are they going to meet the new standard. But you hear people talking about the Hayne recommendations and thinking about what they do. So – yes; a health check is a good idea. It's really part of continually improving what you do.

MR ROZEN: Yes. And I take it, that's something you would be encouraging aged-care boards to be doing.

MS MAXWELL: Yes. Absolutely. You really should – most policies – well, all your policies should have in them a time within which they would be reviewed, and, in fact, it's – I tend to like to review the board charter once a year. I think that's worth doing. You look at your constitution every couple of years and then other governance documents on a – possibly, two-yearly cycle of review so that you're constantly looking at something that you're doing with a view to making it better.

MR ROZEN: Now, a final very broad question, more an invitation really – and it's this: based on the experience – you, obviously, have lengthy experience in relation to governance generally and then more recently in the aged-care sector – what would you be suggesting to the commissioners, that they ought to be recommending as part of a report aimed at improving governance in the aged-care sector? What do you think are the key areas that ought to be the focus of the recommendations by the commissioners? Big question, I know.

MS MAXWELL: Huge question.

MR ROZEN: Perhaps – what are the key areas that ought to be focussed on?

MS MAXWELL: Probably I think the first thing is to emphasise to people that it's an important thing to be doing and to be aware of your responsibilities and to take those seriously and then to reflect on your governance practices and improve them and look at continually improving your governance practices.

MR ROZEN: And what about the regulator in relation to standard 8 for example?

MS MAXWELL: As I understand it, it's only come into effect on 1 July; so it's - - -

MR ROZEN: Early days.

MS MAXWELL: Early days, I would imagine.

MR ROZEN: What would you be urging them to do, though, in seeking to implement standard 8 and enforce it?

MS MAXWELL: I would actually be looking at some of the learnings, because the financial-services royal Commission was as much about regulators as it was about the regulated.

MR ROZEN: Yes.

MS MAXWELL: So I would, probably, be looking at other sectors to see what other regulators are doing. I think – certainly, a comment that I've heard is that the aged-care sector could learn a lot from the healthcare sector.

MR ROZEN: Yes.

MS MAXWELL: So look at some of the good practices in the healthcare sector, and look at where there are cross-learnings.

MR ROZEN: Speaking of which – have you had cause at all to look at the health-sector-guidance standard, the standard 1?

MS MAXWELL: I have looked at that. As I said, I'm not a health - - -

MR ROZEN: No. I understand that.

MS MAXWELL: Yes. It's much more focussed on clinical governance, which is an aspect of governance more broadly, and, probably, I guess, if I'm thinking about it from a risk-management perspective, I would see clinical governance as sitting within your risk-management function really.

MR ROZEN: Yes.

MS MAXWELL: I don't know whether that's abhorrent to someone who works in that sector, but it's an – good clinical governance would be a very important part of your overall risk-management frame-work, essential, really.

MR ROZEN: Commissioners, they are the questions I have for Ms Maxwell.

COMMISSIONER BRIGGS: Thank you, Ms Maxwell. If you were to list the top three things that, you thought, a highly performing aged-care organisation might have in terms of governance, what would they be?

MS MAXWELL: If I can pack a couple of things into one – a skilled effective Board, I think, is number 1, good culture and good management and practices, really, good people and good practices, which at one level, I guess, sounds like everything, but I think they're the really important things.

COMMISSIONER BRIGGS: That's all. Thank you.

COMMISSIONER PAGONE: A lot of the learning on governance – a lot of the early learning on governance – sorry; can you hear me now?

MS MAXWELL: Yes; thank you.

COMMISSIONER PAGONE: A lot of the early learning on governance arose from ad-hoc situations and in many respects were very specific to that particular situation. So Standard Charter might've collapsed, and the question was "Why did it collapse?" And then one had an industry. I don't mean that critically, but we had developed generalised learning about governance by reference to models that were not always clearly articulated, but there was a presumption that somehow or other there was a kind of a standard out there that was sufficiently applicable to all or at least to a lot of them or lot of institutional bodies to be governed. But the details and differences are dramatic, as I'm sure you know better than most, so that the governance model that might best suit a large corporation involved in selling motorcars will be very different from a care facility in outback Australia where you've got a very small community. How do we grapple with those kinds of differences? And how do you grapple with those kinds of differences in the context of trying to think about how you go about working out what governance principles should be?

MS MAXWELL: I'm probably biased, and I guess that's because I've worked a lot with it, but I would look at what is, probably, the Australian statement, which is the ASX principles, and you look at the principles themselves, possibly less at the recommendations but more about what are we trying to achieve, because if you look at the principles, they – if you do those things and do them well, you will have a well-governed organisation.

COMMISSIONER PAGONE: Well, take for example the very sensible recommendation that you referred to earlier on, that you ought not to be on the board forever.

MS MAXWELL: Yes.

COMMISSIONER PAGONE: That makes great deal of sense, but it may not be practical in a small community.

MS MAXWELL: Absolutely, and I think that you, possibly, have to – well, you have to look at finding a mechanism whereby you can get access to what you need in other ways. May be you get different – may be you set up an advisory committee and get expertise in that way. May be you hold your meetings slightly differently; perhaps you use – you don't hold all your meetings on site. You have some by telephone. May be you can Skype people in. So I think you do in much smaller organisations have to be creative, and I think that's where in my experience – having access to a network of people who can help you is good, particularly in the smaller sector, and that's – I think that's where a lot of the smaller providers get a lot of benefit in interacting with each other. It's about – it's through sharing ideas; so it's about building yourself a community of people.

COMMISSIONER PAGONE: And is there helpful learning about how one might adapt the ideal in the context of the differences that one finds in reality?

MS MAXWELL: Could you - - -

COMMISSIONER PAGONE: Well, that as an example – one might have for example a statement of principle, that there ought to be – that Boards ought to be based on skills. In some communities you're just not going to have the range of skills available; simple as that. The market's not or the community's not deep enough to be able to draw upon the kinds of skills that you might be able to draw and find in a city like Hobart.

MS MAXWELL: Yes.

COMMISSIONER PAGONE: So you might have a statement – that's only one of dozens.

MS MAXWELL: Yes; absolutely.

COMMISSIONER PAGONE: That will be the ideal. The other one about tenure of board membership is another. A third would be you ought not to have too many executives on the board. A fourth might be that you ought not to have the owners on the board if – because of potential conflicts. So there are four. Assume that they get stated as ideals as one finds in a lot of the documents, including your own; is there learning about and is there much written about – "Well, that's all very well as an ideal, but in reality you might have to modify and adapt, and here are the kinds of processes that one might think about modification and adapting." Or is it just left to – "Well, you just have to organise yourself as best you can"?

MS MAXWELL: In part our publication acknowledges the fact, that it's very difficult, to have one size fits all, particularly in the not – which is quite difficult, to be prescriptive, particularly in the not-for-profit and charitable sector. And, certainly, several times a week in my day job I take calls from people who will ring me with a particular question of a type that you just described, and we try and work through something that might work for their particular organisation or try and refer them to a source. So I do think – and maybe it's a function of the type of person that I am, but I tend to try and find someone who can answer those sorts of questions or try and find someone who can help me, and in my experience people have been incredibly generous with their time. So I'm sorry, if that - - -

COMMISSIONER BRIGGS: There's got to be a balance in this, though. Hasn't there, Ms Maxwell. Between the fact that most aged-care organisations for example, are receiving a sizable amount of money, even if they're small – and that differs from a smaller organisation that might be managing a sporting-facility or ground or whatever.

MS MAXWELL: You're absolutely right. There has to be accountability.

COMMISSIONER BRIGGS: So there are horses for courses in terms of expectations around organisations that are receiving sizable amounts of Government money, I think.

MS MAXWELL: I think that's absolutely – and it's important, to always have that in mind as well. These are public funds, that are granted by the Government. So it's – you have to be accountable for the spending of those funds. So – yes; it's a very important consideration, and I think that's why I, probably, started a number of my remarks with "It doesn't matter, whether you're – this is a paid or unpaid role; the job's the same".

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Thank you. One matter that I neglected to ask you about, which, I think, is a matter of considerable importance to us – and it concerns information flow and getting the balance right between too little and too much information. We've had evidence of Boards not being told about what would appear to be crucial information associated with risk on the one hand, but then there's the other potential

dilemma, which is getting swamped with information and not being able to see the things that are important. It's a very long preliminary to my question, which is this. Is it an important part of governance, for Boards to set the ground rules about what they need to be told by the Management?

MS MAXWELL: It's often referred to in teaching as the Goldilocks principle, just right. So – and you often do that when you're teaching people about writing minutes; it's just enough detail, not too much, just enough. But it is about the Board having a regular conversation about – "Do we think we're getting the right information? Is it in the format that we need? Does it assist us?" And it's, certainly, a conversation a lot of my members have been having over the last six to 12 months, because particularly for the for-profit sector, financial services royal commission, a lot of – and with the very large companies there is so much information; so particularly the company secretaries of very large companies are finding that they have to curate information. So they're working actively with Boards to get the right sorts of information and the right sorts of reports so that – yes; you've got to keep looking at it, and it's an important conversation to have at board level. "Are we getting what we need?"

MR ROZEN: And that links doesn't it, to having an informed Board.

MS MAXWELL: Yes.

MR ROZEN: That is a Board that understands the industry, understands the law and understands their business.

MS MAXWELL: Yes, and wants to do things properly.

MR ROZEN: It's possible, you don't know what you don't know, as a board member.

MS MAXWELL: Unfortunately; yes. But we have seen that illustrated with some of the very largest companies in Australia quite recently. So it's – and that – yes. That's absolutely true.

MR ROZEN: That's me done. Thank you.

COMMISSIONER PAGONE: Thank you. Ms Maxwell, thank you for coming to give evidence and sharing your knowledge and wisdom. It's been very helpful and informative

MS MAXWELL: I hope so. Thank you.

COMMISSIONER PAGONE: You are free from further restraint.

MS MAXWELL: Thank you.

COMMISSIONER PAGONE: Thank you.

<THE WITNESS WITHDREW [3.19 pm]

MR ROZEN: Commissioners that concludes the evidence that we wish to call in this hearing in Hobart. I do have some closing remarks that I would seek to make at this time, with your leave. Commissioners, the hearing that has just concluded focused on the leadership and governance of aged care providers Southern Cross Care Tasmania and Bupa Aged Care Tasmania. In opening the hearing last Monday we noted that whether an aged care provider is able to deliver care that meets the applicable quality and safety standards is determined ultimately by the governance arrangements in place in that provider. During hearings this week we've examined how decisions made at board and executive level flow down to what happens on the floor in an aged care facility.

We've examined the impact of those decisions on residents at certain facilities run by Southern Cross Care Tasmania and at Bupa's South Hobart facility and on the families of those residents. As in all the previous hearings of this Royal Commission, this week we've been privileged to hear powerful accounts of and about the lived experience of people in the aged care system. This evidence has been at the very core of this hearing. It has had a distinctly local flavour and we're immensely grateful to the Tasmanians who have been brave enough to share their very personal and moving stories with this Royal Commission, and through it with the wider public. Those accounts remind us of the important work in which we're engaged and focus our attention on what really matters in aged care.

We heard about Southern Cross Care Tasmania's Yaraandoo facility from Ellie Valier who cared for her late husband, Brian Harvey. In relation to Glenara Lakes, Mary Sexton gave evidence from her perspective as a registered nurse regarding the care of her late mother-in-law, Lois Parravicini. And we heard from Ann McDevitt in relation to the care received by her late mother, Janet Hellyer. And Judith King described her experience and that of her husband, Professor Neville King. Four daughters gave evidence about one or both of their parents and their experiences at Bupa South Hobart. Diane Daniels told the Royal Commission about her mother, Emily Flanagan. Merridy Eastman described the experiences of her mother and her late father and, finally, just this morning UQ and US conveyed the experiences they had when their late father was admitted as a resident at Bupa South Hobart.

These witnesses all gave personal accounts that raised the overarching themes in the other evidence adduced during the past week: deficiencies in care caused by insufficient care time, deficient organisational culture, insufficient attention to quality and safe clinical care, poor communications from facilities and a lack of responsiveness to complaints. Merridy Eastman explained the impact of poor governance on staff as well as residents. She told us:

> *You don't go and work in aged care for money. Clearly, you do it because you want to be of service to elderly people, so I think –*

she told us –

> *...everyone in these buildings is suffering as a result of bad governance, and I hope that this Royal Commission shines the light on that and changes it.*

And they're our tasks, Commissioners. We will now briefly deal with four themes arising from this week's evidence, noting some of the problems and possible solutions in respect of each theme. Organisational governance raises important questions about the design of the entire aged care system and its regulatory framework. These are matters upon which a great deal of work is being done within the Royal Commission and we, as counsel assisting, will return to this topic in the New Year. For now, the themes that we will address are, first, is providing quality in care sufficiently paramount as the core business of aged care providers. Secondly, is enhanced organisational governance, including clinical governance, required. Thirdly, how can organisational culture be improved and, finally, how can a funding environment be created that does not draw resources away from direct care.

First, is providing quality and safe care sufficiently paramount. Quality and safety of care should clearly be the core business of aged care providers. Financial viability must be a central consideration of proper business management in both profit and not-for-profit entities. Indeed, it is a legal obligation. But it must be remembered that financial viability is a means to an end in aged care; it is not an end in itself. This week's evidence has raised questions about whether the right balance has been struck between quality and safety of care considerations on the one hand, and financial considerations on the other hand in some of our aged care providers.

The problems that have been identified. With some justification many witnesses we called considered that financial considerations were prioritised at Southern Cross Care Tasmania and Bupa South Hobart at the expense of care. Helen Marshall and Patrick Anderson, both former facility managers at Southern Cross Care Tasmania talked about the pressure they felt to reduce staff numbers irrespective of the impact on care. Ms Marshall explained that at Southern Cross Care there was certainly a vision to save on costs but she didn't feel the vision was looked upon as to the effect it would have on the facility and its residents.

Peter Williams, another former facility manager at Southern Cross Care Tasmania, would like to see organisations taking the longer term view noting the cost of a sanction and addressing regulatory action can far exceed the hiring of a few additional staff to improve care delivery. Mr Richard Sadek, the Southern Cross Care Tasmania CEO gave evidence that Southern Cross Care Tasmania spent about $1 million on remediation at Yaraandoo after the imposition of sanctions there. There may be a false economy in cutting staff to save money.

Dr Monks, an onsite GP at Bupa South Hobart, was deeply concerned that decisions made by leadership impacted on residents' clinical care particularly in relation to reducing nursing staff hours and a reduction in their level of experience. Between about November 2017 and October 2018 Dr Monks raised her concerns with "everyone and anyone I could" she told us, including her manager, Dr Tim Ross, Ms Jan Adams, then head of the company, and Mr Neal, then general manager of Bupa South Hobart. In her view, these concerns fell on deaf ears.

Dr Monks' concerns were echoed in the evidence given by other current and former Bupa staff. Ms Hechenberger, the former regional director with responsibility for Bupa South Hobart accepted that it would not be possible to Save A Shift at Bupa South Hobart without at least some impact on care. Commissioners, you recall the evidence this morning of Ms Cooper along similar lines. Ms Hechenberger considered that any shift in resourcing staff has a direct correlation on resident care. At the same time, the directive for Save a Shift was that it can only be implemented in circumstances where it would not have a deleterious effect on care. Ms Hechenberger said this would only be possible if the home was overstaffed and, Commissioners, one thing we haven't heard about is overstaffed care homes.

Ms Hechenberger agreed that the implementation of Save a Shift could only have exacerbated the problems with clinical care that had been revealed in Bupa South Hobart's audit history. Ms Webb, former head of operations at Bupa and also a former regional director, accepted there's a danger in trying to apply a one size fits all numbers of hours of care across an organisation as large as Bupa. She said that Bupa South Hobart warranted variation based on its individual characteristics. Ms Carolyn Cooper, who was the interim chief operating officer at Bupa from November 2018 until July 2019, and is now the managing director of Bupa's aged care business in New Zealand agreed and said that in a case of Bupa South Hobart this did not appear to have happened before the imposition of sanctions.

Ms Hechenberger and Ms Wesols, the regional support manager, accepted that the strategy to reduce nursing staff at Bupa South Hobart was:

A completely misguided strategy.

Ms Cooper agreed that Save a Shift was not a policy that she would endorse. Turning to solutions then and looking to the future, we've heard ideas from witnesses about how organisations can better support the provision of quality and safe care. Tammy Marshall told us about the importance of organisational support for the education of staff, particularly in areas where trends in poor quality care have been identified. Ms Marshall, as well as Jo-Anne Cressey Hardy and Ray Groom, emphasised the need for leadership to provide support for facility managers and ensure these managers have the requisite skills. The evidence that has emerged this week tells us just how important facility managers are in the delivery of safe and quality aged care.

Peter Williams explained that nurses will be moved up into a management role but they're not necessarily good managers, they're good clinicians. He said there has to be a lot of work done around the appointment process, orientation and training associated with these roles and, of course, Commissioners, you heard the evidence this morning from Ms Cooper about initiatives in New Zealand identifying the right sort of people in aged care that echoes some of the evidence we've heard earlier in the Royal Commission.

We explored how a focus on quality and safety of care could be supported by introducing statutory duties for those responsible for governing aged care providers to inform themselves as of quality of care. And of course, such duties would echo existing duties in the law and you heard Ms Maxwell giving evidence about that this afternoon. Stephen Shirley, the chairman of Southern Cross Care Tasmania, accepted that directors should take reasonable steps to gain an understanding of the quality and safety of care provided to residents in their facilities. It may be appropriate for board members and other officers of aged care providers to owe a strategy of duty when exercising powers and discharging duties to take reasonable steps to ensure that the provider delivers quality and safe care.

It may also be appropriate for such officers to be under a corresponding duty to inform themselves of quality of care issues. As Mr Engeler of Anchor Excellence acknowledged yesterday, such duties are already owed by directors in relation to the safety of employees under OHS laws. Ms Payne, also of Anchor Excellence, considered that board members of aged care providers should understand the business that they are governing. We also explored whether it would be feasible to require board members to attest that they have taken action to support quality and safe care within their organisation on a similar basis to that required under the Australian Commission on Safety and Quality in Health Care Standards. Mr Shirley noted that:

> *A board has to have a range of skills capable of overseeing the operations of the organisation.*

He acknowledged that their board's directors with clinical experience, Dr McArdle and Ms Alex MacAskill provide invaluable knowledge and experience as medical practitioner and nurse respectively. He said that:

> *Their role is essential and that they will see things that, to me with the best of intention, I don't see.*

Ms Payne referred to the need to have an appropriate skills mix on a board, a point echoed today by Ms Maxwell of the Governance Institute. We also heard evidence about the difficulties involved in carrying out the responsibilities of a facility manager in aged care. Mr Groom called for some form of national training for facility managers. For our part, we consider the training of managers along with other employees must remain the responsibility of aged care providers themselves.

The second theme that we've touched on this week asked the question whether enhanced organisational governance including clinical governance is required. The role of good governance, in particular clinical governance, has also been a central part of this week's evidence. Ms Catherine Maxwell discussed the central role of boards and executives shaping the priorities of an organisation noting that good governance requires transparency, accountability, stewardship, integrity and risk management. She drew the Royal Commission's attention to the excellent guidance material that the Institute has produced to assist aged care providers to implement good governance structures.

Importantly, Ms Maxwell told the Commission that the sector can and should learn from other sectors such as banking and finance, a point that was echoed yesterday by Mr Engeler. In this regard, Ms Wilson and Dr Webster of Wilson and Webster Consultancy, gave evidence this morning about their engagement by Bupa to look at eight Bupa facilities at the end of 2018. Ms Wilson endorsed Ms Maxwell's adoption, in the aged care context, of key components of the ethical framework described in the final report of the financial services royal commission. Those matters are as follows: obey the law, do not mislead or deceive, be fair, provide services that are fit for purpose, deliver services with reasonable care and skill, and when acting for another, act in the best interests of that other.

Dr Webster said that such an ethical framework must exist in a setting where accountability and scrutiny are promoted and there is engagement by residents, their representatives, the staff and management. As Ms Wilson observed, approved providers have to be open, have to listen to residents, their representatives and staff, have to train their staff, and they have to have the right policies in place and be continually reviewing them. Dr Webster said that:

> *Accountability means openness at all levels so right through from the books of an organisation to knowing who's on duty each day.*

Deficiencies. The Commission heard evidence of deficiencies in responding to complaints and a lack of transparency at Bupa South Hobart. Ms Daniels and Ms Eastman gave evidence that the process for making complaints is opaque. Ms Eastman questioned whether there's a process at all. In the case of Southern Cross Care Tasmania its chief officer, Mr Sadek agreed that the complaints process at Yaraandoo was virtually non-existent. Ms Wiles, from Key2Care Proprietary Limited, who gave evidence yesterday afternoon had been a former adviser at Bupa South Hobart. She was overwhelmed with contact from families expressing concerns. This told her something about the culture. The family members had raised issues with local management but had not been heard or there wasn't not a resolution achieved that they were satisfied with.

Further efficiencies in clinical governance existed in auditing and monitoring system of both Bupa and Southern Cross Care Tasmania. At Bupa South Hobart the July 2018 mock audit was not escalated to Ms Hudec or Ms Webb, who were respectively heads of the clinical services team and the operations team. Southern Cross Care

Tasmania had invested in the QPS Benchmarking system which provided useful feedback about performance against clinical indicators at individual facilities. Despite that, two former facility managers at Glenara Lakes, Mr Williams and Ms Marshall, gave evidence that they received no feedback about any QPS reports. The feedback would have indicated that there were deficiencies in the quality of care at the facility.

In addition, the board and the CEO had never read QPS reports prior to sanctions being imposed. It begs the question why have an auditing system such as QPS Benchmarking at all, and the evidence was that it wasn't cheap. Providing consistent care is also very difficult with a transient workforce. One strong theme in the various case studies the Royal Commission examined in 2019 has been that providers that in trouble have high levels of staff disaffection and turnover at all levels. You heard this morning from Ms Cooper about the revolving door of managerial positions at Bupa. At Southern Cross Care Tasmania's Glenara Lakes there were at least five people working in the facility manager role over a period of 18 months from late 2017. The staff turnover can be seen as both a cause and an effect of the problems at these facilities.

Turning to solutions then. Peter Williams said that a clinical governance framework involves joint accountability and clarity of roles. This needs to be at the carer's, the facility manager level and at a corporate level. Clinical governance is about a whole organisation working collaboratively and with accountability to provide effective, safe, high quality and continuously improving care. The results of monitoring must consistently be taken into account and acted upon. Clear and accessible policies must be available to staff and they must be reviewed regularly and kept up to date. A structured process for making and responding to complaints is essential.

How then can organisational culture be improved. There was evidence about the lack of oversight in a deficient organisational culture. In relation to Bupa South Hobart, Ms Webb said:

> *A leader who sits behind a desk trying to lead a care home from there will inevitably have a culture that isn't accountable out on the floor.*

Ms Cooper this morning told us that there was a need for people at every layer of an aged care business to visit aged care facilities. In her view, if you're in the office and you're not in a care home regularly then you're not doing your job well enough. She said that sitting down with care and other staff and engaging with them, as well as the residents and their family is extremely important. Ms Wilson and Dr Webster told us today there was a cultural issue they considered at Bupa South Hobart. Staff and management were, they said, defensive and hostile to scrutiny and advice. As a result, a window of opportunity was left closed and shuttered.

We heard from a number of witnesses about central elements of good organisational culture. Mr Williams talked about the role of leadership in setting an example of positive culture in what he described as a human industry. He explained how as

facility manager at Glenara Lakes he fostered an empathic warm culture by walking the floor, getting to know staff, and eating with residents. Tammy Marshall and Patrick Anderson identified the importance of communication with staff, particularly to test the impact of key decisions. And for Ms Hudec, head of the CSI team at Bupa, she told us that:

> *Leadership is the role of an executive in any organisation and it is to inspire and motivate and engage their workforce. That is about role modelling, that is about creating inspiration, and it's about sharing your vision.*

Ms Maxwell gave evidence about boards of aged care providers. She emphasised the need for the skills of governing boards and observed that board education is necessary but is not being undertaken routinely. She raised concerns about how boards identify risks and make objective decisions. Finally, Commissioners, we ask the question how a funding environment can be created that does not draw resources away from direct care. We briefly touched during the week on the impact that the funding mechanism, the Aged Care Funding Instrument, or ACFI, can have on approved providers' decisions and behaviours. And it can't be ignored that the changes that were made at both Bupa and Southern Cross Care Tasmania were driven by legitimate financial concerns and centred on maximising income and reducing costs.

This is a vital issue that will be explored in more detail in the Royal Commission's work next year, although I will make initial observations at this point. We heard from Mr Andrew George-Gamlyn, the ACFI coordinator at Southern Cross Care Tasmania, that providers across the sector place a great emphasis on ensuring they claim as much as they can under ACFI. In relation to the role of an ACFI coordinator, Mr George-Gamlyn said that most organisations of the size of Southern Cross Care Tasmania would have a role similar to that of an ACFI co-ordinator. In discussing the needs for alternative funding-models, Andrew Crane told us that service delivery could be improved by redirecting the ACFI overhead to frontline services.

We heard different views about how the funding-system could be improved. Mr George-Gamlyn acknowledged the potential for conflict of interest but suggested the current ACFI system was, probably, about as good as it gets. He said ACFI would be improved by stronger financial control regarding opportunities to claim things that you're otherwise not entitled to. Mr Andrew Crane, the former director of finance at Southern Cross Care Tasmania, suggested the introduction of a significant fifth component available to all residents within an aged-care home.

In conclusion, Commissioners: this week we've heard about the risks to the frail and vulnerable residents that may arise when governing bodies of approved providers prioritise financial and funding-considerations over quality and safe care. We must have an aged-care system in which organisations have the governance, leadership culture and skills to ensure that high-quality and safe care becomes not just a stated vision but the daily practice of all involved in caring for older Australians, a system

in which the decision-makers and approved providers consider not only whether they can make decisions such as cutting staff but whether they should make such decisions. This is what our elderly citizens deserve.

Commissioners, I need at this point to address briefly one house-keeping matter, which is to tender three statements which for various reasons have not been tendered during the course of the week. First is a statement of David Neal, who was the former facility manager at BUPA South Hobart. It's WIT.0557.0001.0001. I tender the statement of David Neal.

COMMISSIONER PAGONE: Yes; that's exhibit 13–41.

EXHIBIT #13–41 A STATEMENT OF DAVID NEAL, WHO WAS THE FORMER FACILITY MANAGER AT BUPA SOUTH HOBART, WIT.0557.0001.0001

MR ROZEN: Secondly there is the statement of Maureen Berry, who was a senior executive with BUPA, whose witness statement is WIT.0553.0001.0001. Ms Berry was excused from giving evidence due to her ill health.

COMMISSIONER PAGONE: Exhibit 13–43 – sorry – 42.

EXHIBIT #13–42 THE STATEMENT OF MAUREEN BERRY, WHO WAS A SENIOR EXECUTIVE WITH BUPA, WIT.0553.0001.0001

MR ROZEN: 42. Thank you. And finally we've received just very recently a third statement by Davida Webb, which has been provided by her legal advisers and responds to some of the evidence that was given this morning by Ms Wilson and Dr Webster, and that statement, which, counsel assisting recommend, ought be admitted into evidence, is WIT.0608.0003.0001.

COMMISSIONER PAGONE: Yes. That's exhibit 13-43.

EXHIBIT #1343 A THIRD STATEMENT BY DAVIDA WEBB, WIT.0553.0001.0001

MR ROZEN: Commissioners, it just remains, for me to indicate on the record that both those representing BUPA and those representing Southern Cross Care Tasmania have applied for leave to tender further documents during the course of the week in response to certain evidence that's been led by us. We have no opposition to that application for leave to identify the documents which have been the subject of

considerable correspondence between those instructing counsel assisting and the solicitors for those parties.

COMMISSIONER PAGONE: Well, do we know what the documents are?

MR ROZEN: We – the list is quite lengthy.

COMMISSIONER PAGONE: I think we should leave the question of whether they be added or not to once they've been identified.

MR ROZEN: I'm quite content with that course. I just indicate on record that - - -

COMMISSIONER PAGONE: It may happen rather than will happen now.

MR ROZEN: Indeed.

COMMISSIONER PAGONE: Right.

MR ROZEN: And I can also indicate – this may fall into the same category – that counsel assisting have added documents to both of the tender bundles during the course of the week. There's much smaller number of those documents. Perhaps the best way to leave it at this point, commissioners, so that there's certainties for all parties is that – those matters can be dealt with internally, and we will in due course correspond with the parties, making it quite clear, what the state of evidence is.

COMMISSIONER PAGONE: All right. Well, we'll defer both questions of additions to the exhibits until we can settle upon certainty.

MR ROZEN: Yes. Indeed.

COMMISSIONER PAGONE: Right.

MR ROZEN: Finally, commissioners, I need to indicate that, in accordance with the usual practice, counsel assisting will prepare written submissions about each of this week's case studies in accordance with the directions that you have made today. Persons with leave to appear will be able to make submissions in reply in accordance with those directions, and the findings that counsel assisting seek, in relation both to the BUPA South Hobart and the Southern Cross Care Tasmania case studies, will be addressed in those written submissions.

COMMISSIONER PAGONE: All right. Well, we'll make those directions.

MR ROZEN: Commission pleases. Thank you.

COMMISSIONER PAGONE: Thank you. Well, it – finally just to thank counsel for their submissions and also the legal team for the parties who are legally represented – I'm sure, that they've been – their work is less visible than those of the

barristers who have been making submissions, but I'm sure, that behind the scenes they've all been of great assistance in making sure that the Commission's work is effective and fair. So thank you to them. Thank you to counsel. And thank you to the staff of the facility where we've conducted these hearings for this week. It's very good, to be able to have this facility available; the staff have all been exceptionally willing and accommodating throughout, from our experiences I'm sure, for the rest of the – those who have been here. So thank you to that.

Thank you to our staff, who, I know, work tirelessly behind the scenes. Many of them don't have the glamour roles that you do, Mr Rozen, and they need to be thanked also very much. And also to thank the various witnesses who have given evidence – as most of you've heard, as we've gone along, we've thanked those who've given very emotional accounts, both – to the Commission but thereby very publicly to the world at large, and it's a very difficult task but very, very important for us, that it should happen. So I thank them again and also those who have had a great deal of experience and expertise in a variety of matters that we need to gain sufficient familiarity about to be able to make meaningful submissions. So we thank those witnesses as well. I think the final act now is, simply, to adjourn the further hearing of the proceeding to Canberra, the 9th of December.

MR ROZEN: Commission pleases.

COMMISSIONER PAGONE: Adjourn the court.

ADJOURNED **[3.47 pm]**

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