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

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

MELBOURNE

9.16 AM, WEDNESDAY, 16 OCTOBER 2019

Continued from 15.10.19

DAY 58

MR P. ROZEN QC, counsel assisting, appears with MR P. BOLSTER and MS E. HILL
MR B. DIGHTON appears for the Attorney-General's Department and Department of Health
MS C. HARRIS QC appears with MR M. McLAY for Department of Health and Human Services
MR E. WHITE appears for Australian Nursing and Midwifery Federation (ANMF)

COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: Commissioners, there are two matters flowing from yesterday that need to be dealt with briefly. There were two statements to be tendered for witnesses who are not to be called. The first is a statement of Linda Narelle Sweetman; that's WIT.0526.0001.0001, if that could be brought up, and which I tender.

COMMISSIONER PAGONE: I think the statement of Ms Linda Sweetman will be 11-17.

EXHIBIT #11-17 STATEMENT OF MS LINDA SWEETMAN DATED 04/10/2019 (WIT.0526.0001.0001)

MR BOLSTER: The next statement is the statement of Elsy Brammesan; WIT.0546.0001.0001, and I tender that statement.

COMMISSIONER PAGONE: The statement of Elsy Brammesan will be exhibit 11-18.

EXHIBIT #11-18 STATEMENT OF ELSY BRAMMESAN DATED 04/10/2019 (WIT.0546.0001.0001)

MR BOLSTER: Commissioners, we then turn to the workforce panel on workplace relations. There are five witnesses: Darren Mathewson, Lisa Anne Alcock, Paul Francis Gilbert, Clare Tunney and Jenna Lea Field. They are all in the witness box – the boxes, and if they could be sworn in please.

COMMISSIONER PAGONE: Yes. Thank you.

<DARREN MATHEWSON, SWORN [9.18 am]

<LISA ANNE ALCOCK, AFFIRMED [9.18 am]

<PAUL FRANCIS GILBERT, AFFIRMED [9.18 am]

<CLARE TUNNEY, SWORN [9.18 am]

<JENNA LEA FIELD, AFFIRMED [9.19 am]

MR BOLSTER: Commissioners, there may be one or two appearances that need to be taken.

MS C. HARRIS: If the Commission pleases, I appear for the State of Victoria.

COMMISSIONER PAGONE: Yes, Ms Harris.

MR BOLSTER: Mr Mathewson, we will start with you, your statement should appear on the screen in front of you in a moment. Do you wish to make any amendments to that statement?

MR MATHEWSON: No, I do not.

MR BOLSTER: Are its contents true and correct to the best of your knowledge and belief?

MR MATHEWSON: They are.

MR BOLSTER: Ms Alcock, your statement should appear on the screen. You can see that?

MS ALCOCK: Yes.

MR BOLSTER: That's your statement?

MS ALCOCK: It is, yes.

MR BOLSTER: Do you wish to make any amendments?

MS ALCOCK: No.

MR BOLSTER: And are its contents true and correct to the best of your knowledge and belief?

MS ALCOCK: Yes.

MR BOLSTER: Mr Gilbert, you should see your statement in a moment.

MR GILBERT: Yes.

MR BOLSTER: Do you wish to make any amendments?

MR GILBERT: No.

MR BOLSTER: And are its contents true and correct to the best of your knowledge and belief?

MR GILBERT: Yes, they are.

MR BOLSTER: Ms Tunney, your statement should be there now, do you wish to make any changes or amendments?

MS TUNNEY: There is one amendment that needs to be made at paragraph 18. I have said that United Voice represents members in bargaining in aged care in Western Australia, Queensland and South Australia. We need to add the Northern Territory and New South Wales as well to that.

MR BOLSTER: Thank you. Take that as read. Other than that, the contents are true and correct to the best of your knowledge and belief?

MS TUNNEY: Yes.

MR BOLSTER: Ms Field, that is your statement or it should be very shortly.

MS FIELD: Yes, that is.

MR BOLSTER: And are there any changes that you wish to make?

MS FIELD: No, there are not.

MR BOLSTER: There has been some redactions in your statement that you're aware of, I take it?

MS FIELD: Yes.

MR BOLSTER: All right. And other than that, is the statement true and correct to the best of your knowledge and belief?

MS FIELD: Yes, it is.

MR BOLSTER: We might start the evidence with - - -

COMMISSIONER PAGONE: Do these need to be tendered?

MR BOLSTER: Yes. I do apologise, Commissioner. Each statement needs to be tendered.

COMMISSIONER PAGONE: And presumably tendered separately as separate exhibits.

MR BOLSTER: Yes, please, Commissioners.

COMMISSIONER PAGONE: All right. Well, the statement of Mr Mathewson will be exhibit 11-19.

EXHIBIT #11-19 STATEMENT OF DARREN MATHEWSON DATED 02/10/2019 (WIT.0362.0001.0001)

COMMISSIONER PAGONE: The statement of Ms Alcock will be exhibit 11-20.

EXHIBIT #11-20 STATEMENT OF LISA ANNE ALCOCK DATED 02/10/2019 (WIT.0463.0001.0001)

COMMISSIONER PAGONE: The statement of Mr Gilbert will be exhibit 11-21.

EXHIBIT #11-21 STATEMENT OF PAUL FRANCIS GILBERT DATED 26/09/2019 (WIT.0430.0001.0001)

COMMISSIONER PAGONE: The statement of Ms Tunney will be exhibit 11-22.

EXHIBIT #11-22 STATEMENT OF CLARE TUNNEY DATED 13/10/2019 (WIT.0577.0001.0001)

COMMISSIONER PAGONE: And the statement of Ms Field will be exhibit 11-23.

EXHIBIT #11-23 STATEMENT OF JENNA LEA FIELD DATED 03/10/2019 (WIT.0363.0001.0001)

MR BOLSTER: Thank you, Commissioners. As an introduction, I would like each of you to speak to the people you represent, not the broader union, because we know how many people are in the union or we know how many people are in your organisations but the people you deal with in your daily work. So Mr Mathewson, who do you come across and who do you represent directly in your role at ACSA?

MR MATHEWSON: We represent a majority of not-for-profit aged care providers delivering residential home care and a range of other services to older Australians. In terms of my daily activities, I deal directly, from a reporting point of view, my employee relations manager and my workforce and industry development manager. I also have responsibility geographically for New South Wales, ACT, Victoria and

Tasmania. So on a daily basis, I'm dealing with the chief executive officers of small, regional and rural providers around employee relations and workforce matters, right through to human resource coordinators and employee relations officers, which are the main gamut of those people directly within my membership that I deal with on these matters.

MR BOLSTER: And what are the things that concern them when it comes to negotiating pay, conditions, workforce-related matters in aged care?

MR MATHEWSON: The biggest issue faced and certainly communicated to me is around the financial constraints in developing good enterprise bargaining agreements that provide for enhanced wages and conditions for employees.

MR BOLSTER: Ms Alcock, you are from Melbourne and you work for a union. Who are the people that you represent on a daily basis?

MS ALCOCK: The HWU is a relatively discrete branch of the Health Services Union which has broader coverage than the Health Workers Union. So the Health Workers Union is branch number 1 of the Health Services Union in Victoria. As branch number 1 we have coverage of everyone else that the health services union in Victoria doesn't cover. That branch coverage is incredibly broad. If you can think of it broadly, we cover the lowest paid, almost invisible workforce in the public and private sector health services. So in public sector hospitals, they are your cleaners, personal care attendants, orderlies, admin workers.

In aged care, we cover everyone except for registered nurses, so personal care workers, enrolled nurses, cooks, cleaners, leisure and lifestyle workers, admin, general maintenance, everyone else that you don't necessarily think of in aged care. And then everyone else in the health sector really, so phlebotomists, special technical roles like theatre and instrument technicians; it's incredibly broad.

MR BOLSTER: Let's just talk about the membership in aged care.

MS ALCOCK: Yes.

MR BOLSTER: It's basically the personal care workers.

MS ALCOCK: Yes. It's everyone in aged care except for our registered nurses.

MR BOLSTER: What is the message that you get from that membership, from your interactions with them. What are the frustrations, what are the things that they want to get out of the enterprise bargaining system?

MS ALCOCK: The two most critical pieces of feedback that we receive from members on a daily basis is the alarming rate of occupational violence, and that is just something you have to accept when you work in aged care. And the second is that the incredibly low rate of pay is something that you have to similarly accept and

it is – it's hard to accept because I feel that you can't have a high quality of care if you have workers working poor and working them into poverty, essentially.

MR BOLSTER: You used the word, "they have to accept", "you have to accept". Why do they have to accept low rates of pay?

MS ALCOCK: In terms of low rates of pay, when we're bargaining with employers, it's part – part of the conversation I was having with Darren before we – before this process began is a structural issue. When employers we're bargaining with – I don't want to use the word "cry poor" but when they come to us and say they just don't have the funding because the government mechanisms and structures just don't provide that level of funding to be able to provide the increase in wages, they can't increase those wages to provide them to us through enterprise bargaining.

MR BOLSTER: We will come back to that in some detail later. Paul, Mr Gilbert, we'll turn to you now. Your membership is a nursing cohort.

MR GILBERT: Nursing – nurses, midwives and personal care workers in private aged care.

MR BOLSTER: You represent in the State of Victoria.

MR GILBERT: That same cohort, yes.

MR BOLSTER: The people that you interact with on a daily basis, who are they are?

MR GILBERT: Well, our structure has an organiser allocated to a geographical area, so each organiser might have between five and 40 aged care facilities each, and they report through to an industrial officer. There's 11 of those, and then they report through to me. So often I get – I tend to deal with the either impossible to resolve disputes, or seemingly impossible to resolve disputes, high level disputes, anything to do with the government's nurse/patient ratio legislation, matters that are high risk to the profession, if you like. Something – you know, if there's something that has happened that could bring the profession into disrepute and how we deal with things like that.

The organisers tend to deal with the performance conduct, underpayment-type issues but they can be escalated to me if they become, as I said, a higher risk sort of issue or otherwise unresolvable. So some of them I end up directly involved with and some of them I'm involved with through giving advice and support to other staff members.

MR BOLSTER: What are the issues that resonate from that bottom-up process? What comes through on a consistent basis of being a concern to your members?

MR GILBERT: Not enough staff. Not enough staff; simple as that. The registered nurse staff – the registered nurse membership have professional obligations. They

have to – they can only delegate care to people who they have assessed as being competent, and they don't have – they don't have the staff numbers or the level of skill required for that safe competent delegation to occur. So it's all about staffing and skill mix.

MR BOLSTER: I know you deal with this in your statement and we will get into it in due course, but how does that inform the negotiating process that you are involved with? How do you seek to put the number of staff and care and safety issues into your negotiation processes?

MR GILBERT: We tend to have agreement provisions around safety issues. So there is a shared interest, if you like, I think with employers on health and safety issues, not to the same level that we would like but there's generally some preparedness to do work in that space. On staffing issues, as my statement said, I think we've got three approved providers in Victoria who've got any level of ratio-type staffing arrangement, and otherwise it's just, you'd have to say, been an impossible thing to achieve in bargaining.

MR BOLSTER: We'll, definitely, come back to that. Ms Tunney, your position – you are from WA, and you represent a similar cohort to Ms Alcock.

MS TUNNEY: Yes. I represent carers, enrolled nurses, maintenance and ground staff and catering staff in residential and home care.

MR BOLSTER: And what are the themes that are important to that membership, the membership that you speak to on a daily basis?

MS TUNNEY: We consistently hear that they're concerned about low pay, the erosion of existing conditions, that they don't have adequate training, they don't have manageable workloads, that there aren't enough staff on the floor and that they have significant concerns about job security.

MR BOLSTER: Thank you. Ms Field, you, like Mr Mathewson, represent an employer body in this area. You work industrially for LASA. What's your daily involvement in the workplace-relations context?

MS FIELD: Yes. So LASA represents members from all across Australia. We have a national focus representing members in residential aged care, home care and retirement living, and our membership is across the for-profit, not-for-profit and public and Government space. So on any one day I can talk to any one of our members. However, predominantly, I do speak to the smaller standalone facilities. So I could be speaking to their CEO, their director of nursing, or, alternatively, I could be talking to another member and the HR-manager. It's quite varied.

MR BOLSTER: The process – could I just deal with the employers then briefly. The process for representation amongst the employer representatives: it doesn't have the historical links to unions, or it's not directly comparable to the union situation on

the other side of the fence. How organised is the employee – employer representation for LASA and ACSA? Is it more a case of – you deal with everyone that doesn't represent themselves?

MS FIELD: In my case, it is whoever actually approaches us, saying that we need representation and assistance.

MR BOLSTER: Is that on a one-off basis, or is – is that on an ongoing basis?

MS FIELD: More so on a one-off basis. For example: in an unfair-dismissal claim – if that's what you're referring to – we wouldn't know about those claims, unless that member approaches us directly. But more broadly we do represent our members. ACSA and LASA partner together in the modern-award-review proceedings, where – we do have more of an organised approach there.

MR BOLSTER: So that's when the aged care modern award is fixed every – how many years?

MS FIELD: Meant to be every four years. However, that was – recently was repealed from the Fair Work Act.

MR BOLSTER: And when's the next review of the aged care modern award?

MS FIELD: The current review, which commenced in 2014, is still ongoing.

MR BOLSTER: Right. Let me introduce that topic, because I think it's a starting-point for award – payment and conditions. The aged care modern award provides minimum rates for a full-time aged care worker ranging from $20 to $25 an hour. That's for the carer workers. Is that the bottom line? Is that the bottom in terms of pay in Australia for aged care workers? Or do you come across rates that are lower than that? Would anyone like to comment about that?

MR GILBERT: I'm certainly aware – we have some workplaces that are on enterprise agreements that have passed their expiry date that have rates that are lower than that. We don't any evidence to say whether the employer is paying that rate or that rate, but we know that the modern award rate is displaced because of an – extant enterprise agreements.

MR BOLSTER: What does that sort of rate say about the way in which aged care workers are valued, Ms Tunney?

MS TUNNEY: Well, I think it says that aged care workers are really undervalued. Yes.

MR BOLSTER: Ms Alcock?

MS ALCOCK: I couldn't agree more. I think it places a societal value on that work, predominantly female work, which is undervaluing that work predominantly performed by women.

MR BOLSTER: Ms Field and Mr Mathewson, what is the – what do your members tell you about that rate?

MR MATHEWSON: I can indicate that our members are consistently disappointed with the rates of pay, and I think they were pleased, when the aged care-workforce-strategy report came out, and strategic action 13 indicated that there was a need to lift remuneration in the sector by at least 15 per cent across the board. And for us, that indicates clearly there is a structural need to adjust remuneration, and we do agree with the unions, that our industry has historically been viewed as an extension of care work previously delivered informally in the past, and there is a need to look at it relative to other industries and lift the value, the social image of that work and, absolutely, the remuneration.

MR BOLSTER: Mr Gilbert, we've been talking about a rate that applies to personal-care workers. The position in relation to your nursing membership: how much better is it under the modern award for nursing staff?

MR GILBERT: It's a very comparable equation. I mean the rates are higher under the nurses' modern award for enrolled nurses and registered nurses, much the same for assistance in nursing as it is in the aged care award. Just my little bit of feedback about the rate of pay for personal-care staff: the comment I hear when I go and have meetings is, "I could get paid more, working on the checkout at Aldi," and it's technically true. And so they see themselves as – "Why is my life treated as being – my – what I dedicate myself to being seen as of less worth than that position?". And that's, interestingly, what they tend to compare themselves to, because they see those jobs advertised with an hourly rate of 24, 25 and 26 dollars. Our enrolled-nurse and registered-nurse members are paid more than the personal-care-worker cohort but not by a whole lot more.

MR BOLSTER: What's the modern award for a graduate nurse in aged care?

MR GILBERT: Well, it depends, what role they are undertaking in aged care. So if they get – which we wouldn't encourage them to do – but it happens, where you can graduate and then work as a care co-ordinator – for argument's sake – then that rate would be in the $40 region. But if you come in and do a graduate program, then the rate would be around the $30 mark.

MR BOLSTER: Just on that question: how common is it, for a graduate nurse to come in as a care co-ordinator in an aged care facility?

MR GILBERT: Uncommon, but it's a question of the ability of the employer to recruit someone, some of the time. If you compare a grade 5 – what I call a grade 5 nurse in the Victorian – in a Victorian publicly-run aged care facility – they're on 19

per cent more than that same nurse doing that same job in a private aged care facility, exactly like for like, 19 per cent different.

MR BOLSTER: Do nurses at that level in the public sector get more support from their workplace generally?

MR GILBERT: Yes. They have mandated staffing-levels to begin with. So they know when they come on how many staff are going to be on. They, usually, have support of clinical educators, further people within the nursing workforce who can provide them with additional support, guidance, HR backup; all of those kind of things tends to be greater in that system.

MR BOLSTER: Just might ask Ms Tunney and Ms Alcock about the difference between the aged care personal-care attendant and the public-health personal-care attendant. How much better off is it, to be a personal-care attendant or personal-care worker in public health?

MS TUNNEY: I don't deal with personal-care workers in public health. So I can't comment.

MR BOLSTER: Ms Alcock?

MS ALCOCK: They will be - - -

COMMISSIONER BRIGGS: Sorry. I'm having trouble hearing; if you could, speak closer to the microphone. That would really help things. If you wouldn't mind repeating what you were saying - - -

MS TUNNEY: Sure. Yes. I don't deal with personal-care workers in public health; so I can't comment.

COMMISSIONER BRIGGS: Thank you.

MR BOLSTER: Ms Alcock?

MS ALCOCK: I don't have the figures at hand, they would be receiving considerably more pay. If I could provide two examples – when I spoke to workers, one woman retold the tale to me, that she had to get someone out to clean her gutters, and that person was paid $150 for an hour of work to clean her gutters, and she was only paid $21 to clean a person. And to – everything that goes with that, to provide dignity and care and support to that person. Now, the male worker – $150. That's not fair.

And another woman told me that her partner was working in the aluminium-smelter and he was paid a hundred thousand dollars. Now, he was uneducated. He didn't have any training. And the comparison in labour – when she had to go and get a TAFE qualification to perform the same work and she was only getting paid $21 an

hour for that work, possibly, $40,000 a year at best with penalty rates and loadings. And it doesn't, necessarily, take into consideration also that we have so much unpaid work on top of that. When we surveyed our members, 70 per cent of workers we spoke to – so 1600 people – reported some amount of unpaid labour. Now, there's so much work that's not being paid, and they're being paid only $21 an hour.

MR BOLSTER: Save-a-shift directives from Management: are people familiar with those requirements or those policies?

MR GILBERT: I am in respect to one major provider; yes.

MR BOLSTER: How does the save-a-shift policy work in aged care?

MR GILBERT: It's where you have five people rostered on a shift, someone calls in sick and they don't get replaced and the employer provides some incentive to the site-manager not to replace that person.

MR BOLSTER: The alternative being to get a casual at a higher rate.

MR GILBERT: Correct .....

MR BOLSTER: What's the rate for a casual nurse to come in on an hourly basis?

MR GILBERT: Well, 25 per cent more than for a part-timer; so it's a 25 per cent loading.

MR BOLSTER: And is the casual workforce unionised?

MR GILBERT: Yes.

MR BOLSTER: Do you have members in that? That turns to the question of casual work generally. How much casual labour is relied upon in aged care?

MS ALCOCK: It's actually something that we try and bargain for in our enterprise agreements. The modern award provides that, if a part-time employee works above their contracted hours, they should be paid overtime. Now, in exchange for not putting that into our enterprise agreements, we provide for three things in the alternative. We provide that part-time employees can increase their contracted hours, if they routinely work above those hours, and we preference part-time employees over casual employees. So it's one of the things we're really proud of, that part-time employees in those enterprise agreements should be preferenced over casual employees. So we are quite proud – that in most of our workplaces in Victoria most part-time employees should be preferenced over casuals. But it does happen.

MR BOLSTER: And why – what's the preference of employers? Do you want a permanent part-time workforce, or do you want a casual workforce?

MR MATHEWSON: I think on behalf of our members we could say that the constant and consistent message we get is that permanent work is the absolutely preferred mode of employment. It's reflected in the aged care-workforce census, which is done every four years. So – it's some time ago now, but the figures in 2016 reflected that permanent part-time was the dominant form of employment, around 80 per cent for both residential and home care, and casual sat at about 10 per cent. In fact, both full-time and permanent part-time had increased from the previous survey results.

But I think the reality at the moment – in talking to our members – is there is some slight increase in casuals that we're noticing, and they're putting in place particular intervention strategies to try and reduce any growing dependence on casuals or agency staff for that matter, because the reality is permanent staff or one – staff is your most important resource in delivering quality care, but permanent staff are those that will have the ability to provide continuity of care and that higher level of quality.

MR BOLSTER: Conversion from casual is – from casual to permanent part-time is a feature of the modern award. Is – and it has to be an element of every enterprise agreement that you negotiate; am I correct in thinking that? What are the barriers for casual-to-permanent-part-time conversion? How hard is it, to get a casual to a permanent part-time position?

MS TUNNEY: Well, I'm not sure about the success rates of casual-conversion clauses, but our main concern is that part-timers are underemployed; so a lot of our part-time members are on zero- or minimal-hour contracts, and like the HWU, we've – try to get into enterprise agreements commitments from employers that there will be a process to review the number of hours that part-timers are working, if they're working in excess of their minimum contracted hours, and that the hours be increased, if they're consistently working more.

MR BOLSTER: What are the sort of hours that your members work, and what would they like those hours to be?

MS TUNNEY: On average, I think, our members work anywhere between 10 and 30 hours a week. So somewhere around the 20-hour-a-week mark for part-time carers, I think, would be the average.

MR BOLSTER: Ms Alcock, what's the position with your membership?

MS ALCOCK: We similarly have under-employment and insecure work for our part-time employees. So – engaged on low contracts and then being ramped up into – so engaged on, say, 10-hour contracts and then being engaged on 30 hours a week. So – as if they're being engaged as full-time employees.

MR BOLSTER: What's the benefit for the employer in structuring matters in that way?

MS ALCOCK: Well, when – should they want to change the roster, they can without needing to consult. It provides maximum flexibility for the employer to change the way they roster that flexibility into the workplace.

MR BOLSTER: Mr Gilbert, is that a feature in the nurse situation, nurses given lower hours but expected to work longer?

MR GILBERT: It was a very – there's three – almost three parts to it; it was a very strong feature of the system here going back a decade ago and more. I think, through bargaining, we have, largely, been able to address that use of part-time employees as pseudo-casuals. I think the other half of the equation that is difficult is – because the rate is so low, there is an attraction amongst some in the workforce to remain casual and work 52 weeks a year, because it brings their rate up to a – something like a liveable wage. So I think that most people that we ever speak to do want more hours and occasionally get more hours, but it's still not a static like it is in most other industries, where you know you're going to be working three, four, five days a week. No one gets to work full-time. It's – people are working multiple jobs to get an income.

MR BOLSTER: Question for you, Mr Mathewson and Ms Field: establishing workforce culture would – I would imagine, may I suggest, involve bringing the employees along with you on a – on the basis that they have some sort of guarantee of hours. Would you – how then do you react to staff that want to remain as casuals for 52 weeks of the year? Wouldn't it be better, for them to be brought in as permanent part-time workers?

MS FIELD: From a culture perspective, I would say it's the individual's decision as to what suits their personal circumstance. Just echoing on the comments just then: in my interactions with members, when we are having the conversation around casual conversion, a lot of the time it is the employees' preference, because they've got other commitments such as secondary employment, study commitments, to remain casual and have that flexibility in the way they work. I don't think I've seen – from recollection – any part-time-conversion request refused by an employer.

MR BOLSTER: Ms Alcock, do you have a similar experience?

MS ALCOCK: The majority of workers who we – who responded, that they had multiple employment, responded, that they did so because they were trying to make ends meet. So I think that's indicative, that they need to do that because they're trying to piece together a living wage, and if they were given the option of having security of employment, they would take that.

MR BOLSTER: A worker that wants – workers that you have experience with that want casual-to-full-time – permanent-part-time conversion: how difficult is it, for them to achieve that?

MS ALCOCK: It's two-part. The difficulty is in two parts. Firstly, it's raising awareness. I know that there are – the majority of people out there at the moment don't know about their rights to be able to convert their employment. They just don't know about it. And then when they do know about it, it's hard. Firstly, they have to collect six months of data regarding their rosters. So the onus is on the employee, to prove it, that they've been covering not workers that are sick, on long-service leave, on annual leave, on Work Cover. So they have to prove it. So they have to get over this first hurdle.

Then they have to put together a request to be able that make – substantiate this claim that they can convert their employment and then if the employer denies it, they have to then go to the Fair Work Commission to get their case heard. So we deal with these claims all the time.

MR BOLSTER: Mr Gilbert, do you have a perspective about that?

MR GILBERT: I think one of the other hurdles – and I agree with what Lisa said – I think one of the other hurdles is you have to be performing regular and systematic work and even our part-time workforce doesn't get to work regular or systematic work. So as a casual how do you prove – how do you get to that hurdle when even the part-time workforce don't enjoy that level of consistency.

MR BOLSTER: Why is there so little permanent full-time work in aged care?

MR GILBERT: A question better asked of the employers, I think.

MR BOLSTER: Mr Mathewson.

MR MATHEWSON: The feedback from our providers is part-time does offer a level of flexibility, particularly if we, say, focus on home care, which is a growing consumer-focused environment, and if we see as the years go on that consumers will be more empowered and make more decisions about how they want things delivered and the timing of those, then there is a growing tension between how you offer that stability of work pattern and respond to the consumer that way.

MR BOLSTER: What about in residential aged care where - - -

MR MATHEWSON: In residential aged care that's similar feedback, that it's quite difficult to roster around a large portion of permanent full-time but if I can add to that by saying that we also – there is a preference in some cases for individuals for permanent part-time for a range of reasons, whether that be family responsibilities or the profile of their family and how things fit together for them. And for some people four days a week is for them as large as they want to get. So there is that preference. There's also, in terms of the casual and part-time, we have had some interesting examples ourselves of people that have been casual for 20 years in the same workplace but they've been there by choice because of the way – for example, one

family runs a farm and for them it's about cash flow, not annual leave and sick leave. And so that's how that fits into the dynamic of that instance.

MR BOLSTER: Can we turn to the issue of negotiating rates of pay in enterprise agreements. I would be interested in your experience of the trend in the sorts of – in the range that operates in negotiations over time. At the moment, what's the sort of increase that's being sought. What's the sort of increase that's being offered by the employers and what's the middle ground that's usually reached? Is there a pattern or is there a body of evidence that can assist the Commission there? How much do you ask for, Mr Gilbert, when you start off a negotiation for a particular - - -

MR GILBERT: Too much, it would seem.

MR BOLSTER: And Mr Mathewson, you would agree with that?

MR MATHEWSON: I think at times the feedback, certainly from our members, is that the claims are relatively ambit, and that creates some fear at the front-end.

MR BOLSTER: But it must be ambit on both sides.

MR MATHEWSON: I would probably accept that, yes.

MR BOLSTER: What's the range? How do you traditionally start off, at the moment, a negotiation on an enterprise agreement?

MR MATHEWSON: Well, depending on the environment and you go back some time ago and the range was obviously, I would say, a little bit more generous. But in the current funding constraints environment, the range we are seeing is anything from one to 3.5 per cent.

MR BOLSTER: That's your starting point or that's the end result?

MR MATHEWSON: Well, it could be potentially either. I don't think our members start at zero or 0.5.

MR BOLSTER: And your members, is there a differential across your membership based upon the size of the organisation?

MR MATHEWSON: There's certainly some greater capacity with some organisations to absorb larger increases and not for others. And that's – you know, their particular model that they operate. But what we're actually finding far more of is our members indicating that if they are going to deal with a low level of indexation they get on an annual basis, if they are going to deal with funding constraints, if they're going to maintain staffing because they don't want to offer wage increases, then become – have an impact on rostering; that they're choosing, with a mind to standard 8 around governance that they do have to look to their reserves to start to fund some of these.

MR BOLSTER: Mr Gilbert, what's your perspective from the other side of that negotiation; do your members have the ability to absorb?

MR GILBERT: No. But I think, firstly, the employer position at the base end is usually we are going to do nothing and we are going to duck and hide and hope you go away. Then the next level up is we will give you CPI or government indexation, whichever is the higher. And the next level up in this round has been two and a half per cent and nothing more. So that's the sort of range that they come from. Our pressure point from our membership, obviously, is that they can't understand why they don't get paid the same rates as other taxpayer-funded positions, and that they do critically understand is that if they get a high wage increase, then their hours will be reduced.

MR BOLSTER: Ms Tunney?

MS TUNNEY: Yes, in terms of what we ask for, that differs from provider to provider, depending on where they sit in relation to the modern award rates. So ideally we would want to maintain the same margin from year to year with the award but in recent years we have seen increases to the modern award between three and 3.5 per cent and in enterprise agreements we are typically getting one per cent or 1.5 per cent annual increases or even CPI.

MR BOLSTER: You mention in your statement a particular negotiation where you got a much bigger increase in wages but there were offsetting provisions about leave that were a concern. Do you want to talk briefly to that example of how you end up in a position like that?

MS TUNNEY: Yes. There was enterprise bargaining negotiations with a large provider in WA, I think in 2011, or in any case I wasn't involved in those negotiations, but we were able to achieve 24 per cent wage increases over three years. But that also involved trading off a number of entitlements including annual leave entitlements. But it needs to be said that that came about during a mining boom in WA and that was a significant factor contributing to those wage increases. And it made that provider the highest payer in WA.

MR BOLSTER: I was actually thinking about the example in paragraph 22 of your statement. Do you have that one there?

MS TUNNEY: Yes.

MR BOLSTER: That was a more recent example.

MS TUNNEY: Yes.

MR BOLSTER: And what was the increase that you were able to negotiate there?

MS TUNNEY: In the end we got 1.5 per cent increases over three years.

MR BOLSTER: Per annum.

MS TUNNEY: Per annum.

MR BOLSTER: What was the trade-off to get that sort of increase?

MS TUNNEY: Well, there were a number of award entitlements – well, a number of entitlements that don't meet the modern award requirements. So for instance, the casual loading is at 20 per cent instead of the 25 per cent under the award. There was no provision for certain allowances that are provided under the award such as first aid, telephone, heat, board and lodging, on-call allowances. The travel allowance, significantly for home care workers was at 66 cents per kilometre instead of 78, so that really affects home care workers; they're always using their cars. And also significantly, the Sunday penalty rates were at 75 per cent instead of 100 per cent that's under the award.

Through a process of us making objections at the Fair Work Commission when the agreement was submitted, we were able to get an undertaking that the Sunday penalty rate be increased to 80 per cent. But it was clear throughout this process that the provider was only prepared to increase entitlements in a very piecemeal incremental way, sufficient to get it just over the line to pass the BOOT test.

MR BOLSTER: So to get a 1.5 per cent increase over three years you had to trade off all of those other award entitlements otherwise present in the modern award?

MS TUNNEY: Actually, we didn't have to trade those off, they weren't there to begin with, so we weren't able to improve those.

MR BOLSTER: So explain how, then, it was able to satisfy the BOOT?

MS TUNNEY: I don't know.

MR BOLSTER: What is the BOOT, Mr Gilbert; can you give us an explanation of how it impacts on these sorts of negotiations?

MR GILBERT: The BOOT is the better off overall test which compares the enterprise agreement that the Commission is considering approval of with the modern award equivalent provisions. I think it's a feature of all of our statements. I don't think it's any secret that we are all a bit annoyed with it, partly because it's based on the modern award which itself has no history in Victoria. It's an amalgam of a whole pile of State conditions into a set of Federal conditions that don't apply to anyone in Victoria and never have. But when we go to get an agreement proved, the Commission is then looking at the agreement and saying, "Well, how is it that the modern award says six weeks of annual leave, but your enterprise agreement says five?"

Well, I'm sorry, but we've never had six weeks of annual leave in Victoria for this group of people. So you've got this sort of weird – it's not the end of the world sort of a problem but it is a problem because it tends to delay or, in fact, complete scarper the approval of an enterprise agreement which is obviously a bad outcome for our members. It's not like we've traded something off. They're missing out on something for not getting something that they never got originally.

MR BOLSTER: Is it fair to say that, historically, the awards are very different on a State and Territory basis across the country?

MR GILBERT: They are indeed, and I think that's one of the dilemmas that we face as unions, is some employers understandably get this rather tickly idea that they might like to have a national agreement which then throws up all of that tricky State historical differences. Every State had their own State industrial tribunals that set State wages and conditions and they differ quite markedly from Queensland, New South Wales, Victoria, Tasmania, etcetera, and that becomes – unless you're going to build everybody up to some level, it's not going to get approved.

MR BOLSTER: Do I take it that the enterprise agreements in Victoria or in Tasmania or in Queensland generally derive from the awards that the parties in those States have been familiar with over time and that their representatives have worked with over time?

MR GILBERT: A good 80 per cent or more of the text in an aged care enterprise agreement can be traced back word for word to State – to State awards.

MR BOLSTER: Mr Mathewson, do you have a view about what Mr Gilbert has been saying there?

MR MATHEWSON: I think all that is correct. There is those historically State-based arrangements that reflect that and certainly frustrate where a growing group of national organisations find it very hard to bring that jigsaw into a single arrangement, and then try to benchmark it against the national award when, in fact, it's the local conditions that are more relevant. The other factor that has encouraged that is whilst our organisation was active in the employee relations space in assisting members in bargaining in New South Wales and ACT and through our template agreement created a level of consistency across that state, what occurred in other States when, I suppose, what was called industry bargaining or pattern bargaining started to disappear and be prohibited, what we saw is providers going and using their own service providers in terms of industrial relations and so a whole range of different bargaining agreements has occurred in those States from those historical circumstances but everyone is also doing their own thing, different expiry dates, different conditions and agreements so it has become very diverse, and very hard to untangle.

MR BOLSTER: All right. Now, Mr Gilbert, I wanted to ask you about how you have, in Victoria, managed to involve ratios in enterprise bargaining; how has that come about?

MR GILBERT: In terms of private aged care?

MR BOLSTER: Yes.

MR GILBERT: Well, we've only achieved it in three approved providers, and I guess they've been approved providers who were prepared to step out into the light. I don't mean that in the way it sounded but, you know, it brings some – I'm sure some of the other employers weren't too pleased that they did it but – so TLC included what are reasonable ratios, not good ratios but certainly a lot better than other staffing levels we have seen.

MR BOLSTER: How do they compare to the public sector ratios in this State?

MR GILBERT: They're quite comparable except on night duty and they don't include – so when they say one to seven, one to eight, one to 15 in that agreement that includes the nurse in charge of a shift; in the public sector, the nurse in charge of a shift is in addition to that.

MR BOLSTER: All right. And what is the night difference?

MR GILBERT: I think it's one to 22 and a half versus one to 15.

MR BOLSTER: Now, is that going to be a negotiating tactic that is pursued by your union across Victoria in the future?

MR GILBERT: We have pursued that in every enterprise agreement; it's just these are the only three that have agreed to do anything reasonably concrete. We have preserved the 24-hour registered nurse cover in almost all of our enterprise agreements but you've got to keep in mind that when that was put in the agreement we had one registered nurse for every 30 beds. Now, we've got one registered nurse for every 100 beds.

MR BOLSTER: What's your success rate for the three – how many have you gotten nowhere with that sort of demand?

MR GILBERT: About 157. No, I think there's about 180 enterprise agreements in Victoria for private aged care, and we've got three that have something beyond 24 hour registered nurse.

MR BOLSTER: Is that, Mr Mathewson, something that has been pursued in any other jurisdiction other than Victoria?

MR MATHEWSON: Not to my knowledge.

MR BOLSTER: Ms Field, have you come across that?

MS FIELD: I think I have seen a lot of claims in New South Wales with the ratio claim.

MR BOLSTER: And are they picking up the themes from the Victorian experience?

MS FIELD: I couldn't say where the background to that claim came from. But from the employer perspective, my understanding was that the claim was refused on the grounds it was an operational matter.

MR BOLSTER: And when did that particular development start in New South Wales?

MS FIELD: I think the first time I saw it would have been around 2017 but that was around the time that I started negotiating, so it could have been prior to that.

MR BOLSTER: Is there a prospect of including a clause along these lines in the modern award, Mr Gilbert?. Is that something that is being considered in any action you take to amend the modern award?

MR GILBERT: We don't think that would be something we would get successfully put into a modern award.

MR BOLSTER: What's the barrier for that in the modern award context?

MR GILBERT: Well, the modern award considerations that the commission has go to things like, to use the capital E, the efficiency, productivity, flexibility, everything that counters against having some mandated staffing level that was meaningful.

MR BOLSTER: Why doesn't the Commission have anything to add to the equation about the safety of the patients?

MR GILBERT: Well they wouldn't see that as their job. That's the job that the Commonwealth, in this particular circumstance.

MR BOLSTER: All right. So, Ms Field, we were talking about the BOOT. What's your membership position about the way in which the BOOT operates?

MS FIELD: It is becoming increasingly more difficult to get an enterprise agreement approved by the Fair Work Commission without, I guess, significant undertakings from the Fair Work Commission or alternatively a lot of back and forward between all of the negotiating parties at the time of lodging an EA for approval and going through that process.

MR BOLSTER: Sorry, I didn't mean to cut you off.

MS FIELD: No, sorry. It's also extending out the time that it takes to get an enterprise agreement to be approved, too, and that it does cause a lot of frustrations, I'd say not just from the employer perspective but also the employee side because then that can have flow-on impacts to new terms and conditions being passed onto staff.

MR BOLSTER: Ms Tunney, what are the issues about getting the consent of your membership to an agreement that you've negotiated? What's the process that's adopted for giving them advice about what they should do when you reach an agreement?

MS TUNNEY: Well, typically after negotiating an agreement, we will go out to membership and highlight for them the advantages and disadvantages under the agreement. If it's a really good agreement, then we will recommend to members to vote it up. If it's not a good agreement and if there have been significant, you know, losses for them, then we would recommend that they don't vote it up. Yes, where it's sort of middle of the range and we have low density, then perhaps we would just highlight the pros and cons and then leave it to workers to decide.

MR BOLSTER: What does low density mean in that context?

MS TUNNEY: Well, I suppose it can mean anything under, you know, 20, 30 per cent.

MR BOLSTER: In terms of membership?

MS TUNNEY: Yes.

MR BOLSTER: Right. And what is the typical voter participation in these sorts of negotiations? How engaged are the workers - - -

MS TUNNEY: Where we - - -

MR BOLSTER: - - - with these processes?

MS TUNNEY: Yes. Where we have higher density, there can be higher participation rates so up to, you know, 70 or 80 per cent voter participation but we also do have agreements where there has been as little as 10 per cent participation rate and the agreement has been approved. Typically, we find in the home care space that there's much lower participation rates and that's a sector that we find extremely difficult to organise in because people are working in private homes, they don't have regular workplaces and we don't have access to those private homes.

MR BOLSTER: Mr Gilbert, your experience in the same context?

MR GILBERT: Very similar. We – you know, the agreements – it's very rarely that you conclude an aged care agreement where you are full of joy and vim and

happiness for reasons I've already said and, you know, we have to go out and say to people, "Well at this stage it's either that or you're preparedness to take protected industrial action, which may or may not improve that but with your support we will go out and try and improve that. If you vote no, then don't vote no unless you are going to vote yes to protected industrial action because that's the only other option". And it's not a comfortable place for people who provide care to take protected industrial action.

MR BOLSTER: How common is it?

MR GILBERT: It's relatively rare, I would say, in private aged care. We have gone through it cycles of it being reasonably common and the Bupa experience was obviously one of those, but the industrial action probably, in terms of the pressure points for Bupa probably had less impact than finding, you know, five by three metre billboards out the front of every facility every day.

MR BOLSTER: We will come back to the Bupa situation which you cover in your statement briefly. Ms Alcock, do you have a perspective on the matters we have just been discussing?

MS ALCOCK: I couldn't agree more that the difficult position that workers face when they make the decision to vote no is very real that you either face lengthy industrial action which, for low paid workers, can mean no income if they go to the picket line or a reduced income if they take a less militant form of industrial action. So, you know, even wearing a T-shirt can mean that your employer can dock your wage by a percentage. So there's a really – there's a real impact on a worker if they decide to take industrial action to try and force an outcome.

And even then, if you take industrial action in the aged care setting, there's a very real possibility that the government will call that action off and say you can't take industrial action because of the impact on your residents. There's a risk to health and safety which means that we find ourselves in a workplace determination space. And then the outcome is possibly CPI, so you are not going to get a better outcome than what we will get in bargaining, so we're in a really difficult space here.

MR BOLSTER: In your experience, have you been involved in industrial action in the aged care space?

MS ALCOCK: No, but my colleague was involved in the Bupa - - -

MR BOLSTER: Tell us briefly, how did the Bupa industrial action end up?

MR GILBERT: What was the outcome?

MR BOLSTER: Yes.

MR GILBERT: Not nurse to patient ratios, I can tell you that much, and that was a bitter disappointment to members because that's, to be honest with you, all they really cared about.

MR BOLSTER: What was the issue that they took action about?

MR GILBERT: Yes, that could be legally trick – I'll just – I'll - - -

MR BOLSTER: You've covered it in your statement.

MR GILBERT: I have. I have. And look - - -

MR BOLSTER: Perhaps you could summarise it.

MR GILBERT: The context at the time was that there had been a couple of quite poor agreements proposed by Bupa without consultation with us, so just gone out to members. Then they introduced a proposal to substantially cut the registered nurse workforce and that triggered - - -

MR BOLSTER: By how much?

MR GILBERT: It was, in Victoria, 23 positions.

MR BOLSTER: Was that across all facilities?

MR GILBERT: Yes.

MR BOLSTER: On a basically on a – the same reduction in each facility in Victoria.

MR GILBERT: Proportional to the bed numbers, more or less.

MR BOLSTER: Just to bed numbers.

MR GILBERT: The EFT of the positions was proportional to the size of the facility. So it was actually, I think, 70-odd positions that were being made redundant but about 40 of those or more were going to be able to be redeployed. So there was a net reduction of, I think, 23 registered nurse positions. And everyone from carer to enrolled nurse to other registered nurses knew that that was not going to be something that they were going to be able to cope with. And so that probably triggered their angst more so than anything else.

MR BOLSTER: What was the end result of the industrial action?

MR GILBERT: They didn't get those positions back. And we had to – I don't like the word "sell" but I guess it's the only way you can describe it, that the only way

we're going to get – we are not going to get ratios out of the likes of Bupa; if we're going to get ratios it's going to have to happen at a Commonwealth level.

MR BOLSTER: All right. Now, when did that situation resolve itself?

MR GILBERT: It resolved itself in sort of – the November – it must be 2108; is it? I don't know. 2017 – 2017.

MR BOLSTER: And has there been any recent developments in that space since that time?

MR GILBERT: Only that the – in some cases the care hours have dropped a bit. We took the case to the Federal Court – about consultation. And we didn't win that, because for a range of reasons the Federal Court didn't consider it to be a significant effect and major change. So Bupa were, largely, free to continue to implement that. Bupa – I don't think it's any secret to this Royal Commission, that Bupa are struggling to meet the current accreditation – the previous accreditation standards in quite a number of their sites. That – whether there's a link there or not: I'll leave that to the researchers, but - - -

MR BOLSTER: All right. Now, Ms Mathewson, Ms Field, you don't represent Bupa; your members are very different entities to Bupa. What's your perspective of what Mr Gilbert's had to say there?

MR MATHEWSON: Look: what I can report is the pressures that exist on our members currently. And, obviously, running organisations in the context of good governance, they would have to, as all businesses do, set targets. What we're finding is they have to be flexible around those targets, particularly in terms of the financial operation of the business, because they're taking decisions now that indicate that they will lessen their ability to provide surpluses to re-invest in the business, because they don't want to compromise the care. And, obviously, one of the critical inputs to the delivery of that care is staff.

MR BOLSTER: Do you come across employers wanting to engage your services in relation to cutting of care-staff hours? Is that something that comes across your desk?

MR MATHEWSON: Our members do, at times, contact us in terms of a range of issues described as major change or others would describe as restructuring. Some of that occurs at the time when we get the announcement of the indexation, which this year was 1.4 per cent; so that's how low it travels at, and they come under pressure to consider how they will continue to remain viable. In most cases, those members of ours that contact us at that point are really struggling to keep their doors open; so it becomes a question of survival. Our brief in that situation is to ensure they comply with the requirements of the modern award and/or what's in their agreement.

MR BOLSTER: And – but do you have any direct experience of cutting staff in the same way that Mr Gilbert relayed the BUPA experience?

MR MATHEWSON: At various stages in the past, there have been organisations that have, at times, decided they will restructure their rosters or make different arrangements. I've got to say the more-recent trend is an indication that they want to stabilise their staffing-arrangements.

MR BOLSTER: Stabilise their .....

COMMISSIONER PAGONE: Mr Mathewson, have I understood you correctly about what you've just said, that some of your – the viability of some of your members is put at risk by the prospect of increasing wages by about 1.4 per cent?

MR MATHEWSON: What I indicated, Commissioner, was that the indexation that's provided by the Commonwealth is – was announced at 1.4 per cent. So, therefore, that's an indicator, when they start to analyse and predict what they can offer on the bargaining-table in terms of wages.

COMMISSIONER PAGONE: So in other – so does that mean that what I should have understood you to have said was that an increase by the Commonwealth of 1.4 per cent is what gets notified – and the viability is caused by what or the risk to viability is caused by what?

MR MATHEWSON: If I understand what you are saying, Commissioner – the Commonwealth announces an increase to subsidies by 1.4 per cent.

COMMISSIONER PAGONE: Right.

MR MATHEWSON: And, therefore, for that organisation, which may have limited reserves at that point in time – and I'm, probably, talking about single-service regional providers that – who may be in the midst of bargaining; then it becomes a real pressure valve in terms of wanting to meet the wage claims, which may well be valid, of their employees and then continuing to operate – also considering that the modern award or the Fair Work increases have travelled, generally, at around three per cent. So most of our providers indicate that, when the Commonwealth announces its increase to subsidies, it travels at half what are the announced annual pay rises in the award.

COMMISSIONER PAGONE: So you've said a couple of times now that any increase beyond the subsidy would be dipping into reserves rather than for example into profits. Why is the link so clearly one of reserves rather than just profitability?

MR MATHEWSON: I think the approach we take is to indicate that in terms of good governance we would expect our members to have reserves to cover all eventualities that may occur in this space. They have collected those over the course

of the years, and they may well be called profit surpluses; essentially, that's what they are.

COMMISSIONER PAGONE: But – so you're talking about current-year reserves as well as past-year reserves? I see.

MR MATHEWSON: Yes.

COMMISSIONER PAGONE: So it might be, that it's a question of reducing the increases to the reserves that you'd be making on a current-year basis.

MR MATHEWSON: That's correct; that might be the decision.

COMMISSIONER PAGONE: I see.

MR BOLSTER: Ms Field, did you have anything you wanted to say on this topic?

MS FIELD: Probably very similar to Mr Mathewson. We do have similar queries come across our desks. I would say, probably, more recently those types of queries around redundancies have declined somewhat. And I couldn't give you an explanation as to why, I think, just the workforce is starting to – and members genuinely do want to stabilise the numbers of workforce that they have.

MR BOLSTER: Could that have something to do with the cost of offering a redundancy?

MS FIELD: I wouldn't have a view on that.

MR BOLSTER: Does anyone have a view about that? Are employers stretched that they – so stretched that they can't offer redundancies? Has that been suggested as a reason why there is stabilisation?

MR MATHEWSON: I haven't come across that. I'm not saying it may not be the case, but I haven't come across it directly.

MR BOLSTER: Perhaps dealing with the question the Commissioner was asking you about 1.4 and 1.5 per cent funding-increases: if you're tied into a three-year enterprise agreement that is 1.5 per cent a year, which would seem to be fairly typical, what does – what is the option there for the employer?

MR MATHEWSON: Look: for the employer, the option is to look at other efficiencies to ensure that the organisation remains viable. But I've got to say the ability to find those efficiencies over the years has declined. They're really operating as efficiently as they possibly can in most cases.

MR BOLSTER: Is there a trend away from longer-term enterprise agreements as a result of funding uncertainty?

MS TUNNEY: Certainly our membership has indicated that they're less inclined to be tied into longer-term agreements when the wage increases are so small; so we are seeing shorter-tender agreements at the moment.

MR BOLSTER: What – how often then do you want to renegotiate?

MS TUNNEY: So we've got agreements of 18 months or two years instead of – in the past, where we've had three- or four-year agreements. So – but with approval times in the Fair Work Commission, often that means that we're bargaining again within six months of just having approved the last agreement.

MR BOLSTER: Mr Gilbert, what's the position of your membership? Do you want to lock the employers in for four, five years, or do you want to have flexibility in case there's a funding-increase in the next 18 months?

MR GILBERT: We would tend to go for the longer agreement; to the extent we've done shorter agreements, that's been at the employer's approach, not ours.

MR BOLSTER: Mr Mathewson, do you look for a longer or a shorter agreement on behalf of your members?

MR MATHEWSON: It would be up to the individual provider, to choose, and that varies. But there is a bit of a trend within the current funding-constraints to look at how they can take a more short-term measure until, they think, things might improve.

MR BOLSTER: And what's the improvement that they are looking for?

MR MATHEWSON: Our members for some time have been indicating they would like a greater injection of funding into the system by the Commonwealth to ensure that they can undertake the sort of improvements that they need to do.

MR BOLSTER: Is there an expectation of that happening in the short term, medium term, long term?

MR MATHEWSON: We hope it's sooner rather than later, but it's been a long time till now. And it's been a difficult road for them.

MR BOLSTER: Ms Alcock, do you have a view about that?

MS ALCOCK: Social-and-community will not negotiate agreements beyond two years now. It is our members' preference, to have an agreement that is locked in, to provide some planning for their lives.

MR BOLSTER: Why not then four years?

MS ALCOCK: Our members will prefer four years.

MR BOLSTER: And what do the employers tell you when you ask for four years?

MS ALCOCK: "No".

MR BOLSTER: Thank you. Could we turn - - -

MR GILBERT: Could I add something to that? In my industrial life-time there have been three times that the Commonwealth Government have increased taxpayer subsidies to aged care to improve wages, and not once did that deliver a dollar in improved wages.

MR BOLSTER: When were those occasions?

MR GILBERT: First time was under the Keating government; second time was when Peter Costello was treasurer, and the third time was the last Labour government. And that was converted back into general income by the – I think, the Abbott government.

MR BOLSTER: And what year was that last increase, and how much was it?

MR GILBERT: I can't remember what the amount was, but it would have been 216, 217, something like that.

MR BOLSTER: Funding increases - - -

MR GILBERT: Wages compact – sorry.

COMMISSIONER BRIGGS: Could I just ask a question. Is that properly documented? Do you know?

MR GILBERT: The first two are in my statement in detail.

COMMISSIONER BRIGGS: Yes.

MR GILBERT: And the last one, I think, is – was known as the workforce compact, and it was money that would be set aside and could only be used, if agreements were reached – that contained certain improvements. And then that link on that requirement was removed after the change of government, and the money was – just flowed out to providers without that link.

COMMISSIONER BRIGGS: And if the money went out without the link – what was necessary, to have that link achieved? In other words: what would've been necessary, to have the nurses' wages increased?

MR GILBERT: The compact contemplated an employer entering into an industrial agreement that gave effect to certain wage outcomes, and the money wouldn't flow, unless they did that.

COMMISSIONER PAGONE: So in the three examples that you've given, there was an increase in Commonwealth funding, but it wasn't directed to increased wages.

MR GILBERT: It was publicly stated, that it was directed for that purpose. So in – and I think I quote Peter Costello's budget speech where they – something like 211 million over four years that, in his budget speech he said quite clearly, was for that purpose, and you will see no change in wage outcomes before and after that event.

MR BOLSTER: So when you went to the negotiating-table for the enterprise agreements that followed that, what was the employer response?

MR GILBERT: "Well, we're always under-funded. It just helped us catch up."

MR MATHEWSON: If I can add something to that, counsel, because – we were involved in the – in that third example of the workforce supplement. And we, certainly, got feedback from members directly, when that $1.2 billion was absorbed into funding, that they would look – it was their intention and it was appropriate, considering the circumstances, the ones that spoke to me: that they would flow that to staffing and, where they were negotiating, they could look at increases. But I think the relevant factor in terms of how that was set up is it related directly to negotiating a particular enterprise agreement, and one of our issues with that was – the larger providers were quite keen to progress it, because they had the capability to do it, and they had agreements in place, and they had the ability to resource those discussions and negotiation almost immediately. The concern we raised was that – what about the regional providers that have agreements, but they will have problems resourcing those being renewed - - -

MR BOLSTER: When you say "problems resourcing those", what do you mean?

MR MATHEWSON: I mean within their staffing-structure they have a – may be a CEO and someone who does the finances and – but they don't have a designated HR structure or specific resources they can apply to those things. And the other relevant factor: we were concerned, that in industry like home care is – that is developing, that where they haven't got an enterprise agreement, they would miss out on funding simply because they haven't got an agreement. So we wanted to see some connection between – not just the enterprise agreement but some other mechanism that didn't disadvantage what we call the small, regional, rural and remotes and home-care providers.

MR BOLSTER: Let's talk about home care briefly. The home-care providers that you represent and you represent, Ms Field: to what extent are they engaged in enterprise agreements with their staff, or is it a far more casualised agency labour hire-type approach?

MS FIELD: Very rarely will I see an enterprise agreement just solely dedicated to home care. There are a few that I'm aware of that have home-care classifications

and specific home-care provisions within them – however, not more broadly in my experience.

MR BOLSTER: Are they larger providers, larger home-care providers?

MS FIELD: Predominantly; yes. Yes. In my statement I've referenced a LASA model enterprise agreement, and we do have home-care classifications under that. That does have a number of single-site providers, but they wouldn't utilise those home-care classifications; they would utilise the residential-aged care stream.

MR BOLSTER: So to what extent would the home-care worker be covered by the sorts of agreements that we've been talking about today – from your experience?

MS FIELD: Very rarely in my experience, because most home-care workers and providers that I work with operate under the award.

MR BOLSTER: Under the award. Mr Mathewson?

MR MATHEWSON: Well, we've seen not only an increase in approved providers into this home-care space. Some of those would be quite small and wouldn't be subject to or wouldn't have in place enterprise-bargaining agreements. So what we're, probably, finding is the larger players in the home-care space have enterprise agreements, but a large portion of home care would be dependent on the modern award, whereas residential care is far more sophisticated, and there's a larger spread.

MR BOLSTER: The recent funding-increases in home care linked to packages: does that have an opportunity to filter through into wages – in your experience, anyone's experience, on the panel?

MR GILBERT: No. I can say that – we've, obviously, got members in some aspects of home care, particularly what used to be the Royal District Nursing-Service, which has now become Bolton Clarke, and the impact in that instance is that they've in fact – all new staff that have come on board since that time have been put on a low-rate Queensland agreement that's never applied to the Royal District Nursing-Service in Victoria. So we're getting the opposite effect of any improvements. We're getting – we're going backwards quite rapidly in that space.

MR BOLSTER: Ms Alcock, do you deal with home-care workers?

MS ALCOCK: We do cover social-and-community home care. Very few are covered by enterprise agreements, and the enterprise agreements that do exist are zombie agreements, agreements that were created under work-choice legislation; so they're quite old collective agreements. They provide very few terms and conditions, very low rates of pay under the social-and-community award. They're really invisible workers. It's really hard, to organise them, because they don't have a central location; so it's hard to – there's really low visibility, and the terms and conditions provided under that award are really minimal. There are women right

now, sitting in their cars, waiting to go into someone's home and not being paid for that time. And that isn't their time. So they're not paid for kilometres travelled. They're not paid to travel between homes. That's not their time, and they're not paid for any of that work.

MR BOLSTER: Let's talk about that particular workforce - - -

COMMISSIONER BRIGGS: Before you move on, I just want to come back to this question of – three times Governments have allocated additional money to increase, I think – nurses' wages, I think; was I correct on my understanding? And three times it didn't occur for one reason or another. What would be necessary, to make that occur? Does it require – because of the current fragmented arrangements between enterprise agreements and basic awards, does it require a piece of government legislation to make it occur or what, Mr Mathewson?

MR MATHEWSON: One of the things that we've talked about in the past, commissioner, is the frustration when you look at – the award system, which set – you'd hope, set the standard for the industries, is dealt with but never with a major funder in the room as a party to those discussions. If that's the valid safety net in terms of wages, when – that is the first port of call in terms of how you make a decision as the Government, to support the increase of wages, and it may well be in line with strategic action 13 from the workforce strategy by that 15 per cent and then flow that through to the award system as the first step.

COMMISSIONER BRIGGS: Thank you.

MR BOLSTER: Isn't one answer to this to have – to bring the Commonwealth to the table and have some form of accord between the peaks across this industry? That is an understanding, an agreement about funding being tied to increases in worker rates of pay.

MR MATHEWSON: If I recall some comments on Monday by Professor Kathy Eagar, where – she talked about separating accommodation, hospitality and care for a similar reason, to ensure that the funding flowed to that, and it's, certainly, a structural change that should be very – should be considered.

MR BOLSTER: Isn't - - -

COMMISSIONER BRIGGS: Well, otherwise the Commonwealth is just throwing money away and getting absolutely no outcome and its intention is not being fulfilled. That's right. Isn't it.

MR MATHEWSON: That can be argued; yes.

COMMISSIONER BRIGGS: Yes.

MR BOLSTER: In this entire process to what extent does quality and safety, which are the hallmarks of this Royal Commission, quality and safety – to what extent do they inform the process at the moment, other than for example in Victoria, where we have a limited adoption of ratios in enterprise agreements? How does it ever enter the bargaining discussions that you have?

MR MATHEWSON: I think it does inherently. The enterprise agreements have the ability to enhance wages and conditions for the workforce. The workforce is the most significant contributing factor to quality and safety. So – it's, probably, not overt. It should be, because that's the most crucial input into what we deliver.

MR BOLSTER: Ms Alcock, do you have a view about quality and safety? How could they be involved in the workplace-enterprise agreements that you negotiate?

MS ALCOCK: I think it should, probably, be considered more, because quite frankly I think we have a culture at the moment which accepts that in aged care and social community – that if you work in this industry, you should be prepared to be assaulted and sexually assaulted on a weekly basis.

MR BOLSTER: We'll come back to that after the morning-tea break. That's a discrete topic altogether. But - - -

MS ALCOCK: But I mean, in terms of the quality of care that we can expect from our workforce – you just can't accept it, when they're working poor. You can't accept a high quality of care from workers on $21 an hour.

MR BOLSTER: Mr Gilbert?

MR GILBERT: I think I'll give an example; until very recently – and it's still the case even now – that if you accept that someone having a base qualification of a certificate 3 is desirable to work in aged care – we still get pushback today from employers saying, "Well, I don't require my employees to hold a cert 3; so I'm not going to pay the rate of pay that applies to someone who has a cert 3". So even though the – because most of the agreements are based on the award that say, if the employer requires you to have a cert 3, you get paid this amount. So the employers say "We don't require you to have one. So we're not going to pay".

MR BOLSTER: How common is that?

MR GILBERT: It's increasing less common, because our enterprise agreements focus hard on it, to make sure it goes away, and it's just been dealt with, I think, in an award review that some of the employers might be able to speak to more broadly than me, because we don't have anybody covered by that award. So it's a bit - - -

MR BOLSTER: And what sort of person are we talking about? Are we talking about a personal carer?

MR GILBERT: Yes. Personal carers. Yes.

MR BOLSTER: And employers tell you they don't need them to have any qualifications.

MR GILBERT: Correct.

MR BOLSTER: And what sort of employers – without naming them – are we talking about large organisations or small organisations?

MR GILBERT: I think the common denominator is, probably, the person – people who represent those smaller employers. So it's not something we hear from the more-corporate employers; it's the more-backyard variety.

MR BOLSTER: That's something they'd never hear from ACSA or LASA in the context that you operate, I take it, Mr Mathewson.

MR MATHEWSON: That's correct.

MR BOLSTER: Ms Field?

MS FIELD: Yes. That's correct.

COMMISSIONER PAGONE: Just before you move on, just taking up the point that's been talked about, about how you would bring about an outcome, that any increase by the Commonwealth would be – would flow through to wages – how would it work, if, Mr Mathewson, you had an arrangement whereby the Commonwealth were a party to the agreement? What would be the mechanics of it, do you think?

MR MATHEWSON: Well, considering the amount of bargaining agreements across Australia it would be a significant resourcing exercise, but I would expect, if the Commonwealth was inclined in any way, it would probably be towards being party to the proceedings around the awards rather than actually being a direct party to the agreements.

COMMISSIONER PAGONE: Presumably the current arrangement simply is that there's an amount that's paid to people and how that then gets divided up between the various expenses that the operators have is largely left to the operators. But if the Commonwealth wanted to ensure that a specific amount be directed to salaries and wages, how might it practically be done?

MR MATHEWSON: I think there's an – well, I mean, firstly, starting with the award system and then creating a link in the movement of the award system to the various agreements, that it acts as a safety net, too, so – and whether you could do that through Fair Work. I haven't been a practitioner at that level for some time. So I would probably have to have a think about the mechanisms for that.

COMMISSIONER PAGONE: Is it safe to assume that 100 per cent of the wages does come from the Commonwealth?

MR MATHEWSON: I think – the Commonwealth provides 80 per cent of funding into the sector. So some of – you know, the majority of that, yes, would come from the Commonwealth and some would come from the fees that consumers pay. It would be a different mix per organisation.

COMMISSIONER PAGONE: Of wages as well as other expenses?

MR MATHEWSON: Yes.

COMMISSIONER BRIGGS: But in all likelihood, Mr Mathewson, you would have to assume that that money would largely come from the Commonwealth because of the quite controlled arrangement of fees that apply to users. So the Commonwealth's current contribution of 80 per cent might rise – of the total cost might rise at the margin to 80.05 or 10 or whatever per cent.

MR MATHEWSON: Correct.

MR BOLSTER: The way of funding, it could be delivered on the supply side of the funding, but there could be a portion of the funding set aside or earmarked or benchmarked, based on a calculation not dissimilar from an ACFI, to be applied for staff, directly to the ACFI for each particular resident.

MR MATHEWSON: Or whatever funding instrument is in place now or in the future but if we're going to satisfy the strategic action 13 which is the lifting of the remuneration then it reads from that, and certainly in my reading, you would need to connect it – yes, you would need to make that connection and make sure it flowed directly.

MR BOLSTER: Has ACSA or LASA done any work about that, that we should inquire about?

MR MATHEWSON: We haven't done any work as yet but we're certainly looking to support the work of the council in that specific action.

MR BOLSTER: Mr Gilbert, did you want to say anything on this topic before we have the morning tea adjournment?

MR GILBERT: Yes, I've had a mild panic in my head because if, for example, the government said, yes, let's lift modern award rates in aged care by 15 per cent, that would not make wages go up for people employed in aged care because you are not covered by a modern award when you're covered by an enterprise agreement. So it would be a nil-all draw.

COMMISSIONER PAGONE: No, but you did say earlier on that you thought it was desirable for there to be the same treatment in this industry as other taxpayer funded - - -

MR GILBERT: Yes.

COMMISSIONER PAGONE: - - - activities. I think they were your words.

MR GILBERT: Yes.

COMMISSIONER PAGONE: How would you bring that about, mechanically, I mean.

MR GILBERT: Mechanically, I think it would require a discrete legislative change to the Fair Work Act to enable particular industries to be treated in particular ways.

COMMISSIONER PAGONE: Do you have some broad architectural idea of what that piece of legislation might look like?

MR GILBERT: The descriptors around it are already in the Act around – where you can have multi-employer agreements, for example. So if they're predominantly taxpayer-funded, if they're predominantly regulated in the same way, so all those steps are already there to describe the type of industry we are talking about. What isn't there is some capacity to impose an arbitrated outcome on people who are already covered by agreements, so that would require some legislative change.

MR BOLSTER: I note the time. Is that convenient?

COMMISSIONER PAGONE: It would except that if somebody else wants to add on this point, it might be desirable to hear it just before – I see that Ms Alcock was indicating agreement with all that, and she might have wanted to add something

MS ALCOCK: Only to say that I think a combination of factors might be appropriate because there may still be employees that fall outside of that scheme. I'm thinking particularly of those employed in state residential services in Victoria. So a combination of proving their award rates, and multi-employer agreement, or the ACT has floated collective bargaining in the past so there potentially could be a range of mechanisms.

MR BOLSTER: Just on that, the state award for aged care employees in Victoria, how do they fare compared to those in the private sector in Victoria?

MR GILBERT: You're asking me how nurses in the State public sector compare or carers - - -

MR BOLSTER: The state public aged care.

MR GILBERT: State public aged care are paid the same as a state public hospital nurse.

MR BOLSTER: And the comparison with the person who would be working at the same level in the same job in the private nursing home across the road?

MR GILBERT: As I said earlier, that would be around 19 per cent for a senior registered nurse.

MR BOLSTER: Thank you, Commissioners. That might be a convenient time.

COMMISSIONER PAGONE: 11 o'clock.

ADJOURNED **[10.46 am]**

RESUMED **[11.02 am]**

MR BOLSTER: Thank you, Commissioners. Ms Alcock, before we started talking at a higher level about some funding issues, you had a home care worker sitting in a car about to deliver some home care. Can you talk us through the coverage and the sorts of industrial relations arrangements that apply to someone like that.

MS ALCOCK: So, in my experience, the majority of social and community workers are not covered by an enterprise agreements. So their terms and conditions come from the modern award. So that award, so the social and community – it's the SCHADS Award, doesn't provide entitlements for travel allowance to be paid between client visits. It provides for split shift arrangements, so workers will only be paid for the time they're performing in someone's house. For a part-time employee – because in my experience those workers are not engaged as casuals, they are engaged as part-time employees, there is no minimum period of engagement. So they can be engaged on the split shift provisions for, say, 30 minutes or an hour at a time over, say, 12 hours, and they're not paid for the time between people – between those shifts.

So I could see quite personally about it because my mother is a social and community worker. She is in this situation right now where she can be working for a 10 hour day and she can potentially only be paid for five hours but she will be working the entire day but she is not paid for that work in between. That's not her time. She is not paid for the work in between where she is sitting outside someone's house potentially eating a sandwich because she is not paid for a meal break.

MR BOLSTER: That person, the person in that particular cohort – and we're not necessarily talking about your mother, do those people have a cert III, or what's their qualification typically?

MS ALCOCK: They potentially have a cert III or cert IV in community care or disability. There's a range of qualifications.

MR BOLSTER: Is there a minimum qualification in home care that you are aware of?

MS ALCOCK: The lowest classification doesn't require one but classification 2 requires a cert III, I believe.

MR BOLSTER: And what does classification 1 involve, what sort of work? Is that cleaning work in someone's home?

MS ALCOCK: Yes. So home and community would be cleaning, so vacuuming, cleaning, making beds, changing sheets, and then there's personal care. So supporting someone with a shower, making a meal, it's personal care for the individual.

MR BOLSTER: All right. That leads me to a topic that is slightly different to the ones we have been discussing and that's registration for care workers for that sort of work and for broader work. But one thing that is obvious in home care is that people are left alone with residents for periods of time in positions of trust, often when they're feeble or where they have an illness. What's the position of your unions when it comes to registration of those workers?

MS ALCOCK: Very briefly, I would also flip that consideration that we have workers in vulnerable situations in homes that I can't exercise a right of entry to make sure they're safe because that's someone's private residence and for work safe they need to get an order from the court to be able to enter to make sure that they're safe because that's not considered necessarily a workplace. So we have no way of knowing, particularly if they've got family members at home, making sure that that female worker is safe in their workplace.

MR BOLSTER: Do you have – is there a body of evidence to support a risk to the workers in those situations, Ms Tunney?

MS TUNNEY: Yes, we repeatedly hear from aged care workers and particularly home care workers that they regularly experience assaults. The home care workers are particularly vulnerable because they're in private residences, they are exposed to difficult situations both with the clients that they care for but also the families of clients, and also they have, as Ms Alcock has outlined, they don't have any control over the actual work spaces that they work in and the sorts of hazards that they are exposed to also like heat – excessive heat and cigarette smoke, those sorts of things.

MS ALCOCK: And dogs.

MR BOLSTER: How do those – sorry?

MS ALCOCK: And dogs.

MR BOLSTER: And dogs. How do those disputes arise in the workplace context, how are they raised with you as a union official?

MS TUNNEY: Well, we just hear that – I suppose I haven't dealt with any particular complaints but I hear regularly from organisers that this is an issue that home care workers are reporting to them, yes, they feel unsafe.

MR BOLSTER: Are they turning into police reports and – with further action or are they, effectively, stopping when the care worker goes back to the employer?

MS TUNNEY: I don't – I don't know. I haven't – yes, I'm not comfortable commenting on that because I don't know personally, yes.

MR BOLSTER: We will come back to worker safety in a moment. Can we just deal with the issue of registration, though, first. What's the problem with cert III qualified carers being registered on a national basis as a means of facilitating quality and safety in residential and home care?

MS TUNNEY: We absolutely agree that there is a need for registration of aged care workers and also regulation. We feel that it should be more around the issue of safeguarding and protecting residents, and something more akin to the model that's being used in NDIS so that it's based on police clearances, reporting of criminal activity, reporting of so-called reportable incidents, those sorts of things. We have particular and significant concerns about who the body should be that administers this type of registration and regulation scheme. We don't believe that it should be AHPRA. There has been some suggestion that perhaps AHPRA would be the appropriate body. We don't agree with that.

AHPRA is set up to regulate health professionals so typically people like medical professionals, dentists, psychologists, physios, typically people who have university degrees, and the scheme looks at clinical skills of those people and how they perform in relation to those clinical skills. Aged care workers do very different work and they shouldn't be doing, you know, the work of nurses and shouldn't be assessed according to the same sort of criteria. We also believe that it needs to be taken into consideration that there is a considerable part of the workforce that is culturally and linguistically diverse and that brings many advantages to aged care as well.

People who come from cultures where there is typically a greater respect for the aged than what we are used to in Anglo-Celtic Australia. But there are also disadvantages for those workers in particular in relation to English language requirements, and I'm aware that AHPRA does have specific guidelines about English language requirements that we're concerned that a number of these workers currently in the system wouldn't meet. We're also concerned that, you know, it's a low-paid, low-hour workforce and that creating excessive barriers to – or false barriers to registration for these people would not be a good move in a sector that

desperately needs more staff. The cost of registration is also something that needs to be considered. That couldn't be borne by the workers themselves.

MR BOLSTER: Just on that point, what's the cost of registration in the NDIA system, are you familiar with that?

MS TUNNEY: In the NDIA system I don't know, but I do know that with AHPRA, nurses pay initially a $300 fee and then $170 as well for the annual – renewing the annual subscription. I think that cost would be prohibitive for care workers.

MR BOLSTER: Ms Alcock, do you have anything different to say about that?

MS ALCOCK: It is the view of the HWU that a registration scheme places the onus on the employee to meet safety screening mechanisms and it places a barrier to entry. We're particularly concerned about the cost and the burden that places on workers who are already in a particularly low-paid industry and the barrier that places on them. It would be our preference to have a worker exclusion scheme, if one needs to exist, and I outline the concerns we have with the ones that are already established in Victoria. I think it's worth noting that the majority of home care workers in Victoria will probably already be holding a Working With Children Check card because the work that they're performing will probably already come in contact with children.

And that scheme runs a continuous check of their criminal history and it's not just charges – it's not just convictions, there would be charges and it's particularly active. I think the concerns that you would be wanting to monitor will probably be picked up in that scheme, at least in Victoria.

MR BOLSTER: What would you suggest if AHPRA is not going to have this sort of scheme, who should carry it out? Should it be a national scheme or should it be a State-based scheme?

MS ALCOCK: One of the concerns we had is that it needs to have a review mechanism. That is one of the main problems with the disability worker exclusion scheme and one of the suggestions we had is that potentially the Fair Work Commission could be the review body because it already has a judicial review mechanism and there are other authorities that review – sorry, refer their powers for review to the Fair Work Commission. We didn't provide particular reference to who should - - -

MR BOLSTER: That would be something you could follow up with, if you thought it necessary.

COMMISSIONER BRIGGS: Might I ask, why is it necessary to have a working with children qualification if it's not necessary to have one with working with elderly people who are quite vulnerable themselves?

MS ALCOCK: Potentially the scheme could be, the Working With Children Check scheme could be expanded to include reference to elderly people. So it wouldn't necessarily require two checks considering that it would be checking for the same criminal history.

COMMISSIONER BRIGGS: I beg your pardon, I misunderstood. So you're happy to see such a scheme cover generalised workers in these different kinds of care fields?

MS ALCOCK: I'm particularly cautious about placing an additional cost burden on incredibly low-paid workers, that's my particular concern. And considering they already have to pay, I think it's approximately $150 which organisations refuse to pay for. If they already have to pay for this one card, potentially the Victorian scheme could be expanded to include – you have to check that you have to work with children potentially, an additional box could be included that you have to work with elderly people; the scheme could be expanded.

COMMISSIONER BRIGGS: Or people with disabilities.

MS ALCOCK: Exactly.

COMMISSIONER BRIGGS: I get what you are saying, Ms Alcock. Thank you.

MR BOLSTER: Mr Mathewson, the perspective of employers, when it comes to these sorts of registration schemes, is that something that you want?

MR MATHEWSON: Look, we think the time has come to look at a scheme for, particularly, care workers. One of the reasons for that is our focus, particularly in our workforce development exercises, is around supporting right-fit workers as well. So that's a philosophy we push, but also to professionalise and put them in the position that they should be in, recognised as a key contributor to the aged care team, whether it be home care or residential. And also reflecting the fact that over time there will be specialist elements to that role, and I know one employer is looking at a dementia support worker role which is – they see as a specialisation.

Our view is there's an ability to offer some positive licensing and there are online ready-made products at the moment that could be looked at and linked in with an overall scheme. I acknowledge what Ms Alcock said in terms of there are currently vulnerable people checks and state-based schemes so we have got to ensure we don't create another kingdom, that we utilise the resources that are currently there but we think it has positive elements. In terms of negative licences and potentially exclusions, we have had some discussions about this because we would need to ensure that the individual is protected in that, and where we've landed is really looking at an independent body to make that exclusion because, you know, at the end of the day, you are playing with someone's life.

MR BOLSTER: Who would that body be; if it's not AHPRA, who would it be?

MR MATHEWSON: Look, we haven't developed a view on who, essentially, that could be, other than there are a range of institutions in place at the moment, whether that be the workforce council, the Quality and Safety Commission, various state-based schemes. So they should all be considered at this point.

MR BOLSTER: In terms of cost, it would be a significant benefit to the employer to confirm the workforce, to make sure that they are safe, at least from this perspective. Why wouldn't the employer pick up the cost of registration for the workers on this?

MR MATHEWSON: Certainly, our members indicate that it's an absolute benefit to them, and we think the industry and the government has a role to play here. We do accept that it's a low-paid workforce and the capacity for them to cover the costs of such a scheme is limited.

MR BOLSTER: Ms Field, does LASA have a view about worker registration?

MS FIELD: That was actually outlined in the statement provided by our CEO, Sean Rooney.

MR BOLSTER: Mr Rooney. All right.

MS FIELD: Yes, it is a policy matter that sits outside the scope of my position.

MR BOLSTER: We will be tendering that in due course. Is there anything you wanted to say about this issue?

MS FIELD: No, thank you.

MR BOLSTER: What about you, Mr Gilbert?

MR GILBERT: I think we've got a pretty unambiguous position. We do think that AHPRA has a role to play, particularly the Nursing and Midwifery Board. Personal care work, at least, certainly in the residential setting, is a subset of nursing work. It's work delegated by nurses according to care plans created by nurses. It's, in fact, the same work I did as a nurse in 1986. So AHPRA already regulate people who are VET-educated; enrolled nurses, for example, are VET diploma educated. It's not only tertiary qualified people. It's an embedded system. As I said, nurses have to delegate work to people who are competent to do the work and without the board telling – the current qualification, for example, is delivered badly. I think there's plenty of evidence of that to this Commission, is being delivered badly by some RTOs.

If you become regulated by AHPRA, and particularly the NMBA, then the deliverer of the course also has to be approved by the NMBA. So it adds a degree of safety and quality. Criminal police checks, you know, they have a place but what professional registration achieves is a fit and proper person kind of test. To give an

example of that, as a nurse, I can't go out – or I can but I would get into trouble, if I go out saying don't get vaccinated, it will cause autism. Or is it the other way around. Anyway, not it's that way. If I do that, I can be subject to – to consequences by the board. That's not a criminal thing to do. That's professional behaviour.

And I think what we see as the vision, if you like, is a workforce that's well paid, proud, that the community has confidence and trust in and they're all things that can't happen in isolation from several things happening at once, of which we say registration is one, and the Commonwealth supporting the cost of that is another and transitional arrangements for people's qualifications, different English language standard is another.

MR BOLSTER: We have a panel dealing with this particular issue later in the week but thank you for your views. The issue of worker safety is a very important issue and I was wanting to get your perspective on that, Mr Gilbert. How often are your – the members that you come across put in danger by the work in aged care?

MR GILBERT: Could I just comment briefly on that; the home visit side of things – obviously we've got members who do that, there is a code in Victoria for the safety of workers who visit people in their homes. And that requires, for example, a two-person risk assessment being done prior to anyone going there on their own, a return risk assessment in the event of a change in circumstances. So there are things that lend themselves to broader application. I think we've got a very immature industry when it comes to health and safety, whether it's residential aged care but particularly home care is really, really immature. The concept of a risk assessment would be a mystery to them. It's - - -

MR BOLSTER: OH&S – worker OH&S, how does that arise in the Australian residential aged care home?

MR GILBERT: In a residential aged care home it happens predominantly with manual handling and we have obviously championed a – over 10 to 15 years, a no-lift process and you are now seeing that embedded in lots of aged care facilities where there's tracking in the ceiling and all those kinds of things. When I started there was one lifting machine for 30 residents and it took you 15 minutes to get near it. Now, though, you know, we've got a very embedded good system around manual handling, if it's properly monitored, in residential care. In home care not so much. You can have a very dangerous shower arrangement where it's slippery, got a high wall, the patient – resident – client slips. The nurse tries to catch them, that's where they injure themselves. It doesn't have that same maturity.

The other problem with the home care industry is if you have got a good operator who does take all of those steps to provide a safe workplace and pay people well, they'll get trumped at the next contract by someone who won't. And we're seeing that over and over and over. There's no floor on what a contractor has to do.

MR BOLSTER: Assaults on staff in nursing homes, how common?

MR GILBERT: Very common. There are a couple of aspects to it. I think sometimes you be assaulted a because you happen to be down doing up somebody's shoe laces and it's a matter of convenience. I've never understood sometimes. I've been assaulted – in my history – in that same circumstance. On other occasions, it's a consequence of being rushed. People are rushing people to comply with their timelines and that's creating a situation where someone who has already got issues around their mental competence is getting frustrated and angry at being forced down a path and that's a consequence of being rushed. People are getting six minutes to get a resident out of bed, washed, in a chair, in a lounge room. It's just madness.

MR BOLSTER: Does this issue get raised at the negotiating level, at the workplace enterprise agreement level?

MR GILBERT: We get told you go talk to the Commonwealth about it. If you get more funding we might do something about it, but as I said before, my evidence is that it's not just funding; there has to be mandating that goes with it.

MR BOLSTER: Mr Mathewson, to what extent do the employers you deal with engage with worker representatives on these issues?

MR MATHEWSON: Look, in terms of home care, and it's a developing industry where health and safety, we need to strengthen the systems. But it's also a difficult area because you have got a dispersed workforce. The care coordinator role in the home care system is crucial, and having those protocols and processes around ensuring, you know, when you take a new client on, there is a health and safety assessment done, is crucial. But it's difficult circumstances and I will provide a couple of examples. We have a client who hoards and there are a whole range of other challenges around that particular site. They attempt to deliver services. They withdraw. The care coordinator does the assessment, indicates they can't send a worker into this sort of environment, and that is then subject to a complaint.

At the time it was the Complaints Commission, and then a story in the media. That's a problem for the provider who, at the time, is protecting the worker from those circumstances. Another example, particularly in rural areas where the visibility of firearms is a concern for workers, and the care coordinator has to make a call that in the circumstances if they are not removed they feel the worker is unsafe. A common one is around passive smoking, for example. An older person who still has the right to smoke in their own home but the worker should be protected in those circumstances. The care coordinator role is crucial in that in terms of negotiating an arrangement where at least that doesn't occur while the worker is there so that at least the client then gets those services.

In terms of residential care, we know there are workload issues and we have made many statements in the past in terms of increased staffing but, again, there's some complexities and I only heard of a case the other day where a podiatrist said he couldn't continue to provide services to this individual because every time he got down, he got kicked. And then it became – and ultimately when they spoke to the

resident, the resident said, "I don't want anyone touching it. I don't want anyone down there. I'm happy with the way things are." Now, that's a difficult circumstance when, particularly, the clinical staff know the potential result of that. But there's a choice that the resident makes and everyone at the end of the day has to watch on a challenging situation.

MR BOLSTER: Ms Alcock and Ms Tunney, health and safety in the negotiating process; does it ever raise its head? Is it ever addressed?

MS TUNNEY: Well, in terms of workload management issues, yes. I mean, we have been successful in some enterprise agreements in getting workload management clauses into the agreements but we – I mean, I don't have any kind of stats on the success rate of those, or the effectiveness of those sorts of clauses but - - -

MR BOLSTER: What, in effect, do they do? What does a workload management clause do?

MS TUNNEY: Basically, just setting up a process that can be followed when someone has workload issues, that there's kind of steps that they follow in who they go to and - - -

MR BOLSTER: A grievance process.

MS TUNNEY: Yes, yes. So, ideally, we would link it to the dispute resolution clause so that if it's not – if workload management issues aren't able to be solved at the workplace level that they then escalate to some kind of external body that can make a decision.

MR BOLSTER: Ms Alcock, do you have a similar situation?

MS ALCOCK: Certainly. It's incredibly difficult to try and get those clauses inserted. We also try to negotiate staff replacement clauses, that if a staff worker is unwell or if a vacancy arises that that vacancy – or employee needs to be replaced as soon as possible but they're really incredibly difficult to get inserted.

MR BOLSTER: All right. Can I raise a new topic: cameras. What's wrong with – we heard evidence yesterday of a family putting a camera in the room to make sure that the care was up to standard, was safe for their loved one. What's the position of the employers and the employees about whether that should be allowed?

MS TUNNEY: We have had some feedback from membership about this. I know of one facility in WA that has given families the option of putting cameras in rooms, and then if families wish to do so then a notice is put outside the resident's room so that staff are aware that there's a camera in the room. Members at that facility have told us that they're fine with that. But so long as they know that there are cameras there, they're happy but members aren't happy with the idea of being filmed and not knowing, yes.

MR BOLSTER: Mr Gilbert?

MR GILBERT: Yes, it's a – don't know if dichotomy is the right word. I think, professionally, it feels weird when we are so used to being taught about privacy, that the thought of filming somebody in that intimate situation seems quite out of order. Having said that, I've seen some of the horrible videos that have arisen from that and had they not – it's intimate care. It's one-on-one . There's no one supervising that. My fear about it is: are we going to have a generation of people sitting around a TV screen watching videos to see if somebody is doing something wrong, and is that going to come out of the money that's currently going into care? You know? I can see and understand why families do it, and I wish there was another way; that's probably the best way I can describe it.

MR BOLSTER: And approach - - -

MR GILBERT: There are clearly people who shouldn't be working – who are showing behaviours that show they are not fit to work in this environment.

MR BOLSTER: Ms Alcock, does your membership deal with this?

MS ALCOCK: I agree that there are some people that just shouldn't be working in the industry and we don't want to represent those people. We only want the highest quality care for residents. My only concern is that you are going to see the result of unsafe practices borne out by facilities not rostering people, and by that I mean if you roster someone one to 30 and a resident is compelled to go to the bathroom and you don't have time, say, you're not night and your pair is in the other facility and you don't have time to get that other person to your facility and that resident gets up and they fall; is that going to come back on the worker because that's a two-person assist and you're directed not to help them.

Now, that's filmed, that person fell and you're responsible for their care but you were directed not to help them because your pair isn't there yet. And our workers get disciplined for situations like that all the time.

MR BOLSTER: That's my next question. Your claims of assaults by care workers and nurses seem to be escalating if reports are correct. Wouldn't this be a way of protecting them to establish objectively what happened in a person's home?

MS ALCOCK: Yes.

MR BOLSTER: So what's the end result, from your union? What would you be happy with in terms of cameras in rooms?

MS ALCOCK: We need to make sure that workers are always aware when there is a camera and when it's on and aware of footage. We had a very recent example where there was footage and the worker, being conscious that that footage may be deleted, went to film it himself and then to use it for a subsequent case, was

disciplined for it and then the workplace did go and delete it. So thankfully, he did film it. So mechanisms in place to report some things, potentially.

MR BOLSTER: Mr Mathewson, do your members want cameras in place?

MR MATHEWSON: Our members are certainly raising this issue now and we've recently put out a guidance document which we have really called a working paper to provide our members as much information as possible in considering requests and looking at it as an option. We haven't taken a position either way. Our view is that we should build the capability of our members to understand, one, the legislative parameters around it, the various issues they would need to consider, including consulting very closely with their workforce and opening up communications with families.

I've got to say, as this discussion was occurring, my mother's voice was ringing in my head. She had spent a number of years in residential care, and I got to say she would kill me if I ever considered such a thing but that is also – reflects the individual nature of each person and family.

MR BOLSTER: Yes. Ms Field, is LASA moving in any direction here?

MS FIELD: We do have a position; however, it is a policy position which I can't speak to because of the nature of the role I'm in.

MR BOLSTER: We can find that through other means, I take it?

MS FIELD: Of course.

MR BOLSTER: All right. That leads me to wrapping up the panel discussion and giving each of you an opportunity to indicate anything that you wish to convey to the Commission about the way forward, what the sector might look like in five years time, if there was reform in this particular area. Ms Field, do you want to go first?

MS FIELD: I think I probably outlined everything I wanted to outline in my statement, so I've got nothing further to add. Thank you.

MR BOLSTER: Ms Tunney.

MS TUNNEY: Yes, I suppose we would like to see increased funding into the sector, mandated minimum staffing levels, that there be training and continuing professional development provided for aged care workers; that and – that funding be – address the total needs of residents, so not only their clinical needs but also their basic physical needs and emotional and social needs.

MR BOLSTER: What about in the IR space, what could happen to make getting higher quality, more safety in the workplace, both for your members and for the residents they look after?

MS TUNNEY: Well, I suppose there are some changes that could be made in relation to enterprise bargaining but we don't believe that those – that enterprise bargaining is going to be the solution to the problems in the sector and that fundamentally it is a funding issue.

MR BOLSTER: Mr Gilbert, what's your position?

MR GILBERT: I will just try to reiterate what I said before about I think we have got to inject some pride into the work so that people are proud to be working there and equally importantly that residents and their families have a level of – more than a level of confidence that what they're doing is in the best interests of their family member. And at the moment that's simply not happening. I think, as I said, the regulation of the workforce would be a big step forward in that space with all of the points that everyone has made about the poor – the low pay, the English language test, those sort of things that you'll no doubt go into this afternoon.

I think it has the capacity to generate a clear career path for people in aged care, either within aged care or across other parts of health, which I think is a good thing because if somebody doesn't want to work in aged care then they shouldn't be there. So giving people career opportunities width-ways and height-wise is a good thing. I think the Commission has had so much – it just sort of dawned on me more and more in the last few weeks that staffing levels are currently set by reference to the StewartBrown report, I've decided.

COMMISSIONER BRIGGS: With reference to what, sorry?

MR GILBERT: The StewartBrown report. It's a chartered – a firm of chartered accountants, I think, who take data from about 900 aged care facilities and then they send that out to their clients and you can compare how much you spend on meals compared to another facility, how much you spend on care compared to another facility. And when I've been looking – which I've had the obvious pleasure and fortunate to be able to do so, at the statements of people and the evidence before the Commission is that they use that to decide whether their care is at the right level. If I'm sitting at this comfortable level that's kind of like most other people, that's good enough. And that's the benchmark they're now using to set staffing levels.

Whereas – and then we're copping criticism about ratios being a blunt instrument when what they've got now couldn't be more blunt. It's just comparing "I'm not as bad as that person, and in the event that I have got higher staffing levels then my directors are going to come down on me and make me drop them". And I think you've seen that evidence quite vividly. So I – ratios have – we have nursing hours per patient day in a number of states in various areas already, and we're advocating for a case mix-based funding system that is linked to mandated minimum nursing hours per patient day which includes a skill mix of personal care staff and nurses. That will turn into a ratio; it's just the nature of the industry. And ratio is simply X number of staff for X beds. There's already ratios now; they just dreadfully low.

So if we implement ratios, the benefit of that, of course, is it sets in stone that that money is for care and that care will be delivered and there's no gaming opportunity. The five star system haunts me a little bit. I can see the initial attractiveness of it. But as I said, the employers currently compare with each other what is an acceptable level of care. They could drive that star level down through that comparison process and then we will end up back where we started from. I'm also fearful of doing any more long-term background work because I think we have seen in one of our statements it's time to stop kicking the can down the road.

We have had 20 reviews in 20 years, and things haven't been implemented. Sending things off for another review or having a marketing program to improve the image of aged care, seriously, it's time things were put in place, and we know what needs to be put in place, and we need to make it unambiguously uncomfortable for the Commonwealth to put those things in place.

MR BOLSTER: Ms Alcock, would you like to say anything?

MS ALCOCK: Only to say that workers in this industry enter it because they care deeply about providing high quality care to residents. I think it's probably true to say they don't enter the industry to earn incredible amounts of money; they know they're not going to come out with $100,000 a year. But we're not going to be able to retain workers unless we increase their rates of pay, and we make the industry safer. We're just not going to be able to retain workers, and we're not going to be able to generate and attract the next generation of high quality workers either. I think from the HWUs perspective we need to increase funding and that funding needs to be directly linked to wage increases and increases in staffing as we've discussed today.

We need to respect the work of our carers and our cooks and our cleaners and our leisure and lifestyle workers and everyone else in the industry that are critical to the provision of care, and it's not just personal care workers and nurses; it's the entire gamut of the workforce that provides high quality of care to residents, particularly leisure and lifestyle workers. Without that key component in the mix, the skills mix, to residents, you don't have any quality of life in residential care facilities, and without minimum safe staffing practices, we can't have a safe workforce. And I'm convinced that we will potentially have a death in residential aged care unless we address occupational health and safety seriously.

MR BOLSTER: All right. Mr Mathewson, you've got the last say, and is there anything you want to say about the Eagar research that was before the Commission earlier this week?

MR MATHEWSON: Thank you. I will come to that in a sec. I just want to touch on what Mr Gilbert said in terms of StewartBrown and say it is something that providers do have a look at. I don't think it's right to say all providers slavishly follow the benchmarks and their reports offer a whole – offer ranges for consideration. The other thing I would say is that when we utilised StewartBrown

for a regional group of providers to assess their inputs and how they compare nationally, what we found – and a number of those were already in the survey, is that their staffing inputs were quite higher, in fact. And a number of those are already in that benchmarking survey. So they were making their own decisions.

The other thing I would say is, you know, on an average, 70 per cent of all – of the subsidies that we receive go into wages and salaries, and that's fairly constant. It's just that our view is the subsidies aren't high enough to build on that. The four elements I've just mentioned is, our view is that the Matter of Care: The Workforce Strategy report is crucial and that the 14 strategic actions need to be accelerated. They need to be implemented and they need to be well resourced and funded. The second point I'd make is around the University of Wollongong report that was recently forwarded to us and, look, we've taken an initial position from our point of view that this potentially acts as the circuit-breaker because it does offer a move away from a blunt instrument that the industry can consider. It does recognise resident acuity. It does offer the opportunity for transparency for residents and their families in the community. We think that's an important aspect here in building confidence.

We think it could do with some work and some co-design work and we note the responses of other parties and think they're constructive contributions that should be considered in it but we think there is enough flexibility if that was converted into a staffing model and it had that allied health component and a number of other components around holistic care. We think it has real potential. We do acknowledge the one concern that it is a star rating system and then when you look at what the US have done over the last 10 years is they have star rated, they've measured.

Our view would be is, we need to take a different approach of, yes, absolutely use the star rating but then we need to agree on what is the community benchmark that we think should be reached and funded so that people have confidence. I note, you know, that could be anything between three to five stars and Professor Kathy Eagar did say she just came up with their subjective terminology but we would need to consider that. But absolutely there needs to be an agreed community benchmark that we all reach and the community absolutely should expect.

My third item relates to, really, the bargaining environment and also relating that to strategic action 8, which is a consideration amongst all those strategic actions of all the parties getting together and collaborating around a workplace relations framework that accepts that we are in an industry that is transforming and what are the things that we can put in place. I have already learnt something today around, you know, our – our view or the one that we have considered is quite narrow about utilising the award system and it's really a discussion with my colleagues from the trade unions about how we can utilise the Fair Work Act to ensure that wages are lifted, if we are given the opportunity to do that.

So I think there's an onus on all of us to get back together, look at that strategic action 8, not say everything else we can do in that Matter of Care report we can do

but that one is quite difficult. I think we need to actually face the difficult one and have those discussions. And my last comment is what we're doing at ACSA is we have brought our workforce development unit and our employee relations unit. We plan on bringing them closer together, because our view is they've been separated for too long and that finding the right-fit employees and creating that critical ground for our most important input means that we need to take a holistic approach ourselves in this space.

MR BOLSTER: Nothing further, commissioners, from me.

COMMISSIONER BRIGGS: I found this session particularly useful. So might I thank you all. One of the things we haven't talked about – and this is important, when you're thinking that – as a Royal Commission, we will be looking to make major changes to the sector. And one of the most important things about major change is, I think, feedback from the front line, and this industry, as we've seen right throughout this Royal Commission, has had problems with complaints from users and their families. And – but we've heard very little apart from nervousness amongst staff around how they raise concerns they have and ways to do that effectively. So do you have suggestions around what needs to happen to really give a step up in the acceptability and the normality of front-line-staff feedback to leaders in the industry?

MR MATHEWSON: I might start, if you like, commissioner. I think the leadership of the industry now needs to undertake – and many are involved in that process or commencing utilising the resource that the workforce gives and the knowledge and engaging at a higher level with that group. It's an important part of developing a progressive organisation. And we've, certainly, seen examples of that. I think lifting the image of the work is extremely important. And I don't think that's just about marketing; that's about community conversations right across the nation about aging itself and then lifting that conversation up and connecting it to the most important group of people that support a wellness and a holistic aging-process, and that's the workforce.

COMMISSIONER BRIGGS: Thank you. Yes.

MS ALCOCK: To provide feedback from personal-care workers – they don't feel empowered to provide direct feedback, and when they do, they don't feel listened to or heard, particularly, I think, because there's such a hierarchical structure in residential-care facilities, from the personal-care worker to the enrolled nurse to the registered nurse. If a personal-care worker raises the concern with the registered nurse, they often don't feel heard. There are plenty of facilities which don't allow personal-care workers to actually physically write and document complaints. They're not allowed to document a concern about a resident. So that's one change that needs to immediately be changed. I think one of the facilities was actually named in one of the witness statements through our submission – that they're not permitted to write incident reports about residents.

So one of the practical changes I would suggest is having at least one person in each facility being that person you can go to that – if you're not being heard by someone, that you can go and raise your complaint with that person, and that's a person that can hear you and can be the voice for those residents, because I think by nature of that hierarchical structure they just don't feel empowered to raise concerns.

COMMISSIONER BRIGGS: It's also not just raising concerns; it's about suggestions about how the place can work better, how we can get more relation-based care in the thing and so on. Do you want to talk about that?

MS ALCOCK: Yes. I think particularly, because it's the personal-care workers now that are providing that direct one-on-one care every single day with residents, that there's just – there's such a disconnect with those individuals being respected in the work that they're performing now. And there is no feedback – there's no one talking to those workers, listening to their feedback, hearing it and then feeding it back to management structures. I think a lot of emphasis has been placed on nurses and hearing their feedback and working that into the structures. It's the personal-care workers, that are not being listened to, and they're the ones that are on the ground, providing direct personal care every day, changing residents, showering them, hearing their concerns when they're helping them into bed at night. I don't think those workers are being heard.

MR MATHEWSON: If I can just add, commissioner – and I'd add the other staff as well; the most important staff to my mum were the catering staff. And they were the connector for her. And they were the people that she spoke to. And they were the people that were incredibly respectful to her.

MS ALCOCK: Yes. Someone bringing the cup of tea at night and a coffee and serving the meals.

COMMISSIONER BRIGGS: Thank you; unless anyone else wants to comment

- - -

MR GILBERT: Just – there are a number of the more – larger approved providers who've adopted a – forgive me. I forget the terminology – some sort of web-based software that allows staff to provide de-identified suggestions and concerns back to Management, and that information is available to assessors when they visit, and it's available to the broad staff group. So whilst you are, obviously, going to get – you'll get some good suggestions and some curious ones; it's a vehicle that is, potentially, worth exploring more broadly, that – there used to be a suggestion box, painted brown, on the wall, that nobody put anything in for fear of being seen, putting it in there. Now with the software capacity, you can do that at home, de-identify; they don't know it is you, and that is a mechanism that is available for people.

COMMISSIONER BRIGGS: Yes. A simple phone app would do the trick, I would've thought.

MR GILBERT: There is.

MS TUNNEY: Commissioner, if I could just add to that as well – obviously, there are various reasons why workers feel that they don't have a strong-enough voice to address issues like workload management and their pay and conditions, but one of the most important things that, we think, needs to be taken into consideration is that these are particularly vulnerable workers on low pay and low-hour contracts, and so it's even more difficult, for them to raise concerns, because of the consequences that they can suffer in relation to that.

MS FIELD: If I could also add something – sorry. I think it also comes back to a workplace culture that – I guess there is a workplace-culture element to this discussion. I think in a lot of facilities – just in my dealings with members – there are the channels to provide feedback and suggestions, but a lot of the time those avenues aren't always understood by employees, and therefore they don't feel empowered to utilise those channels, because they don't know they're there. So I think it's education to employees, leaders. There's a broader discussion, and that's my personal view around how we can actually enhance the sector and provide more channels for feedback and complaints to make it better.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Thank you to each of the panellists. They've been very, very helpful and very informative. Now they can all be excused?

MR BOLSTER: They can be excused; yes. Thank you, commissioners.

COMMISSIONER PAGONE: Yes; thank you.

<THE WITNESSES WITHDREW [11.52 am]

MR BOLSTER: While that's – some documents to tender, commissioners, some – three statements of witnesses who are not giving evidence. The first one is WIT.0487.0001.0001. That's the statement of Carolyn Smith dated 26 September 2019. Ms Smith is the secretary of United Voice WA. Her statement includes information about working-conditions of United Voice members, largely, personal-care workers, and enterprise bargaining in the industry. I tender that statement.

COMMISSIONER PAGONE: The statement of Carolyn Anne Smith will be exhibit 11–24.

EXHIBIT #11–24 THE STATEMENT OF CAROLYN ANNE SMITH

MR BOLSTER: The next witness statement is that Ms Field referred to, of Mr Sean Rooney – it's WIT.0536.0001.001 – of 2 October 2019. Mr Rooney is the chief executive officer of LASA, and he has provided a statement to complement the statement of Ms Field in the circumstances in which Ms Field described during her evidence. The third statement is WIT – I tender that statement of Mr Rooney.

COMMISSIONER PAGONE: Yes. The statement of Mr Rooney will be exhibit 11–25.

EXHIBIT #11–25 THE STATEMENT OF MR ROONEY

MR BOLSTER: The third statement is – WIT.0471.0001.0001 – of Nadine Patricia Williams dated 30 September this year. Ms Williams is the deputy secretary – skills and training – in the department of employment, skills, small and family business. Her statement addresses the involvement of the department in terms of training for the aged care workforce and particularly with regard to the aged-services-industry reference committee. I tender that statement.

COMMISSIONER PAGONE: Yes. The statement of Nadine Williams dated the 30th of September 2019 is exhibit 11-26.

EXHIBIT #11–26 THE STATEMENT OF NADINE WILLIAMS DATED 30 SEPTEMBER

MR BOLSTER: That concludes my evidence for this morning, commissioners. Mr Rozen will take over.

COMMISSIONER PAGONE: Thank you. Thank you, Mr Bolster. Yes, Mr Rozen.

MR ROZEN: Thank you, commissioners. Commissioners, before I ask for the two witnesses in the next panel to be sworn or affirmed, there's a house-keeping matter I need to deal with – of some significance and relevance to the evidence that's going to be given by these witnesses. It's best done by reference to the transcript of the evidence that was given by Professor Eagar on Monday, and I think the simplest thing would be to ask for transcript page 5790 to be displayed on the screen. While that's being done, commissioners – this was the evidence given by Professor Eagar in which she expressed the view that, if the Nurses' Federation ratios – if I can use the shorthand expression – were to be implemented, they would attract a star rating of three. Commissioners may recall that evidence being given on Friday.

The transcript is now on the screen. If – line 46 could please be highlighted; perhaps if the next page could also be displayed side by side with this one – might be

the simplest thing. The relevant part of the transcript starts at the bottom of page 5790, and you can see that Professor Eagar – at line 46 – said:

> *The other comment I would raise – and I know the Nurses' Federation is giving evidence on this; the Nurses' Federation has developed a model, and when we mapped it to these standards – the Nurses' Federation model is equivalent to five star for registered nursing and one star for total care, giving a three-star rating.*

Commissioners will recall that was the evidence that she gave. Overnight, Professor Eagar has communicated with the Commission by way of an email, which I've now asked to be displayed on the screen. It's RCD – actually, it's tab 215 of the general tender bundle. This was an email addressed to me, copied to a number of other people, including Mr Bonner, who's the witness about to give evidence, dated the 15th of October 2019, at 4.50 pm. And, commissioners, as it's being brought up, I'll read it out.

> *Hi, Peter and Rob. Rob Bonner, ANMF, approached me at the conclusion of yesterday to query my comment that the methodology in the ANMF report would result in a three-star rating. My colleague, Carol, has checked the figures today, and as Rob recognised yesterday, we did misinterpret the numbers in the ANMF report. The ANMF methodology results in an overall five-star rating, not three stars as I stated yesterday. The details are below. My apologies for our error in interpretation, and I would appreciate it, if you could correct the record. Yours sincerely, Professor Kathy Eagar.*

And then, commissioners, you will see displayed on the screen the table which was included in the report, and at the risk of giving evidence from the bar table – and I will no doubt be corrected, if I get this wrong; the relevant part of the table where the Nurses' Federation figures would lie would be in column 4, row 5. I see Mr Bonner and Professor Willis nodding. I'm relieved about that. Perhaps – if that box could be highlighted, perhaps that is – in excess of 63 minutes of RN minutes and between 242 – actually – sorry; it's the next box down from there. So column 4, row 5 – that's it. Cutting a long story short, commissioners: that's the state of the evidence in relation to that matter. We have sought from Professor Eagar a brief supplementary statement, just confirming that, which, when it's obtained, we will tender - - -

COMMISSIONER PAGONE: Why don't you just tender the email?

MR ROZEN: I was just about to do that. I'll do that by reference to the code RCD.9999.0259.0001. It's actually part of the general tender bundle; so it's, effectively, in. Commissioners, are you saying that a supplementary statement would be unnecessary in the circumstances?

COMMISSIONER PAGONE: Probably.

COMMISSIONER BRIGGS: I feel we've had it clarified.

MR ROZEN: It'll save, probably, no more than the email, and - - -

COMMISSIONER PAGONE: Yes; exactly. So we'll take that. Yes.

MR ROZEN: Take that on board. If that position changes in any way, we'll let you know. With that matter being dealt with, I formally call Dr Eileen Willis and Mr Robert Bonner.

<EILEEN WILLIS, SWORN [12.00 pm]

<ROBERT BONNER, AFFIRMED [12.01 pm]

MR ROZEN: Emeritus Professor Willis, could you please state for the purposes of the transcript your full name?

DR WILLIS: Eileen Willis.

MR ROZEN: And "Dr Willis", I think, is your preferred title.

DR WILLIS: Thank you.

MR ROZEN: Nice, to have a choice, I suppose. Dr Willis, you together with two of your colleagues, Dr Julie Henderson and Dr Ian Blackman, have prepared a witness statement for the purposes of the Royal Commission?

DR WILLIS: We have; yes.

MR ROZEN: And its code is WIT.0465.0001.0001. And that'll be displayed on the screen in front of you. Can you confirm for us that that is at least the first page of the witness statement that you've prepared for the Commission?

DR WILLIS: Yes; it is. There are two corrections.

MR ROZEN: I would ask you to direct our attention to those now, please.

DR WILLIS: Right. So paragraph 5 – the second "federation" is spelt incorrectly.

MR ROZEN: So we're on page .0002, paragraph 5.

DR WILLIS: Yes. So you see "Australian Nursing and Midwifery Federation", and the E is left out.

MR ROZEN: About 10 lines into paragraph 5A, immediately before the acronym "ANMF" in brackets.

DR WILLIS: Yes. 10 lines down. Yes.

MR ROZEN: So instead of – you'd ask that that be spelt correctly as "federation".

DR WILLIS: Absolutely.

MR ROZEN: All right. We'll make that change; thank you.

DR WILLIS: And the other one is paragraph 18, and the reference to James Buchan – his name is there twice and – together, and there should be a full stop.

MR ROZEN: So in the second line of paragraph 18 – you would ask that Professor Buchan – it that the correct pronunciation?

DR WILLIS: Yes. "Buhcan".

MR ROZEN: His name only appears once?

DR WILLIS: No. No. "Mr Rob Bonner recommended Professor Buchan" – full stop. "Professor Buchan is adjunct professor".

MR ROZEN: Thank you. So the full stop's to be inserted between "Buchan" and "Professor". And at the risk of stretching the friendship – is there also a small typographical error in paragraph 8, at the bottom of page .0003, in the line commencing "our understanding was that"? Looks like the word "the" has crept in there unnecessarily.

DR WILLIS: Yes. I was comfortable with it, but happy enough to take it out. It was for the 2015 senate inquiry.

MR ROZEN: No, no. I mean the "the" where it first appears in the line. "Our understanding was that the we"

DR WILLIS: Sorry. Yes. Yes. Thank you.

MR ROZEN: Do you see that? If the word "the" was deleted, that would be better.

DR WILLIS: Yes; thank you.

MR ROZEN: With those changes being made, Dr Willis, are the contents of the statement true and correct?

DR WILLIS: Yes, they are.

MR ROZEN: And are – you're in a position to say that on behalf of the two co-signatories, Dr Henderson and Dr Blackman?

DR WILLIS: I am.

MR ROZEN: And I tender the statement of Dr Willis, Dr Henderson and Dr Blackman dated the 30th of September 2019, commissioners.

COMMISSIONER PAGONE: All right. Well, the joint statement of the doctors Willis, Henderson and Blackman will be exhibit 11-27.

EXHIBIT #11-27 THE JOINT STATEMENT OF THE DOCTORS WILLIS, HENDERSON AND BLACKMAN

MR ROZEN: Mr Bonner, welcome back to the witness box.

MR BONNER: Thank you.

MR ROZEN: You were asked some questions on Monday in relation to an earlier witness statement that was tendered. You've also made a witness statement for the purposes of the evidence you're about to give presently?

MR BONNER: I have.

MR ROZEN: And the code for that's WIT.0488.0001.0001. That should be displayed on the screen in front of you.

MR BONNER: Yes; that's correct.

MR ROZEN: You had a chance to read through that before giving your evidence today, Mr Bonner.

MR BONNER: I have.

MR ROZEN: And anything in it that you wish to change?

MR BONNER: No

MR ROZEN: Contents true and correct?

MR BONNER: They are.

MR ROZEN: Tender the statement of Mr Bonner dated the 2nd of October 2019, commissioners.

COMMISSIONER PAGONE: Yes. The statement of Mr Bonner of the 2nd of October will be exhibit 11–28.

EXHIBIT #11–28 THE STATEMENT OF MR BONNER OF THE 2ND OF OCTOBER

MR ROZEN: Mr Bonner, I know that in your statement you set out some relevant biographical details. I just want to very briefly summarise those, if I could. I'm not sure, that you're asked about them when you gave evidence on Monday. You're the director of operations and strategy with the ANMF – that is the Australian Nursing and Midwifery Federation – South Australian branch?

MR BONNER: That's correct.

MR ROZEN: You've spent 34 years, working with the federation in a range of capacities, which has seen you representing nurses in the aged care sector for many years?

MR BONNER: Yes. I have.

MR ROZEN: You have – are on and have been on a range of committees associated with aged care. They're set out at paragraph 5 of your statement, and I don't need to go through those. But that is the case, that you are.

MR BONNER: That's correct.

MR ROZEN: And importantly for present purposes since 2014 you've co-ordinated the work of the federation which is – has led to the national aged care staffing-and-skill-mix project report.

MR BONNER: Yes; the most current phase of that, and I was engaged in the earlier report before that time.

MR ROZEN: And I'll ask you about that. The more-recent aspects of that work, the project report that I'll ask you about in a moment, has been a collaborative project together with Flinders University.

MR BONNER: Between the ANMF, Flinders University and the University of South Australia.

MR ROZEN: Yes. Thank you. Dr Willis, appropriate segue, I think, to ask you a little bit about yourself – you're the – an emeritus professor at Flinders University in South Australia.

DR WILLIS: That's right. Yes.

MR ROZEN: And before 2017 you worked at Flinders University for 30 years?

DR WILLIS: I did; yes.

MR ROZEN: And you were working as an academic teacher and researcher in the faculty of medicine, nursing and health sciences.

DR WILLIS: That's right; yes.

MR ROZEN: You were – at one point were deputy dean of that faculty?

DR WILLIS: I was for three years. Yes.

MR ROZEN: For three years? And your PhD, importantly, explored the impact of policy reform on the working-time of nurses in the acute sector?

DR WILLIS: That's right; yes.

MR ROZEN: And you've performed extensive research on the work of health professionals.

DR WILLIS: Yes.

MR ROZEN: For completeness, the qualifications and experience of your fellow researchers, Dr Henderson and Dr Blackman, are set out in the witness statement that is exhibit 11-27, at paragraph 4.b and 4.c respectively.

DR WILLIS: That's right; yes.

MR ROZEN: Before I ask you about the details in your statement and the report, I thought, I might introduce this session of the evidence by asking that a legislative provision be put up on the screen – which I want to ask you about. It's section 54(1)(b) of the Aged Care Act, commissioners, and it's at RCD.9999.0002.0288. Section 54(1)(b), which is about a quarter of the way down the page, could be highlighted, please. Summarising the opening words of the section: one of the statutory responsibilities of an approved provider in relation to the quality of aged care is, as we can see, to maintain an adequate number of appropriately-skilled staff to ensure that the care needs of care recipients are met. My question perhaps firstly for you, Mr Bonner – and you'll be familiar with that statutory requirement.

MR BONNER: I am indeed.

MR ROZEN: And you'll be familiar with both the current standard and the previous standards which reflect that; why isn't that good enough to ensure appropriate staffing-levels in our aged care facilities?

MR BONNER: The provision – in the vernacular – is as long a piece of string. So in whose eyes ..... the appropriate number of skilled staff and what are the needs of residents that we're seeking to meet. And that's been an issue that two Productivity Commission inquiries have grappled with over the last two decades – and asked the question about how do we go about quantifying that. There has been no accepted standard in this country at least about what the appropriate answer to that is. So it has always fallen into matters of opinion, matters of conjecture, matters of debate. And when the standards organisations have been going in and assessing that, of course, there's been no real measuring stick that will allow them to determine on any objective measure whether or not the staffing-numbers and mix are appropriate for the needs of the clients.

MR ROZEN: Dr Willis, anything you'd like to add to that?

DR WILLIS: Only to say that – objectively, that we have done research in which the workers say they cannot do all the work that is required. So it's clear, that it's not met.

MR ROZEN: The reason I ask you is because, for me anyway for what it's worth, there's a paradox at the heart of all the issues we've been examining this week, and it's this: that we have a statutory requirement which on its face would appear to be likely to achieve that outcome; one would expect it would achieve the outcome of having an adequate number of appropriately-skilled staff, and yet the evidence from Professor Eagar on Monday was that more than half of our aged care facilities don't have an adequate number of appropriately-skilled staff, and that's consistent with so much of the individual-experience evidence that we've heard in this Commission.

MR BONNER: Absolutely, and it's consistent with the thrust of our report, although there is a different approach in terms of the outcome of that.

MR ROZEN: Before we come to your approach, I wonder if I can just tease this out a little bit further with you. Is the problem here the wording of the provision, or is it the way it's enforced in practice by the various regulators, presently the Aged Care Quality and Safety Commission, or is it both?

MR BONNER: I think it's, probably, both, in my view. There's no guidance about what "appropriateness" or "appropriately" means. So it becomes, as I say, a matter of whose best guidance or best view applies. I think, if there were provisions contained in the Act, that gave guidance in our view, direction about what "appropriate" was to be taken to mean, then you could hold people accountable for whether or not they were meeting those standards. But currently there's nothing there that would allow the Agency to really apply rigour.

MR ROZEN: Mr Bonner, I imagine from your experience with the union you'd be familiar with the modern occupational health and safety laws which set performance standards in a statutory provision, not unlike that type of provision, that an employer shall provide a reasonably – a safe workplace so far as is reasonably practicable.

And then, sitting under that, we have regulations and codes of practice which provide some detailed guidance both for employers and for regulators in relation to the enforcement of such a provision.

MR BONNER: Correct. Yes.

MR ROZEN: Is that a model that could, potentially, be adapted in the aged care area?

MR BONNER: Exactly. Whether the mandating occurs within the Act itself or in regulation that has effect under the statute, I think, is a matter of convenience. But for us it's about providing a legal platform that requires a level of performance that is enforceable across the sector.

MR ROZEN: It's fair to say, isn't it? That a vague standard that's not enforced is not really in anyone's interest. It is not really in the interests of providers either, is it? Or – what would you – what do you say to that?

MR BONNER: I think that it gives a cosmetic appearance of interest in quality that's not really provided with any capacity for it to be enforced or given rigour. So I think it's unhelpful all round.

MR ROZEN: Dr Willis, is there anything you want to add to that?

DR WILLIS: No. I'm supportive of Rob on that.

MR ROZEN: It's an appropriate point at which to start to ask you about the report that was jointly produced. There's a bit of background to the report. Perhaps we will get the report brought up on the screen. It's tab 1 in the documents already tendered, exhibit 1-20 which was tendered back in the first Adelaide hearings, Commissioner Briggs. Documents already tendered, tab 2 – I stand corrected, thank you, Ms Hill. I might start with you, Mr Bonner, because according to your statement there's some background to this report which – no, I'm sorry, exhibit 1-20.

MR BONNER: It's referenced in my statement at 6.1, if that's helpful.

MR ROZEN: Could we try tab 1 in the documents already tendered.

DR WILLIS: That's it.

MR ROZEN: That's it, we've got it.

DR WILLIS: That's it, yes.

MR ROZEN: Excellent. Okay. In your statement, Mr Bonner, you explain to the Commission that there was some work that had been done earlier that the union had

been involved in – the federation had been involved in, which informed some of the thinking in this 2016 report. Can you just briefly describe that to us, please.

MR BONNER: The stage 1 piece of research was really looking at trying to get a picture about what the patterns of staffing were across the industry, and looking to see whether we could determine from that initial piece of research whether there was consistency, whether there was any particular differences due to the sector. We were still dealing with the fallout from the collapsing, if you like, of low care and high care into a single stream so working out whether or not there were differences in practice there. Originally, the intention was to follow that piece of work with a direct observation study similar to the one that Professor Eagar described on Monday under the RUCS stage 1 sample but that changed as a result of consideration of the findings.

MR ROZEN: Sorry; as a result of consideration of the findings.

MR BONNER: As a result of the consideration of the findings of stage 1.

MR ROZEN: If we could go to paragraph 6 of your statement, please, which is on page .0004.

MR BONNER: Yes.

MR ROZEN: Consistently with what you have just told us, you say stage 2, I'm looking at the second line of paragraph 6:

> *Stage 2 built on an earlier project which resulted in the ANF Aged Care Staffing and Skills Mix Project Final Report produced for the Department of Health and Ageing in June 2012.*

So the client then was the Commonwealth Department of Health and Ageing.

MR BONNER: It was.

MR ROZEN: What became of that work or that report?

MR BONNER: The department declined to allow us to publish the report. It has never been released.

MR ROZEN: Okay. And are you able to assist the Commission with understanding the link between that earlier work and the 2016 report before I ask you about that?

MR BONNER: Yes. I mean, what that report did was to identify some significant variation in the staffing of aged care facilities of similar type and size, so with similar mixes of clients, huge variations between the better staffed and the lower staffed facilities that weren't really explainable by reference to the client mix, and the consultants that were used in that stage used the Medicare database to access some of

the information about the residents that would give us some of the kinds of observations that the University of Wollongong study is doing in a much more sophisticated way by looking at the overall case mix records of clients.

So it became clear to us that there was nothing in terms of the demand for care or need for care for the clients that was linked with the staffing product that was then being used to allocate the resources. So that became the driver, if you like, for that second piece of work which was establishing what the demand for care was, rather than just looking at supply.

MR ROZEN: I will just pick up on something you said there and take you on a slight tangent if I could, that is, you talked about the wide disparity in staffing levels for similar groups of residents. And it called to mind something that occurred to me when Professor Eagar was giving her evidence the other day and that is it's too simplistic, isn't it, to say that this is all about funding, that is, if funding was increased more staff would be employed and perhaps higher wages would be paid because we know that under the current funding arrangements which apply broadly equally across the sector, some providers are operating at four and five stars whereas obviously are at one and two.

MR BONNER: I think that we need to remember the timeframe since that stage 1 data was being crunched which was sort of 2011 and '12 and without repeating it, my observation would be that there has been a narrowing, and certainly in terms of my general observation in terms of the bandwidth, so that the top providers have come down in terms of their staffing levels over that period. So I think there has been some compression but it's right to say that there's no logical explanation, looking at that particular study, that says funding results in differing – you know, the same staffing outcome.

MR ROZEN: Can I tease that out; maybe there is a logical explanation. Perhaps some organisations are just better managed and can achieve better outcomes than others with the same funding. Is that a fair observation in your experience?

MR BONNER: I don't think that we had any data to say that outcomes were any better or worse as a result of the particular models. What we found was that public sector providers were overwhelmingly providing better staffing for the same groups of clients than non-government providers, but that there wasn't much of a difference between the staffing allocations that would be used between the not-for-profits and the for-profit sectors which was not what we expected to find, to be frank. We sort of started with a view that the not-for-profits would probably be better off but the evidence didn't bear that out.

MR ROZEN: I didn't catch those last words, Mr Bonner. The evidence is?

MR BONNER: The evidence didn't bear that out.

MR ROZEN: Right. Dr Willis, anything you would like to add at this point to those observations?

DR WILLIS: No, no. I just concur with what Rob has said.

MR ROZEN: Thank you. Now, if we could turn then, please, to the methodology that was utilised for the 2016 report and I would ask that that be brought back up on the screen. That's a document already tendered, tab 1. In your statement, which I will – you can just leave that on the screen, we don't need to go to the statement for the moment, but you describe, essentially, three or perhaps four stages to the research and I want to take you through each of those, starting with you, Mr Bonner, and then Dr Willis, please feel free to jump in at any point. The purpose of the research was to establish – sorry, rather, was conceived as a means of establishing demand for care in the residential aged care sector and appropriate staffing levels to reflect care needs. Is that a fair description?

MR BONNER: Yes, that's correct.

MR ROZEN: We know that at times this work and the campaign the federation has been actively running is derisively referred to as a ratios system and that it's a blunt instrument. We heard the previous witness, Mr Gilbert, talking about that earlier. It is, on the contrary, isn't it, it's a methodology to achieve appropriate staffing levels within the parameters of the work. Is that right?

MR BONNER: Absolutely. This was about establishing whether or not we could derive groupings of residents that were meaningful in terms of the care that they required, both in terms of volume and the type of staff providing that care that was responsive to their particular circumstances. So it was never intended to produce a single outcome that would apply to every resident in terms of the care they received each day of the week in their particular aged care facility. It was about coming up with an appropriate number that dealt with the industry as a whole.

MR ROZEN: Are we right to start with the resident profiles, is that a good place to start with our examination?

MR BONNER: Yes, that's fine.

MR ROZEN: All right. You've just said a moment ago that what you tried to do was identify resident profiles that broadly reflected particular care needs. Is that right?

MR BONNER: Yes. What we did was we gathered de-identified resident care plans and assessments from – for about just over 200 residents from a variety of facilities, and then subjected those to analysis in terms of what the presenting assessments were, what the interventions – tasks for want of a better word, were that sat arising from that and then calculated the amount of time that should be spent in delivering that care. I should say that we already had access to an observational

timings database because we had done joint work with the Department of Health in South Australia that collected 180,000 observations of time that were spent by nurses and care staff in the delivery of those interventions in the state system.

MR ROZEN: Now, you gave the six resident profiles names.

MR BONNER: Yes.

MR ROZEN: They're made up people aren't they, they are not actual people?

MR BONNER: Absolutely. We arrived at – from the analysis there were broadly six groupings or sort of areas where there was a concentration of hours of care that related, so natural clusters in the data. In order to explore those in the second round which was a qualitative piece of feedback and validation, we wanted to be able to describe those to focus group participants. And so we used the device of creating a name for those, so Voula was our basic category 1 of client through to the other people, so that people could describe the person rather than being talking about categories in a sort of relatively cold way.

MR ROZEN: Let's go to Voula perhaps, resident profile 1, page .3197 in the report.

MR BONNER: Yes.

MR ROZEN: And just whilst that is being brought up on the screen, it's .3197, so this is a category of resident care needs. It's not unlike the 13 categories that Professor Eagar told us about on Monday; is that right?

MR BONNER: Indeed. The methodology that she has used in the University of Wollongong approach has 16. We have ended up with six on the way through.

MR ROZEN: I think 13, she told us.

MR BONNER: Sorry, 13. Yes, because they - - -

MR ROZEN: She hasn't named them.

MR BONNER: No.

MR ROZEN: They're just categories 1 to 13. If we can just identify the characteristics of resident profile 1. What's the significance of the personal information, age, widowed and the language skills? What's the relevance of that?

MR BONNER: It was to try and give some background to the kinds of things that would influence care for a resident in an aged care facility. So the fact that you were dealing with someone who is from a non-Anglo-Saxon background, has particular cultural needs, her family circumstances in terms of support, social engagement and the like are relevant to the kinds of work and support that you would want to do in

providing care to the character. So this was the kind of social circumstance that was relatively normal for residents in this group.

MR ROZEN: You haven't – importantly, as I'm understanding it, you haven't limited yourself to the clinical characteristics of the person in the profile.

MR BONNER: No, absolutely. No. And, indeed, if I can sort of make the point that there has been, I think, unhelpful characterisation of nursing and personal care that comes from a misunderstanding that nurses and personal care workers are somehow constrained to medical-related interventions when that's one part but by no means the scope of nursing practice. So nursing is a biosocial, psychological, holistic professional practice area and cuts across a whole range of areas that don't fit neatly into what some people would describe as clinical care.

MR ROZEN: All right, or a medicalised model as it's sometimes referred to.

MR BONNER: Precisely.

MR ROZEN: That's certainly the way nursing is taught in universities in a contemporary setting.

MR BONNER: And has been, I would argue, at least since the 1980s.

MR ROZEN: Yes. Now, as far as the clinical needs of Voula, category 1, we see them at the bottom of the page there - - -

MR BONNER: Yes.

MR ROZEN: - - - significant medical history, dementia, hypertension but well controlled on medications, and osteoarthritis, regular pain management and therapy - - -

MR BONNER: Correct.

MR ROZEN: - - - with no allergies or alerts.

MR BONNER: No.

MR ROZEN: I'm correct in understanding, aren't I, that category 1, this is the lowest category of care needs?

MR BONNER: It was, and to be – to be fair, the feedback that we had in the focus groups and is reported is that it's unlikely that Voula would find herself in residential aged care if she hadn't already been in there at the time the study was being conducted. So, importantly, we need to remember this work is now three years old.

MR ROZEN: Yes.

MR BONNER: And there has been a gradual ramping up, as you know, in terms of the acuity of residents in residential care and greater attention paid to home care of people such as this category of person who would have found themselves in aged care in the past.

MR ROZEN: That's consistent, is it not, with the evidence we heard from Professor Eagar on Monday.

MR BONNER: Yes, absolutely. And the expectation is that that will continue to incrementally grow.

MR ROZEN: Without go through each of the resident profiles, for reasons of time, can we jump to profile 6 which is the highest need category. That's page .3212; do you have those numbers in your copy there? You probably don't but you - - -

MR BONNER: No, that's fine.

MR ROZEN: You know your way around it.

MR BONNER: I've found Norma.

MR ROZEN: Terrific. Now, can you tell us about resident profile Norma; what is it about a person in this category that puts them into the highest care needs category?

MR BONNER: I guess that this person aligns with the special category that Professor Eagar described as adding to the case mix approach in her study, which is active end-of-life palliation. So Norma has significant experience of cancer and is – has been admitted to assist her to die.

MR ROZEN: Professor Eagar told us about the importance of a case mix approach to these classifications. This is also a case mix approach, is it not?

MR BONNER: Indeed. There's a huge amount of similarity in the way that we have used and constructed the – this tool. So the assessment instruments that are used in this process and in the later process of the RAST that is connected to my statement, we have used many of the same assessment tools as have been used by Professor Eagar and her team to develop the case mix approach. So there's a consistency between the two instruments in terms of what assessment tools get used and what they result in.

MR ROZEN: Did you a moment ago say RAST?

MR BONNER: Yes, RAST, a resident assessment tool that comes in my later statement.

MR ROZEN: Yes. Thank you.

MR BONNER: Which is a simplified version of this piece of work.

MR ROZEN: Is there anything further you need to tell us about the resident profiles, Mr Bonner, or Dr Willis, for that matter, to assist us in understanding the research.

MR BONNER: Just to – and hopefully not to sort of take you past the next stage of the research; you will see that under each of the names there's the evidence-based nursing resident care hours per patient per day and then there's the focus group moderation score in each. What we did was to look at the interventions for each of those residents that are – if you look at Norma – on the next page of Norma's profile, you will see - - -

MR ROZEN: I will get that brought up for us; that's .3213, page 63 of the report.

MR BONNER: So you will see that consistent with what I've described, there's a series of assessments of her needs. And then the next table down, resident profile 6 care provided across shifts. There's then a list of interventions that sit underneath those assessed needs that are specified to be delivered on each of the shifts over the three shifts over the day. So - - -

MR ROZEN: If I can just jump in there, if I could, for a moment, Mr Bonner. So if we just take a simple example that is easily understood.

MR BONNER: Yes. So in the morning - - -

MR ROZEN: The cognisant status of Norma, we can see in the top box that she is incontinent. That's the identification of the need; is that right?

MR BONNER: That's correct.

MR ROZEN: And then you have got what flows from that, in terms of what you call interventions - - -

MR BONNER: That's right.

MR ROZEN: - - - but other tasks - - -

MR BONNER: Yes. Which – which particular services, functions, tasks that you're going to do during that particular period of time.

MR ROZEN: And whether they need to be done in each shift or only one shift - - -

MR BONNER: That's right. Or whether they have to be done four-hourly as might be the case where they're on medications, for example.

MR ROZEN: Yes.

MR BONNER: So the frequency is relevant as well as the response and each of those interventions has a time that sits with that, that is a standardised time that we collected in the earlier piece of work.

MR ROZEN: Can I just tease that out if I could, please, because that's a very important consideration. The assessment of the time taken – we'll take a simple example in the middle box; sponge in bed am. What's the science, if I can put it that way, behind determining how many minutes are needed to do the sponge in bed?

MR BONNER: I can perhaps deal with that best by going to one of the appendices or attachment to my statement.

MR ROZEN: Yes.

MR BONNER: And it's marked ANM.0011.0001.0041.

MR ROZEN: If that could be brought up.

MR BONNER: Sorry.

MR ROZEN: No, that is okay. It's very helpful, thanks, Mr Bonner.

MR BONNER: And this is Norma's profile using the modified assessment tool that I talk about in the statement and if you flow through about four pages in - - -

MR ROZEN: So to 0004.

MR BONNER: 44.

MR ROZEN: 0044.

MR BONNER: That's the table, yes. That will give you the breakdown of each of those interventions in the second column.

MR ROZEN: If we could perhaps expand the second column, please.

MR BONNER: Yes.

MR ROZEN: And where would you draw our attention to?

MR BONNER: So that's the list of interventions that is consistent with the kind of table that we saw earlier.

MR ROZEN: So it's sort of the second main box. Thank you.

MR BONNER: That's right. That's the intervention list that sort of matches, if you like, the abbreviated intervention – so, sorry it's in about font size 2, I think, but if

you go over to the right-hand side, so the final group of columns, you will then see next - - -

MR ROZEN: If the right-hand one-third of the two pages could be highlighted perhaps.

MR BONNER: So yes, there. And if we can just below that up, you will see next to each of those the time that is associated with each of those tasks by shift. So that's the - - -

MR ROZEN: Expressed in minutes, are they or - - -

MR BONNER: Expressed in minutes.

MR ROZEN: - - - fractions of minutes.

MR BONNER: So 12.96 minutes which was the standardised time after we collected the data, across the system. So for meal supervision, that's 12 minutes and – 12.96 minutes. And this is where we get ourselves into trouble because of the 46 seconds or .46 and then five minutes .46 for hydration status being assessed.

MR ROZEN: Okay. Just for completeness, what is behind those numbers, where have they come from?

MR BONNER: They have come from direct observation and timings of those interventions being undertaken across a range of South Australian health environments. As I say, 180,000 observations of people doing those tasks. In order to get into the scoring and the database you had to be able to see it performed in that environment at least 10 times. So the data could be standardised along the way, so a very rich database. All of the collectors of the data went through a central training process and the results were then moderated by SA Health's chief statistician to make sure that we were not making ill-informed statistical choices as would be the case if we were left unsupervised.

MR ROZEN: Dr Willis, you have been sitting quietly and patiently there while that's all been explained. What role did your team play in relation to this aspect of the work?

DR WILLIS: We conducted focus groups in Victoria, New South Wales, Queensland, South Australia and we did one remotely for rural and remote nurses. We took the six case studies and two people from ANMF came to the focus groups and talked through the case study. Dr Terri Gibson from the University of South Australia, and Dr Luisa Toffoli ran the focus groups; Terri was the lead.

And what they did, in the focus groups, was to get the registered nurses to look very carefully at the profiles and say, "Is this accurate or are we overstating the care that is needed or are there particular care tasks that have been left out?" And so that was

recorded. We ran two in Victoria and two in New South Wales, one in Queensland. So we brought that data back. Luisa and Terri did the first analysis of it, so it's transcript so you're needing to look at what people say. What we did then was to write - - -

MR ROZEN: Before you move on, I'm sorry to interrupt, but you said that the people that were spoken to were registered nurses.

DR WILLIS: Yes.

MR ROZEN: Was it only registered nurses that were involved?

DR WILLIS: It really was only registered nurses. There were three other people who actually came along to the focus groups but we had actually advertised for registered nurses with experience in working in residential aged care.

MR ROZEN: And that's by distinction from enrolled nurses, for example.

DR WILLIS: Absolutely. Or care workers.

MR ROZEN: They weren't involved in this process.

DR WILLIS: They weren't involved.

MR ROZEN: No. Okay. Is that significant, do you think, looking at it from the point of view of the validity of the research; does that matter?

DR WILLIS: I think so. I think – particularly when we came to do the missed care survey, the observation there is that registered nurses observe more of the care that's missed than other categories of workers. They've got a better overview of what the resident requires.

MR ROZEN: Right. So it's relevant in the sense that perhaps it adds to the validity of the research rather than detracts from it.

DR WILLIS: It adds to it, yes.

MR ROZEN: I see. Mr Bonner, do you want to add to that?

MR BONNER: It was important because this is an assessment-driven process and assessment by and large sits with the registered nurse in terms of making that and then devising the care plan which is then delegated to others on the way through. So it was, if you like, a natural thing to flow from that, that the majority of people who would want to participate and who came from that group.

COMMISSIONER BRIGGS: I fully appreciate what you are saying. In fact, I think it's really right. I suppose my question is, did your analysis enable any assessment of

the personal interaction time that might be required in order to provide a good quality of life, and nurses might not necessarily be the ones best equipped to assess that?

MR BONNER: The timing studies cut across class categories. So we were able to observe the communication and wider activity that sits around the task that's being performed. I think that what our timings would not collect were some of the kinds of interactions that Professor Eagar talked about on Monday that occur in the corridor, for example, where you come across a resident and there's a need to engage or a wish to engage. So they wouldn't be captured in terms of an active interaction. This is about planned structured care rather than ad hoc responses.

COMMISSIONER BRIGGS: Thank you, that's very helpful.

DR WILLIS: There's another example in the case study on Voula where the nurses in the focus groups pointed out to us that if Voula woke up in the middle of the night and wanted to go to the toilet, it's just not 10 minutes taking her to the toilet. Given that she has got dementia, it would require perhaps getting her a warm milk drink and sitting with her for a few minutes. So doing that kind of emotional interactional work which would stretch it out to 20 or 30 minutes.

MR ROZEN: Of course, we have heard considerable evidence, particularly in the Sydney hearings, that without that time taken when someone has dementia, especially high end dementia, there can be consequences in terms of behavioural problems and the like which can themselves add to the work involved.

MR BONNER: And if I could say that was at the heart of why this approach, because if we had just gone out and looked at care where staffing was insufficient or not of the right mix, then what you would observe is the inadequacy that is already there rather than working from what is required and then building the hours from a zero base. So that's the difference of our approach from Professor Eagar's team approach which was they are observing what is there with whatever constraints are around it. We were building for the assessment, building what should be occurring with clients, how much time is required regardless of what was there. That allows a freer thought process and planned response to the staffing question.

MR ROZEN: And if I can just tease that out. I take it from that, that you mean with the work done by Professor Eagar, tasks may have been completed in less time than ideally would have been available for those tasks because of all the pressures we have heard about in the system.

MR BONNER: That's correct. So in her work, you wouldn't – you – the staff were recording and scanning their tags as they delivered service to a client.

MR ROZEN: Yes.

MR BONNER: If they didn't get to do it, then nothing gets scanned, and therefore it's not captured, whereas in our survey we were saying this should occur this many

times during the day, and therefore the time gets allocated for it. So it's more of a – what should be occurring, what is needed to occur, rather than just observing what is there.

MR ROZEN: The outcome of that process was examined through a Delphi study which you refer to.

MR BONNER: We moderated - - -

DR WILLIS: Well, yes, in the sense that the formula as it were or the methodology for the staffing was moderated through the Delphi - - -

MR ROZEN: Yes. Not the numbers.

DR WILLIS: Not the numbers.

MR ROZEN: No. I understand.

DR WILLIS: No. Not the numbers.

MR ROZEN: Yes.

DR WILLIS: Yes. So that was – yes. So the Delphi went out to residential-aged care managers, who, we assumed, would be mostly registered nurses, but not all, just over 2000.

MR ROZEN: Yes.

DR WILLIS: We got the addresses from a Commonwealth site, sent them a letter, indicating that we were doing this Delphi. Would they engage in it. They then had to type in the address into their Internet – in order to get to the survey monkey and fill out the Delphi. We had 102 responses from about 2000 letters that we sent out to aged care centres.

MR ROZEN: Go back a step, if I could. A Delphi study is a study - - -

DR WILLIS: Study of the experts. So what you do is – you ask the experts. "We would like your expert opinion on these particular questions." And the major one for us was "Do you think this particular methodology makes sense and is accurate?". We would hope that, if we didn't get an agreement, a significant agreement – and you need really about an 80 per cent agreement on most of the questions; you then send it out again and say, "Well, these are the results we've got. What do you think now?". And we were prepared to send it out about three times. But in the 102 responses that we got, we got over – we got, roughly, 90 per cent agreement on all but two questions.

MR ROZEN: And the data flowing from that process: I won't take you to it because of constraints of time, but it's all in chapter 6 of the report, the outcome of the Delphi report.

DR WILLIS: It is, yes. And – yes. That was managed by Dr Kay Price.

MR ROZEN: Now can I draw your attention to the summary of all of that. So with each of the categories, a number of hours and minutes of time was determined as the appropriate amount of time needed to provide care for that resident for a day.

DR WILLIS: That's right.

MR BONNER: Correct.

MR ROZEN: And that's where we get the acronym which we saw up on the screen a moment ago – just make sure I've got it here – RCHPD.

MR BONNER: Resident hours per patient per day.

MR ROZEN: Care hours per day?

MR BONNER: Yes. Care hours per day.

MR ROZEN: If we could go to page 3159 – just while that's being done, I note the time, Commissioners. I could, probably, conclude the evidence of this panel within 15 minutes, if that would be considered an appropriate approach.

COMMISSIONER BRIGGS: Yes.

MR ROZEN: Thank you. So 3159 is part of the summary at the front of the report. It has a box, blue box, which you'll see, page 9 of the report, Mr Bonner.

MR BONNER: Thank you. I have it.

MR ROZEN: And we see in point 3 an average figure of 4.30 resident-care hours per day or four hours and 18 minutes of care per day is the average figure that emerges from the six categories?

MR BONNER: That's correct.

MR ROZEN: Right. Want to ask you about the next part of that, which we can see, if the point 3 in the box could, please, be enlarged. We see that the 4.3 hours or four hours, 18 minutes is broken down into percentages, 30 per cent registered-nurse time, 20 per cent enrolled-nurse time, 50 per cent personal-care-worker time. And the statement there is that that's the evidence-based minimum-care requirement and skill mix – skills mix to ensure safe residential and restorative care. Firstly what does the reference to restorative care mean there?

MR BONNER: So this was addressing a real focus on the living well of residents. So – rather than just assuming continual and gradual decline, that there was the opportunity to recover health where that's possible. So – improving functional condition, improving response to management of chronic disease. So that's the philosophical approach to it.

MR ROZEN: Yes. Dr Willis, did you want to add anything to that?

DR WILLIS: No. I think Rob's right. It's about restorative – and re-ablement.

MR BONNER: Dr Price in our team was – had an overlapping appointment with her role from University of South Australia with a leading aged care chain that was actually actively engaged in piloting that work in the state. So I think it was – part of her particular focus was to make sure that we were examining those components through the study.

MR ROZEN: Yes. The breakdown of the 30, 20, 50 is what I would like to explore with you; how does one come up with those – how did you come up with those figures rather?

MR BONNER: So if I can refer you to table 2.3 in the report, which is on page 28 - - -

MR ROZEN: So with our coding that's 3178, table 2.3, sample from observation, timing and motion database.

MR BONNER: Yes. That's the one. I've already talked you through the interventions broadly – concept.

MR ROZEN: Yes. That was the table you took us to earlier?

MR BONNER: That's right; the Norma. Down the right-hand side here what you will see – it doesn't occur at resident level; it occurs at facility level for reasons I'll explain. You'll see a staff class next to each of those interventions. It's not prescriptive in saying that, every time, pressure care will be performed by a personal-care worker, but what we did was to assess the lowest of the three levels of work, PCW, enrolled nurse or registered nurse, that was competent to perform – the role was within their scope of practice – and then allocate the intervention to that class. So when we were rolling up the timings, you could get a sense of the balance overall.

The reason that that doesn't sit with the individual is it doesn't make sense, to allocate that to individual residents. It's the total volume of care across the set, that's important, and that gave us the split between the 30, 20, 50 at the end of the exercise. So it was a consideration of how often those interventions arise and who is able to do them most likely. I just want to make the point really clearly – that it's critical, that registered nurses, in order to inform their wider work, also engage in the fundamentals of care. So it's not saying that, because a care worker can do that work

– that it always should be, and, indeed, there's very clear evidence to say that the other classes of worker should be doing some of that work as well.

MR ROZEN: Yes. Just if I can clarify this aspect of the work a bit further – some tasks would, presumably, be unarguably only the role of a registered nurse, particularly in relation to medications and the like.

MR BONNER: Yes.

DR WILLIS: Yes.

MR ROZEN: At the other end of the spectrum if I can put it that way, other tasks would be, unarguably, a personal-care worker's responsibility; it might be sponging or showering or those sorts of tasks. In between there must be a grey area, where there's a degree of judgment involved.

MR BONNER: It's – oral medications are the usual one where things get a bit hairy in terms of who should be doing what, and that's the fourth one up from the bottom of that list, and we've allocated that to an enrolled nurse. We believe that the evidence is that's the level at which there's sufficient educational preparation for safe delivery of that function, consistent with the scope of practice and educational prep. Now, there are care workers out there who are administering medications, we concede, but we don't believe that that's appropriate. And therefore the class that's allocated to that in our study was EN.

MR ROZEN: I guess what I'm getting at is – are some of these categories ones in which reasonable but educated minds could differ?

MR BONNER: I think at the margins – I think that the broadness of it would be – no. There would be a broad alignment of view.

MR ROZEN: Yes. Dr Willis, I think you wanted to add something.

DR WILLIS: Rob mentioned – used the word – "fundamentals of care", and so – I think behind that notion is that you would expect the registered nurse also to do some personal hygiene, simply because in doing so, as he's mentioned, she or he would have a broader notion of what – she might notice that the client is getting a pressure sore or needs some re-assessment about their care needs. So while you mightn't have the registered nurse doing the fundamental hygiene care every day, you would expect that they would do – they would be familiar and do some on the wards, on the floors.

MR BONNER: And that goes to some relationship with the evidence of Professor Eagar on Monday, which was we need to make sure the registered-nurse time is not spent on documentation and ACFI claims and quality-assurance activity exclusively, that we're actually seeing registered nurses in the delivery of direct care to clients in this kind of proportion.

MR ROZEN: Now, if I've understood the evidence given by Professor Eagar on Monday – and I've – we've all heard you say that there's a deal of overlap between the work that she's done and the work that you've done; one point of difference, though, might be this, if I understand it correctly: her evidence seemed very clearly to be that a replacement for ACFI in the form of ANACC as she described it, arising out of the RUCS work – excuse all the acronyms – was necessary before making any significant change to these sort of staffing-aspects. Do you have a view about that, Mr Bonner?

MR BONNER: We would disagree with that approach.

MR ROZEN: Why is that?

MR BONNER: The – we believe that there's a compatibility between our position in relation to mandating safe effective minimum staffing-levels alongside prescription about what staffing-inputs there have been under a case-mix approach for quality assessment overall, which is the thrust of the CMS system in the US. It's not used for allocation or future rostering of staff. It's used for retrospective guidance in terms of what measures of quality have been achieved from the system considering those staffing-inputs. This tool is about helping people understand over time what they should be putting in the rosters this week, next week and the month after by constant refreshing of the resident profile over time.

MR ROZEN: Dr Willis, did you want to add anything to that?

DR WILLIS: Yes. I'm not familiar enough with Kathy Eagar's proposals.

MR ROZEN: I should note for the record, Mr Bonner, that the federation has put in a detailed written response to Professor Eagar's work.

MR BONNER: We have.

MR ROZEN: And that's part of the evidence before the Commission. I won't take you to it now. Is there anything else you want to say about Professor Eagar's work at this point?

MR BONNER: Look: I think the point we would make fundamentally is that we would disagree with Professor Eagar's characterisation of the three-star rating as being somehow – and she said herself it was her label rather than something objectively within the system – as being appropriate.

MR ROZEN: She did describe it as a bare minimum in fairness.

MR BONNER: Yes. Yes. That's right. It was labelled as appropriate, and that causes us concern, because it's very clear from our study, that staffing-levels of that number and of that mix would fail to provide the adequate staffing for categories 4, 5 and 6 of our residents and our study.

MR ROZEN: Yes.

MR BONNER: So it would mean that for half the resident profile at least there would be inadequate care in terms of volume and the growing proportion of people in the system.

MR ROZEN: And the most needy half.

MR BONNER: And secondly we would say that the skills mix that's derived from the CMS system using the American model is grossly inadequate when compared to the skills mix that is arrived at through consideration of the intervention level of activity in our study.

MR ROZEN: One thing that's missing from both your work and the work of Professor Eagar is the allied-health dimension.

MR BONNER: Yes.

MR ROZEN: Do you want to make any observations about that? Is there – put that another way: could there be some tweaking done – to include a component of allied health done to your system?

MR BONNER: Indeed. We've already identified an intervention-timings database for allied health. It would be a simple matter of doing the same kind of work as we've done for nursing and personal-care staff, to identify the interventions that are found in aged care and then derive from those timing studies the amount of time that could be added to another module of this piece of work. So it's not – now that we've got the sort of theoretical construct nailed, it's not all that hard, to bolt on the suite for allied health professionals.

DR WILLIS: But it wouldn't substitute for the care that's missed at the moment. For example: one of the major cares missed is oral hygiene. You're not going to see a speech pathologist take up that missed care. So you would still need a mandated staffing-level of registered, enrolled – and care workers.

MR BONNER: Yes, and, certainly, our piece of work was never to explore the total aged care workforce input into residential aged care. It was focussed on nursing and personal care. But the approach, as I say, is adaptable to be added onto in terms of those other inputs.

COMMISSIONER BRIGGS: In your unpublished stage 2 report, did you make an estimate of the additional cost that would be required to have this kind of proportionality?

MR BONNER: There is another study that – I think, that we had commissioned subsequent to this report, conducted by another team from Flinders University, that modelled the costs, Commissioner.

COMMISSIONER BRIGGS: Do you have any sense of what they are, just an indicative - - -

MR ROZEN: Could I ask it be brought up? Because – it's in evidence, Commissioner.

COMMISSIONER BRIGGS: Good. Good.

MR ROZEN: It's – document's already tendered, tab 2, exhibit 1-21.

COMMISSIONER BRIGGS: Sorry. I'm getting ahead of myself, Mr Rozen.

MR ROZEN: No, no. That's – I'm sorry to cut you off, Commissioner, but I thought it might be helpful, to have it, and the costings are in the document at 3314. Just whilst that's being brought up, hopefully, to assist everyone – the magic figure is $5.3 billion for implementation of the report in 2016, but it's important, to understand that the authors of the report identified a number of offsets against that. In other words – increased taxation revenue, reduced workforce attrition and so on. And the bottom line's this, Mr Bonner, isn't it? That the authors of the report calculated that there'd be a – it would be at least benefit-cost-neutral?

MR BONNER: Optimistically ..... I think it's 2.7 in raw costs. If you look at the summary on the pages marked with ..... 3 - - -

MR ROZEN: If we go to 3314, at the bottom of the page, the final paragraph, in summary - - -

MR BONNER: Benefit-cost-neutral; correct.

MR ROZEN: There is a recognition in the research, isn't there? Of limitations, modelling.

MR BONNER: There a range of assumptions that were used in modelling the cost, and they include expectations in terms of reduction in transfer for example, from residential-aged care facilities to acute-care hospitals. Now, they are costed, and the assumptions are published in the report. So they've been explored somewhat and are open to verification or challenge.

MR ROZEN: Commissioner Briggs, does that adequately address that question?

COMMISSIONER BRIGGS: Yes. I'm assuming the raw costs of 2.7 billion is per year in 2016 dollars with that level of acuity. But when you say "at least benefit-cost-neutral" – that means in terms of tax returns from employing more nurses and what have you.

MR BONNER: Health system. That's right; correct.

COMMISSIONER BRIGGS: And that's – okay. Thank you.

MR BONNER: Overall.

MR ROZEN: And there is a recognition – is there not – that that's a – from 2016 onwards that's bound to be an increasing figure both – on both sides of the ledger.

MR BONNER: That's right. The savings will equally be mounting as well.

MR ROZEN: They're the questions that I have for Mr Bonner and Dr Willis.

COMMISSIONER PAGONE: Well, thank you both for that. It's very informative, very helpful. Thank you.

<THE WITNESS WITHDREW [1.04 pm]

COMMISSIONER PAGONE: 2 o'clock.

ADJOURNED [1.04 pm]

RESUMED [2.04 pm]

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Commissioners, I call Kym Lee-Anne Peake, who is seated in the witness box.

COMMISSIONER PAGONE: Yes. Thank you.

<KYM LEE-ANNE PEAKE, AFFIRMED [2.04 pm]

<EXAMINATION BY MR ROZEN

MR ROZEN: Thank you Commissioner. Ms Peake, for the purpose of the transcript could you please state your full name?

MS PEAKE: Kym Lee-Anne Peake.

MR ROZEN: And you have made a further witness statement for us, having made previous statements; this one has the code WIT.0481.0001.0001, and that should be appearing on the screen in front of you now, I hope. That's a statement dated 4 October 2019, and is there one typographical error that you would seek to correct in 12.2?

MS PEAKE: Yes, please. And it's just – I think there was a typo where we have used the word "rations" rather than the word" ratios".

MR ROZEN: Yes. Okay. An unintentional error, I'm sure. And with that change, are the contents of the statement true and correct?

MS PEAKE: They are.

MR ROZEN: I tender the statement of Kym Lee-Anne Peake dated 4 October 2019, Commissioners.

COMMISSIONER PAGONE: All right. Well, that statement with the amendment will be exhibit 11-29.

EXHIBIT #11-29 STATEMENT OF KYM LEE-ANNE PEAKE DATED 04/10/2019 (WIT.0481.0001.0001)

MR ROZEN: If the Commission pleases. Actually, there is some further information which you have provided to us. I will ask that that be with brought up on the screen; it's WIT.0481.0002.0001. And these were some additional questions that you were asked, from memory, in conference, I think; is that right?

MS PEAKE: That's correct.

MR ROZEN: And this is some further information. Do you see that on the screen in front of you, Ms Peake, it's coming up now, I think.

MS PEAKE: It's still coming.

MR ROZEN: I think you are familiar with the document I am talking about. Have you had a chance to look at that before giving your evidence?

MS PEAKE: I have.

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

MS PEAKE: They are.

MR ROZEN: It may, Commissioner, be appropriate, perhaps, for this to be marked the same exhibit but B rather than A might be a suggested approach. It's related to the statement.

COMMISSIONER PAGONE: It may as well just form part of this one exhibit, mightn't it; it's easy enough to identify this document.

MR ROZEN: From the coding, yes. That's quite sufficient. Thank you, sir.

COMMISSIONER PAGONE: All right. We will include that as part of 11-29.

MR ROZEN: If the Commission pleases.

I'm sorry about all that, Ms Peake, You have been the secretary of the Department of Health and Human Services here in Victoria since 2015.

MS PEAKE: That's correct.

MR ROZEN: And as you've indicated, you've made other statements and you've previously given evidence here including in the first Melbourne hearing a few weeks ago about young people.

MS PEAKE: I did.

MR ROZEN: Yes. For present purposes you have been asked to give some evidence about the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Ac*t (2015) and you have done that in some detail in both the witness statement and the additional information. I thought I would start – before examining that legislation, I would like to ask you a little bit about the public sector aged care part of Victorian aged care services. And maybe we can do it by way of a summary because it is also all set out in your statement. There are 73 health services running 178 public sector facilities in Victoria?

MS PEAKE: That's correct.

MR ROZEN: And just so that we're clear about that. Those 73 health services, they're primarily government-owned services; is that right?

MS PEAKE: That's correct, yes. They are all government-owned facilities.

MR ROZEN: Okay. Perhaps I will return to that but for the moment, I understand, in them there are 5600 beds, according to your statement.

MS PEAKE: Yes.

MR ROZEN: That represents 11 per cent of the Victorian aged care sector?

MS PEAKE: That's correct.

MR ROZEN: The remaining 89 per cent being private.

MS PEAKE: Correct.

MR ROZEN: Either profit or - - -

MS PEAKE: Or not-for-profit.

MR ROZEN: - - - not-for-profit or so on. Okay. Thank you. Now, they are concentrated in regional and rural areas.

MS PEAKE: There are but there is also a range of public sector residential aged care services across metropolitan and larger regional as well.

MR ROZEN: And, importantly, in a number of regional areas, those public facilities are the only aged care facilities that are available to the population.

MS PEAKE: That's correct, particularly in smaller rural locations.

MR ROZEN: Yes. Now, importantly for the evidence you are going to give about nurses and nursing ratios, the resident cohort in Victoria's public sector facilities present particularly complex challenges in terms of their care.

MS PEAKE: That's correct. And particularly in our metropolitan and larger regional services, the acuity of the residents is higher than in non-government services generally.

MR ROZEN: I want to ask you a little bit about that. Firstly, how are you able to say that? What's the information source that enables you to make that observation?

MS PEAKE: Yes, so there is information that is collected about the complexity of residents through the Aged Care Funding Instrument and on two occasions in the last few years, we have done an analysis of that data. In the first instance that analysis was conducted by the Australian Institute of Health and Welfare. That was in 2014 contrasting the ACFI data for public sector residents versus residents in non-public sector services, and then more recently we commissioned a further piece of work, which is recently reported looking at 2018 comparative data.

MR ROZEN: I will ask you about the first of those data sources which is from the Australian Institute of Health and Welfare, and you cite that in your statement and it's significant, I think, isn't it, that it's 2014 data. It's at paragraph 20 of your statement. If that could be brought up, page .0003. That more recent study that you referred us to, are the findings of that consistent with the 2014 study?

MS PEAKE: They are but the method was slightly different but the findings are consistent.

MR ROZEN: And what is it about the cohort that dictates the greater complexity? For example, is it to do with the age or what other features?

MS PEAKE: Yes, part of it is that there are a higher number of slightly younger residents who have more complex needs but across the board there are a higher proportion of residents that have either complex health care needs, complex psychosocial or behavioural management needs or more broadly psychosocial care needs.

MR ROZEN: You detail some of those features of the cohort and some of the particular health needs at paragraph 17 of your statement, which I would just like to ask you about briefly. And I note that the references there are not only to complex health needs but also behavioural needs and psychosocial needs.

MS PEAKE: That's correct.

MR ROZEN: And that's a function of the matters that you were just describing to us?

MS PEAKE: That's correct.

MR ROZEN: Thank you. If I could turn then to the questions of staffing, by reference to your statement. You make the observation at paragraph 32 on page .0005 that:

> *A range of academic literature shows the relationship between staffing levels and patient outcomes.*

And you go on to say:

> *This literature has found that higher nurse staffing numbers lead to better patient outcomes, with lower mortality rates, shorter length of stay, fewer readmissions, fewer falls with injuries and fewer health care associated infections.*

You cite a number of studies. I'm right, aren't I, that each of those studies has examined the question of any link between staffing levels and patient outcomes in a hospital setting?

MS PEAKE: That's correct.

MR ROZEN: The evidence that we have heard including on Monday from Professor Eagar is that there is a great deal of literature that addresses that link in the

context of hospitals and the acute health sector. There's less in relation to aged care facilities, is there not?

MS PEAKE: That's correct. I think it is much more of an emerging field of research.

MR ROZEN: Do you say, Ms Peake, that nonetheless, from the literature about the health sector, that at least the inference is open that similar results could be expected in aged care settings?

MS PEAKE: I do, particularly given the health needs of many of the residents who are in particularly public sector residential aged care.

MR ROZEN: And I take it from that you mean that they're akin to the health needs that one might come across in a hospital setting?

MS PEAKE: That's correct.

MR ROZEN: Yes. You explain to us that the background to the Victorian legislation goes back to 2000 when there have been enforceable requirements for minimum nursing staffing levels in enterprise bargaining agreements?

MS PEAKE: Yes.

MR ROZEN: Has that been limited to the public sector in Victoria?

MS PEAKE: That's correct, in terms of the enterprise bargaining arrangements, that's my understanding that it's, yes, public sector-oriented.

MR ROZEN: What led to the translation, if I can call it that, from the enterprise bargaining agreements into statute in 2015?

MS PEAKE: Yes, so it was really – it was a government commitment but it was in recognition that having had that period of an experience of ratios through enterprise bargaining agreements, that there was a very compelling case for the importance of those staffing levels, both for quality, safety and appropriateness of care, but also as a contribution to recruitment and retention of staff. And so in order to really enshrine that standard into, in an enduring way, government committed to translate the EBA instrument into legislation.

MR ROZEN: Now, it's important for our purposes to appreciate that this legislation is not obviously solely concerned with aged care facilities, is it?

MS PEAKE: That's correct. It's also acute care in public sector hospitals.

MR ROZEN: It's fair to say this, isn't it, Ms Peake, it's principally concerned with a range of aspects of work in hospitals?

MS PEAKE: That's right. It's across the board in terms of nursing and midwifery in our public sector hospitals.

MR ROZEN: And the key definition, I suggest, in the legislation, is that the ratios only apply to things that are defined as hospitals.

MS PEAKE: That's correct. And hence the relationship, back to your first question about our public sector residential aged care services which are operated by our public sector hospitals. There are, with the exception – and apologies, you might be just about to ask me this – of four services that were under the pre-existing enterprise bargaining agreement that are in addition to those public sector hospitals.

MR ROZEN: That's exactly what I was going to ask you about next. There are four identified – without going to the definition, because we don't need to, but in section 3 there's a definition of hospital links you to a schedule which lists various public hospitals in Victoria and then there's a "and also the following four facilities", and you have explained to us that they are there because they had been the subject of enterprise bargaining agreements before 2015.

MS PEAKE: That's correct.

MR ROZEN: Okay. Thank you. I think we may have heard some evidence from Mr Gilbert of the Nursing and Midwifery Federation about that this morning. He referred, I think, to three private sector organisations that had been prepared to commit to ratios in enterprise agreements.

MS PEAKE: But to your earlier question, so I should correct the record, it's overwhelming predominantly the public sector that those enterprise agreements apply to.

MR ROZEN: And as you have already, I think, agreed, there are sections in that Act that impose particular nursing to patient ratios in different contexts, so in a neonatal ward, for example, there has to be one nurse for every two cots, for example.

MS PEAKE: That's correct.

MR ROZEN: And there are similar ratios, without going into detail, for a coronary ward and an operating theatre, and so on. And that's the explanation for why it's only aged care as conducted in hospitals that is picked up by the legislation.

MS PEAKE: That's correct.

MR ROZEN: The other pre-condition is that the aged care ward in the hospital has to have been one that was classified as a high-care ward when we still had that definition back in 2014.

MS PEAKE: That's correct, and again that reflects what had been in the industrial instrument as well. I should add that in legislating, the State obviously also was focused on its responsibilities, its stewardship and governance responsibilities for public sector organisations, recognising the broader regulatory role and funding role of the Commonwealth for the remainder of the aged care sector.

MR ROZEN: So because the definition is linked to an aged care ward that was a high-care facility when that definition was included in the Aged Care Act before 2014, what is the effect of that on a newly established aged care facility in a public hospital since 2014 when the definition has no longer been current?

MS PEAKE: Yes. So, certainly our intention has been that we won't set and forget the legislation; that we will continue to reflect either changes in services or changes in – in models of care and make adjustments either to regulations or, if necessary, to principal legislation to ensure that it remains – the coverage remains as intended and the operation is effective.

MR ROZEN: I understand. At paragraph 35 of your statement, if that could be brought up at the bottom of page 5, and over to page 6. Perhaps if that and the following two paragraphs could be highlighted for us. So the ratios are as set out there. In one of the wards that we have been talking about there's a requirement during the morning shift for there to be one nurse for every seven residents and one nurse in charge. And I will come back to how that's applied in a moment. For an afternoon shift it's one nurse for every 8 residents and one nurse in charge. And overnight or night shift one nurse for every 15 residents. I take it that those numbers, those ratios were direct lifts from the enterprise bargaining agreements that were in place?

MS PEAKE: That's correct.

MR ROZEN: Now, at paragraph 36 you explain that under the legislation, the nurse in charge must be a registered nurse while the other staff can be either registered or enrolled nurses, and we also heard some evidence earlier today about that. That means, as I understand it, that if we just take the morning shift, it would be – a provider would be compliant if they had a registered nurse in charge and then for every other 7 residents an enrolled nurse, that would meet the requirement?

MS PEAKE: That's correct.

MR ROZEN: All right. There are – as you say in 37, there are other methodologies which introduce a degree of flexibility into it.

MS PEAKE: Yes.

MR ROZEN: Can you explain to us what they are, how that works?

MS PEAKE: Yes. So, really, para 37 was an attempt to explain that in other places other sorts of methodologies have been adopted but that why we have preferred to use ratios rather than using nursing hours per patient days, so that was what we were intending to communicate in 37. I would, though, in answer to your question, say that there is flexibility within the legislation and we expect clinical judgment to be exercised so that if there are higher acuity needs, for example, that there would be staffing above ratio for particular rosters. And I'm certainly aware of one example at an Austin Hospital-operated service which is called Wattle House Lodge where there are residents with particularly significant behavioural management needs where there is rostering in the morning above ratio.

So there's an extra nurse, and 80 per cent of the nursing staff have psych qualifications to reflect the needs of the residents. So the ratios are not intended to be a ceiling on the staffing that is provided but, really, the minimum necessary for safe and quality care.

MR ROZEN: To pursue that metaphor a bit further, they're a floor rather than a ceiling, or that's the intention.

MS PEAKE: Yes.

MR ROZEN: Of course, there has been evidence before the Commission – I'm sure you've heard this – that one of the dangers of introducing ratios is they operate as a de facto maximum; that's what people staff to and it takes away the need for an assessment of whether or not higher staffing levels are necessary. As I understand your evidence you say that in Victoria, at least in the example you have given us, that's not the case. Are you able to speak more broadly about the Victorian experience?

MS PEAKE: Yes. And in my statement I've attempted to go on and provide a little bit of evidence, through data around performance indicators that we collect on quality of care which I think underscores that the focus of all rostering decisions is on making sure that the needs of residents is met, rather than a compliance approach to a minimum ratio model.

MR ROZEN: All right. We will come back to those indicators in a moment, if we could. Before doing that, though, I need to ask you about personal care workers and allied health workers because the evidence the Commission has heard, particularly from Professor Eagar on Monday of this week from the University of Wollongong, is to the effect that her view, based on her international research, is that whilst the time – the care time provided by registered nurses is important, so too is the overall amount of time provided by all care workers, particularly including personal care workers. That does not appear to be the focus of the legislation in Victoria. There's no mandatory requirements for personal care workers.

MS PEAKE: That's correct. The focus of the legislation really was based on the characteristics and acuity of the resident base in public sector residential aged care

services. As I indicated earlier, the translation of the industrial instrument in the legislation really was looking at what was necessary to assure quality, safety and appropriateness of care.

MR ROZEN: Has there been any consideration given to imposing minimum personal care worker numbers?

MS PEAKE: It's not under current consideration in the Victorian Government but I would reinforce there has been a strong government commitment to monitor the impact of the legislation and a very strong commitment to not – I know there has been evidence led about not setting and forgetting ratios so we will continue to monitor the quality indicators and the impact of ratios and if there are further changes needed, consider those.

MR ROZEN: Yes. I think you may have partly answered my next question but I'm wondering whether there's the potential at least for the operators of these facilities, in complying with their obligations under this legislation, to reduce the number of personal care workers so as to comply by having the right number of nurses. In fact, the inverse what we tend to see what happening in the rest of the industry where the opposite is occurring; where personal care workers are replacing nurses, do you have any experience of that?

MS PEAKE: Look, I don't have any experience of that occurring and we quite deliberately – and, again, I might be pre-empting a question you ask, but we quite deliberately provide extra subsidy to meet the wage cost of the nurse to patient or nurse to resident ratios so that there isn't a perverse incentive to not provide the full range of personal care support that is also necessary for residents.

MR ROZEN: If I could turn then, to the evidence of whether this Victorian system leads to better outcomes for patients or for residents because ultimately that is obviously of great importance to this Commission. You point to four sources of evidence or four indicators which provide support on your statement for the proposition that the outcomes are better for residents - - -

MS PEAKE: Yes.

MR ROZEN: - - - in these facilities than in their equivalents in the private sector where the Act doesn't apply. I want to go through each of those in turn. Before I do that, it's fair to say, isn't it, that the evidence – it doesn't really – it's not compelling. Is that fair to say?

MS PEAKE: Look, I would certainly – I would contend that particularly the quality indicators and the improvements over the time that we have had ratios for me is the most compelling evidence. Some of the other examples we have given in here are less direct.

MR ROZEN: They require inferences to be drawn, essentially.

MS PEAKE: Yes.

MR ROZEN: If I can start with the first, then, and this is the accreditation results that you've referred to. These are the findings of noncompliance in Victorian public sector residential aged care facilities versus the non-public sector. And you've included a table in your statement on page 7, which I would ask could be put up on the screen by the operator, please. Do you have page 7 of your statement open there?

MS PEAKE: I do.

MR ROZEN: Thank you. What does this table depict?

MS PEAKE: So it shows the relative performance between public sector and non-government providers against the accreditation standards that each provider is assessed against.

MR ROZEN: What, these are the previous standards, aren't they?

MS PEAKE: That's correct.

MR ROZEN: The ones that were in operation before July of this year. And just so we understand this, so standard 1 was concerned with management systems. Standard 2, health outcomes. Standard 3, lifestyle, and Standard 4, the physical environment. And you here are showing the number of occurrences of noncompliance.

MS PEAKE: That's correct.

MR ROZEN: And we can see that they're considerably higher. Once again, this is pretty old data now, isn't it, from 2012 to 2015?

MS PEAKE: That's right. And - - -

MR ROZEN: Is there anything more recent that you can draw our attention to?

MS PEAKE: Not in terms of accreditation standards. We can certainly give you raw data, and I'm very happy to take that on notice. The value of this was that it provided that comparative picture and we don't have access to that, the broader non-government data to provide comparative data. But I can certainly provide to the Commission just the raw data about our public sector services.

MR ROZEN: Thank you. The second matter that you draw our attention to is complaints data. This is paragraph 45 of your statement, or more particularly you talk about complaints at 43, and you note that the most common three complaints in the period 2015, 2016 related to issues you describe as nurse-sensitive. That is clinical care, medication management and continence management. This is the

complaints data which is now maintained by the Aged Care Quality and Safety Commission and its predecessor bodies. And at 45 you say:

> *This result's unsurprising, given many residential-aged care services do not appear to have clinical-staffing levels. While there is no numerical comparator that can be used to differentiate public and non-public sectors in nurse-sensitive-complaints data, it could be expected, that this would follow accreditation patterns.*

So I want to unpack that phrase, if I could, please, "it could be inspected". Do you mean that that's your expectation?

MS PEAKE: It is, and, certainly, based on the feedback we get through what comes through to Safer Care Victoria so far since its operation that we would see, we would expect to see that more-comprehensive dataset held by the Commonwealth to follow that pattern.

MR ROZEN: Can you tell us a bit more about Safer Care Victoria; it's not something we've had evidence about before, I don't think. What's its remit?

MS PEAKE: Yes. So Safer Care Victoria was established in 2017 in response to a review into quality and safety in Victorian health services. It is our lead agency to drive quality improvement in health services including, from this year, having a specific focus on aged care delivered by health services. And it both provides a vehicle for there to be oversight – an assurance of quality but most significantly to lead collaborations between clinicians and management on improvement priorities.

MR ROZEN: And if I'm understanding your evidence correctly, you would anticipate that, through the work of Safer Care Victoria, more data will emerge – that will enable these sorts of comparisons to be made.

MS PEAKE: That's right. It is also – there is a companion Agency that's important in that regard, which is the Victorian Agency for Health Information. It was also established on the back of that review into quality and safety in our health services, and it provides – it really is the Agency that looks at, both, developing better quality indicators but then also developing the datasets that support better line of sight into quality and safety.

MR ROZEN: Now, the third data source that you refer the Commission to concerns 000 calls, demand for ambulance services, which is a matter the Commission's heard quite a bit about; that is that there is often extensive referrals out by way of ambulance travel by residential-aged care facilities for people to be treated in emergency departments. What you refer to us is the triaging service that is operated by the – I think it's the Emergency Services' Telecommunications authority. Is that right? Where they triage 000 calls to see whether they really are emergency calls or whether they can be addressed through some lesser form of transport; is that right?

MS PEAKE: That's right.

MR ROZEN: And the figures you cite are that across the entire callout numbers about 10 per cent of services are triaged through to what's called a secondary triage service.

MS PEAKE: That's correct.

MR ROZEN: In other words: that 10 per cent are ones that are assessed as not needing ambulances.

MS PEAKE: That's correct.

MR ROZEN: They're less serious or less urgent.

MS PEAKE: Less acuity .....

MR ROZEN: And you contrast that with the figures for residential-aged care facilities in Victoria, where there is a much-higher figure.

MS PEAKE: 26 per cent.

MR ROZEN: 26 per cent. That's at the top of paragraph 47. But it's important – isn't it – to note that there is no differentiation in that data between private and public sector.

MS PEAKE: No; the informal feedback when we looked for this data source, looked to this data source was that, predominantly, the callouts are to non-public-sector aged care facilities, but that isn't identifiable in the data. And so I can't give it to you as a statistical form.

MR ROZEN: Understand. Finally you refer to almost the opposite situation of in-reach health services, which we've heard quite a bit about in other contexts. Interstate they're referred to as flying squads; that is hospitals that provide services where geriatricians and others visit residential-aged care facilities to address clinical need.

MS PEAKE: That's correct.

MR ROZEN: And that's what you're talking about, referred to as in-reach services, and that data is set out in another table that you have included in your statement, at page 8, which I would ask to be shown. And can you talk us through this table, please, Ms Peake.

MS PEAKE: Certainly. So, again, this is – as you've described, just having – setting out reliance on residential in-reach services by Government or public residential-aged care facilities versus non-Government residential-aged care facilities

from between the period of 2012-13 to 2017-18 and just shows that there's a much-higher rate of referral for those in-reach services from the non-Government services. And that is, I think, both a product of not having access to GP services but also not having the nursing and clinical staff on site to be able to support or manage the lower-acuity predictable health needs of residents in those non-Government services.

MR ROZEN: If I could play the devil's advocate to some extent there, it might also – the higher number of callouts might, possibly, be reflective of higher number of nurses in the sense they're more likely to identify problems that need to be addressed by an in-reach service. Is that possible, or is it not consistent with your understanding?

MS PEAKE: It's not consistent with my understanding. My understanding and – I think, supported by some of the deeper-dive research that we've had done, is that, where there is that clinical expertise available within the facility – that there is less need to call on similar sort of expertise to come to the facility because it's not only specialist geriatricians that come with residential in-reach; it's also nursing support, that is provided through that service.

MR ROZEN: Yes. It could be complex wound-management for example.

MS PEAKE: Correct.

MR ROZEN: A facility that doesn't have registered nurses would be more – less likely to manage that in-house and would - - -

MS PEAKE: That's right; dehydration – there are a range of likely predictable health needs that do require there to be a level of clinical expertise to support.

MR ROZEN: Now, you have provided us with some of that research in the form of two reports prepared, as I understand it, for the department by La Trobe University.

MS PEAKE: That's correct.

MR ROZEN: They're both part of the general tender bundle. If the first of those could be brought up – it's at tab 213 of the general tender bundle, and if we could go, please, to – it's the sixth page; "page 6" appears at the top. I don't – I'm sorry – have the – it's the next page. Yes; thank you. And if – the first three paragraphs could be highlighted, please. As we see there, this was a study, an in-depth evaluation – reading from paragraph 1.2 – of the residential in-reach service of the eastern health region from the perspective of the users of the service, and it was particularly focussed on use of the service by residential-aged care facilities.

MS PEAKE: That's correct.

MR ROZEN: So it's right on point as far as this issue is concerned.

MS PEAKE: Yes.

MR ROZEN: And there was – was it a follow-up report, the one that was done in 2019, or was it done in two parts? Are you able to tell us?

MS PEAKE: That was a follow-up. So we – having done the work in Eastern – and recognising that we thought that the Rastern Service was a particularly good service, we wanted to test those results in another part of the state, and so there was a follow-up that was conducted in relation to Melbourne health.

MR ROZEN: Right. Now I must confess I've only – we only received this overnight, commissioners, and I've only given it the quickest of reads, and it may be, Ms Peake, that we might call on you to – for the Department to provide a bit more of an analysis of these reports. But if I could just draw your attention to something that appears on page 26 of the first report, the 2017 report – I'm sorry, commissioners. I thought it was 26. Section 4.3, that I'm looking at.

MS PEAKE: Page 27, I think, 27 and 28.

MR ROZEN: Yes. The bottom – sorry; the bottom part of the left-hand page there, the paragraph that starts "One of the lowest users of the Eastern At-home Service was the public-sector facility" – which would appear to be consistent with what you're saying in your statement. I want to try and understand, though – this was a pretty small sample, was it not? There was only the one public-sector facility included in this study?

MS PEAKE: That's right. It was – it's a significant facility. So – our metropolitan services are much bigger facilities.

MR ROZEN: Yes. Anyway, I take it, that overall your evidence to us is that these – this study by La Trobe, these two studies by La Trobe are consistent with your observation that public-sector residential-aged care facilities are less likely to make use of the in-reach facility than their private-sector counterparts.

MS PEAKE: That's correct.

MR ROZEN: And you put that down to the availability of high levels of clinical expertise in those facilities.

MS PEAKE: That's correct.

MR ROZEN: Now, you did anticipate that I would ask you about the cost issue, because obviously very important, for us to understand that. You say in your statement that Victoria subsidises these facilities, this 11 per cent of the Victorian aged care sector, to the tune of $97.8 million per annum.

MS PEAKE: Yes.

MR ROZEN: And you give us a breakdown of that costing in the further information that you've provided to us, which is part of exhibit 11-29. If we could, just go to that; it's the third page of that document. So – page .0003. If that could just be highlighted for us, please – so we see there the breakdown of the 97.8 million per annum amount that is paid, and in the second dot point we see that 78.3 million – so the majority of that – is a contribution towards the higher cost of nursing staff in public-sector residential-aged care services because of the need that arises from the ratios.

MS PEAKE: That's correct.

MR ROZEN: We've heard evidence about remuneration levels for registered nurses and enrolled nurses in aged care, generally, being lower than is the case in the acute sector Australia-wide. We've heard estimates of 10 per cent, 15 per cent in different reports. What's the position in Victoria in relation to that? Do you know?

MS PEAKE: My understanding is that for registered nurse in charge that's about a 20 per cent differential and – almost 20 per cent, and for enrolled nurses, it's up to 10 per cent lower in private- rather than public-sector facilities.

MR ROZEN: I see. I'm also interested in the comparison between the public-sector residential-aged care services and the acute-health sector. So – a registered nurse working in one of these facilities where there are ratios as compared to a registered nurse working in another part of the hospital that's not aged care. Are you able to assist us with that comparison?

MS PEAKE: My apologies. I don't have that number with me, but I, certainly, can get that to the Commission.

MR ROZEN: Thank you. In fairness: we didn't ask you for it; so I don't expect you to have it at your fingertips. But it's important, isn't it? In understanding how that 78.3 million is made up. In other words – are you seeking to ensure that wage levels in the public-sector residential-aged care facilities are the equivalent of what those nurses would earn in the acute sector, or are you only seeking to ensure that they get what they get in the private aged care sector for example?

MS PEAKE: So it's, certainly, higher than the private aged care sector.

MR ROZEN: Higher than that.

MS PEAKE: Let me confirm for you the equivalence with public-sector hospitals.

MR ROZEN: Thank you.

COMMISSIONER BRIGGS: Can I just ask you about the second-last dotted point on that page. So there's been a longstanding arrangement, I take it, that the

Commonwealth provides a lower level of subsidy to state-Government-provided aged care facilities than it does to other facilities.

MS PEAKE: That's right. Initially that was because there was a capital component that was funded for non-Government providers, but even since the capital component is no longer provided, the differential has continued for public- and private-sector providers.

COMMISSIONER BRIGGS: That's very interesting. Thank you.

MR ROZEN: Now, we know that this whole area of remuneration levels and staffing-levels in residential-aged care facilities, generally, is – operates in a pretty politicised environment. The question that necessarily arises is whether this statutory arrangement in Victoria is vulnerable to a change of government for example. Would that – do you have a view about that? Or maybe that's asking you to speculate.

MS PEAKE: Look: there's a degree of speculation. I would say that, obviously, there is much more of a process involved in making changes to legislation than there is to a policy document, and I think the – obviously, the findings of the Commission will also be very influential in terms of future policy and any future bills that might be put to a Parliament as well.

MR ROZEN: In the remainder of your statement you refer to some important but perhaps less tangible benefits that flow, as you say – as you see it, from these arrangements, including for example the ease with which or the relative ease with which Victoria is able to recruit nurses into its public-sector residential-aged care facilities, and you also refer to benefits in terms of attraction, career paths and general professional development of nurses. Can you expand on that, and, in addition, if I could ask you, has there been – is there any data, any research that's been done about such matters that we could look at?

MS PEAKE: Certainly. So if we go back to – the genesis of ratios in Victoria really did come from a – an industrial-relations case in 2000 that was all about retention, attraction and retention of the workforce. The feedback that we get from nurses working in aged care is that the level of staffing is an important attractor to them, both in terms of the ability to have certainty and flexibility about their roster and be able to have family-friendly rostering practices, but also the opportunity in working as part of a team for there to be learning on the job and that professional development and support so that there can be then more time spent on focussing on building the relationship with residents.

And to your question about the sort of – the research that we have done into that: we have had funded work done, a survey of our nursing staff that was conducted in about 2017, I think; that was really getting to understanding – because we're aware of the perceptions of working in aged care, getting feedback from staff about why they've chosen to enter the profession and work in an aged care setting and what it is,

that they would promote about their work environment and their workplace to other nurses. And they were the very strong themes that came through that work. And I think we've made that survey available; if not, we can, certainly, make the results of that survey available to the Commission.

MR ROZEN: Yes. Just so I can clarify that we are talking about the same thing – on page 4 of the further information you've given us, you're asked the question "What are the positive aspects of working in public-sector facilities as expressed by nurses?", and there's a reference in the third dot point to the positive aspects of aged care nursing-project. Is that what you've just been talking about?

MS PEAKE: That's correct. That's correct; yes.

MR ROZEN: And I think we have asked you if you're able to provide us with that report; we'd appreciate it.

MS PEAKE: Yes. Certainly.

MR ROZEN: Thank you. Just finally: is there a corresponding risk that, whilst the public-sector residential-aged care sector is more attractive for nurses in Victoria – that the knock-on effect unintended is that the remaining 90 per cent of the Victorian aged care sector is less attractive and might struggle even more to attract nurses?

MS PEAKE: It's a difficult question to answer. I would come back to the higher acuity of residents that are in public-sector residential-aged care services. So in terms of aligning skilled workforce, my starting point would be that it's very important, that we have highly skilled appropriate workforce in our public-sector services. So I guess I'd be a little bit unapologetic about ensuring that that is the case. I would also hope that this sort of work that points to the importance of workforce to the experience of working in aged care and the ability to attract workforce would have influence over other operators, irrespective of whether they're subject to formal ratios or not.

MR ROZEN: Yes. Perhaps to paraphrase: you'd like to see a levelling-up to the level of the public sector rather than the other way - - -

MS PEAKE: Correct. I wouldn't like the response to be us not having appropriate staffing in our own services.

MR ROZEN: I understand. And do I also understand you to be saying that, because of the particular features of the public sector in Victoria that would – you're not necessarily comparing apples with apples when you look at the private sector because of that higher acuity?

MS PEAKE: My point would simply be that it's really important for those services, that we do have those levels. In an ideal world we wouldn't have only the public sector providing an option for high-quality high-need care to residents, but we would

have a diversity of providers who are making that offer. So I, certainly, wouldn't want to be interpreted as saying that I don't think that workforce is important for the rest of the aged care sector in Victoria or anywhere else.

MR ROZEN: I understand. Thank you, Ms Peake. They're the questions that I have of Ms Peake, Commissioners.

COMMISSIONER BRIGGS: I've got one question. Let me say I found your evidence today very helpful, Ms Peake. The residential in-reach services: have you found since they began that they do actually save the State of Victoria money, or are they a net cost?

MS PEAKE: So I would, certainly, say that, because we have seen there being improved retention, certainly – and we didn't go to this quite as directly, but in my statement I do talk about, at paragraph 85, the improvements that we have seen in reductions in pressure injuries and falls that – overall that means that we're having less – and that residential in-reach data – having less transfer of people into acute settings. That's not the driver. We do this, because we want positive outcomes and positive experience for residents of our public-sector residential-aged care services, but I think overall the answer to your question would be that there is a net economic or a net financial benefit as well in having people cared for in an appropriate setting rather than being transferred into an acute-ward setting.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Thank you, Ms Peake. Be excused?

MR ROZEN: Thank you, Commissioner.

<THE WITNESS WITHDREW [2.53 pm]

MR ROZEN: We have got 10 minutes before the video.

COMMISSIONER PAGONE: The video. I was wondering whether the video might be brought forward; that was all. Is it - - -

MR ROZEN: I don't think that is possible, but we're not going to lose the time, because there's a house-keeping matter that I would seek to address now, commissioner, if that is suitable.

COMMISSIONER PAGONE: I see. Okay. Sure.

MR ROZEN: It concerns the tender of a number of statements that have been obtained by the Royal Commission during the course of its preparation for this week. There were so many statements obtained that in the end we had to make hard

decisions about which witnesses we would hear from or not, but we would not want to suggest at all that those statements are in any way unimportant or less important. What I propose to do, commissioners – and I think a list has been provided to you – of these.

COMMISSIONER PAGONE: I did see one. Yes. I did see one.

MR ROZEN: Mr Bolster did tender three earlier as part of his earlier session.

COMMISSIONER PAGONE: Yes.

MR ROZEN: It's a list that looks like this. I hope it's got three columns, document numbers in the first – I think Mr Flynn is able to provide further ones. I'm grateful.

COMMISSIONER PAGONE: Thank you. Yes. I have not seen that list before.

MR ROZEN: It's now in front of you. It's, probably, self-explanatory.

COMMISSIONER PAGONE: Yes. It is.

MR ROZEN: I would prefer not to read out each document ID, unless you think that's appropriate, given that you've got them in front of you.

COMMISSIONER PAGONE: I think I would prefer you not to read it out, and I would prefer not to hear them.

MR ROZEN: Thought that might be your position, commissioner. What I had intended to do is just give a very brief summary of each of the statements so that there is some record of what they deal with on the transcript and for the benefit of the parties and the public obviously.

COMMISSIONER PAGONE: I see. Okay.

MR ROZEN: So if I could start with the first, being the statement of Adjunct Professor Stephen Cornelissen dated the 9th of October 2019 – Adjunct Professor Cornelissen is the chief executive officer of Mercy Health. His statement includes information about the steps taken by Mercy Health to attract male workers into aged care. And I would tender the statement of Adjunct Professor Cornelissen.

COMMISSIONER PAGONE: That'll be 11–30.

EXHIBIT #11–30 THE STATEMENT OF ADJUNCT PROFESSOR CORNELISSEN

MR ROZEN: The second is a statement of Tony Leanne Hawkins dated the 27th of September 2019. Ms Hawkins is a member of the Board which operates the Esperance aged care facility, a not-for-profit facility in Esperance, Western Australia. She tells us in her statement that the facility has recently constructed a new wing, with construction partially funded by the Commonwealth, but it's unable to open that wing due to an inability to recruit enough staff. I'd seek to tender the statement of Ms Hawkins.

COMMISSIONER PAGONE: Yes. That'll be 11–31.

EXHIBIT #11–31 THE STATEMENT OF MS HAWKINS

MR ROZEN: The next three have already been tendered by Mr Bolster. So if we could, go to the statement of Karen Elizabeth Toohey dated the 30th of August 2019. This is part of a group of statements that've been obtained as part of the Commission's investigations of the registration issue, the personal-care-worker-registration issue, and whether existing health-complaints facilities are adequate to address issues that might arise in relation to inappropriate conduct by personal-care workers in the aged care setting. This is a statement of the health-services commissioner in the ACT human-rights Commission, and in her statement Ms Toohey deals with complaints relating to aged care received by her office, and I tender the statement of Ms Karen Toohey dated 30 August 2019.

COMMISSIONER PAGONE: 11-32.

EXHIBIT #1132 THE STATEMENT OF MS KAREN TOOHEY DATED 30/08/2019

MR ROZEN: The next is a statement of Stephen Dunham; he's the Northern Territory counterpart, the health-and-community-services-complaints commissioner. His statement addresses complaints received relating to aged care in the Northern Territory community-services-complaints Commission. I tender the statement of Mr Dunham.

COMMISSIONER PAGONE: 11-33.

EXHIBIT #1133 THE STATEMENT OF MR DUNHAM

MR ROZEN: Richard Anthony Connock is the Tasmanian health-complaints commissioner. He provides a similar statement concerning the jurisdiction in which he operates. And I tender the statement of Mr Connock.

COMMISSIONER PAGONE: 11-34.

EXHIBIT #1134 THE STATEMENT OF MR CONNOCK

MR ROZEN: Dr Grant Thomas Davies is the South Australian counterpart of those officers, and his statement deals with complaints received by his office relating to aged care. I - - -

COMMISSIONER PAGONE: 11-35.

EXHIBIT #1135 DR GRANT THOMAS DAVIES, HIS STATEMENT

MR ROZEN: Susan Elizabeth Dawson is the New South Wales counterpart, and her statement deals with that subject in New South Wales.

COMMISSIONER PAGONE: 11-36.

EXHIBIT #1136 SUSAN ELIZABETH DAWSON, HER STATEMENT

MR ROZEN: Sarah Jane Cowie is the equivalent in – she's the director of the health-and-disability-services-complaints office. I'm presently unclear on what jurisdiction Ms Cowie operates in. We can clarify that, but that's – I seek to tender the statement of Ms Cowie.

COMMISSIONER PAGONE: 11-37.

EXHIBIT #1137 THE STATEMENT OF MS COWIE

MR ROZEN: And the last one is a statement of David Pritchard, who is the registrar and director of regulation at Social Care Wales. Commissioner Briggs will recall we heard evidence from Dr Trigg from the same organisation earlier in the Royal Commission. Mr Pritchard's evidence relation to a registration scheme for social-care workers in Wales.

COMMISSIONER PAGONE: 11-38.

EXHIBIT #1138 A STATEMENT OF DAVID PRITCHARD

MR ROZEN: And I've been informed that Ms Cowie, whose statement is 11-37, is the Western Australian complaints-office director. The next batch of statements concerns workplace health and safety; inquiries were made of each of the state and territory workplace-health-and-safety regulators about complaints they have received or notifications they have received about incidents in aged care facilities. Commissioners will recall we heard some evidence earlier today about the health-and-safety challenges faced by workers in aged care facilities. I'll tender each of those in turn without going into detail but indicating the jurisdiction in which each of them operates. Mr Ian Oliver Munns has provided a statement dated the 15th of August 2019, and he's a representative of the Western Australian work-safety regulator.

COMMISSIONER PAGONE: 11-39.

EXHIBIT #1139 MR IAN OLIVER MUNNS – A STATEMENT DATED 15/08/2019

MR ROZEN: And Mark Andrew Crocker has provided a statement dated the 15th of August 2019. His evidence deals with the position in Tasmania.

COMMISSIONER PAGONE: 11-40.

EXHIBIT #1140 MARK ANDREW CROCKER – A STATEMENT DATED 15/08/2019

MR ROZEN: Ms Lisa Taylor has provided a statement also dated the 15th of August 2019 that addresses notifications from approved providers in the Northern Territory.

COMMISSIONER PAGONE: 11-41.

EXHIBIT #1141 MS LISA TAYLOR – A STATEMENT ALSO DATED 15/08/2019

MR ROZEN: Mr Gregory Stephen Jones has provided a statement dated the 14th of August 2019 and deals with the same issue in the ACT.

COMMISSIONER PAGONE: 11-42.

EXHIBIT #1142 MR GREGORY STEPHEN JONES – A STATEMENT DATED 14/08/2019

MR ROZEN: Mr Martyn Campbell has provided us with a statement describing the position in South Australia.

COMMISSIONER PAGONE: 11-43.

EXHIBIT #1143 MR MARTYN CAMPBELL – A STATEMENT

MR ROZEN: And Mark Dennett has provided a statement dated the 13th of August 2019 about notifications received in Queensland.

COMMISSIONER PAGONE: 11-44.

EXHIBIT #1144 MARK DENNETT – A STATEMENT DATED 13/08/2019

MR ROZEN: Andrew Gavrelatos provides evidence of the position in New South Wales.

COMMISSIONER PAGONE: 11-45.

EXHIBIT #1145 ANDREW GAVRIELATOS – EVIDENCE

MR ROZEN: And finally Ms Marnie K. Williams has provided a statement dated the 16th of August 2019 about the very large number of notifications received in Victoria by the work-safe authority.

COMMISSIONER PAGONE: 11-46.

EXHIBIT #1146 MS MARNIE K. WILLIAMS – A STATEMENT DATED 16/08/2019

MR ROZEN: The next small group of statements deals with technology-in-the-workplace issues and particularly picks up on some of the evidence that was given by Mr Pollaers about strategic action number 12, which is the proposal that there be a research centre established in Australia, and each of these witnesses has – gives evidence that it is relevant to that. The first is Rob Grenfell, who is the director of

health and biosecurity at the CSIRO, and his evidence deals with the CSIRO's digital-health-research program and the barriers to the uptake and use of technology in aged care.

COMMISSIONER PAGONE: 11-47.

EXHIBIT #1147 ROB GRENFELL, HIS EVIDENCE

MR ROZEN: Dr George Margelis is the independent chair at the aged care-industry information-technology council, which is a body that was established by ACSA and LASA, the two aged care peak bodies, and he describes the work of that council and some of the challenges that he sees to the uptake of technology in the aged care sector.

COMMISSIONER PAGONE: 11-48.

EXHIBIT #1148 DR GEORGE MARGELIS – A STATEMENT

MR ROZEN: Dr Tanya Petrovich is the innovation-business manager at the centre for dementia learning at Dementia Australia, and her statement addresses technologies that Dementia Australia has developed, including an interactive virtual-reality experience that a number of the staff of the Royal Commission have had the opportunity to experience. I tender her statement.

COMMISSIONER PAGONE: 11-49.

EXHIBIT #1149 DR TANYA PETROVICH, HER STATEMENT

MR ROZEN: And finally in that group is a statement of Associate Professor Frances Briony Dow dated 4 October 2019. Ms Dow is the director of the national aging-research institute, NARI. Commission's heard evidence from representatives NARI, including Dr Batchelor in the Darwin hearing. Dr – Associate Professor Dow's statement addresses technologies that NARI has developed which directly and indirectly support the workforce in providing care to older Australians. She also describes efforts that NARI has made to discuss with the Commonwealth Government whether NARI would be an appropriate body to oversee the body that's envisaged by strategic action number 12 in the Pollaers report. We'll be addressing some of those questions to the Commonwealth on Friday. I tender that statement.

COMMISSIONER PAGONE: 11-50.

EXHIBIT #1150 ASSOCIATE PROFESSOR FRANCES BRIONY DOW'S STATEMENT

MR ROZEN: There's a few more to be done, but more appropriate, they be dealt with later, because we do need five minutes to make arrangements for the video.

COMMISSIONER PAGONE: Will five be enough?

MR ROZEN: People are nodding furiously behind me.

COMMISSIONER PAGONE: All right. We'll resume at five past 3.

ADJOURNED **[3.03 pm]**

RESUMED **[3.08 pm]**

MR BOLSTER: Commissioners, I call Amy Lazzaro, who is on the screen from the AGS office in Sydney.

COMMISSIONER PAGONE: Yes.

MR BOLSTER: Ms Lazzaro, I think, will take an affirmation through an officer in Sydney.

<AMY LAZZARO, AFFIRMED **[3.08 pm]**

<EXAMINATION BY MR BOLSTER

MR BOLSTER: Do you have in front of you, Ms Lazzaro, a copy of your statement?

MS LAZZARO: I do.

MR BOLSTER: If the statement, WIT.0562.0001.0001, could be brought up on to the screens that can show it; do you wish to make any amendments to that statement?

MS LAZZARO: No, I don't.

MR BOLSTER: And are the contents true and correct to the best of your knowledge and belief?

MS LAZZARO: Yes.

MR BOLSTER: I tender the statement, Commissioners.

COMMISSIONER PAGONE: The statement of Ms Lazzaro of 9 October 2019 will be exhibit 11-51.

EXHIBIT #11-51 STATEMENT OF MS AMY LAZZARO DATED 09/10/2019 (WIT.0562.0001.0001)

MR BOLSTER: Ms Lazzaro, you are nurse practitioner for one; correct?

MS LAZZARO: Correct.

MR BOLSTER: And you are the program lead Geriatric Rapid Evaluation, Assessment & Treatment team member at Westmead Hospital; correct?

MS LAZZARO: That is correct, yes.

MR BOLSTER: Tells us, what does that team do, which we'll call GREAT because that's its acronym.

MS LAZZARO: Yes, and it is great. We are an outreach time from the geriatric medicine department at Westmead Hospital which is located in Western Sydney. We go out and provide consultation to residents who live within the local aged care facilities surrounding our hospital. There are around 46 aged care facilities to be exact that we cover or go into. And we do this via receiving referrals from local GPs in the area who would like a consultation, opinion or management on their residents. And we will go out and provide that.

MR BOLSTER: If we could bring up the figure that's in paragraph 14 of your statement, just so that people can get a sense of the area in which you operate.

MS LAZZARO: Yes.

MR BOLSTER: That district covers a population of nearly a million, 832,000 people?

MS LAZZARO: That's correct.

MR BOLSTER: And do you visit all of the nursing homes in that district?

MS LAZZARO: No, we only cover the nursing homes in the surrounds of Westmead Hospital itself. So there are four public hospitals within my district and we only cover the nursing homes that surround the Westmead Hospital.

MR BOLSTER: Right. Now, let's talk about you for a minute. You are a nurse practitioner, and that's the highest level of training, isn't it, for a nurse in New South Wales?

MS LAZZARO: It is, yes.

MR BOLSTER: And you outline your experience in your statement. We won't go through that in detail, but one line struck me when I read it, and that talks about how you loved doing geriatric training, and how you loved aged care when you started out as a nurse even though you didn't expect to. Tell us why do you love it?

MS LAZZARO: I love it because the patients – the elderly patients that I look after are some of our most vulnerable and yet so wonderful. They have years of experience and knowledge in life. They've raised their own families. They've worked hard to educate themselves, to own their own homes. They're at a point in life where they should be respected and looked after, and I just felt such an emotional connection to this population. I take a lot of pride in being able to look after those members of our society.

MR BOLSTER: All right. Can you describe for us a typical day in your work on the outreach program?

MS LAZZARO: A typical day would involve – we start at about 7.30 in the morning. We arrive at Westmead Hospital and we meet in our office which is located in the aged care wards at the hospital. We go through any referrals we've received overnight or from late afternoon the day before we and we triage them appropriately in terms of urgency. We then collect a vehicle which we have pre-booked from the hospital fleet service and we get out on the road going around to see the residents based on priority.

MR BOLSTER: And when you say "we" how many are in your team?

MS LAZZARO: There is myself, who is the nurse lead. We have a clinical nurse – two clinical nurse specialists who are also aged care trained who work with me, and we have a senior geriatrician from the hospital who is allocated one day a week to the service.

MR BOLSTER: All right. And you've been doing that for how many years now?

MS LAZZARO: It's around about four and a half years, since May 2015.

MR BOLSTER: What was the impetus for the program? What was – it's a research program associated with the hospital; what was the aim of this program?

MS LAZZARO: The aim of the program, from my understanding, was to minimise hospital presentations that were deemed unnecessary, to expedite discharges from the hospital so where patients could get discharged under our team's care where they didn't have to stay an extra couple of days and we could go out and provide the care, and it was to obviously upskill the nursing staff out in the aged care facilities and to provide a connection to the local public hospital, so build relationships between the facilities and ourselves.

MR BOLSTER: All right. I would like to ask you about your experiences when you get to residential aged care and the themes that you have seen over time and we would like to get your perspective about an overview of what you have observed. Can you tell us briefly about staffing mix and numbers.

MS LAZZARO: From what I have seen – from the moment I started the service and got out there on the road in 2015, I was shocked, to be honest. There are a large number of carers or assistants in nursing that work within residential aged care. They seem to make up the bulk of the workforce and a very, very minimal – or a small number of RNs. I found that the RNs are responsible for sometimes a whole level or a whole wing of the nursing home, with one RN on to, say, maybe 50 residents or 80 residents. And then they're working within their shift with a large number of assistants in nursing whom they're responsible for overseeing within a shift. And I think that's quite challenging for them working in those conditions.

MR BOLSTER: The people that you need to interact with to get to the residents and deal with them; who do you normally interact with: the assistant in nursing or the registered nurse?

MS LAZZARO: Both, to be honest. I find that when I want a detailed patient history, if I have been called out for something and you always start with investigating in great detail and length, I can only obtain a certain amount of information from the RN because they're too pulled – too extended all over the facility, that they can't possibly know their residents and what has been going on in great detail. So I rely on the assistants in nursing just as much as the RNs to obtain information about what has been going on with the resident, you know, such things as how much have they been eating and drinking lately, what their mood has been like, what their behaviour has been like. A lot of that information, I have to obtain from the assistants in nursing.

MR BOLSTER: What's your opinion of the overall level of staff training and expertise for nurses and care workers in the nursing homes that you visit?

MS LAZZARO: In my opinion, it's very, very poor. A lot of assistants in nursing that I come in contact with have only completed, say, a 12-week training course. They have graduated and then come out and are working with some of society's most chronically ill and vulnerable patients, and I feel that 12 weeks of training is not enough. They're ill-equipped for what they're walking into. RN training, however, is quite different. They obviously complete their bachelor degree at university, so

they come out with, you know, a good sound entry level of knowledge. However, I find that a lot of the RNs working within the aged care facilities are still quite junior or a new graduate. I don't come across a lot of senior RNs working in nursing homes; they're often quite junior.

MR BOLSTER: You mentioned that you see newly graduated nurses going into senior management roles. How often do you see that?

MS LAZZARO: Often. Out of the 46 facilities that I go into, staff turnover is very high. So they come and they go at management levels quite quickly and to replace who leaves, often who enters is quite junior. So I see it quite often.

MR BOLSTER: Do you ever talk to the staff about the turnover issues?

MS LAZZARO: Yes, absolutely. I've asked - - -

MR BOLSTER: What's the message you get from the staff about turnover?

MS LAZZARO: A lot of them report back to me that – sorry – a lot of them report to me that turnover is subsequent to pay. If they come across a job where they may be offered more money, they will move on. It comes down to – some of them tell me organisational pressures and management within the organisation they are working in. They don't necessarily elaborate into detail on what those pressures are, just that they're not happy working under the management that they're working under.

MR BOLSTER: Do you see staff from one nursing home in the area appear in another one in the same area?

MS LAZZARO: Absolutely, which confuses me.

MR BOLSTER: How common is that?

MS LAZZARO: Very common. I just returned to work from maternity leave and on the 12 months that I was off, one manager, who I am quite familiar with had jumped three facilities in that 12 months, all at a manager level.

MR BOLSTER: And did you get an explanation as to why?

MS LAZZARO: Generally, it's the remuneration, and the management was her answer.

MR BOLSTER: If we could turn to particular aspects of the clinical care, you identify in paragraph 30 wound management as being a particularly problematic area. What is the defect there when it comes to wound management, that you see?

MS LAZZARO: The defect is that a small insignificant wound to start with, without the right assessment and treatment quickly progresses to something that is far more

chronic and complex and acute needing hospital care. And this alarms me because wound management is a part of basic nurse training even at an endorsed enrolled nurse level and I'm getting called out for wounds which are as simple as, say, a stage 1 pressure injury which is just a reddened area. I'm getting called out for advice on what to do with such a wound which to me is so basic and is such an early part of nurse training, and I feel that they're ill-equipped for managing these.

MR BOLSTER: What other aspects of care do you see that are deficient?

MS LAZZARO: Other aspects of care that are deficient, managing patients with behavioural and psychological systems of dementia. A lot of our advanced demented population live within aged care, so you would think that nursing staff within those aged care facilities would be experts in managing this sort of thing. However, I find that they are struggling in managing adverse behaviours. I also find that they're struggling with managing palliative care. Again, most people who enter residential aged care have entered because they're entering the latter parts of their life and they're requiring higher care needs. And I find that a lot of the facilities are struggling offering care at the end of life.

MR BOLSTER: You detail at some length the issues that arise in palliative care, and you point to a, seemingly a lack of confidence in the staff that you come across in that area. Is that a fair description?

MS LAZZARO: Yes. Most definitely.

MR BOLSTER: Are there other palliative care outreach programs that facilities in that area can call upon in addition to yours?

MS LAZZARO: There are no programs that go into residential aged care. From my understanding, Silver Chain, which is a private organisation, they offer palliative care within Western Sydney, however, they don't enter residential aged care; they just enter community home dwellings. And in terms of outreach from our hospital, we don't have a palliative care service that goes into residential care.

MR BOLSTER: And to what extent do GPs call on your service to provide support on palliative care?

MS LAZZARO: On a daily basis.

MR BOLSTER: Is that your job or should that be the job of the GP?

MS LAZZARO: Well, I think to answer your question, it should be the job of all of us. I think GPs have in the past probably not offered palliative care the way they're required to now. I think in the past a lot of people passed away in hospital or in hospice-type care. The shift has changed where they are passing away in nursing homes and so GPs who are probably unfamiliar with the delivery of palliative care are now required to. And so we're seeing a shift in this and the fact that GPs are

seeking support from organisations such as mine, because they are dealing with a lot more palliative care than, say, they used to.

MR BOLSTER: If your team was not there, how would palliative care be managed in the nursing homes around Westmead Hospital?

MS LAZZARO: I fear to answer that question. Prior to our service, I don't think that there was really any support at all and I really fear thinking about how it would be managed if we didn't exist.

MR BOLSTER: You mention the inability of other specialists, urologists, etcetera, who may have seen a resident before they went into residential aged care, coming into the nursing home. Is that as bad as it sounds in your statement?

MS LAZZARO: It is, yes. I find a lot of residents who, for example, having seeing a cardiologist for the last 10 years will still go out and see their cardiologist for appointments because a family member will generally take them. As they decline or they become more immobile, the ability to take them to an appointment, it becomes quite difficult in terms of transport and getting them there, so I just find that the appointments stop.

MR BOLSTER: Who becomes the medical practitioner in place of all of those other specialists once someone goes into residential care?

MS LAZZARO: The GP is the primary carer and then if the person is in a facility in an area that has an outreach area such as mine you would then be able to get consultation from a geriatrician who is, say, linked to my service.

MR BOLSTER: All right. Transfers to hospital, are you able to avoid unnecessary transfers with the work you do?

MS LAZZARO: Most definitely, yes.

MR BOLSTER: Where are mistakes made by care facilities when they transfer people to a hospital?

MS LAZZARO: I think it's from a lack of education with the nursing staff where quite often patients will be sent into hospital because the staff are just lacking confidence, skill and experience in basic assessment of patients. So for an example which I used in my statement, patients with dementia who may be suffering some BPSD or behavioural and psychological symptoms of dementia, staff will quite often panic because their behaviour has changed and just simply send them into hospital, and quite often without having done some of their own investigations first. So simple things such as checking their vitals, do they have a temperature today, doing a urine analysis, a simple dipstick check of their urine to see if they may have a UTI that's exacerbated their behaviours.

Checking their bowel chart to make sure they're going to the toilet and that they're not constipated, because constipation is often a frequent presenter to our emergency department. Basic things that are all a part of nurse education and training, particularly with regards to dementia patients.

MR BOLSTER: Does this happen across the homes that you visit or is it limited to one or two or a handful of them?

MS LAZZARO: Across every home.

MR BOLSTER: There's no homes that stand out as being models of care when it comes to these sorts of things?

MS LAZZARO: I would like to say yes, but, unfortunately, no, because even when I come across exceptional nurses working within the facilities, there's always nurses within that facility who aren't as exceptional and so we will get patients sent in for things, potentially unnecessarily.

MR BOLSTER: All right. And the skill level of the assistant in nursing and personal carers, how do you observe the work that they do?

MS LAZZARO: Sorry. Could you repeat that?

MR BOLSTER: What is your opinion of the level of skill of the personal care workers and assistants in nursing that you come across?

MS LAZZARO: The level of skill is varied, however, it's very basic. I find the level of skill is, you know, it's obtained from a 12-week course and then whatever years of experience they've managed to obtain, and I find that the organisations within which they work often do not offer continuous educational training. So once they enter the workplace, any skill they acquire is just from basic patient contact and experience. It's certainly not from getting sent to education sessions or upskilling.

MR BOLSTER: Do you have a view about the level and quality of the education that the nurses and care workers receive in the facilities that you visit?

MS LAZZARO: My opinion on it is that it is at the bare minimum. It's appalling, really. When I receive feedback from staff that one RN only two weeks ago mentioned to me that in the last 12 months she had been sent to one education session in the last 12 months, and that the AIN staff in there are lucky if they get sent to anything.

MR BOLSTER: All right. Before we conclude, what would you change, if you could, about the residential aged care system?

MS LAZZARO: I would change – I would implement nurse to patient ratios, including more RNs on per shift and over a 24-hour period, and I would most

definitely implement more education and ongoing training to nurses at all levels on all nursing topics within aged care.

MR BOLSTER: Was there anything else that you wanted to say? Everything is set out in your statement but now is your opportunity to say anything else about what needs to change?

MS LAZZARO: No, I think that's it. I think my statement covers it, yes. Thank you.

MR BOLSTER: Thank you. That's the questioning, thank you, Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Ms Lazzaro. Thank you for your evidence and for taking the time to be doing it by video link. Thank you very much.

MS LAZZARO: Thank you.

<THE WITNESS WITHDREW [3.30 pm]

MR BOLSTER: Commissioners, we will need to set the video for another witness who is in another hemisphere.

COMMISSIONER PAGONE: Yes. And is that likely to happen - - -

MR BOLSTER: It's likely to happen – the same amount of time that we took to set this one up, I think.

COMMISSIONER PAGONE: But possibly earlier than anticipated?

MR BOLSTER: Possibly earlier, yes.

COMMISSIONER PAGONE: All right. We will resume in 10 minutes.

ADJOURNED [3.30 pm]

RESUMED [3.43 pm]

MS HILL: If the Commission pleases, before I formally call the next witness, if I can indicate that the next witness is Professor Sara Charlesworth who is present via the video link before the Commission. Professor Charlesworth is currently located in Sicily. The wi-fi is somewhat precarious and for that reason I won't be seeking to

bring any aspect of the Professor Charlesworth's statement up on the screen, lest it interrupt with that connection.

COMMISSIONER PAGONE: Yes, I think that's understandable. Thank you.

MS HILL: Commissioners, I call Professor Sara Charlesworth and I ask the associate, Mr Flynn, to administer the affirmation.

COMMISSIONER PAGONE: Yes, Mr Flynn.

<SARA CATHERINE MARY CHARLESWORTH, AFFIRMED [3.44 pm]

<EXAMINATION BY MS HILL

COMMISSIONER PAGONE: Yes. Thank you, Ms Hill.

MS HILL: Professor Charlesworth, could I ask you please to state your full name.

PROF CHARLESWORTH: Yes, Sara Catherine Mary Charlesworth.

MS HILL: And what is your role?

PROF CHARLESWORTH: I'm a professor within the School of Management at RMIT University and I'm also a director at the Centre for People, Organisation and Work that sits within the College of Business, also at RMIT.

MS HILL: And you are typically based in Melbourne in that role?

PROF CHARLESWORTH: I am.

MS HILL: But we find you in Sicily this afternoon?

PROF CHARLESWORTH: Yes, I'm currently on sabbatical and I'm having a brief holiday with my family in Sicily.

MS HILL: Professor Charlesworth, in the context of the hearing before the Royal Commission this week, you've prepared a statement dated 30 September 2019; is that right?

PROF CHARLESWORTH: That's correct, yes.

MS HILL: And you have subsequently taken the opportunity to review that statement, found some typographical errors and provided the Commission with a further statement dated 14 October of this year?

PROF CHARLESWORTH: That's correct.

MS HILL: For the purposes of the transcript, that's document ID WIT.0381.0002.0001. Professor Charlesworth, you have identified a change that you seek to make to paragraph 21 of that statement. Commissioners, that's at the top of page 6. And I understand, Professor Charlesworth, that that sentence presently reads:

The Commission so part-time aged care workers –

and you seek to make the change so that it reads:

...a reference to part-time home care workers?

PROF CHARLESWORTH: Correct.

MS HILL: With that change being made, Professor Charlesworth, are the contents of that statement true and correct?

PROF CHARLESWORTH: They are.

MS HILL: Commissioners, I tender the statement of Professor Charlesworth dated 14 October 2019.

COMMISSIONER PAGONE: All right. Well, the statement of Ms Charlesworth of 14 October 2019 will be exhibit 11-52.

EXHIBIT #11-52 STATEMENT OF PROFESSOR SARA CHARLESWORTH DATED 14/10/2019 (WIT.0381.0001.0001)

MS HILL: As the Commission pleases. Professor Charlesworth, in your statement, you describe having a longstanding research interest in the employment conditions for the frontline workers in aged care, both in Australia and abroad, and I understand that's an interest that extends some 25 years.

PROF CHARLESWORTH: Yes. That's correct.

MS HILL: Professor Charlesworth, could I ask you to describe who are the frontline workers that you are referring to in this interest?

PROF CHARLESWORTH: The frontline workers are the people who are known as home care workers within home care services or personal care workers or sometimes assistants in nursing. They've got different titles in different organisations in different states, but they're the workers who do the hands-on care work within aged care.

MS HILL: And why do you hold that interest?

PROF CHARLESWORTH: Well, it goes back to – quite some way back into 1993, and I was then asked by the then department – the Federal Department of Industrial Relations who had just set up a pay equity unit to undertake a pay equity study of low-paid workers, and in discussions we agreed that we would look at home care workers in Victorian local government. And we set about – back in those days there was very much an emphasis on comparators. So we compared aspects of their job with – and the remuneration for different aspects of their job with assistant gardeners also employed in local government. So it was a kind of classic comparable worth case study and, really, ever since then I've been dipping in, dipping out, but for many years was very interested in what was happening, particularly in the home care space.

Following that work, I undertook some work for the Australian Human Rights Commission, which was wanting to have a look at some of the problems that were being raised in award restructuring back in '94 and we looked at the differential over award payments that very feminised occupations like home care workers received when compared to more masculinised occupations. And then when enterprise bargaining was brought in, there was a lot of concern at the time that this may not be helpful once again to low-paid women workers, and as part of that work, I took a study which involved a number of studies not only aged care but a wide variety of low-paid women's jobs. And we looked at different organisations to actually have a look to see what the potential opportunities were but also challenges for enterprise bargaining would be and that report was called Stretching Flexibility and that goes back to '96.

MS HILL: In your experience, is the work of those frontline workers valued?

PROF CHARLESWORTH: It depends what level. I don't think – societally, I think it's not valued. If you speak to the workers, they themselves know that the work that they're doing is important and valuable, particularly to their clients and the residents for whom they provide care and support; but they feel very strongly that broader society doesn't value their role, and they sometimes feel that their employers don't particularly value their role.

MS HILL: Does the fact of it being a majority female workforce explain, in and of itself, why the work is undervalued, in your view?

PROF CHARLESWORTH: That characteristic is a very important one. In Australia we are very occupationally segregated along gender lines. But what's particular about care work is that it is assumed to be the work that women are born to do naturally and, as such, with paid care work being seen as equivalent to unpaid care work it's therefore viewed as something that a lot of women are capable of doing, and so that it's not particularly skilled work.

MS HILL: In your statement, you describe the Commonwealth as being the real employer in aged care in Australia. Why is that?

PROF CHARLESWORTH: Well, the Commonwealth is the – overwhelmingly the majority purchaser of aged care services in Australia, and I mean, I would say the absolute purchaser, but it purchases the formal aged care services. It's clearly – an enormous amount of aged care is provided by family members, you know, through unpaid care. But it purchases, through a contracting line, and I often think of the Federal Government, really, in the current model we have, as being at the head of a supply chain. So that right down at the bottom you have this group of frontline workers that I'm talking about.

MS HILL: What role does the Commonwealth have in improving the conditions and the remuneration of aged care workers in Australia?

PROF CHARLESWORTH: It has a huge potential role but in fact over the years, because there have been inadequate rises in – how can I put this – there has been inadequate accounting for normal rises to wages, particularly through the national minimum wage case, which is the main way that wage rises are received if they're frontline care workforce, and by not paying indexation some years, by paying part of indexation, by not paying CPI wage increases, providers don't have the money to be able to pay better.

MS HILL: Can I ask you to expand on a matter which you address in your statement in respect of the current industrial setting in Australia.

PROF CHARLESWORTH: Yes.

MS HILL: What effect can current industry awards and enterprise bargaining arrangements have on improving remuneration and conditions of aged care workers?

PROF CHARLESWORTH: Look, in theory they're very appropriate mechanisms, particularly awards because the advantage of awards is that they cover all employees within the sector. So that it doesn't depend what enterprise you're employed in. But in point of fact, they have – and I mentioned award restructuring way back in '94 that wasn't particularly favourable for female-dominated occupations. In our current industrial relation systems, awards – we give precedence to enterprise bargaining so the main way to improve wages and conditions is through enterprise bargaining.

That has been an abject failure, in my view, in aged care partly because a lot of workers, particularly home care workers don't have practical access to enterprise bargaining and, you know, the Fair Work Commission itself has observed in the low-paid bargaining case, that whenever enterprise agreements exist, they provide for very meagre and in some cases no wage increases over the award minimum. So it's extremely hard to get improvements via the industrial relations system. There has been this current long tortuous process that the relevant aged care awards are still subject to, the modern award review.

And over – before then and now, a lot of that has been kind of clawing back conditions that were lost in the award modernisation process which saw a whole lot

of awards, state, territory, federal awards, aggregated into two separate awards, one the social community – what's known as the SCHADS award, Social, Community, Home Care & Disability Services Award which covers the home care workers for our purposes, and the Aged Care Award which covers personal care workers in residential aged care. But very meagre improvements are gained and with one step forward, we then see a couple of steps back and, at the moment, I suppose what I find very concerning is that the argument from the employer groups is that with funding models such as consumer-directed care, more flexibility is needed. We need more flexible permanent part-time work, etcetera, that, ironically, does nothing to create the conditions of work that would support – good conditions of work, that would support good conditions of care.

MS HILL: Do you consider we can rely on current enterprise bargaining and industry awards to support the aged care worker?

PROF CHARLESWORTH: Well, there's a number of ways to go. I think enterprise bargaining is not practical for the reasons that I mentioned but particularly in home care. It's very hard to organise outside when you don't have an institutional workplace. So it's somewhat easier if you are in residential aged care but still extremely difficult, and I read some of the submissions to the Commission which set that out very clearly. In home care, it's almost impossible. Increasingly you are dealing with a workforce who may never go into their employer's place of operation; they receive – on their smart phones. They communicate via their smart phone. So that there is very little opportunity to – for unions to organise and, indeed, to be able to go for enterprise agreements.

That's not to say that there aren't enterprise agreements that cover home care. There are. They're with very large providers. But in the main, the typical home care worker certainly is not covered by an enterprise agreement which means you're then reliant on the award system. Ideally, the award system would be revitalised. It would need, industrially, to be given a far more important place than it has in our industrial relations system, and that goes more broadly, but if we're just thinking about aged care workers we really need awards that are fit for purpose. And you've got your wage rates that are set out in those awards but you have also got the classification structures that they refer to. And those classification structures are incredibly repressed.

They have very meagre descriptions of the kinds of work and responsibilities that are undertaken at the different levels that are specified in the award. So at the moment, and this is both employers and unions, are spending an enormous amount of resources in this modern award process and it's just inching forward and, as I said, over the time since the modern awards came in, 2010, there have been some very small improvements in conditions but they are not improvements over and above that had existed prior to award modernisation, certainly in some awards.

MS HILL: What should change, then?

PROF CHARLESWORTH: It depends what level you are looking at. I don't think you can change industrially unless you have a major change at the way in which aged care work is – or the work of aged care and by that I mean the care and support that is provided to people whether they be in residential aged care or in the community in their homes. But we need more funding but not just more funding, we need to recognise and value both the care that is provided to the frail and vulnerable elderly people as well as the workers who provide it. And that requires a major injection of funding but it also requires a restructuring of the way in which we organise the work of care.

MS HILL: You refer to employer groups indicating that they need more flexibility in the workforce.

PROF CHARLESWORTH: Yes.

MS HILL: And in your statement, Commissioners, at paragraph 22, Professor you refer to employer-oriented flexibility. Could I ask you to explain what you mean by that and what the role is – or the impact of a flexible workforce in the aged care sector?

PROF CHARLESWORTH: By employer-oriented flexibility, I'm thinking particularly of the permanent part-time workforce which is the majority workforce in both residential care and in-home care. And under the relevant awards, unlike – and it's always instructive to do comparison with awards in male-dominated sectors, but if one looks at the manufacturing awards, for example, if your contracted hours are 20 hours a week and your employer asks you to stay back and work a couple of extra hours, you are paid overtime for those hours. In aged care you can be, as I describe it, be flexed up to 38 hours; it's with mutual agreement but you can be asked to work additional hours and you are paid at ordinary time rates. You receive no compensation for the disamenity of being available and working additional.

So that's one indicator of employer flexibility, without going into the minutiae of the Social, Community, Home Care & Disability Services Award but, for example, if a client cancels their appointment or their – you know, for some reason and if they do it the evening before, by 5 pm the evening before, then the part-time worker will still be entitled to be paid for that time but she will have to make up those hours, so outside of her normal schedule hours. And a practice in the industry is to keep people on short part-time hours. We see quite extensive – and this is documented in the National Aged Care Workforce Census and Survey, quite extensive under-employment where people want more hours of work in their current job.

And so if you keep people hungry for hours and you then say, well, you know, can you work a few extra shifts over the next month, you know, we've got some people taking leave, people will do it but they don't get any extra premia for being available to work those extra hours as they would if they were covered by an award such as the manufacturing award.

MS HILL: Can I turn to the issue of travel time for the home care worker. We have heard evidence this morning of the home care worker sitting in their car, waiting to go in to deliver care to the next client, not being paid for that time and on a split shift working 10, being paid for five. Professor, in your statement – Commissioners, at paragraph 24 – you address the introduction of travel time in New Zealand.

PROF CHARLESWORTH: Yes.

MS HILL: Could I ask you to describe why that's important, how that came about, and what lessons there are to learn in the Australian experience?

PROF CHARLESWORTH: Yes, I think the whole issue of travel time is absolutely – it's very revealing about the lack of value we accord home care workers' work. It's hard to think of any other job where you are required to travel from client to client and you are not paid for your travel time. You are recompensed for your mileage when you travel, when you use your own car, which home care workers do but you are not paid for your travel time. It's – some of the enterprise agreements – the better enterprise agreements in the sector do pay travel time; local government in Victoria pays travel time. When it had its own home care service, the New South Wales home care service used to pay travel time.

But it isn't paid and it just seems to me quite extraordinary. It has been addressed in a couple of countries but most importantly in New Zealand back in 2012 the New Zealand Human Rights Commission had an inquiry into aged care. The inquiry and the report of that inquiry is called Caring Counts and they recommended but also placed significant pressure through a Caring Counts coalition on the government to remedy that situation and in the event the government agreed that travel time should be paid and it provided quite a bit of additional funding for that purpose.

That was in sharp contrast to the situation in the UK where an employment tribunal had found, as a matter of law, that travel time of home care workers was work time and therefore should be paid at the national minimum wage which is what social care workers earn in the UK. However, the UK government didn't fund that additional travel time to providers and, not surprisingly, that requirement that travel time be paid is mainly observed in the breach. So the New Zealand case is instructive. It's not only providing or mandating that travel time between clients – and this is not travel from your work to your first client, it's travel time between clients, should be paid time and providing funding to cover that.

MS HILL: How does job quality then compare or differ in New Zealand for the home care worker to the Australian home care worker?

PROF CHARLESWORTH: Well, I had the privilege of accompanying a number of New Zealand home care workers as they did their rounds. It made – they, though, were also the beneficiaries of a substantial wage increase, as I put in my statement, the whole New Zealand aged care system has been entirely renovated in terms of employment conditions and attaching wage rates to achieved competencies via

qualifications. But the workers were incredibly appreciative of it. However, there had been some implementation issues emerging and this goes to the not quite full recompense of the actual travel time. So in the settlement that was agreed between the parties in New Zealand, if you travel under 15 kilometres it's assumed to take you 8.3 minutes. Now, let me tell you, in Auckland traffic that doesn't work. So workers are often taking longer.

And the stress for workers is they might be allocated 15 minutes to travel between clients and this happens in Australia; it can take you longer than that amount of time. So you are behind the eight ball when you arrive at a client's house. You then need to stay if you're 40 minutes, they need to say for the 40 minutes so your clients are pushed back for the day so that you end up kind of working on unpaid time, if you like, when you finish your last client for that day. But there are real problems with it and then when you put that, if you're a home care worker then you have a one hour minimum engagement so that's really where you can have that incredibly – you know, you could be available for up to 14 hours across the day, and you might have four or five hours of paid work so you work, you know, with one client.

You might be then just parked in your car waiting for another two hours before you then go to another client, etcetera. So one of the reasons that the New Zealand government, they brought in the travel time and then – because before then they didn't have any guarantee of regular hours, they have introduced a system called regularisation because the government figured if it was paying for travel time, it was worth then organising the work of home care in a way that provided joined-up hours for the home care worker so that you would minimise the kind of gaps between clients.

MS HILL: It has frequently been said in evidence before this Commission that it is important to get the right people for the right job in respect of home care workers, aged care workers more generally. Do you agree with that proposition?

PROF CHARLESWORTH: Of course it's important to get the right people for the job, like it is for any job. Any job I can think of, you need the right person to do it but you also need a set of skills that will enable that person to be able to do the job. And I think that what one often hears in the aged care sector – and I've heard employers say for example we're thinking of introducing psychometric testing, we need to work out how to get the right person. And it is important to have somebody who is people-oriented but it is just as important for nurses, it's just as important for doctors. What you absolutely need is somebody who has a set of skills that will enable them to do, you know, fairly difficult, challenging but very individualised work that needs to be done in aged care and I'm thinking both in residential aged care but also in the community in terms of home care.

So for me, the problem, the emphasis on the right personality really undercuts the – and devalues the skills that are currently being exercised and they can be gained through formal qualifications such as certificate III, certificate IV, but also the skills that are required on the job and with experience. So the knowledge of how to handle

a frail aged person in a shower, it may be a 90-year old women, her limbs might be quite stiff. Her skin will be very thin. You need to be extremely gentle, you need to work with her and it takes time. And one of the main problems in aged care – and I know that you have heard a lot about this, is that everything is rushed in home care and in residential aged care and that makes it extremely difficult for workers to use the skills that they've gained.

MS HILL: Are those skills that are required, that you described as being currently exercised, recognised in the current job classification for aged care workers?

PROF CHARLESWORTH: Well, absolutely not. So while it's only an entry level – I will just give you an example. For home care workers they're required to have basic oral communication skills. That seems absolutely ridiculous; they need highly developed communication skills. They need to be able to talk to somebody, maybe a new client, the first time they meet them who is very anxious about having someone in their home. They need to have the communication skills to be able to put someone at their ease, to work out fairly quickly how somebody likes to be spoken to. A lot of older people prefer to be addressed quite formally. They want to be Mrs Jones, for example. They don't want to be called Madge. They don't want to be called "love".

You need to be able to really work out how you're going to communicate with that person. So that's just one example. The way that the skills are described in a very rudimentary way in both awards really fails to acknowledge the complexity of the work that is being done, the judgment and the deep knowledge that people have to have about working with – if you just think of just straight body, intimate body work with a variety of older people who have not just different needs as individuals, but have different needs on different days at different times of the day.

MS HILL: How can those skills be recognised in the current awards framework?

PROF CHARLESWORTH: Well, there's some templates out there. The former New South Wales home care service under their – it was a state-based award, they have very well-described skill descriptors, as do a number of the Victorian local government enterprise agreements. So, if you like, I describe it as they've unpacked what the skills are. They have actually set out the skills that are required. They've set out the particular competencies that are required at different levels of care and they clearly make it – they are able to differentiate between more routine care and more complex care. So I think that if one were to redesign the award system, then you would start with some existing templates and they have been negotiated over the years.

So I referred right back to '93 when I first did that work and I worked then – a union which is – a Victorian union which is no more. It's been amalgamated but it was called the Municipal Employees Union and they covered what they called the outdoor workers, the garbage workers, the gardeners and also covered home care workers, and over the period of time after we – after I initially did that pay equity study, they started – they had one skills classification for their home care workers;

they unpacked it into three quite distinct skill classifications and where the complexity of care, particularly personal care was seen as denoting or requiring a higher level of skill.

MS HILL: Professor, you've described the aged care workforce as one which is highly feminised and given evidence about the gendered undervaluing of aged care work.

PROF CHARLESWORTH: Yes.

MS HILL: What role, in your view, would an increased participation in aged care work by males have in improving the conditions of aged care work?

PROF CHARLESWORTH: I think in terms of just providing additional source of labour – I think that that's very important. In Australia, it's been incredibly slow to change, but I can just turn you to table 3 of my statement; it's under paragraph 56, but there, where I'm talking about migrant workers, you can see clearly we are beginning to get more men particularly into residential aged care – that's personal-care assistance – by migration so that we're seeing men form a larger – overseas-born workers in aged care – both in home care and in aged care, men form a larger component. So that is, certainly – we're beginning ..... more men come in. But as I said, there is some degree of stigma for men in aged care. There also some practical difficulties.

I was recently in a Scottish aged care home. Now, in Scotland there's been quite longstanding – particularly the area I was in, Glasgow, longstanding male unemployment. So there are increasing numbers of men in caring-type jobs, but – including aged care. But in this particular organisation, one of the dilemmas they had was – when they had men on shifts, doing personal-care work, a lot of older women – and increasingly you find the service users within aged care are increasingly women, because people who are using formal aged care services tend to be older, and because of the increased longevity of women, you tend to find a greater portion of female clients in residence; if they don't want their personal care done by a man – that's fine, and organisations ..... organisations and residential facilities respect that; then that actually creates – and I saw this with my own eyes; that actually creates extra load for the female workers on that shift.

So the – somebody will say "Look: I don't have a man doing my personal care"; that's fine. But somebody who's got another six residents to get up, dressed, toileted et cetera has to do that job. So depending on people's preferences, which they are perfectly able to exercise in the aged care setting, there can be some practical difficulties. But in principle, it's really important, to be getting in a whole diversity of people in aged care. And as I said, we can see already – and we've done some work with – I've done some work with colleagues; we've been tracking the increasing number of men coming in by the overseas-born.

MS HILL: What can be done, in your view, to overcome the perception that aged care work is work that's done by women and accordingly is not ascribed – is undervalued?

PROF CHARLESWORTH: Well, I think we need a decent – and this goes back to remedying the award – a decent skills structure that not only differentiates between various levels of care and various levels of skill that's required but provides a career pathway. At the moment, while there are certain levels designated in the awards, if you have a look at the remuneration for them – they are very – they are tiny, in some cases cents' difference per hour as you go from one level to the other. So you need decent increases. But, clearly, if you want to make the sector more attractive, well, you really need to do something about the remuneration. But I would also say, because this goes hand-in-glove with the working-time conditions, we need to be providing income security and working-time security to the workers. And it's instructive, to have a look at the New Zealand ..... because the wage increases there were really quite profound; aged care workers had only been entitled to their national minimum wage. So there was a significant increase in wages, but then there are meaningful relativities between the different levels, the four levels of aged care worker that they have there, in both residential and home-care work. So that's also going to be crucial in creating that value.

And, well, I think industrially one has to start there, because, as I said at the very beginning, aged care workers know that the work that they do is valuable. They know and they are told by clients and residents and residents' and clients' families that the work is valuable. But they feel very strongly that they are undervalued, and that means being involved in decision-making. So in some of the better facilities I've been in, you'll actually see aged care workers, the frontline workers bought into meetings with the families, when you're discussing how the resident is faring; the workers really feel that something like that recognises the fact that they're the ones who spend most time with that particular individual, and I've seen situations where allied health staff have been quite surprised at the level of knowledge that the frontline aged care worker actually has about that particular resident. So in some organisations – and I've had the privilege of going into, probably, better organisations than most, but even in the better organisations, there can be a view that your frontline workforce is unskilled and your registered nurse is the skilled one and, if you're lucky enough to have any enrolled nurses there, then – they're also much more skilled than the home-care or the residential-aged care worker.

MS HILL: You've described the opportunities that you've had to see residential aged care facilities in Auckland, in Scotland. Is that part of the Decent Work and Good Care International Approaches to Aged-care project that you're a part of?

PROF CHARLESWORTH: Yes. Yes. I'm leading that project with Scottish colleague and two Canadian colleagues, one of whom used to be based at the University of Sydney, but she's now at the University of British Columbia. So – yes. That's a large Australian research-council-funded project.

MS HILL: And what is the objective of that research?

PROF CHARLESWORTH: The objective of the research is to have a look at different – we're also looking at Canada, but because in Canada aged care is organised at the provincial level – so we're confining our investigation to Ontario, the largest province there. But the main objective is to really understand how different national systems – so these are the different policies, the funding, the regulation. So it's things like employment regulation, but it's also things like migration for example – how all of that then gets operationalised through organisational practices and work design and how that then shapes the quality of the work and the quality of the care. So we've been doing a lot of mapping work, a lot of systems-mapping work; we've been spending time in aged care organisations that have been recommended to us in the relevant countries as being of good quality. And we are really interested, to see what they're doing right. So we're there to try and pick up promising practices, but within the countries we're looking also at what we call promising policies.

So for example: the travel time in New Zealand is, clearly, a promising policy, but we also very interested in the way that they have there – of organising a more-devolved aged care system. So aged care is organised through district health Boards, and particularly within one district health Board, where we've spent quite a bit of time at aged care services, they have this – they call this "alliancing model" – so that the designated providers for example of aged care work together, and this is really interesting in this particular case, because two for-profits, two not-for-profits, but they actually share information. They share clients coming into their particular area, and they have – because they work directly with their local health Board, they are able to feedback what's working on the ground.

And one of the terrific things that has happened through this is then – the assessment and re-assessment of clients' needs as they change is actually done through the – done through these particular organisations. So if you like – an assessor from the district health Board is actually located in these organisations, and from the workers' and the clients' perspective, they can say, "Look: I'm worried, that Mrs Brown for example, seems to be getting a bit frailer. I really think we going to provide some additional care", and the next day, an assessor will be out there, re-assessing that particular person's needs. So you have a very responsive system, partly because it's more localised. So that's one example of the kind of promising policies that we're picking up.

Another one – and I'm still digging through it, but – in Scotland they have a care inspectorate, and the care inspectorate is responsible for auditing all of aged care, residential and home care, but it's done – well, their whole system is very much outcomes-focussed, and in these reports, which are put up online, which are posted so, if you go into the residential aged care facility – the results of that latest care-inspectorate report is up on the notice-board for families, for visitors coming into the centre, and they are rated across various areas of standards. But in gathering the information, the care inspectorate will be talking to residents for example, if you're

in residential aged care, residents' families. It'll be talking to workers. It requires organisations to be doing regular surveys of its workforce and of its family and resident population. So it's a very – it creates a lot of transparency within the system.

So I'm thinking of some service for my mother for example, I can go online to the care inspectorate, look at the name of a particular service I'm interested in and see how they've rated over the time. And it's not just a rating; it's not just a "passed" or "failed". They're scored, and what's extremely interesting is that, when you pull it up, I can actually see how things have improved or perhaps not improved in various domains. And then a narrative report is produced. So it's quite a bit of detail about what the inspectors observed, any areas, they think, need to be improved and if there are areas designated to be improved. And they can be quite minor things.

For example: in one aged care facility where I was, they felt that the deck – you've got to remember this is in a grim Glaswegian summer – that the deck wasn't very accessible for some of the residents so that they were immediately – had set about – they got a carpenter in to try and make it somewhat more accessible by lowering the angle of the ramp. So that's the kind of details that are provided, and it's – because somebody's actually out there in your facility and talking to you about how you go about it, but talking, as I said, to residents, family members and, I think, very importantly to workers – workers are seen as an absolute central part of that auditing process.

MS HILL: And that project that you are involved in, Decent Work and Good Care: when is that due to conclude?

PROF CHARLESWORTH: Well, we are getting to the end of our data-gathering phase. As with all Australian research-council projects, once ..... we're in our third year, doing a lot of gathering of data, and then we'll be spending the next several years, really, synthesising that, but we've started the slow publication process. But we're using a quite-good website that we've specially set up for the project to present our findings as we go. Whenever we go into aged care facilities and run a case study, we give a very detailed report back to that aged care organisation about what we've found, the promising practices we found but also things that, we think, they ought to consider. And, luckily, because they're the kinds of organisations that are open to more innovative practice, they welcome that feedback. A number have said to us that they really welcome an external set of eyes just coming in and seeing how things work.

And we use quite an immersive process. So in every case study we have a number of researchers, both what we call insider researches – so if it's in Australia, I'm an insider researcher, but my Scottish and Canadian colleagues can, if you like, ask the dumb questions; they can say "How does that work? I don't understand that. That's different from where I am from". And likewise I'm able to do that in New Zealand and most recently in Scotland, and that's very useful, because it means we pick up things that you mightn't pick up, if you really knew the system, or you mightn't pick

up, if you were totally outside the system and didn't really understand the rational for the ways in which things work. So we – as I said, going back to your question, we are starting to publish from it. We're having an expert workshop next year, but we provide regular feedback to an ever-widening list of people through our newsletter and remain in contact with all the organisations with which we've been conducting those in-depth case studies.

MS HILL: Bearing in mind the stage of the project – that the project's up to: what ability is there, in your view, to take these promising practices, these promising policies that you've identified in your work to the Australian aged care sector?

PROF CHARLESWORTH: I think that they're all food for thought. It's very hard in the policy sense, to just translate things holus-bolus. The example I gave you of the Scottish care inspectorate only works, if you've got health and care standards, health and social-care standards that are outcomes-focussed, that recognise the important roles of workers et cetera. So that – there are various parts to the puzzle. You can't just – in Australia you couldn't just import for example, the Scottish care inspectorate; you would need a total renovation of our quality standards. So you need to be mindful, I suppose, of what parts you're adopting. But if I go back to the example of – New Zealand totally – well, increasing wages but also renovating the classification structure and hanging that off specific skills that are – qualifications that are required – I, certainly, think that that provides a basis to start thinking about how we might do things differently in Australia.

MS HILL: Professor Charlesworth, that concludes the questions that I've got for you, and I'm conscious of not testing my luck with the Internet connection. Were there other matters that I haven't taken you to in your evidence that you'd like to raise at this time before we conclude?

PROF CHARLESWORTH: I suppose just one thing that I was originally asked to comment on and we touched just obliquely on – but I do think it's important – is the whole issue of the fact that we're starting to rely on temporary migrant workers in aged care, and I think that can – that is concerning. Australia's history – Australia's always – in aged care we've always had more overseas-born workers, but they tend to have be long-term permanent migrant workers who've got the full rights and social protections of people with citizenship and permanent-visa status. We are increasingly using what my colleagues and I describe as a number of back doors.

So international students are used a lot in residential aged care. They are here on temporary visas. They have very strict criteria as to how many hours they can work, be in paid employment a week. But we've recently started in an Australia Pacific labour scheme, which is a front door if you like, which is – the aim is to bring in Pacific islanders to provide – to do a range of work. It's based on the seasonal-workers program, but the idea is it wouldn't be seasonal. And the idea is – this is something that is – been described as a triple win. It's a win for the women and the families, because it'll be mainly women doing the care work – women and their families in the sense that they will be earning money. It's a win for the countries in

that they'll be receives remittances, and it's a win for Australia, because we will be doing something to address what is seen as this looming labour-force deficit.

Concern is that these are temporary visas. The women will not be allowed to bring their families when they're here. They are not covered by any social protection; by that I mean basic things like Medicare. The employment in the industry is not organised around a full-time norm. They will be located outside major cities, and that just sets up a whole lot of hallmarks of vulnerability. And we know – it's been extremely well documented in both the UK and Europe, the plight that temporary migrant workers can find themselves in. They're often anxious to keep their jobs so that – they may not be reporting for example, health and safety issues. But there is also, I suppose, a concern that – this is seen as the solution to the labour-force deficit, rather than addressing decent wages and remuneration. Australia will always have a lot of migrant workers in aged care, and that is important for a whole number of reasons, not least those who have the language skills to be able to communicate with older people, older migrants who often revert back to their mother tongue as they age. They find it increasingly difficult, to speak English. So there's a really valuable workforce.

But we do know that both in Europe and in the UK, that a lot of migrant workers have been treated very poorly by employers and there is also some elements of racism, sometimes among clients and residents, but sometimes among co-workers and I've spoken with workers who have experienced this. There's a view that they shouldn't be speaking another language if they're talking to a colleague who is of the same language group as them. So that there can be a whole lot of issues raised. So I just think it's importing another – bringing in some more vulnerability and it's really only a temporary solution. The solution is to do something about the wages and the working time conditions, the skill recognition in the sector and rather than relying on what are seen as short-term fixes.

MS HILL: At paragraph 58 of your statement, you describe the work of Anna Howe who has looked at other developed countries and that the Australian situation was best described as migrants working in aged care rather than as migrant aged care workers.

PROF CHARLESWORTH: Yes.

MS HILL: Is that something that you have observed as changing since that time in 2009 when Anna Howe made that observation?

PROF CHARLESWORTH: Yes, yes. Yes, I mean, I think – still think it is predominantly true because when I've, with other colleagues, done other work, and we've used the National Aged Care Workforce Census and Survey and we've kind of looked at where people are right, but increasingly having a look at the – an integrated dataset that the Australian Bureau of Statistics provides with its census and it matches settlement data and that works for permanent migrants, but if you look at the characteristics of recent Australian migrants, you can see that people working in

care, and it's hard to get below that level because it's essentially a labour force survey, that are overwhelmingly now tending to arrive on temporary visas and are more likely to stay on temporary visas so – and that really reflects the changes in Australia's migration regime.

We used to be a country of permanent migration. We've shifted now much more to rely on temporary migration and where you do a pathway to permanency depends – and this is where the undervaluing of aged care work, particularly frontline care work in the ABS occupational classifications really makes an effect, if you are – for example, you're an aged care worker, you are on a temporary visa, you would like to transition to permanency, because your job is allocated ANZSCO level 4, you are highly unlikely to be given or have access to permanency in that job. That is if it's an aged care worker. We do know that there is a number of people that arrive from India and the Philippines and they will have nursing qualifications which are not recognised in Australia, and they could apply for permanent residency if they were able to have their qualifications recognised and trade up and be then going into a nursing job, that's possible.

But as long as they are an aged care worker and they want to stay as an aged care worker, they will find it increasingly hard to achieve permanency. And I think I cited there; Peter Mares has this wonderful expression talking about, you know, permanent temporariness. So that is something that I think is going to be an ongoing issue and gets back to the kind of labour force that we need in aged care, which is a stable, sustainable labour force. So however it is made up, we need people who are going to be able to stay there and having – spending a lot of time in the UK, the real concern there is with Brexit looming, very soon the people who are there from Europe will suddenly not be able to work there any more. So aged care is – the aged care sector, certainly in Scotland, the people I've been speaking to there are very worried about the impact of losing those people, and that's because they are essentially temporary migrants.

MS HILL: Commissioners, that concludes my examination of Professor Charlesworth.

COMMISSIONER PAGONE: Yes. Thank you.

COMMISSIONER BRIGGS: Ms Charlesworth, it's Lynelle Briggs here. Thank you for your evidence. I think it's your morning in Sicily so thank you for getting up early for that. I wanted to ask you about a couple of things; it's my understanding that the rate of unionisation in this sector is quite low, I think under 15 per cent, so quite low. And we've had a sort of bunch of evidence today about there being different awards, state-based, federal and enterprise agreements. And it's almost like it's a collage or a matrix of different arrangements coming from everywhere. And it's very hard to see your way through this fog of different arrangements to get to what you're talking about, which is an improvement in wages across the board and conditions across the board and career-related pathways to higher wages and so on.

So how do you do that? How do we get there? Do we need a new model award that's a national award or what are you proposing?

PROF CHARLESWORTH: Well, I hope I haven't confused you, Commissioner Briggs. There are, in fact, just two relevant awards. So the award modernisation that took place in 2009, for example, in the award that covers home care workers – the Social, Community, Home Care & Disability Services Award – there were, I think, from memory 32 awards. They were state, federal, territory awards, that were, if you like, smooshed into that one award.

COMMISSIONER BRIGGS: I didn't appreciate that.

PROF CHARLESWORTH: Yes. So – and then there's the Aged Care Award which covers the residential frontline workers, the personal care workers. So we do just have two awards. But I think, if I can just – and then obviously you have your two awards and where you have an enterprise agreement, the enterprise agreement is supposed to sit on top of the award. In theory, it's supposed to be you bargaining for better wages and conditions. In practice, as you point out, unionisation is very low and it's very hard to get data on unionisation in the sector. But I think your estimate is probably at the higher end. I suspect it's – overall that it's lower than that. It is higher in residential aged care. It's probably very much lower in home care.

But in terms of what can be done, I mean, there is the industrial relations system. But a bit like in New Zealand, it was an act of will by their government that said right, we're going to fix this. So I think trying to effect change through our current system of modern awards is incredibly difficult because our awards have been basically hollowed out under the Fair Work Act but it was something that started under the Workplace Relations Act. I think we are going to need a multi-pronged approach but I think what it starts with is government will that these issues are going to be addressed and if these issues are going to be addressed, then there needs to be additional funding, and there needs to be specific funding that is tied to these kinds of improvements.

COMMISSIONER BRIGGS: Thank you, that is very helpful.

COMMISSIONER PAGONE: Professor Charlesworth, thank you very much for sharing your research and depth of experience. Your statement is very informative and we are grateful that you were able to give us the time at what must be a lot earlier there than we think it is, and I thank you.

PROF CHARLESWORTH: Thank you.

<THE WITNESS WITHDREW [4.43 pm]

COMMISSIONER PAGONE: Adjourn until 9.15 tomorrow morning.

MS HILL: As the Commission pleases.

MATTER ADJOURNED at 4.43 pm UNTIL THURSDAY, 17 OCTOBER 2019

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