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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

9.23 AM, THURSDAY, 17 OCTOBER 2019

Continued from 16.10.19

DAY 59

MR P. ROZEN QC, counsel assisting, appears with MR P. BOLSTER and MS E. HILL
MR G. KENNETT QC appears with MR B. DIGHTON for the Attorney-General's Department and Department of Health
MR J. DELANY QC for Japara Healthcare Limited

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Apologies for the delay, Commissioners. There was some confusion about whether the witnesses could be called together or sequentially, and we're doing it sequentially so that's sorted out. My learned friend, Mr Delany, wants to announce his appearance.

MR J. DELANY QC: If the Commissioners please, I appear for Japara in this matter. There are two witnesses the Commission will hear from this morning. One, Ms Mnich, and the other, Ms Farrell. They're both former employees. I should just mention: Ms Mnich has been travelling around Australia and she hasn't had a lot of access to the documents, so if the Commission would bear that in mind. Ms Farrell's statement, you will have an amended statement from her, which includes a couple of additional letters that we've found in the last few days. Although the statement doesn't exhibit interview records, investigation reports and so on regarding the relevant incidents, I think they have been already produced to the Commission. So I think the Commission should have the files that relate to any of the incidents in their entirety.

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

MR ROZEN: Commissioners, the evidence this morning consists of a case study which will examine the conduct of a former employee of Japara Healthcare Limited, I will refer to as Japara. The former employee is being referred to by the pseudonym UA. As I indicated in opening on Monday morning, UA has not been the subject of any court findings in relation to the conduct that will be the subject of examination, and it's considered appropriate for him to have a pseudonym in those circumstances. Before I call the first witness, who is on the video link, Commissioners, I tender the Japara case study tender bundle which has 53 tabs in it.

COMMISSIONER PAGONE: And are we tendering them as one exhibit or as 53 exhibits?

MR ROZEN: One exhibit.

COMMISSIONER PAGONE: All right. So the tender bundle will be exhibit 11-52.

MR ROZEN: I'm sorry. I didn't quite catch the number, sir.

COMMISSIONER PAGONE: 11-52 – sorry, 11-53.

MR ROZEN: Thank you.

EXHIBIT #11-53 JAPARA CASE STUDY TENDER BUNDLE

MR ROZEN: Thank you. I wasn't intending to provide an opening about the case study to the Commission in the circumstances. It's quite a narrowly confined case study.

COMMISSIONER PAGONE: Thank you.

MR ROZEN: I call Dianne Patricia Mnich.

<DIANNE PATRICIA MNICH, AFFIRMED [9.27 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Good morning, Ms Mnich. Can you please state for the transcript your full name?

MS MNICH: Dianne Patricia Mnich.

MR ROZEN: And Ms Mnich, you have made a witness statement for the Royal Commission which has the code WIT.0489.0001.0001. Is a copy of that statement to hand where you are?

MS MNICH: Yes, I have it. Thank you.

MR ROZEN: Have you had a chance to read through that statement before giving evidence this morning, Ms Mnich?

MS MNICH: Yes, I have.

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

MS MNICH: Correct, yes.

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

MS MNICH: No.

MR ROZEN: All right. I tender the statement of Dianne Mnich dated 4 October 2019, Commissioners.

COMMISSIONER PAGONE: Yes, that statement will be exhibit 11-54.

EXHIBIT #11-54 STATEMENT OF DIANNE MNICH DATED 04/10/2019 (WIT.0489.0001.0001)

MR ROZEN: Now, Ms Mnich, I understand that you are able to see documents where you are; is that right?

MS MNICH: That's correct.

MR ROZEN: I also understand from counsel for your former employer, Japara, that you've not necessarily been able to familiarise yourself with some of the correspondence and the documents relevant to this case study; is that right?

MS MNICH: Correct.

MR ROZEN: What I intend to do is I will ask you questions by reference to the documents. In some cases, I will ask you to accept from me the documents say what I'm going to indicate to you they say, but if at any point you want to see a document, please let us know. Do you understand?

MS MNICH: I do. Thank you. I do, yes.

MR ROZEN: All right. Now, I am sure you are aware that the case study we're examining is about a former employee who worked at the Bayview facility where you were the facility manager.

MS MNICH: Correct.

MR ROZEN: How long were you the facility manager of the Bayview residential aged care facility?

MS MNICH: Four and a half years.

MR ROZEN: And can you tell us when that was?

MS MNICH: I started on 2 July 2012 and I resigned on 5 February 2017.

MR ROZEN: And you are a registered nurse and midwife by training?

MS MNICH: Yes. Correct.

MR ROZEN: And you've worked in aged care for 31 years?

MS MNICH: Correct.

MR ROZEN: Was your role as facility manager at the Bayview aged care facility your last job in aged care?

MS MNICH: Yes.

MR ROZEN: You've been retired since that time?

MS MNICH: Correct.

MR ROZEN: And prior to 2 July 2012, were you working for Japara or for a different aged care provider?

MS MNICH: No, no I was working for a standalone company.

MR ROZEN: I see. Also in the role of facility manager?

MS MNICH: It was director of nursing.

MR ROZEN: Okay. So a slightly different title but same idea?

MS MNICH: Yes. Yes.

MR ROZEN: Okay. Now, I want to ask you some questions about the employment of UA and you know - - -

MS MNICH: Yes.

MR ROZEN: - - - to whom we are referring when we refer to UA?

MS MNICH: I do, yes.

MR ROZEN: According to the documents that have been provided to the Commission, UA was employed at the Japara Bayview facility as a personal care assistant; is that right?

MS MNICH: Correct.

MR ROZEN: And he commenced his employment on 24 September 2007?

MS MNICH: I don't know that.

MR ROZEN: That's what the document that has been provided by Japara tells us. You just don't know, from your independent memory; is that right?

MS MNICH: I know that he was there when I commenced but I don't know the actual date that he was employed.

MR ROZEN: All right. You would agree, wouldn't you, that he had been there for some time when you commenced in 2012?

MS MNICH: Yes.

MR ROZEN: Now, can I take you forward to, in time to a letter that you wrote to UA on 23 March 2015, and for these purposes, I will ask that tab 8 please be

displayed on the monitor where you are. You have in front of you a redacted letter; if we can perhaps go to the second page, please, you will see your name there.

MS MNICH: Yes.

MR ROZEN: Do you see that?

MS MNICH: I do.

MR ROZEN: And do you agree that this is a letter that you sent to UA on 23 March 2015?

MS MNICH: I do.

MR ROZEN: The letter is by way of allegations of what are referred to as serious misconduct, do you see that in the header in bold? Ms Mnich?

MS MNICH: Sorry?

MR ROZEN: Do you see that immediately underneath the salutation at the top of the first page, you've written:

Allegations of serious misconduct.

Do you see that?

MS MNICH: Sorry, yes, I do.

MR ROZEN: Yes. And then I suggest to you that the misconduct referred to there are the four items of conduct that are set out in bold in the body of the letter.

MS MNICH: Yes.

MR ROZEN: And can I ask how these matters came to your attention before you wrote this letter?

MS MNICH: I can't recall.

MR ROZEN: Okay. Having now had the opportunity to prepare to give your evidence here today, and seeing some of the documents relevant to this case, has that jogged your memory about this case at all?

MS MNICH: Somewhat, yes.

MR ROZEN: Because when you prepared the statement for the Royal Commission, you told the Commission that you had no independent recollection of these events. That's a fair - - -

MS MNICH: At the time – sorry.

MR ROZEN: No, go on.

MS MNICH: At the time I was shown the letters, I was – I couldn't recall the issues but I've since looked at other documentation which has jogged my memory.

MR ROZEN: Now I want to ask you about the conduct that is described in the letter. Before I do that, in the first line, you advised UA that another letter of the same date had told him that he had been suspended from duty; is that right?

MS MNICH: That would be right, yes.

MR ROZEN: And that was pending the investigation which was being initiated by this letter; is that right?

MS MNICH: Yes.

MR ROZEN: Yes.

MS MNICH: Yes.

MR ROZEN: And who made the decision to suspend UA from his employment while the investigation was being carried out?

MS MNICH: The executive director, yes.

MR ROZEN: The executive director of Japara?

MS MNICH: Yes.

MR ROZEN: Was that Ms Reed?

MS MNICH: Yes.

MR ROZEN: And she conveyed to you, did she, the direction to write to UA, suspending him?

MS MNICH: I believe so, yes.

MR ROZEN: Okay. Now, the conduct that you have set out is divided into four separate incidents, which, as we can see, involve, on the first page, three residents who have been given pseudonyms, UC, UD and UB. Do you see that?

MS MNICH: Yes.

MR ROZEN: And what is described there is three separate incidents involving those residents, all on 18 March 2015 during the course of UA's employment at Bayview; is that right?

MS MNICH: Correct.

MR ROZEN: And I want to ask you briefly about the third of those, in which it is said:

At approximately 1830 hours you were attending to resident UB with PCA.

PCA, that's personal care attendant? Is that right.

MS MNICH: That's right.

MR ROZEN: And then the name is redacted. Then it goes on.

Resident UB was awaiting to be showered where you had allegedly turned on the water in the shower and started to wet the resident. You allegedly put the hose on the resident and the resident reacted, yelling and raising her voice. At this time, another PCA entered the room, bathroom and resident allegedly stated words to the effect to that PCA "The water is cold". That PCA allegedly felt the water and stated words to the effect to you, "Don't you check the water? It's cold." You then allegedly responded words to the effect, to her, "You can do it then". The resident was visibly cold with goose bumps and was shivering. The resident stated words to the effect to the PCA, "He shouldn't be allowed in women's rooms."

That's the description you gave to UA of the alleged conduct.

MS MNICH: Yes.

MR ROZEN: Then I will ask you briefly about the fourth instance which alleges conduct on an earlier date around 4 March 2015. Do you see that on page 2 of the letter?

MS MNICH: I do, yes.

MR ROZEN: And what is alleged there, if I can summarise, is that it's alleged to UA that:

During your shift you were attending to this resident, UB, and allegedly slapped her hand, stated words to the effect, "You can't have that". It is then alleged you took the resident's biscuits away. The resident notes your behaviour as loud, sharp. The incident was reported to the facility manager at 9.30 hours by a personal care attendant.

Do you see that?

MS MNICH: Yes. She wasn't actually a personal care attendant, she was an enrolled nurse.

MR ROZEN: I'm sorry, thank you for that correction. Now, when you sent this letter to UA, you had no doubt, Ms Mnich, that the conduct you were describing in the letter was serious misconduct.

MS MNICH: Correct.

MR ROZEN: And you made that assessment by reference to a definition of serious misconduct, did you or just your own – I'm sorry, go on.

MS MNICH: I didn't actually make the decision as to serious misconduct. It came from HR.

MR ROZEN: I see. We see on the second page that you copied the letter to Nicole Farrell, senior human resources adviser.

MS MNICH: That's right. Yes.

MR ROZEN: Was it Ms Farrell that made the assessment that it was serious misconduct?

MS MNICH: I don't know that. It was somebody in HR but I don't know who it was.

MR ROZEN: All right. That was conveyed to you by HR; is that the case?

MS MNICH: That's right. The letters were done in – at HR head office, and they were sent to me, and then I would send them out. I would sign them and send them out.

MR ROZEN: I see, I understand. But drawing on your extensive experience in the industry, you considered that the conduct described in the letter fell within the definition of serious misconduct?

MS MNICH: I – I think, looking back on it, I might have thought misconduct, but I certainly went along with serious misconduct.

MR ROZEN: Well, a moment ago, Ms Mnich, you told us that you didn't have any doubt that it was serious misconduct. Is your evidence to the Royal Commission that at the time you did?

MS MNICH: I certainly went along with the serious misconduct, yes.

MR ROZEN: Okay. Now, there was a process of investigation which was carried out by Japara in relation to these four allegations; that's right, isn't it?

MS MNICH: Correct.

MR ROZEN: And the investigation involved an interview with UA in which the allegations were put to him and he was asked for a response.

MS MNICH: Correct.

MR ROZEN: And ultimately the decision was that each of the four allegations was substantiated by Japara.

MS MNICH: Correct.

MR ROZEN: As a result of that, you wrote a further letter to UA, and if I could ask for tab 9, please, to be brought up on the monitor. Do you see a letter dated 9 April 2015 bearing your signature, Ms Mnich, on the second page?

MS MNICH: I'm having difficulty seeing that. I've got it, thank you.

MR ROZEN: Do you have it now?

MS MNICH: Yes, I have it now, thank you.

MR ROZEN: Was this another letter that was drafted for you by HR in relation to this matter?

MS MNICH: Yes, indeed.

MR ROZEN: Okay. But you agreed with its contents?

MS MNICH: Yes.

MR ROZEN: And in the first paragraph, if we can go back to the first page, you referred to your earlier letter to the meeting that had taken place on 7 April 2015 at which UA was represented by a union officer; is that right, from the Health Workers Union?

MS MNICH: Correct.

MR ROZEN: And in the last sentence of the first paragraph you wrote:

This letter confirms that I am satisfied that the following concerns regarding serious misconduct have been substantiated.

Do you see that?

MS MNICH: Correct. I see that, yes.

MR ROZEN: The concerns that are set out are identical to the way they were expressed in the first letter I asked you about; do you agree?

MS MNICH: Yes. I agree.

MR ROZEN: At the top of the second page, you made reference to the process of investigation; is that right? Do you see that?

MS MNICH: Yes. I see that, yes.

MR ROZEN: And then six lines into that first paragraph on the second page, you wrote:

In my opinion your serious misconduct towards our residents is unacceptable and incompatible with ongoing employment if repeated.

Do you see that?

MS MNICH: I see that, yes.

MR ROZEN:

It is only the absence of proven wilful and malicious intent which has caused me to stop short of terminating your employment. On the balance of probabilities I deem your conduct to be a serious risk to the health and safety of our residents and a grave concern for the continuation of your contract of employment.

Do you see that?

MS MNICH: Yes, I do.

MR ROZEN: And it went on to inform UA that he was being issued with a first and final written warning in accordance with the Japara disciplinary procedure.

MS MNICH: Correct.

MR ROZEN: In addition to the warning, UA was directed to comply with an improvement plan; is that right?

MS MNICH: Correct.

MR ROZEN: And the steps that he was required to follow are set out in the four dot points on the second page. Can you see that?

MS MNICH: Yes. Yes, I do.

MR ROZEN: I want to ask you about the second of those which was:

Complete the elder abuse self-directed learning package and return to the facility manager no later than 20 April 2015.

MS MNICH: Right, yes.

MR ROZEN: Do you know if, as at the date of your letter, 9 April 2015, UA had completed the elder abuse self-directed learning package? In other words - - -

MS MNICH: I can't recall.

MR ROZEN: Okay. Could you have a look at tab 5, please. I will ask that that be shown to you. Do you see that, Ms Mnich?

MS MNICH: I do.

MR ROZEN: That's a document headed Elder Abuse Questions with the name UA, designation, PCA, dated 28 March '13. Do you see that?

MS MNICH: I do.

MR ROZEN: And that's the elder abuse self-directed learning package, isn't it, at Japara?

MS MNICH: I believe so.

MR ROZEN: Yes. So it would appear that he had done it previously; do you agree?

MS MNICH: Yes.

MR ROZEN: And he got 100 per cent, if you look at the second page.

MS MNICH: Yes.

MR ROZEN: Is your evidence you didn't know that at the time you sent him the letter on 9 April 2015 directing him to do it?

MS MNICH: I – I can't recall.

MR ROZEN: All right. After you sent your letter on 9 April 2015 informing UA that a first and final warning was being given to him, there was correspondence between his union, the Health Workers Union, and Japara about the case, wasn't there?

MS MNICH: I didn't recall until I saw the documentation recently.

MR ROZEN: Okay. Having seen the documentation recently, does that trigger your memory that there was communication between the union and Japara about UAs case?

MS MNICH: No, I don't recall.

MR ROZEN: Okay. I wonder if I could ask for tab 12, please, to be shown to Ms Mnich. Do you see at the bottom of that page there is an email from a redacted address at hwu.org.au; that's Health Workers Union.org.au. Can you see that?

MS MNICH: Yes.

MR ROZEN: And I would ask you to accept from me that the email was directed to one of the HR officers at Japara, whose name has been redacted but you can see that it was copied to you. Do you see that, Ms Mnich?

MS MNICH: I see that, yes.

MR ROZEN: And in the email, if I can summarise, the union was taking issue with Japara's giving UA a first and final warning.

MS MNICH: That's right.

MR ROZEN: Do you see that?

MS MNICH: I see that, yes.

MR ROZEN: And they weren't taking issue with characterisation of the conduct as serious misconduct, were they?

MS MNICH: Sorry, could you repeat that?

MR ROZEN: It doesn't appear that they were taking issue with UA's conduct being characterised as serious misconduct.

MS MNICH: No.

MR ROZEN: Rather, they were raising concerns about whether there was legal authority in Japara to issue a first and final warning.

MS MNICH: Correct.

MR ROZEN: Yes. And does that now trigger your memory of the interchange between the union and Japara subsequent to you sending the first and final warning letter?

MS MNICH: No, sorry, no.

MR ROZEN: Okay. Ultimately, the first and final warning was retracted by Japara, wasn't it?

MS MNICH: I believe so, yes.

MR ROZEN: Yes. And it was replaced with a first warning.

MS MNICH: Correct.

MR ROZEN: And were you a party to the decision by Japara to downgrade the disciplinary response from a first and final warning to a first warning?

MS MNICH: I don't know. I don't believe so.

MR ROZEN: Could you have a look at tab 15, please. And if you look at the second page of that, please, Ms Mnich, you will see that this is a letter that you signed on 4 June 2015 to UA. Do you see that?

MS MNICH: Yes, I do.

MR ROZEN: And read the letter, if you want to, but I would ask you to accept from me that it is very similar to the letter you sent to UA in April advising of the first and final warning but rather it's characterised as a first written warning. Do you accept that summary of the letter?

MS MNICH: Yes, correct. Yes.

MR ROZEN: And is it the case that as with the earlier letter, this was drafted for you by HR and you signed it and sent it to UA?

MS MNICH: Correct.

MR ROZEN: Did the HR department discuss with you whether you agreed with the downgrading of the disciplinary response?

MS MNICH: I can't recall.

MR ROZEN: You had been prepared to sign the initial letter describing the conduct as serious misconduct; you agree with that, don't you, Ms Mnich?

MS MNICH: I do, yes.

MR ROZEN: Had your view changed about whether the conduct was serious misconduct between your letter in April and this letter on 4 June?

MS MNICH: I don't recall.

MR ROZEN: Because it's the case, isn't it, that if it was serious misconduct, it couldn't be the subject of a first written warning, could it? It either would be dismissal or a first and final warning.

MS MNICH: Correct.

MR ROZEN: That was the case under the disciplinary procedure at Japara, wasn't it?

MS MNICH: Correct.

MR ROZEN: If I could go then, please, to an incident in January of the following year. Before I do that, UA remained employed at the Bayview facility under your management between June of 2015 and January of 2016; is that right?

MS MNICH: Correct.

MR ROZEN: And were there any further incidents involving misconduct directed at residents by UA in the period June 2015 to January 2016?

MS MNICH: Not that I recall, no.

MR ROZEN: Was there a further incident in January 2016 involving UA?

MS MNICH: I believe so, yes.

MR ROZEN: The incident in January 2016 was reported to the Department of Health and the police, as required by the Aged Care Act, wasn't it, Ms Mnich?

MS MNICH: Correct. Correct.

MR ROZEN: Were any of the incidents that I've just asked you about in March of 2015 reported to the Department of Health?

MS MNICH: I – I don't recall. I presume so.

MR ROZEN: Have you seen any records of them being reported?

MS MNICH: No, I haven't.

MR ROZEN: Now, if I could ask you, please, to look at tab 16, which is an email from you dated 15 January 2016.

MS MNICH: Yes.

MR ROZEN: Do you have that? That's an email that you sent to Julie Reed who is the senior officer at Japara that you've referred to earlier?

MS MNICH: Yes, correct.

MR ROZEN: Also to Mr Stuart Woodley, another senior officer but subordinate to Ms Reed.

MS MNICH: Correct.

MR ROZEN: And then HR officers are identified there as well, Nicole Farrell; Narelle Wood was a quality manager, is that right?

MS MNICH: Correct.

MR ROZEN: What about Lynne Pelgrim: who was she?

MS MNICH: She was a quality manager, I believe, at that time as well.

MR ROZEN: Okay. In your email you wrote:

Dear Julie, please find mandatory report for Bayview. Please can you OK the Rolls incident report to send to DSS –

that's the Department of Social Services; is that right?

MS MNICH: Correct.

MR ROZEN:

...as this is all they have asked for.

And you went on:

Nicole I've been unable to contact UA to suspend him, however, we have sent a text message from the Bayview SMS requesting he ring urgently. If he does not contact us, do we have permission to SMS him asking that he not come to work tomorrow morning?.

That decision to suspend UA, was that a decision once again made by Ms Reed and given effect you by you, Ms Mnich?

MS MNICH: Correct.

MR ROZEN: And then if you turn to tab 17, if that could be shown to you, please. I don't think that's tab 17. Yes, thank you. Do you see an incident report dated 15 January 2016 there, Ms Mnich?

MS MNICH: I do, yes.

MR ROZEN: And that's the report that was referred to in your email to Ms Reid of the same date? Can you confirm that?

MS MNICH: The actual information to the Department, I believe.

MR ROZEN: So I'm not sure I understood that answer. Is that the incident report that is referred to in your email?

MS MNICH: I don't believe so.

MR ROZEN: But it's the same incident that led to the suspension of UA, isn't it?

MS MNICH: Correct. Correct.

MR ROZEN: Yes. Thank you. And the description of the incident, if we can just read that a quarter of the way down that first page:

Received Have Your Say form.

That's a complaint form, is it, at Japara?

MS MNICH: It's a form for any – for anyone to have a say, it might be compliments, not necessarily complaints, no.

MR ROZEN: It could be compliments too.

MS MNICH: And it could be for improvement.

MR ROZEN: Yes. And it went on:

Received Have Your Say form written for Mrs FR by –

and then a redacted name –

...alleging that staff member UA was changing FR into her nightie. He forced her head and neck down causing terrible pain.

Do you see that?

MS MNICH: I do.

MR ROZEN: And it was that allegation that led to you suspending UA on 18 January 2016?

MS MNICH: Correct.

MR ROZEN: If you have a look at tab 18, please, Ms Mnich, that's your – sorry – that's your letter suspending UA in relation to this incident?

MS MNICH: Correct.

MR ROZEN: And in the second paragraph of the letter you wrote:

Your suspension from duty is necessary due to the nature of very serious allegations which have been raised with management concerning your conduct. I believe that it is now necessary, to suspend you from duty, to protect both you and our organisation until this matter can be resolved.

Do you see you wrote that?

MS MNICH: I do.

MR ROZEN: Was this another letter that HR wrote for you and you signed?

MS MNICH: Correct.

MR ROZEN: Was it any part of your thinking, Ms Mnich, that it was necessary, to suspend UA, not only to protect him and Japara but also the residents at Bayview?

MS MNICH: I have difficulty remembering the actual incident, but looking back – yes; that would be correct.

MR ROZEN: That would be the obvious reason to suspend him, wouldn't it, Ms Mnich?

MS MNICH: Yes. That's correct.

MR ROZEN: Can you assist the Commission to understand why there's no reference to that in the letter?

MS MNICH: Sorry. Can you repeat that?

MR ROZEN: Yes. Why is there no reference in the letter to one of the reasons for suspending UA being to protect the residents at Bayview?

MS MNICH: I'm afraid I don't know. I don't believe that, when we sent suspension letters out – that it actually included anything but suspension.

MR ROZEN: I see. Do you I understand you to be saying this was a standard-form suspension letter prepared by HR?

MS MNICH: I believe so. Yes. Yes.

MR ROZEN: Okay. As with the earlier incidents that I asked you about in April of 2015, there was an investigation by Japara of this allegation. Is that right?

MS MNICH: Sorry. Can you repeat that, please?

MR ROZEN: Yes. Japara investigated this allegation. Didn't they? While Mr – while UA was suspended?

MS MNICH: This particular one in January, are we talking about?

MR ROZEN: Yes.

MS MNICH: Yes.

MR ROZEN: Yes. And the investigation involved, once again, a discussion with UA, where the allegation was put to him and he had an opportunity to respond to it. Is that right?

MS MNICH: Yes. That would be correct. Yes.

MR ROZEN: And in inviting him to the meeting where that occurred, you characterised this conduct as serious misconduct, did you not, Ms Mnich?

MS MNICH: Yes.

MR ROZEN: Could you have a look, just for completeness, at tab 20, which was your letter of 19 January 2016? Do you see that? Your signature appears on the second page?

MS MNICH: Yes, that's correct.

MR ROZEN: And we see, once again, under the salutation, "allegations of serious misconduct", on the first page.

MS MNICH: Yes.

MR ROZEN: And once again, you had no doubt, that this conduct, if substantiated, would fall within the definition of "serious misconduct by a personal-care attendant"?

MS MNICH: Correct.

MR ROZEN: And it was substantiated as a result of the investigation?

MS MNICH: I believe so. Yes.

MR ROZEN: And you provided UA or you sent UA a second written warning as a result of this allegation being substantiated, did you not?

MS MNICH: Correct.

MR ROZEN: Could you have a look at tab 25? Do you see that?

MS MNICH: I do.

MR ROZEN: This is the second written warning that you sent to UA on 5 February 2016?

MS MNICH: Correct.

MR ROZEN: It's the case – isn't it, Ms Mnich – that if the first and final written warning had stood in relation to the March 2015 conduct, the substantiation of this incident in 2016 would've resulted in the termination of UA's employment, wouldn't it?

MS MNICH: Correct.

MR ROZEN: But because it had been downgraded to a first warning, the consequence was that a second written warning was sent; is that right?

MS MNICH: Correct.

MR ROZEN: Do you recall – when you were discussing this matter that is the January 2016 incident with HR – whether there was any consideration of issuing a first and final written warning in relation to this matter rather than a second written warning?

MS MNICH: No, I don't recall.

MR ROZEN: There was also another improvement plan for UA to follow as part of this second warning; is that right?

MS MNICH: There would've been. Yes.

MR ROZEN: The four dot points at the bottom of page 1 are the improvement plan?

MS MNICH: Yes. Sorry. Yes. Sorry.

MR ROZEN: And once again – we can see in the second dot point that he was required to complete the elder-abuse self-directed-learning package. Do you see that?

MS MNICH: I do.

MR ROZEN: Now, this time you knew he'd already done that as a result of the 2015 incidents, didn't you?

MS MNICH: Yes.

MR ROZEN: Why did you direct him to do it again?

MS MNICH: To reinforce, I guess, the education.

MR ROZEN: Did you think perhaps the education from the first two occasions that he'd done it wasn't sinking in?

MS MNICH: I can't recall.

MR ROZEN: There was another incident involving UA and misconduct by him directed at residents very soon after your letter of the 5th of February 2016, wasn't there, Ms Mnich?

MS MNICH: I believe so. Yes.

MR ROZEN: Even before the date by which he was required to complete the elder-abuse learning-package, there was another allegation involving misconduct by UA. That's the case. Isn't it.

MS MNICH: I believe so. Yes.

MR ROZEN: If you have a look at tab 26, please, do you see that's a letter that you sent to UA on 15 February 2016, advising him that he'd been – he was being suspended from duty on full pay?

MS MNICH: I do. Yes.

MR ROZEN: And in the second paragraph you wrote:

Your suspension from duty is necessary due to the nature of very serious allegations which have been raised with Management concerning your conduct.

MS MNICH: Yes.

MR ROZEN: If you – look at tab 28, please. That misconduct is described. That's a letter you sent to UA on 16 February 2016, Ms Mnich?

MS MNICH: Correct.

MR ROZEN: Once again, you've characterised the allegations as being of serious misconduct, and you've spelt them out in bold in the middle of the first page. Do you see that?

MS MNICH: Correct.

MR ROZEN: And you wrote:

On 12 February 2016, it was brought to Management's attention by resident FS, that on Wednesday, 10 February 2016, when you worked as a PCA from 1430 to 2130 hours, you, allegedly, engaged in unacceptable and unprofessional behaviour that posed a risk to the health and safety of residents. And your actions are, potentially, damaging to the reputation of the organisation and residents.

And then you spelt out specifically what the allegations were, and the first four of the dot points there are concerned with allegations of improper conduct whilst feeding a resident, UE. Do you agree with that summary?

MS MNICH: Correct. Yes.

MR ROZEN: And in summary what you were describing there was a complaint by the resident, that the food that they were being fed by UA was too hot?

MS MNICH: The complaint was by another – from another resident.

MR ROZEN: The complaint was from a second resident, that the resident who was being fed was concerned that the food was too hot; is that right?

MS MNICH: That's correct. That's correct.

MR ROZEN: And the substance of the complaint was that, when this was drawn to UA's attention by the resident who was being fed, he said words to the effect of "Blow on it then" and forced the food into the resident's mouth.

MS MNICH: I believe the resident themselves complained it was too hot and then, yes, he – the – UA then told him to – told her, actually, to blow on it.

MR ROZEN: Yes. And forced the food into her mouth.

MS MNICH: Correct.

MR ROZEN: It then goes on to say that the resident who was being fed, coughed and splattered – "spluttered", perhaps – and that UA continued to push food into her mouth.

MS MNICH: Correct.

MR ROZEN: It then went on – that the resident who was raising the complaint said words to the effect to UA – "If you fed me like that, I would spit it back at you". Do you see that?

MS MNICH: I do, yes.

MR ROZEN: There was then another complaint about UA's conduct, in which it was alleged, that he threw a call bell referred to as Charlie at a resident, hitting them on the leg, causing pain. Is that right?

MS MNICH: Correct. Correct.

MR ROZEN: Once again, those incidents were investigated by Japara?

MS MNICH: Correct.

MR ROZEN: And they were substantiated?

MS MNICH: Yes.

MR ROZEN: They were substantiated after investigation followed a similar process to the ones you've described earlier?

MS MNICH: Yes.

MR ROZEN: And as a result, a further warning was given to UA; is that right?

MS MNICH: I believe – yes. I believe it was a final warning.

MR ROZEN: A final warning. And if you look at tab 35 – that's the final warning?

MS MNICH: Yes.

MR ROZEN: You look at the second page of that letter, and in fairness to you: the – it's under the signature of a different person, Angela Manganas. Had she taken over as the facility manager by this time?

MS MNICH: No. I, obviously, must've been away at the time. Angela was a facility manager of a Japara facility very close to Bayview.

MR ROZEN: I see. So she signed the letter. It was copied to you, as we can see.

MS MNICH: Yes.

MR ROZEN: Once again, UA was directed to participate in an improvement plan; is that right, Ms Mnich?

MS MNICH: Yes, correct.

MR ROZEN: And once again one component of the improvement plan was to complete the elder-abuse self-directed-learning package.

MS MNICH: Indeed.

MR ROZEN: There was one final incident that ultimately led to a separation between Japara and UA; is that right, Ms Mnich?

MS MNICH: Correct.

MR ROZEN: And in relation this to incident, which occurred in April of 2016, you received a letter from the daughter of the resident that was involved?

MS MNICH: I believe so; yes.

MR ROZEN: Yes. If you have a look at tab 38 – that's a copy of the handwritten letter. Do you see that? It's quite a lengthy four-page letter. Do you recall receiving it from the - - -

MS MNICH: No.

MR ROZEN: You don't recall it?

MS MNICH: No. I don't recall receiving it, and I haven't seen it since.

MR ROZEN: I see. Well, you can take a moment to read it. I must indicate to you, Ms Mnich, that it seems surprising, that you don't recall this series of events.

MR DELANY: I object to that question. The witness has said that she didn't recall the letter. She hasn't been asked whether she had a recollection of the events; perhaps she might be asked that question.

MR ROZEN: Well, you say in your statement, don't you, Ms Mnich? That you don't recall the events?

MS MNICH: At the time, I didn't recall the events. But as I've gone through some of the documentation, I – it, certainly, has jogged my memory.

MR ROZEN: Yes.

MS MNICH: And I do remember this incident. I remember it well, because I was very distraught and very upset, in tears, when I was told of the incident.

MR ROZEN: Yes. Yes. And it was this incident that led you to say in an email that you did not want UA working at your facility. Wasn't it.

MS MNICH: That's correct.

MR ROZEN: Do you – yes. And the incident is summarised on page 2 of the letter, Ms Mnich, at about eight lines down on page 2. Do you see the sentence that starts "UA"? It's actually highlighted on the document you are looking at.

MS MNICH: Yes. Yes. Yes, yes.

MR ROZEN: UA insisted she – that is the mother of the author of the letter – go with him, but she refused; she says he started shouting and saying horrible things to her. And then in brackets – "I'm crying as I write this". Then he stamped on her clothes and slapped her face. She said she was frightened and started screaming. That's how the daughter described the incident.

MS MNICH: Yes.

MR ROZEN: And then on the bottom of the next page, if I could just draw your attention to that – after referring to the police attending at the facility, the author wrote – this is eight lines from the bottom of the third page:

I believe he should be sacked, because it is unacceptable, for a person in charge of the wellbeing of a resident to do what he did, especially when it was completely unprovoked. It isn't good enough, for him to continue at Bayview even in a different section. He shouldn't have any access to Mum whatsoever. Who knows what he's capable of.

And then if you turn to page 4, do you see at the top of the next page she wrote:

I suppose it will be like the Catholic priests who are moved on to offend elsewhere. I know this is hard for you, Di, but this is a very serious matter.

That's the letter you received which, you told the Commission a moment ago, was so upsetting to read; is that right, Ms Mnich?

MS MNICH: No; it wasn't the letter, that I was so upset, reading. It was when I was phoned and told of the incident.

MR ROZEN: I see. And who told you of the incident?

MS MNICH: I don't know who rang me. I was at a conference at the Yarra Valley. I just remember getting the call and being devastated.

MR ROZEN: I see. And there wasn't a completed investigation into this incident at Japara, was there, Ms Mnich?

MS MNICH: A completed – it didn't – no; it wasn't completed. No; true.

MR ROZEN: And that's – you wrote to UA, initiating a process of investigation.

MS MNICH: I believe so; yes.

MR ROZEN: Have a look at the letter on – behind tab 40, please. 27 April 2016. This is the letter initiating the investigation of this incident involving a resident who is referred to as FT in the letter; is that right?

MS MNICH: Correct.

MR ROZEN: And there are other allegations there in addition to the ones set out in the letter that I just read sections of to you, aren't there?

MS MNICH: Sorry; would you repeat that?

MR ROZEN: Sure. Do you see the first dot point there in bold, "You shouted at resident FT and threatened to break her walker"?

MS MNICH: Yes. Yes. Yes, I see that.

MR ROZEN:

You hit resident FT on the right side of her cheek, and it hurt. The resident FT shouted and hit you, and you swore at the resident.

And then there's a description of the incident in very similar terms to what I just read to you in the letter, about stomping on the clothes and wiping the bathroom floor with your feet.

MS MNICH: Yes. Yes.

MR ROZEN: Do you see that?

MS MNICH: Yes; indeed.

MR ROZEN: And I think you just agreed with me: that matter was not ultimately investigated, because UA submitted his resignation from his employment before the investigation could be completed; is that right?

MS MNICH: That would be correct; yes.

MR ROZEN: Were you involved in the process of drafting a deed of agreement between Japara and UA and providing him with a statement of service, Ms Mnich?

MS MNICH: No; not at all.

MR ROZEN: They were matters that were dealt with by HR, are they?

MS MNICH: Indeed; yes.

MR ROZEN: All right. Did you have any further dealings with UA after sending him the letter that I've just asked you about on the 27th of April 2016?

MS MNICH: No. Not at all.

MR ROZEN: Okay. He had been suspended from duty before you sent that letter; is that right?

MS MNICH: Yes. He was suspended from duty on the day that the allegation was made.

MR ROZEN: Yes, on 18 April; is that right?

MS MNICH: 16 April, I think it was.

MR ROZEN: Okay. Thank you. Yes, I have no further questions for Ms Mnich, Commissioners?

COMMISSIONER BRIGGS: No questions.

MR ROZEN: If she could be excused.

COMMISSIONER PAGONE: Yes, thank you, Ms Mnich, for your evidence and being available.

MS MNICH: Okay. Thank you.

COMMISSIONER PAGONE: You are excused from further attendance, thank you.

MS MNICH: Thank you very much.

<THE WITNESS WITHDREW [10.20 am]

MR ROZEN: If the link could be concluded, and I will call Nicole Farrell.

<NICOLE SUZANNE FARRELL, AFFIRMED [10.21 am]

<EXAMINATION BY MR ROZEN

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioners. Ms Farrell, can you please state your full name for the purposes of the transcript?

MS FARRELL: Nicole Suzanne Farrell.

MR ROZEN: Ms Farrell, you have made two witness statements for the Royal Commission in relation to this matter; is that right?

MS FARRELL: Yes, one that is updated.

MR ROZEN: Yes, if I can just clarify that.

MS FARRELL: Yes.

MR ROZEN: So you made an initial statement on 3 October 2019 which is WIT.0490.0001.0001. It should be on the screen.

MS FARRELL: Yes.

MR ROZEN: I think you might also have a hard copy in front of you, Ms Farrell.

MS FARRELL: Yes. Thank you.

MR ROZEN: Is that the statement that you made on 3 October 2019 and signed and provided to the Royal Commission?

MS FARRELL: Yes, that's correct.

MR ROZEN: I tender the statement dated 3 October 2019, Commissioners.

HIS HONOUR: Yes, the statement of Ms Farrell of 3 October 2019 will be exhibit 11-55.

EXHIBIT #11-55 STATEMENT OF MS FARRELL DATED 03/10/2019 (WIT.0490.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR ROZEN: And if you could be shown another statement, please, WIT.0490.0002.0001. It's a statement made by you dated 15 October 2019; do you see that?

MS FARRELL: Yes.

MR ROZEN: And can you confirm for us that that is your statement which is – I think you have said is an updated version of the one dated 3 October 2019?

MS FARRELL: Yes.

MR ROZEN: As I read it, the major difference between the two statements is in the second one, you explain the process by which the first and final warning issued in April of 2015 became a first warning in June of 2015. That's the principal change, isn't it?

MS FARRELL: I think we also updated just in relation to point 14.

MR ROZEN: In any event, perhaps we can come back to that but - - -

MS FARRELL: Sure.

MR ROZEN: - - - are the contents of this second statement true and correct, Ms Farrell?

MS FARRELL: Yes.

MR ROZEN: I tender the second statement.

COMMISSIONER PAGONE: The second statement of Ms Farrell dated 15 October 2019 is exhibit 11-56.

EXHIBIT #11-56 SECOND STATEMENT OF MS FARRELL DATED 15/10/2019 (WIT.0490.0002.0001)

MR ROZEN: Ms Farrell, you were a human resources officer employed by Japara between 2015 and 2016; is that right?

MS FARRELL: No, I was an adviser.

MR ROZEN: A human resources adviser?

MS FARRELL: Yes.

MR ROZEN: Is that the title?

MS FARRELL: Yes.

MR ROZEN: You have subsequently worked in other positions elsewhere in the human resources area?

MS FARRELL: Correct, yes.

MR ROZEN: And do you have qualifications in relation to human resources?

MS FARRELL: I have a bachelor's degree but not in specific relation to human resources.

MR ROZEN: I see. What is your bachelor's degree agree in?

MS FARRELL: Legal and dispute studies; a social science degree.

MR ROZEN: When did you commence employment with Japara in a human resources capacity?

MS FARRELL: I think 2012 – I can't - - -

MR ROZEN: Sorry. It's not a trick question. I've just seen in paragraph 6 of your second statement - - -

MS FARRELL: Yes. Sorry.

MR ROZEN: - - - you say you started in January 2014; is that right?

MS FARRELL: Sorry. Yes, that is correct. Pardon me. Yes.

MR ROZEN: And you were there until 12 July 2018?

MS FARRELL: That's correct.

MR ROZEN: You there say you were senior human resources business partner. Is that right?

MS FARRELL: Yes, I worked as a number of roles for that duration.

MR ROZEN: I see. You were only the human resources business partner for part of that time, were you?

MS FARRELL: Correct, yes.

MR ROZEN: You started as a human resources adviser; is that right?

MS FARRELL: Correct, yes. Yes.

MR ROZEN: Thank you. Now, as part of your commencement of your work, you no doubt familiarised yourself with the enterprise agreement that applied to Japara, its employees and the relevant unions?

MS FARRELL: Correct, yes.

MR ROZEN: And if I could just ask you briefly about that. It's at tab 6 in the tender bundle and it will appear on the screen in front of you at page .0075.

MS FARRELL: Yes.

MR ROZEN: Do you see that there, clause 61 concerns the disciplinary procedure.

MS FARRELL: Correct yes.

MR ROZEN: Those familiar with human resources will see that it contains a fairly standard series of graduated responses to misconduct by employees. Do you agree with that description?

MS FARRELL: Standard, I mean across in relation to what other EBAs would state or?

MR ROZEN: Yes.

MS FARRELL: I've only focused, really, on this EBA so I can't comment.

MR ROZEN: But it provides a graduated series of warnings, does it not.

MS FARRELL: Correct yes.

MR ROZEN: Culminating in potential for termination of employment.

MS FARRELL: Correct yes.

MR ROZEN: But importantly it says at 61.5 at the bottom of that page that:

Summary dismissal of an employee may still occur for acts of serious misconduct (as defined in the Fair Work Act 2009).

Do you see that?

MS FARRELL: Correct. Yes, I do.

MR ROZEN: Then it goes on:

Where an allegation of serious misconduct is proven –

reading from the top of the next page - - -

MS FARRELL: Yes.

MR ROZEN:

...and the employer, having considered all the circumstances does not wish to terminate the employee's employment, a warning may be issued under clauses 61.2 or 61.3.

Do you see that?

MS FARRELL: Yes, I do.

MR ROZEN: And you were familiar with this clause at the time you were advising Ms Mnich in relation to UA's case?

MS FARRELL: Yes, that's correct.

MR ROZEN: I suggest to you that the effect of clause 61.5 is that in a case where serious misconduct was substantiated as defined in the Fair Work Act, that Japara had two options in responding to such a substantiated allegation.

MS FARRELL: Yes.

MR ROZEN: It could either terminate the employee's employment or issue a warning under clauses 61.2 or 61.3?

MS FARRELL: Yes.

MR ROZEN: In fairness to you that's probably three options. 61.2 is a second warning and 61.3 is a third final warning. That's the case, isn't it?

MS FARRELL: Yes.

MR ROZEN: The effect of that is this, isn't it: you can't get a first warning in relation to a case of serious misconduct under this agreement; do you agree with that?

MS FARRELL: Yes, correct.

MR ROZEN: There was also a disciplinary procedure in place at Japara, was there not?

MS FARRELL: Correct, yes.

MR ROZEN: In addition to the enterprise agreement. It's behind tab 7 in the tender bundle. And presumably you are also familiar with this procedure at the time in 2015/2016 that we've been examining?

MS FARRELL: Yes.

MR ROZEN: And it contains a definition of "serious misconduct" on page 0002. Do you see that?

MS FARRELL: Yes.

MR ROZEN: I don't want to get too technical but it's slightly different to the one that appears in the Fair Work regulations, isn't it, Ms Farrell?

MS FARRELL: At the time or are we talking about today?

MR ROZEN: At the time

MS FARRELL: I suppose, yes.

MR ROZEN: More importantly, though, do you agree with Ms Mnich's evidence – I think you've been in the hearing room haven't you while she has been giving evidence?

MS FARRELL: Yes.

MR ROZEN: Do you agree with her evidence that you were advising her between April and June of 2015 about how to respond to the UA case?

MS FARRELL: Yes.

MR ROZEN: And you were applying a definition of "serious misconduct", presumably, to enable you to do that. Is that right?

MS FARRELL: Correct, yes.

MR ROZEN: Which definition were you using – the one in the Fair Work Act or the one in the disciplinary procedure?

MS FARRELL: Fair Work Act is where we would look at the definition.

MR ROZEN: Okay. Thank you. Now, can I ask you about the letter behind tab 8, please, Ms Farrell. You heard me asking Ms Mnich about this letter earlier. This is the first letter sent to UA making allegations of misconduct – I will use a neutral term for the moment - - -

MS FARRELL: Sorry - - -

MR ROZEN: - - - which are the four instances that are set out in bold in that letter. Do you see that?

MS FARRELL: No, I don't. It's not – I don't believe that I've got the right letter.

MR ROZEN: No, I think you don't have the right letter. I apologise for that.

MS FARRELL: That's okay.

MR ROZEN: You do now.

MS FARRELL: Thank you.

MR ROZEN: Do you see in bold there are three dot points on the first page and then a fourth one on the second page?

MS FARRELL: Yes, I do.

MR ROZEN: Do you have a recollection of this case, as you sit there now, Ms Farrell?

MS FARRELL: After reviewing the documentation presented to me for this Royal Commission, I've somewhat had a jog of my memory.

MR ROZEN: Okay. But before that, when you were first approached to assist the Commission, you had no memory of these matters; is that the case?

MS FARRELL: Not – not to the extent of what I do now, so not really, to be honest.

MR ROZEN: This is quite a serious case, is it not, Ms Farrell, a serious case of employee misconduct in an aged care facility?

MS FARRELL: Of course, yes.

MR ROZEN: Presumably they wouldn't have been frequent, not over this period of time, or were they?

MS FARRELL: Not – it was infrequent.

MR ROZEN: Right. So I'm trying to understand why you have such little recollection of this. One explanation might be that it wasn't out of the ordinary. Is that the explanation?

MS FARRELL: The explanation is that it's four and a half years ago.

MR ROZEN: Okay.

MS FARRELL: Yes

MR ROZEN: Did you draft this letter?

MS FARRELL: I did. I think I did, if I can just have a look at the – yes, I did, yes.

MR ROZEN: And it was copied to you when it was sent by Ms Mnich, we see, don't we, on the second page?

MS FARRELL: Yes.

MR ROZEN: And so it was your characterisation, was it, of this conduct as serious misconduct?

MS FARRELL: It was in consultation with the group executive of HR at the time or group manager HR at the time and also the executive director at the time of care who would have made the decision to assume that it was serious misconduct.

MR ROZEN: So that is Ms Reed that we heard about before.

MS FARRELL: That's correct. Yes.

MR ROZEN: Julie Reed. She's the executive director. And who was the first person that you referred to?

MS FARRELL: Sorry; apologies. The – at the time, I believe his title was the general manager of HR.

MR ROZEN: Was that Mr van Winkel?

MS FARRELL: Correct, yes.

MR ROZEN: So in consultation with them - - -

MS FARRELL: Correct.

MR ROZEN: - - - the decision was made that this was serious misconduct, and you had no doubts about that yourself, did you, at the time? You weren't uncomfortable with that characterisation?

MR DELANY: Well, my learned friend is overlooking what the witness previously said. This is an allegation of serious misconduct and there are obviously two steps as to whether it's made out, the allegations, what the witness has been asked about.

COMMISSIONER PAGONE: I don't see what is wrong with asking the witness, though, about any doubt that she may have had about the conduct.

MR DELANY: Well, that's a separate question. But one question is: had she characterised it? The second is: is it made out? And in the previous question the witness rolled up the two. That was the objection.

MR ROZEN: I will reframe the question, Commissioner. I'm not troubled by that.

COMMISSIONER PAGONE: All right.

MR ROZEN: You understand, at this point in the questioning, I'm dealing with this as an allegation only, not asking you about whether or not it was substantiated; you understand that?

MS FARRELL: Correct. Yes. That's fine.

MR ROZEN: It's necessary to characterise it in a letter of this type ahead of any investigation.

MS FARRELL: So based on the information that we had at the time, and looking at it on face value then you could potentially see that there's quite a risk in the actions so, therefore, yes, what we saw was that it could potentially be serious misconduct. So that was the reason. Does that answer your question, counsel? Apologies.

MR ROZEN: It does. Yes, thank you, Ms Farrell. The decision to suspend UA in relation to these allegations, was that a decision made by you in conjunction with Ms Reed and Mr van Winkel as well?

MS FARRELL: More so the – Ms Reed and Mr van Winkel. They made the ultimate final decision to clarify.

MR ROZEN: And you conveyed it to Ms Mnich?

MS FARRELL: Correct, yes.

MR ROZEN: And she acted on it by sending a letter directing the suspension; is that right?

MS FARRELL: Correct, yes.

MR ROZEN: The power to suspend employees was conferred on Japara by the disciplinary procedure, wasn't it, Ms Farrell?

MS FARRELL: Yes.

MR ROZEN: Yes. Can we go back to that, please, behind tab 7, page .0003. There's no power to suspend under the enterprise agreement, is there, Ms Farrell?

MS FARRELL: I don't believe so. I don't believe it sets it out.

MR ROZEN: No. But there is a power to suspend as part of the procedure on page 3, if the top third of that page could be highlighted please, operator. You will see step 2 there:

Where the circumstances of the issue are so grave that there is a risk to people, property or assets regarding the employee's actions, in consultation with human resources the decision may be made to suspend the employee from service.

Do you see that?

MS FARRELL: Yes.

MR ROZEN: And it was pursuant to that power that UA was suspended on each of the occasions that the Commission is concerned with. Is that right?

MS FARRELL: Correct, yes.

MR ROZEN: And the clause refers to there being a risk to people, property or assets. What was the particular risk here from your perspective that triggered the operation of that power?

MS FARRELL: Risk to people, I would say.

MR ROZEN: Which people, Ms Farrell?

MS FARRELL: Residents.

MR ROZEN: Yes. And on each occasion – and I won't go through them in the detail that we've just been through them with Ms Mnich, but on each occasion where a suspension was effected by Japara in relation to UA, it was because of a concern about risk to residents; is that right?

MS FARRELL: Correct, yes.

MR ROZEN: Now, we know that as a result of the initial investigation here, a first and final written warning letter was sent to UA; is that right?

MS FARRELL: I believe so, yes.

MR ROZEN: Yes. Well, no need to be guessing. It's behind tab 9.

MS FARRELL: Thank you, yes.

MR ROZEN: If you could just have a look at that. I note on page 2 that this time, although it was signed by Ms Mnich, it's copied to a different human resources officer.

MS FARRELL: Correct, yes.

MR ROZEN: [REDACTED] – I take it she is a colleague of yours.

MS FARRELL: Yes.

MR ROZEN: Do you recall now – and I'm not asking you to guess – do you recall whether you drafted this letter?

MS FARRELL: I think I assisted in drafting the letter but I – actually to be honest, I don't – I don't know. I don't recall.

MR ROZEN: And can you assist the Commission – sorry, I withdraw that. It was open to Japara lawfully to summarily dismiss UA in these circumstances, was it not?

MS FARRELL: Like based on the information available to us at the time?

MR ROZEN: Yes.

MS FARRELL: Correct, yes.

MR ROZEN: So having identified the conduct as, if substantiated, serious misconduct, and then having substantiated it, it triggered the lawful power to terminate, did it not?

MS FARRELL: Yes.

MR ROZEN: Yes. But it also, in keeping with the disciplinary procedure, left open the alternative of issuing a warning.

MS FARRELL: Correct, a first and final warning, should it have been serious misconduct.

MR ROZEN: Yes. And that's what was done. Why was that ultimately withdrawn and replaced with a first warning, Ms Farrell; can you tell the Commission?

MS FARRELL: Yes, I – obviously, reviewing the information available to me, there was a series of communications between us, Japara and also with the union, and the union questioned the definition of "serious misconduct", I believe. And we reviewed the information available to us at the time and felt it was unjust, harsh, unreasonable. We had a look at the information as well and found that, potentially, it would have been harsh and we reconsidered and that's why – the reason we made the decision to downgrade.

MR ROZEN: I suggest to you, Ms Farrell, that the union never took issue with the characterisation of it being serious misconduct?

MS FARRELL: Okay. Can you - - -

MR ROZEN: You say they did?

MS FARRELL: I believe so, yes.

MR ROZEN: The documents that have been provided to the Commission suggest otherwise. Do you have a personal recollection of, what, a conversation with someone from the union along those lines, or what?

MS FARRELL: Can I just have a look at the first page, please? I just have to trigger my memory, apologies, on the case.

MR ROZEN: Sure. I know it is a while ago; does that help?

MS FARRELL: I'm probably getting confused, to be honest, with the different cases and the communications, to be honest.

MR ROZEN: Sure. Can I suggest to you what the union was concerned about was not the characterisation of the conduct as serious misconduct but whether there was a lawful power to issue a first and final warning. Does that ring a bell?

MS FARRELL: Right. Based on the emails?

MR ROZEN: Yes.

MS FARRELL: Yes.

MR ROZEN: And ultimately in your second statement, you explain to the Commission that you were involved in some discussions with Mr van Winkel about the union's concerns; is that right?

MS FARRELL: Yes, I think – I believe. Is there an email that you are referring to, counsel?

MR ROZEN: I will ask you to have a look at paragraph 15 of your second statement. This is exhibit 11-56 at page 3.

MS FARRELL: Yes.

MR ROZEN: In paragraph 15 you set out – and I won't take you to the detail unless you need me to.

MS FARRELL: Yes. Sure.

MR ROZEN: But you set out some correspondence that passed between the Health Workers Union, [REDACTED], at the union - - -

MS FARRELL: Yes, yes.

MR ROZEN: - - - and the human resources section at Japara.

MS FARRELL: Yes.

MR ROZEN: And ultimately it involved Mr van Winkel who, I think you've told us, was the head of the HR section; is that right?

MS FARRELL: Yes. That is correct.

MR ROZEN: And then do you see at paragraph 16 of your statement, you say:

On 1 June Mr van Winkel sent me an email forwarding correspondence that he had with Clare Dewan, an external IR consultant noting that [REDACTED] of the Health Workers Union was contesting that the conduct was correctly characterised as serious misconduct and for that reason contended that there was no ability to issue a first and final warning.

Do you see that?

MS FARRELL: Yes, I do.

MR ROZEN: The reference you make there is to a document which is coded and which is NF-10A to your statement. Do you see that?

MS FARRELL: Yes.

MR ROZEN: And that document is in the tender bundle at paragraph 53 which I would ask be brought up on the screen, please. It's the next – I think that's 52, isn't it? It's the one that is JAH.0034.0001.0001. I'm sorry, it's 52, my apologies. Thanks. That's it. That's the email correspondence that you are referring to in your statement, is it not, Ms Farrell?

MS FARRELL: Yes. Thank you, yes.

MR ROZEN: You will see in the bottom half of the page there's an email from Ms Dewan, the external HR consultant, to Mr van Winkel about this case and she wrote:

Hi Ashley, my recollection is that she has never –

"she" being [REDACTED] from the union, is that right?

MS FARRELL: Correct. Yes.

MR ROZEN:

...has never accepted that it was serious misconduct, so even though she accepts there is the ability to issue a final warning where there has been serious misconduct, this is not one of those situations.

And then at the top of the page there's an email to you from Mr van Winkel:

Hi Nicole, see below correspondence. [REDACTED] is still contesting this matter. It seems the question is substantive and not procedural even though she has never said that.

Do you see that?

MS FARRELL: Yes.

MR ROZEN: And I suggest to you that's right. Prior to this time the union's concern was procedural in the sense of what was the right outcome rather than the characterisation of the conduct.

MS FARRELL: Yes, as defined by me presenting the letter, yes.

MR ROZEN: Yes.

MS FARRELL: Yes.

MR ROZEN: And he wrote:

Can you please bring the file around so we can review together. Set up a time today please.

Do you see that?

MS FARRELL: Yes, I do.

MR ROZEN: And then we know three days later that a letter went to UA downgrading it to a first warning, don't we; that was on 4 June.

MS FARRELL: Yes, that's correct.

MR ROZEN: What happened in between 1 June and 4 June; did you meet with Mr van Winkel?

MS FARRELL: I did meet with Mr van Winkel. I would have – I would have done that.

MR ROZEN: And whose decision was it to downgrade the warning?

MS FARRELL: It would have been the general manager of HR, Mr van Winkel.

MR ROZEN: Mr van Winkel.

MS FARRELL: Yes.

MR ROZEN: And do you remember now what he said to you in support of his position that the warning should be downgraded?

MS FARRELL: Unfortunately, I don't. There's only just the letter to confirm the communications to the union.

MR ROZEN: Was it a matter of just taking the path of least resistance and doing what the union wanted, Ms Farrell?

MS FARRELL: No.

MR ROZEN: Did you personally change your mind about the characterisation of the conduct from what it had been back in March which was that it was serious misconduct; did you have a different view about it in June?

MS FARRELL: No. Granted I don't have all the information because it was four and a half years ago, however, it would always just would revert back to the definition of serious misconduct and understanding, is it wilful, deliberate and the risk. So looking at that definition and does it satisfy that definition.

MR ROZEN: But there were no new facts that had come to light, were there, to change the application of the definition, Ms Farrell.

MS FARRELL: No, you are correct.

MR ROZEN: What had changed was the union campaign to convince you to take a different position.

MS FARRELL: I think we looked at it a little bit more further based on them wanting us to review it. So it wasn't about the campaign of the union – what you are suggesting, I don't believe.

MR ROZEN: Now, I'm right about the legal effect of the change, aren't I, that if it had stayed a first and final warning, any further instance of serious misconduct would have resulted in termination of UAs employment.

MS FARRELL: Yes, correct. Yes.

MR ROZEN: There would have been no choice.

MS FARRELL: We could have potentially issued another first and final written warning but, no, we had – we would have had the choice to – sorry, we would have had the ability to make the decision of termination.

MR ROZEN: So when the next incident occurred in January 2016, had the first and final warning stood, in all likelihood that would have resulted in termination.

MS FARRELL: Yes. That's correct, yes.

MR ROZEN: And there wouldn't have been the later incidents, at least at Japara; do you agree with that?

MS FARRELL: I agree with that, yes.

MR ROZEN: Now, can we – sorry, just one other matter. You would have heard me asking Ms Mnich about the continual requirement for UA to engage in that educative process relating to elder abuse.

MS FARRELL: Yes.

MR ROZEN: Were you a party to the drafting of the various improvement plans that we see in the letters?

MS FARRELL: Yes, I was.

MR ROZEN: And did you give any thought to whether, having completed the elder abuse education program several times, that it was of limited benefit in asking or directing UA to do it again?

MS FARRELL: No, I agree with Ms Mnich's statement where she said it was to reinforce, and if there's issues or concerns we would have tried – we would have wanted to reinforce the correct behaviour.

MR ROZEN: One final matter is the terms on which UA completed his service at Japara, and I don't think you were personally involved, were you, in the drafting of the statement of service that - - -

MS FARRELL: No, I was not.

MR ROZEN: Accepting that, can I ask you, please, to have a look at tab 45. So this was an initial statement of service, I would ask you to accept, that was provided to UA on his resignation from his employment at Japara, and you will see that it certified that he had been employed, although it says at Bonbeach Aged Care, that was clearly incorrect, do you agree, Ms Farrell?

MS FARRELL: Well, I didn't draft this statement of service so - - -

MR ROZEN: But as a matter of fact, it is not right, is it; he was employed at Bayview.

MS FARRELL: He was employed at Bayview – I mean he was employed at Bayview, not at Bonbeach, apologies. Yes.

MR ROZEN: Correct. And you will see that it lists the duties that he performed at Japara, and the third dot point is that his duties included:

Contributes to the physical, emotional and lifestyle need and wants of the residents.

Do you see that?

MS FARRELL: Yes.

MR ROZEN: Do you think that's an accurate description of UA's time at Japara?

MS FARRELL: The statement of service outlines what they're expected to do in terms of their role and their tasks. In terms of specific to UE, I didn't write it, I couldn't comment but potentially that could be a question mark. But, again, he did resign. So – based on the information.

MR ROZEN: What do you mean "potentially it could be a question mark", Ms Farrell?

MS FARRELL: Well, if you think about it from – essentially what he has done in the past, would you put that in there? I don't think that that would warrant it, I agree with you.

MR ROZEN: It might be a little - - -

MS FARRELL: It was questionable.

MR ROZEN: It might potentially be misleading to a future employer, do you think?

MS FARRELL: Yes, but the future employer may not have information of what has previously happened at Japara.

MR ROZEN: Well, that's my point, really.

MS FARRELL: Yes.

MR ROZEN: If this is all they had, then it could potentially be misleading.

MS FARRELL: I agree.

MR ROZEN: If you look at the next tab, 46, there was correspondence that passed between UA and Ms Sultana. She was another member of the HR group, I take it, at Japara?

MS FARRELL: Yes.

MR ROZEN: And you will see that UA wrote to her, halfway down the page, do you see that:

Hi Michelle, can you please amend the statement of service to state the facility I actually worked at, Bayview.

Do you see that?

MS FARRELL: Yes, I do.

MR ROZEN: Then he also asked:

Could you please include on the jobs that I was giving medication until last year.

Is that a common process at Japara, in your experience, that there's a bit of negotiation about the contents of a statement of service?

MS FARRELL: No, the statement of service is a factual document in terms of the position description and what their roles were. So I don't think it would be unreasonable – I wouldn't consider that a massive change in terms of what their tasks that they had done. So whether it's one, two sentence or, you know, it's just about the facts.

MR ROZEN: Just for completeness, if we go to tab 47, the two amendments sought by UA were in fact made by Ms Sultana.

MS FARRELL: Okay.

MR ROZEN: The factual location was corrected to Bayview. Do you see that?

MS FARRELL: Yes, good.

MR ROZEN: And the sixth dot point was added:

Administer Webster-pak medication under the supervision of a registered nurse.

MS FARRELL: Pack.

MR ROZEN: Is that right; "pak". Yes.

MS FARRELL: Yes. Sorry.

MR ROZEN: Yes, Webster-pak medication; do you see that?

MS FARRELL: Yes.

MR ROZEN: Did you have any further dealings with UA after the time that he was provided with these statements for service?

MS FARRELL: No, I did not.

MR ROZEN: All right. I have no further questions for Ms Farrell, Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Ms Farrell, you're free to go.

<THE WITNESS WITHDREW [10.52 am]

MR DELANY: Can I just mention there was an error in the course of the witness's questioning. I'm not sure when it was but reference was made to [REDACTED] by name and there has been a non-publication order concerning her so perhaps – I'm not sure how that works mechanically but - - -

COMMISSIONER PAGONE: Yes. I'm not sure how it works mechanically either, but if I give a direction that the identification of [REDACTED] be removed from the - - -

MR ROZEN: Can I just clarify that. There is apparently no non-publication order in relation to her, but we have agreed to redact her name.

COMMISSIONER PAGONE: I see. All right.

MR ROZEN: So that will be done in the transcript.

COMMISSIONER PAGONE: Can I leave the mechanics to you, Mr Rozen.

MR ROZEN: Yes.

COMMISSIONER PAGONE: I'm sure that neither of us have any idea how the mechanics work.

MR ROZEN: And I leave it to others, Commissioner.

COMMISSIONER PAGONE: But thank you for drawing that to our attention.

MR ROZEN: Yes, thank you, Mr Delany. All that remains for me to do in relation to this case study at this point, Commissioners, is to tender one additional statement which was provided by Japara – two additional statements I'm being told. The first is a statement of Valeria Camara, C-a-m-a-r-a. It's WIT.0575.0001.0001. I'm in the Commission's hands as to exactly how to proceed with this. My submission would be that it would be appropriate to receive the tender now but if it was preferable for it to be deferred, then that's obviously – we can do it that way. Can I indicate briefly what the statement addresses? It might perhaps be of some assistance.

COMMISSIONER PAGONE: If you don't actually need to do it now, why don't we deal with it later unless you are proposing to deal with it in some other way now.

MR ROZEN: I think it's important to place on record at this point what it contains. The tender can be deferred in those circumstances, if that's an acceptable process.

COMMISSIONER PAGONE: All right. Yes.

MR ROZEN: Ms Camara was the Group Executive, People and Development, Japara Healthcare Limited (Japara). She responds to a notice which asked her a number of questions about the governance arrangements in relation to Japara

addressing circumstances such as those disclosed by UA. The evidence she gives is not really directly on point for this case study but it's no doubt a matter that Japara would seek to have before the Commission. We would say as a matter of procedural fairness that's entirely appropriate so it's in that context that we would seek to tender it.

COMMISSIONER PAGONE: Well, I must say not actually having it in front of me, it's difficult for me to form a view about whether it's appropriate.

MR ROZEN: Yes.

COMMISSIONER PAGONE: If Japara wish to have it put on record and you are content for it to be on record, that's a different circumstance and if that be the position then perhaps it should be put on record.

MR ROZEN: Yes, I think that is a fair description of the circumstances. Mr Delany is nodding.

MR DELANY: I think it would be desirable because it sets out the processes of notification of such matters.

COMMISSIONER PAGONE: All right. Well, on that basis, then it should be exhibit 11-57.

EXHIBIT #11-57 STATEMENT OF VALERIA CAMARA DATED 14/10/2019 (WIT.0575.0001.0001)

MR ROZEN: There is another statement of Ms Camara which is actually in the tender bundle and so technically it's in. It is behind tab 51.

COMMISSIONER PAGONE: Well, if it's technically in, let's just leave it alone.

MR ROZEN: Yes. I just should indicate what is in it, Commissioner, because once – for reasons that will become obvious. It is a response to requests from the Commission of Japara seeking information about whether any other aged care facilities have contacted Japara making inquiries about UA in circumstances where he might have been seeking employment elsewhere in the aged care industry. And as I read the statement, that matter has been thoroughly investigated by Japara and they inform the Commission that based on those investigations, no such inquiries have been made.

COMMISSIONER PAGONE: Thank you.

MR ROZEN: I'm now informed that has been removed from the tender bundle so I would seek to tender it but that can be deferred if that's a preferable course, Commissioners.

COMMISSIONER PAGONE: Let's defer it.

MR ROZEN: And that concludes the Japara case study, Commissioners.

COMMISSIONER PAGONE: Thank you. Now, how are we going for time otherwise?

MR ROZEN: I think reasonably well. We started a little bit late.

COMMISSIONER PAGONE: Yes, we did.

MR ROZEN: We are hopeful that we can catch up. We probably lost about 10 minutes. So a brief morning adjournment might be appropriate if that is acceptable.

COMMISSIONER PAGONE: We will resume at five past.

ADJOURNED **[10.57 am]**

RESUMED **[11.09 am]**

MS MAUD: Thank you, Commissioners. I call the next witness, Janice Hilton.

<JANICE HILTON, CALLED **[11.09 am]**

MS MAUD: Ms Hilton, can you state your full name, please.

MS HILTON: My name is Janice Hilton.

MS MAUD: And have you prepared a witness statement for the royal Commission?

MS HILTON: Yes.

MS MAUD: Do you have a copy of that letter in front of you?

MS HILTON: Yes, I do.

MS MAUD: In the top right-hand corner does it have the numbers WI - - -

COMMISSIONER PAGONE: Just before you get – I know that you're enthusiastic, but we might swear in the witness first.

<JANICE HILTON, SWORN [11.10 am]

<EXAMINATION BY MS MAUD

COMMISSIONER PAGONE: Thank you. Ms Maud, back to you.

MS MAUD: Thank you. We'll do that again for the transcript. Is your full name Janice Hilton?

MS HILTON: Yes, it is.

MS MAUD: And do you have a witness statement there that you've prepared for the Royal Commission that has the code – in the top right-hand corner – WIT.0576.0001.0001?

MS HILTON: Yes.

MS MAUD: And have you had an opportunity to read your statement recently?

MS HILTON: Yes, I have.

MS MAUD: In paragraph 3, there's some words that have been blacked out. With those redactions, is your statement true and correct?

MS HILTON: Yes.

MS MAUD: Thank you. Commissioners, I tender the statement.

COMMISSIONER PAGONE: Yes; the statement of Ms Hilton of the 11th of October 2019 will be exhibit 11–58.

EXHIBIT #11–58 THE STATEMENT OF MS HILTON OF THE 11TH OF OCTOBER 2019

MS MAUD: Ms Hilton, can I ask you please to read your statement, beginning at paragraph 3.

MS HILTON:

My full name is Janice Hilton. I am 64 years old and I'm currently employed as a home care worker for a large private provider. Prior to home care, I worked as a disability-support worker. I also worked as a live-in carer in the home care sector, as a childcare educator at an OSCH, which is an Outside School Hours Care Service, and as a youth worker. The children I was working with as a youth worker were traumatised and had challenging behavioural issues. It was difficult work. After a while, I decided to move into aged care.

I have now worked, providing care in the home, for 10 years, working in aged care home care for the last six years. I'm a foster parent. I am also my father's carer, and in the past, I looked after my husband, who was chronically ill for eight years. My father receives home care services from another provider. So I have a broad overview of what is happening in the sector.

Under the title "Qualifications": I have a certificate 4 in disability, a certificate 3 in Children's Services and an associate diploma of business. I have done a counselling-course called Counselling skills, and I've a partial certificate in Individual Support. My employer in childcare paid for my certificate 3, but I had to pay for the other qualifications myself. My certificate 4 in Disability was more than $2000.

When I was working in childcare, the national quality frame-work was introduced – which required childcare educators to have minimum qualifications. When the frame-work was introduced, the private service that I worked for paid for my certificate 3 in Children's Services. I completed the certificate 3 through Peake Training with other employees at the service where I kept working. It took me about nine months, to complete my certificate. The service received funding so that all of its childcare workers could get the minimum qualifications needed under the national quality framework.

My experience as an aged care home care worker: I work with disabilities and aged care. I do personal care, social support and domestic assistance. Domestic assistance is cleaning clients' homes or units. There is more domestic assistance happening these days. Some days I might get six hours of cleaning without a break. It's physically demanding, especially in a heatwave. I also take people to appointments and shopping, which is called social support. I have a lady I take shopping; that takes two hours. If clients have walkers, then it's a lot slower. Many clients don't have driver's licences anymore. So sometimes I have to take them to appointments.

I am more qualified than a lot of other home care workers, although my employer does not recognise my qualifications. When I started with my current employer, they offered me casual work as a grade 3 care worker. A grade 3 does complex care such as bowel care, hoisting, lifting and PEG feeding. A grade 2 just does personal care, like showering clients. A grade 1 care worker just does domestic care, mainly cleaning.

I wanted to be permanent part-time, because I wanted job security and to get annual leave and sick leave. My employer offered me permanent part-time position but only as a grade 2 care worker. That meant I had to take a pay cut. As a part-time grade 2 care worker, I got paid about $7 an hour less than I got as a casual grade 3. As a grade 2 care worker, I still do some grade 3 work. I have the skills and experience to do grade 3 work. If I see a grade 3 client, I get paid at a higher rate. However, I don't get many grade 3 clients now, because the company I work for decided to provide – not to provide NDIS services anymore, because they say that they can't afford to do NDIS work. They just focus on aged care now, which for me involves mainly grade 2 work. My employer is transitioning the remaining NDIS clients out to other providers. The aged care packages pay for travel time, whereas the NDIS packages don't.

My work day. On a work day, I leave home and drive about 15 minutes to my first client. I shower and dress them, then it is domestic assistance. Sometimes it's four and – four to five hours straight domestic assistance. This can be very physically demanding. I might spend one and a half hours with my first client, depending on their personal care and domestic needs. It may be two hours. Then it's straight on to the next client and then the third. I get no breaks. I, usually, travel 10 to 15 minutes by car between clients. If I am running late, I usually create a note on my work phone as to why. The allocator, who prepared the roster, is supposed to read the notes. I usually see three clients a day. My employer has tightened up a lot on overtime. So I'm usually just meeting my contract hours, and the money I take home has been reduced as a result.

Management. The home care provider that I work for employs Service Co-ordinators, who manage clients' home care packages, and people called Allocators, who do the rostering. The Service Co-ordinator is based at the office. They occasionally visit clients and do interviews or reviews. The Service Co-ordinators manage the clients and connect them with services and workers. They also are the team leaders, leading a team of eight to ten or up to twenty home care workers. They run the team meetings. The Service Co-ordinators communicate with the Allocators about what the individual clients need, whether a grade 2 or grade 3 worker is required, and they create the roster. One of the Service Co-ordinators at my work told me that the Co-ordinators have to manage 170 to 200 clients. Two Service Co-ordinators at my work have just left. There is a high turnover of Co-ordinators.

Because the Service Co-ordinators have to manage so many clients, some clients fall through the cracks. By way of example of how clients fall through the cracks: there is a 90-year-old couple that I provide domestic services for. I emailed the Case Supervisor or Service Co-ordinator to say I only have 15 minutes to do all the ironing for two people for a fortnight and that it wasn't enough. The Service Co-ordinator arranged for them to be assessed by somebody from My Aged Care. But there has been no increase in the – to their hours that I can help this couple.

A lot of the Service Co-ordinators have no formal qualifications. They come from various backgrounds. A lot were care workers who have stepped up. Their

understanding of what a client needs is often lacking, as they are not health professionals. And they answer to a Branch Manager who, in many cases, is also a former Care Worker. We need healthcare professionals as Service Co-ordinators.

An example of how the Service Co-ordinators don't understand the needs of the clients is a recent experience where I attended one of my regular clients. But he wasn't there. I called the Service Co-ordinator, and she asked me to locate a key to check the rooms to make sure he wasn't dead on the floor. I asked the Service Co-ordinator if it was possible, that he was in hospital. She said she'd let me know. I went on to my next client. After my last client, I called back, and the Service Co-ordinator told me that the client had been in hospital and transferred to a therapy hospital. I asked what was wrong with him and "Was he okay?". The Service Co-ordinator had no idea, what was wrong with him. I just received a blunt "I don't know". There was no follow-up of the client that I know of.

My father receives home care services from a different provider. His provider has an occupational therapist as the Co-ordinator and only manages about 23 clients. It is a big contrast compared to the company for which I work. After my father was recently hospitalised, the occupational therapist arranged follow-up care with doctors, a social worker from the hospital and family on a phone conference. The difference in follow-up care between my father's provider and the experience with my employer is extraordinary.

When my father moved to his current provider, the Co-ordinator immediately upgraded my father to a level 3 package, and he was given a lawn-mowing service as part of his package and began to receive regular domestic services. He can be transported to medical appointments, if they are not local and I'm not available due to work commitments. This provider also offers activities for clients and outings in a small bus, if they choose to attend social events and want to get out of their home for a day. They even offer dog-washing services that are fully funded for their clients.

Rosters and worker shortage. I'm on a 30-hour contract fortnightly, which can be up to 39 hours fortnightly. If I ask – if I get asked to do extra shifts, I do them, if I can. I have foster children, one with a disability. So I need to spend time with them as well. Rosters are changing regularly, which makes it difficult to try and have some work-life balance and plan ahead for events.

I was in this situation recently where I only had one client on my roster for the day, but I knew it would change. So I did not know exactly my starting or finishing times. I had to ring the office and say "I have two kids that need to get to a swimming-carnival 20 minutes away". One of my kids had made it to zone level, but I didn't know what was on my roster.

On a recent Thursday between my second and third client, an Allocator called me to ask me to go to a client in a suburb I was not familiar with. The client wanted one and a half hours of domestic assistance. I queried the short notice. The Allocator said that they would put it down as a refusal to work if I didn't take it. I explained

that I had just arrived at another client and, by the time I was done and travelled to the new client in another suburb that I wasn't familiar with, I would be out of my work hours. The Allocator backed off then, but I felt I needed to report it to the Union. They are trying to pressure you into taking jobs and being threatening. I found out later that the Allocator did put a refusal-to-work on my payslip. This was the first time in six years that this has ever happened. So I'm working with the Union and the Office to have it removed.

Another time I had an Allocator ring me around 9.15am. She told me that she'd been verbally abused several times that morning by clients. She told me that she had to change clients' rosters suddenly and send different people to them or cancel the rostered services, as three care workers from the same team resigned that day. That puts a strain on administration staff who are trying to fill unfilled services. The staff shortages happen so often now that many clients don't receive their service and miss out altogether.

The travel time between clients' homes isn't right. They might have me down for ten minutes, but it will take me twenty minutes to get there. I don't get paid for the wear and tear on my car. Consistency of staff is a problem. A lot of people need a bit more social support, which isn't happening. I go into people's places, and I might only be there for one hour, and that's all they see for two weeks. Clients get upset when care workers are getting chopped and changed about and they have to show the new person where everything is.

The system is very broken. It's not working for the carer or the client. Some weeks ago I was put into a home that I hadn't been into for two years. This person's physical health was deteriorating rapidly due to Huntington's disease. This was a two-person service. I was there for three days. Then nothing happened for two days. Then they put another provider in to do the showering, and we suddenly got told we're going back there again.

Services may not be performed safely. For example when I was with the client with Huntington's disease, I witnessed the other care worker mixing two antibiotics into syringes and putting them into the person's stomach. I was shocked. This went on for the next two days. I emailed the Service Co-ordinator. It was not in the care plan. I said that may be she should be supervising this and checking that it's done correctly.

Staff shortages are happening with my father's provider as well. The manager who runs the system there told me she had eight people calling about not coming in. They couldn't provide a worker so I had to run my dad to an eye appointment on my day off. The whole system is broken and in crisis. My dad has $13,000 worth of funding sitting there. A client of mine has $6000 worth of funding, and he is upset because he has to catch taxis everywhere. The Office said they need a week's notice to be able to take him to appointments. He can't get there. He needs to try and catch a taxi. Then he's out of pocket of his own money, when he's got $6000 sitting there, which would fund a carer to do the job.

Induction and training. Once upon a time, when I first started, we had two weeks of full-on induction training followed by two weeks of buddying. Now, new staff only get two days of induction training, when they're put out with a buddy, and then they're put out with a buddy for five to seven days. They have to work out the new phone and roster system on the job. New staff are just pushed out the door. I don't get paid any extra for being the buddy. My current employer does not provide quality training for new starters. This means new staff are given clients they don't feel prepared to care for, and they get burnt out.

Established care workers also don't get a lot of refresher training. They just provide small courses, that is on small complex-care issues. They provide some online training, but the quality is lacking. I get repeat messages on my phone that my training is out of date. I just have to work around the required training. Some sessions take half an hour. I did one on privacy and one on abuse and neglect. The training that they have is a bit hit-and-miss. Sometimes it seems like the employer has funding and they can – they ask, "Who can we send to the training?" They sent me to the same training twice, which was ridiculous. For other types of training you have to go through a computer. But some people have to look – have to book in time on the – in the office, because they don't have a computer.

The day I came back from my annual leave in December last year, I had phone calls, asking me if I could do a complex-care course at a spot quite a way – while away from me. My employer seemed frightened because they hadn't done any courses for a long time so they were trying to push us through to do all these courses. They did pay me for the three hours of training. It was just hoisting and lifting and everything, just a brush up thing on manual handling.

Support. Mentoring. I'm a professional coach and mentor out at schools in my spare time. Last year I applied for a care worker coach position that was advertised by my employer. The role involved responsibility for about 50 care workers spending about 50 per cent of the time in the field with other care workers and then doing your own care work for the other 50 per cent of the time. They said they would pay a higher rate for the 50 per cent of the work done mentoring. They only had four people apply.

I had to do a montage interview which involved answering a series of questions by recording my response on the computer. It was difficult. Although I was suspicious that the coaching position would mean one person got overloaded I was interested because I wanted to try and get my foot in the door. I did not get offered the position. The person who did get the position resigned before she even started, and nobody else has been offered the position since then.

Union. Because I am a union rep, when new care workers start I am supposed to be informed so I can attend the induction. However I don't get told or the induction for the new staff is held at a time when neither I or the other Union rep can attend. Some time ago I attended an induction with four new care workers. One was extremely stressed. The girl rang me and told me that she hadn't been paid for her

training. She said she was on a 30-hour contract but she was doing 52 hours. She hadn't been paid overtime. She was upset. She had no work/life balance as they hadn't got her availability right. They told her she couldn't change her availability for three months. I got her to contact the Union and report it and say the contract hours exceed her availability. They're burning these young people out because the young people don't know their rights.

Team. Team meetings are only held once a month and on occasions a team may miss out and it may be scheduled for the following month. Service Co-ordinators lead the team meetings. When a meeting is held, there may be a new face sitting at the table as a new care worker had started and nobody knew about it. Most often, care workers are isolated from one another and only see one another at a team meeting.

Pay. When I started with my current employer, we got a pay rise. It was long overdue. Our Union has helped us with our new enterprise bargaining agreement and subsequent incremental pay rises. Our pay doesn't keep up with the cost of living so we're attracting the wrong sort of people into the positions now. Now, I mostly get domestic assistance work so I don't get paid at the higher level for grade 3 work but I'm not just doing domestic assistance. When people come straight out of hospital they have high needs. Sometimes they burst into tears. Even if I'm rostered for domestic assistance, I need to help them in the situation they're in. However, I don't get paid for that.

My pay fluctuates each fortnight, but it's difficult to understand and to monitor. The pay can vary on whether you see a grade 2 or grade 3 client and the amount of travel you do. With the recent decision to transition the NDIS clients to other providers, care workers have lost hundreds of dollars in penalty rates and many have been forced into taking second jobs or leaving the sector altogether. Many of these workers have a skillset that is being lost to the sector.

Recommendations. Linkages. We need professional help services staff at the helm that can link everything together. At the moment, everything is disjointed. People come out of hospital, they're confused, all this medication to deal with. The clients drop pills on the floor. They miss medication, then they're back in hospital. It's about linking the professional staff with health professionals at the helm who can coordinate people underneath them who are professional.

My dad's occupational therapist with his home care provider is brilliant. They even sent someone to the hospital to assist with my dad's care for when he returned home. Things need to be linked together. When they go from a nursing home to hospital, there's no follow-up. It's up to the carer to do the washing of the clothes, etcetera. Yet they still take their pension from them.

No bullying. There's bullying with clients and care workers and it needs to stop.

More funding. We desperately need the funding to get people from our universities and from our health systems into these roles. We need to start attracting the right

workers. Wages need to be lifted. Qualifications should be recognised. Someone can walk in off the street and be paid exactly the same as me. 95 to 96 per cent of this profession is female. They're keeping the women's wages down. A lot of these women are there for a reason: they have to work. It's not fair to them, the system with very low wages.

Staff training. Some service providers just set up businesses and are using all untrained staff. This goes for disabilities and aged care. It's extremely dangerous not just for the client but for the support person. It's putting everybody at risk.

Community visitor. Appointment of a community visitor external to companies to interview clients, families, care workers, allocators and office staff. Not someone hand-picked but at random to do checks on how the system is working every 12 months.

National quality framework. A national quality framework like child care. I was thrilled to see Aged Care National Standards. There are a lot of fly-by-night providers starting businesses in the sector. There needs to be a closer look at these providers and penalties for people who break those codes or standards. We need to have a version of the Child Care Quality Framework in Aged Care. Thank you.

MS MAUD: Thank you, Ms Hilton. Can I just clarify one matter? You said that when your father changed his home care provider, the Coordinator immediately upgraded him to a level 3 package. I just want to clarify that. Is it your understanding that the Coordinator arranged that?

MS HILTON: She arranged for him to be upgraded to a level 3 package. He is now on a level 4 package.

MS MAUD: She arranged that with My Aged Care.

MS HILTON: Yes.

MS MAUD: Yes. Thank you. That's the evidence of this witness.

COMMISSIONER BRIGGS: Ms Hilton, thank you very much. This is very important evidence for us, and I'm interested, you made the comparison at various times with the child care worker arrangements which I'm familiar with for other reasons - - -

MS HILTON: Yes.

COMMISSIONER BRIGGS: - - - but I'm interested in the comparison between how the NDIS system worked and how the aged care system worked in terms of those issues around coordination. And I know the individual receiving a package in NDIS is supposed to settle with the provider, the services themselves and so on.

What was your experience in the way workers were treated in that system compared with the aged care system?

MS HILTON: Well, I have a NDIS client first thing tomorrow morning at 8 am, and it's similar but the funding has been drastically reduced by the Federal Government and reduced so much that our organisation decided to withdraw and transfer NDIS clients because it was not profitable enough for them.

COMMISSIONER BRIGGS: Okay. And the comments you made around the isolation of the carers, I find that quite disturbing. Have those linking arrangements and the support and training, given your own experience with the reduced levels of training, have you seen a worsening of this situation over the years?

MS HILTON: I definitely have from when I first started to currently, there has been a decline.

COMMISSIONER BRIGGS: And what do you think is the cause of that?

MS HILTON: Probably privatisation of the sector. Many other – there's no regulation in the system, nothing is regulated and there needs to be regulations and like – well, the Quality Standards, that's a start. I was overjoyed to see a chart on our wall but we're yet to receive individual copies. There is a chart on our wall with a national quality set of standards for aged care and that needs to happen with disabilities as well.

COMMISSIONER BRIGGS: And do you see within the system you're working on, a trade-off between the personal care services like shopping and so on, and the health care related services? Because in your statement in your evidence, you are concerned that the Coordinators don't have sufficient health knowledge, for example.

MS HILTON: Yes, we need health care professionals that understand clients' needs a lot more. I work with some clients – I had – the couple that I refer to, they're in their 90s. I was with them on Tuesday and the man broke down and it was heartbreaking, absolutely heartbreaking. He broke down because his wife had been in hospital, they didn't know how to even to press a Webster-pak with medication. They had never been in that situation before. And there's just no other funding for them. There's no other services. They're on a waiting list, they're on a government waiting list of 12 months and people don't realise. They don't have time. They're in their 90s and he expressed that to me and he just broke down into tears, "We don't have that time. We need the help now."

COMMISSIONER BRIGGS: Thank you. I can imagine how heartbreaking that must be.

COMMISSIONER PAGONE: Ms Hilton, thank you very much for your evidence. It's really, really important that we hear people like you. We are listening. We hope

others are listening too, and that action can be taken immediately where necessary to be taken. We really thank you very much for sharing your experience with us.

MS HILTON: Thank you.

COMMISSIONER BRIGGS: Thank you.

MS HILTON: Thank you.

MS MAUD: May the witness be excused.

MS HILTON: Thank you.

<THE WITNESS WITHDREW [11.42 am]

MR ROZEN: Commissioners, the next witnesses will give evidence as a panel and as arrangements are being made there, I will call Jason Howie, Richard Hearn, Kerri Rivett and Sandra Hills.

MR ATKIN: Commissioners, my name is at Atkin. I have leave to appear for Mr Howie in this hearing.

COMMISSIONER PAGONE: Thank you.

<RICHARD JOHN HEARN, SWORN [11.43 am]

<KERRI LOUISE RIVETT, SWORN [11.44 am]

<JASON ANDREW HOWIE, SWORN [11.44 am]

<SANDRA RAE HILLS, SWORN [11.44 am]

MR ROZEN: Ms Hills, we will start with you and reverse the order. Could you please state for the transcript your full name?

MS HILTON: Sandra Rae Hills.

MR ROZEN: You have an Order of Australia medal?

MS HILLS: I have an Order of Australia medal. That's correct.

MR ROZEN: Yes. You had to be reminded there, I think.

MS HILLS: I've worn it today.

MR ROZEN: Thank you. And Ms Hills, you are the Chief Executive Officer of Anglican Aged Care Services trading as Benetas?

MS HILLS: Correct.

MR ROZEN: For the purposes of the Royal Commission you have made a witness statement which is WIT.0450.0001.0001, which will appear on the screen in front of you, and can you confirm for us, please, that that is the first page of your witness statement.

MS HILLS: That's correct.

MR ROZEN: And is there anything in the statement you wish to correct? It's not a trick question.

MS HILLS: Probably, in the section under stewardship, I would just like to suggest there, I think there's a question there. Do you want me to say it now?

MR ROZEN: It might be better, if it's an addition rather than a correction or an expansion then perhaps we will deal with that in your oral evidence, if that is all right.

MS HILLS: Okay.

MR ROZEN: That issue aside, are the contents of the statement true and correct?

MS HILLS: They are correct and true.

MR ROZEN: I tender the statement of Sandra Hills dated 25 September 2019, Commissioners.

COMMISSIONER PAGONE: That will be exhibit 11-59.

EXHIBIT #11-59 STATEMENT OF SANDRA HILLS DATED 25/09/2019 (WIT.0450.0001.0001)

MR ROZEN: Mr Howie, I will ask you to state your full name for the transcript, please.

MR HOWIE: Jason Andrew Howie.

MR ROZEN: Thank you. And you the Chief Executive Officer of KinCare Health Services Proprietary Limited.

MR HOWIE: That's correct.

MR ROZEN: Known as KinCare, I think, generally, is that right?

MR HOWIE: Yes.

MR ROZEN: And you've also made a witness statement for the Royal Commission, WIT.0383.0001.0001? Is that right?

MR HOWIE: Yes.

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

MR HOWIE: No.

MR ROZEN: Are its contents true and correct?

MR HOWIE: They are.

MR ROZEN: I'll tender the statement of Mr Howie dated 18 September 2019.

COMMISSIONER PAGONE: Exhibit# 11-60.

EXHIBIT #11-60 STATEMENT OF MR HOWIE DATED 18/09/2019 (WIT.0383.0001.0001)

MR ROZEN: Ms Rivett, can you please state your full name for the transcript?

MS RIVETT: Kerri Louise Rivett.

MR ROZEN: And you are the Chief Executive Officer of Shepparton Retirement Villages?

MS RIVETT: Correct.

MR ROZEN: You've made a witness statement for us, WIT.0441.0001.0001 dated 16 September 2019?

MS RIVETT: Correct.

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

MS RIVETT: No.

MR ROZEN: Are its contents are true and correct?

MS RIVETT: Correct.

MR ROZEN: I will tender the statement of Kerri Rivett, 16 September 2019, Commissioners.

COMMISSIONER PAGONE: That is exhibit #11-61.

EXHIBIT #11-61 STATEMENT OF KERRI RIVETT DATED 16/09/2019 (WIT.0441.0001.0001)

MR ROZEN: And finally, Mr Hearn, can you please state your full name for the transcript.

MR HEARN: Richard John Hearn.

MR ROZEN: And, Mr Hearn, you're the Chief Executive Officer of Resthaven Inc.

MR HEARN: Yes.

MR ROZEN: And you have made a witness statement, WIT.0440.0001.0001, dated 13 September 2019. Is that right?

MR HEARN: Yes.

MR ROZEN: Is there anything in your statement you wish to change?

MR HEARN: No.

MR ROZEN: No. Are its contents true and correct?

MR HEARN: Yes.

MR ROZEN: I tender the statement of Mr Hearn.

COMMISSIONER PAGONE: Exhibit# 11-62.

EXHIBIT #11-62 STATEMENT OF MR HEARN DATED 13/09/2019 (WIT.0440.0001.0001)

MR ROZEN: What I would like to do at the outset, go back to the order we just went perhaps starting with you, Ms Hills, if we could, I would like each of you in turn to give the Commission a one minute or so overview of the business that you are the Chief Executive Officer of.

MS HILLS: Benetas is a Victorian-based only organisation. It provides – it's just over 70 years old or young. It provides the full suite of aged care services ranging from home care, in-home nursing, respite services, residential care, Department of Veteran Affairs assessment and home care services, allied health, retirement living and residential services. 40 per cent of our services are in rural and regional parts of Victoria. We also support the Centre for Cultural Diversity in Ageing, and we also have a research arm as well. We have – sorry, I should mention we also have around about 9000 clients, just over 1600 staff and 600 volunteers.

MR ROZEN: Thank you very much. Mr Howie, over to you, the same question, please.

MR HOWIE: We are a specialist in-home care services provider.

MR ROZEN: This is KinCare?

MR HOWIE: That's right. Yes. We deliver aged care services, disability services and health care services to people in their homes. We operate across the country in all states and territories apart from the Northern Territory.

MR ROZEN: And you are what is referred to as a for-profit organisation?

MR HOWIE: Yes, we are.

MR ROZEN: Yes. And Ms Rivett, Shepparton Retirement Villages?

MS RIVETT: Shepparton Villages is an organisation – a community-based organisation based in Shepparton. It's a not-for-profit organisation catering for about 301 residents in residential care. It has about 300 independent living units, and it has a small community program. So we care for people who require a little bit of help right through to people that care – need quite a lot of help. It's a regional-based service so it's a medium-sized organisation developed by the community of Shepparton.

MR ROZEN: Thank you very much. Mr Hearn, Resthaven Inc?

MR HEARN: Resthaven was established in 1935 and is associated with the Uniting Church. It is a mission-focused not-for-profit organisation, primarily working with older people and carers. Resthaven is an independently incorporated organisation and governed by the Resthaven board. The scope of federally funded services include residential aged care homes, home care packages, Commonwealth Home

Support programs, short-term restorative care, veterans home care, veterans nursing services. We also are a regional assessment service for MAC, for My Aged Care.

MR ROZEN: Thank you very much. Can I commence with a broad open-ended question and I will ask you to address it in turn, if you wouldn't mind. I will start with a quote from the witness that you have all just heard sitting here in the hearing room, Ms Hilton who is a home care worker. She told the Commission the whole system is broken, in crisis, and from the evidence you have heard in this Royal Commission, you might think that that is not an exaggerated assessment of the aged care system. But here is the paradox; we've heard evidence of remarkably well-run organisations, very well-managed, providing a terrific service. And so I suppose the question, is if I can start with you, Ms Hills, operating within essentially the same funding system, how is it that some organisations can do such a great job in aged care whereas others seem to be really struggling, providing substandard care and are poorly staffed.

MS HILLS: I think it all starts from the culture of the organisation right from the very top, the board of directors, right through to the executive. For example, do they have a strategic plan, have they identified what their workforce plan might be and if they did have a workforce plan? Then you would actually work out the skill level of staff that you require and how many of those staff you would need. And therefore you would – you know, that would lead you to issues of induction, training, what staff, what characteristics and qualities and attributes you actually want from those staff. And you develop up from that a program of works that would identify the sort of leadership you wanted, what style of training and development you were going to follow through.

I mean, at Benetas we have a coach approach. This is something that we are progressively implementing, and how you are going to apply your training. And also when things go wrong, it's a whole process of when things go wrong what do you do about it? Are you encouraging your staff to report issues, are you encouraging complaints to be made, and what do people see in the organisation? A family member, as we heard previously, or a family member or one of the staff raise an issue about substandard care, what do you do about it? So I think there are a number of reasons why, it's not just about funding. We all get the same amount of funding.

I do think there are issues around size. Large organisations have greater capacity but they don't always do a good job, as we have heard. So – and I do think we need to also focus on the staff that provide support so the corporate services staff. It's not just the direct care operational staff; it's also what goes on in the back of office. What sort of supports, what are the relationships, are the roles – do people know what their roles are between the HR business partner and also the staff, the management? Are people clear about what their roles are?

MR ROZEN: All right. We will come back to a number of those issues, I think, during the course of your evidence. Mr Howie, I wonder if I could throw that question to you and ask you, particularly having regard to the evidence we have just

heard about home care workers and the degree of poor staffing conditions that seem to apply in the home care area, as we've heard quite a bit of evidence about – what is KinCare doing to address those sorts of concerns?

MR HOWIE: Certainly, staffing is a significant challenge in the home care sector and I should just make it very clear I can't comment on the residential care sector at all. We have no involvement in it. But from a home care perspective, certainly a number of the challenges that the previous witness outlined are very familiar to us. We are an industry at the moment that's in the middle of a significant transformation from a business to government model, to a business to consumer model, and the economic drivers in that are completely different. The structures and the skill sets that we need across our organisations are completely different. And what I see across the industry at the moment is a whole series of organisations that are in different stages of addressing some of those challenges.

I would like to think that we are reasonably well advanced in terms of our own approach but what we need in the new marketplace, in some respects is similar to what we needed in the old marketplace as far as the workforce is concerned, but in many ways the expectations of our workforce are increasing dramatically as well. So it's no longer enough to just be delivering a good service and engaging well with our staff. We also need them to be brand ambassadors and customer service representatives, and a whole range of other skill sets that they've not needed before.

And there is this constant tension between the flexibility that our customers are requesting from us and the stability that our employees are requesting in order to build solid, consistent rosters and consistency of income.

MR ROZEN: That's a very helpful segue to a couple of follow-up points that I wanted to raise with you about staff conditions and remuneration. You heard the previous witness, Ms Hilton, talking about the trade-off between higher wages as a casual and more security as a permanent part-time worker and the dilemma that presents, and she is not the only witness that has told the Commission about that dilemma. How does KinCare address that?

MR HOWIE: She raised an issue that I would hope we wouldn't see too often in our organisation. That is, that she was required to take a step backwards from a grade 3 to a grade 2 level. We're certainly wanting to increase the number of permanent part-time staff across our organisation. The trade-off for employees is that while they lose the 25 per cent casual loading, they do gain sick leave and annual leave, and a range of other conditions. But the bigger complaint that we hear across the industry – and there was certainly a flavour of that in the previous witness's testimony as well, is that the bigger problem that our staff are facing is the consistency of the hours they get, rather than the hourly rate that they receive.

And so what we're driving towards as an organisation is to be able to provide much more consistency of rosters to a much larger portion of our workforce, which is a better service experience for our customers because they've got more consistency in

terms of the people that are coming into their homes to deliver these services. But it's also a better experience for our staff. But there's a significant economic cost and risk that sits around running the organisation in that manner and it requires some sophisticated leadership and technology.

COMMISSIONER PAGONE: Mr Howie, can I just ask you a question about the change from a casual to permanent part-time. Is a drop of income from the point of view of the carer, the work of the employee, is that partly to be understood because the cost to the employer might be greater for a permanent part-time person than a casual?

MR HOWIE: The difference in cost for the organisation is nowhere near as great as the 25 per cent loading would suggest, because while someone will lose that 25 per cent loading, we have to then provide them with four weeks annual leave, two weeks of sick leave. We need to provide them with guarantees around their hours as well, which pushes up the cost to the organisation in terms of unbilled hours, which has become a key metric for our organisation to watch on a monthly basis, as our financial statements come in.

So there are significant costs to the organisation to go down that road. Our analysis would suggest that a permanent part-time employee over the course of a full 12 months, if they were to take all their entitlements, is probably earning a fraction less, but they're getting in – on a per-hour basis, but they're, possibly, earning more by the time you factor in the fact that they are getting a consistency of pay across hours that they're, potentially, not working because there's been changes to customer demand.

COMMISSIONER PAGONE: Just in terms of understanding the dynamics between the employer and the employee – if I understood it correctly, the position of casuals is that – because they don't get a whole range of other benefits that an employer gives, they – the trade-off for them is that they get a bit more in their hand, but they don't get the benefits of things like annual leave and other matters.

MR HOWIE: Correct.

COMMISSIONER PAGONE: Is that the trade-off so that – from the employer's point of view, although they might be paying a bit less in terms of salary, the cost to the employer, once you take into account all of the other elements, might be more.

MR HOWIE: Yes. I think our analysis indicates that we're, probably – it's, probably, saving us a small amount, but it's a significant transfer of risk between the employer and the employee.

COMMISSIONER PAGONE: Thank you.

MR ROZEN: I'll come back to some of those issues, Mr Howie, but if I can ask for your perspective on the broader question, Ms Rivett, if – I can remind you about the

paradox that appears in the evidence before the Royal Commission, between the really good providers with satisfied staff and residents, compared to so much of the evidence which suggests the contrary, particularly from your perspective as a regional provider.

MS RIVETT: Look. I agree with the two – these two. The biggest thing is, probably, we've gone from this little cottage industry to a business, and regardless of whether you're not-for-profit or profit, you're still a business. And it's around your governance. It's really having really strong governance systems in place with a skilled Board and a skilled Executive and skilled staff, which is – everybody actually struggles with it, and it's your systems and processes that you have in place to actually guide everyone through that as well.

And it's about size as well, because there is a certain size where you're able to attract those higher skills as well. And the smaller you are – you will actually find the CEOs and the Executive Directors of care services getting in amongst the business as well, because you just don't have the size to be able to employ multiple people to do the same amount of work that you might see in a big organisation. So they're some of the things that I see.

But governance is one of the key issues around what is your business, where's your business going, what's actually happening in your business and what are the risks in your business, because you need to know the risks to be able to put in interventions to actually manage those risks. And it's up and down. It's from the coalface up – from to the Board to the coalface.

MR ROZEN: I have to say that a number of the case studies that have been heard in the Commission indicate that substandard care is often aligned with a lack of good governance structures. So that's – what you are saying is resonating there. Mr Hearn, what's Resthaven's approach to governance arrangements and particularly Board representatives? There hasn't been a lot of evidence given before the Commission about how Board members come to be chosen for aged – approved providers. Can you expand on that in addition to answering the general question that I've asked?

MR HEARN: In terms of the general question I think there's many thousands of people, like our previous witness, who are absolutely committed to working with older people and assisting them in their capacity needs to sustain quality of life. So I would say, in terms of the ..... I, probably, have a different view. I think there's many thousands of people who are very committed and dedicated and working very hard. But I note the challenges, and I won't repeat the various other comments that've been made, and they're all relevant comments that we all are considering and dealing with.

On the other side, the perception – I think we are all experiencing the challenges. So the broader challenges that are being shared in this Royal Commission, I think, are wide-spread. I think we're all dealing with them. So even though some

organisations would appear to be sustaining quality at a more-consistent level, I think they're still dealing with the challenges.

In terms of our Board – so the Resthaven Board – I think, like many organisations, we have a governance structure, a governance framework which includes a clinical governance model framework, and we have a skills-mix consideration; because we have links with the Uniting Church, they're an appointing authority. Even though we operate independently, they still have some oversight of the final agreement as to who comes onto our Board.

We have four committees that reflect the key elements of our organisation. We undertake activity to try and ensure the Board are connected to services and to our consumers, our residents and clients. It's not uncommon, that our Board members have had family in different aged-care services, but particularly we look for the expertise and skills that, we think, are required in this current environment.

MR ROZEN: And what are they? Just out of interest what's the – what do you think is the desirable skill mix for a Board of an aged-care provider?

MR HEARN: We're going through some change at the moment. So I'm assisting the Board with some retiring Board members and new Board members. The types of skills that we see are very important, including understanding of the sector. We're noting many comments about the Banking Royal Commission about understanding the business. And so we're wrestling with that, and we've had some significant Board members' contributions – that are retiring at this moment, that have understood the sector, and it's not easy, to find people who understand the sector.

So that's something we see as very important. We have people with a finance background – and understanding the particular needs of organisations with respect to managing the organisation and managing risks related to that and investments related to the organisation. We have people from education. We've seen people with similar sectors, human-service sectors being very appropriate in an aged-care environment in the way they think, similarly, legal people. We have a lawyer, and we've found that not necessarily the direct involvement in aged-care as critical but the way they think – we've found that to be quite important in terms of the Board being challenged.

MR ROZEN: Just take up a couple of those things, and if I could throw in the mix something that I've, certainly, been thinking about – that is whether – you may be familiar in workplace health and safety or with the officer of due diligence duty, which has been something that's been introduced in Australia in the last decade or so in all jurisdictions, funnily enough, except Victoria as it turns out, and it's a duty that requires officers – which essentially means "directors" – to be pro-active in understanding the risks, the OHS risks, of the business, in ensuring that they're appropriately addressed and appropriately resourced so that they can be addressed. And it's a duty which is ultimately – can invite a criminal sanction if it's not complied with by the director. Without intending to put the fear of God into you

about that – is there a place for something like that in aged care? It seems a big gap in the regulatory frame-work.

MR HEARN: This has been debated in the wider community in recent times. The first thing I would say is we are covered by those obligations. So in terms of the obligations of directors, of Board members and the wider community – we already are covered by those, and we treat them seriously, and it was a significant change. In terms of singling out aged-care directors and Board members and providing additional sanctions, you might say, or potential penalties for inappropriate performance – I did question why we would do that in particular in aged care.

And my view on that in – in particular that topic is – I think that wouldn't be an appropriate step. I think there are enough related issues about – generally, about standards for Board members on – in organisations that we have to comply with also. And I believe the actual penalty or sanctions approach that's available to the Department has significant impact on Board members in its responsibility. So I err on the side of what will attract people to aged-care, and I think that would raise a concern for some individuals who, we think, could make very positive contributions.

COMMISSIONER PAGONE: What steps do you have – and I don't want to just focus upon you, Mr Hearn. It's – perhaps one of the others might want to chime in, but what steps do you take to monitor whether the Board members are actually doing what they should be doing? Often for Board members, it's a matter of preparing for the quarterly meeting, looking as though they're awake during the length of the meeting and hoping that nothing comes up, that hasn't been dealt with by the CEO. What can you do to make sure that Board members are doing what they are supposed to be doing? You all want to have a go, I can see.

MR HEARN: ..... minimal level. There's obligations about their minimum requirements to be a Board member so they're not part of an insolvent group, part of a bankrupt group. We monitor that and check that from time to time. So we check the minimal requirements you will generally see in organisations. We have lots of engagement with our Board; we know of them through their involvement in the wider community. We don't have any investigative processes that we undertake to find what they're doing, but I think we, generally, know our Board members well, and we see their commitment. And we see their engagement.

MS HILLS: I think it really starts from who you choose and all the work that you go into at the front-end to make sure that the people are right, they've got the right skill mix and they've got the time to actually put into being a director. It's interesting; at the moment we're actually having a director evaluation that's happening, and we do that every two years. So that's a survey. It's actually getting them to assess their own capacity but also other directors, and then they do a face-to-face with a consultant, and a report will come out of that with a list of recommendations.

In addition, the chairman does take the time between Christmas and the new year, when it's a bit quieter, to have individual meetings which – with each of the directors, just to check in to see how they're going, how are things going, what's on your mind, and each of the four committees of the Board that we have: they also – they have terms of reference, which are evaluated annually, and they also do an annual self-evaluation. And it's also a discussion in my performance review annually too about feedback.

MR HEARN: Can I add we do all those as well.

COMMISSIONER PAGONE: I presume there's also a concern, that Board members don't get too actively engage in management, though. How do you deal with that balance?

MR HEARN: The current environment encourages consumer engagement and Board-member connection ..... so we've always – increasingly we're encouraging the Board members to understand the customer experience. And so we'll go to different sites. We'll include, in that, engagement with the residents of that site as an example of informal catching-up. Those types of engagement activities, we encourage. Sometimes Board members feel uncomfortable about that, about the separation of their role and the operations.

MS RIVETT: I'd have to say in our organisation our Board has actually gone on a journey, a real journey of moving from – getting in amongst the operations and moving into a much more – governance role, and that's been a journey over four years. And we've actually brought in experts and consultants to actually assist us, move through that with a development of systems and processes to govern that. And the systems are called – governance evaluators and all that kind of stuff come into your Board meeting and evaluate you as to how you're performing and whether you're operating in a – at a governance level and not an operational sort of level. Does that answer your – help answer some of your questions?

COMMISSIONER PAGONE: It does. Presumably, that's because in your – the case of your organisation the Board was much more operational as it first got going, and I imagine that would've been the case of a number of them, including some of the religious-based organisations. Do you have any sense about what proportion of the current sector still operates on that kind of model?

MS RIVETT: I think in rural, remote areas, when you're dealing with very small organisations – and if you're the only residential-care service in that small community, the Board is the community. And often they're expected to get involved in – very much in the operations of the business. Yes. And it's that difficult balance, because when you – if you're a Board member in a small country town, you go down to the supermarket, family members and that will raise issues with you in the supermarket or in the bank, or even the bank person or the post office will actually do those sorts of things with you. Yes.

COMMISSIONER PAGONE: Now, it may not apply to any of you, but what about the tension between as it were, the ultimate owner and the CEO and the Board?

MS RIVETT: I can't make any real comments on that. My learned colleagues here might want to make some comment. But I think – I would imagine they – we're all looking at you.

MR HOWIE: I'm, probably, not best placed to comment on some of these matters. We're a family-owned business, and we've been through a number of iterations in terms of our government – our governance processes. With the rapid transformation that was required in the business and the amount of financial risk we were taking on as a consequence of that, we've scaled right back to family members for a period of time. But they are family members that are very involved, very knowledgeable about the business, been involved for the last 20 years, and I can assure you that Board meetings are not comfortable places for me to be when things aren't going well. So we do have a very strong governance process at the moment, but it's a relatively contained environment. We would be looking to expand that again over time as we stabilise in this new marketplace.

MR HEARN: So can I offer comment?

MR ROZEN: Yes, please.

MR HEARN: An organisation like Resthaven – being incorporated, we're not actually owned by the church, notwithstanding they have a role as the appointing authority. I'm not a Board member. I'm not a voting member of the Board; so there's separation in that regard.

MR ROZEN: Can I change the emphasis a little and focus on staffing-questions more generally, and I'd like to do it in the context of the Pollaers taskforce, which, I know, Ms Hills in particular is very familiar with. We heard evidence from Professor Pollaers on Monday, raised a number of very interesting issues for the Royal Commission. One that resonated with me was a survey that'd been conducted when the taskforce was operating, which produced the result that there's a disconnect between Management and employees within a lot of approved providers, with Management having a more rosy, optimistic view of the relationship than the staff themselves were having.

And there is a recommendation in the Pollaers report, that all providers assess levels of engagement and enablement of their organisations. So I could start with you, Ms Hills; both at Benetas specifically but also because you are on Mr McCoy's Board – if I can call it that or "the committee" – I'm sure he'd love to hear it described that way – the aged-care-workforce industry council – what your perspective is on those issues.

MS HILLS: Was I surprised when I read that part of the report. I was actually, because it sits – it's out of step with the staff-engagement surveys that Benetas has

undertaken. We've done a number of them. We do them every two and a half years. So – but then you've got to understand it looked at a number of people in the industry. We've always taken the view that the manager is the most influential person in a facility. So I'm just going to focus on residential care, but it has its – it plays out in the home-care area as well. So we've put a lot of effort into looking at who we recruit into those roles and how we train them and how we support them.

So the engagement surveys – we have a new strategic plan that's just recently been launched, our next-generation strategic plan, and staff engagement is really – and providing exceptional customer service are really at the very centre of our strategic plan. So we are wanting to recruit particular people with particular skills that match our model of care. So staff engagement – we want our staff to jump out of bed in the morning and go, "Woohoo. I'm going to Benetas to work today."

And we've got a bit of work to do – needless to say. The survey that we had delivered to us at the end of the last year – and this is a company that does a lot of surveys nationally, and it's a good company in that they benchmark it so you can see how you're travelling with particular cohorts, and we measure ourselves against the aged-and-community-care industry. We had dropped a bit since the previous two and a half years, where we had 76 per cent engagement and we were at the highest level, a culture of success; when we got that result, I thought, "How can I keep that?" But the one we received two and a half years ago: it has dropped a bit, but we still have a fairly high level of staff engagement, and we've dropped down to ambition, which is the second-highest level.

But that information gives us some really good data. So we're still above the industry average, but it gives us some really good data from which to work. And this is an area that the Workforce Council is currently looking at, how could we undertake such a survey, what would it look like, and we've done quite a bit of work in this area, because it does give you a benchmark to work from for the future, and it does give you an idea of what people are thinking and where they see improvements, and for us it meant at Benetas we came up with three areas, people's perception of – that they're short staffed, using coaching for our – the leader as coach and some of the issues around staff when they're part-time and how they're treated or not treated well in the organisation or perceived to be left out. So I think undertaking that piece of work would give us some guidance, because – how else do we get that information from the sector.

MR ROZEN: Thank you. Can I just ask a follow-up question there about the Council. We heard evidence from Kevin McCoy, who's the acting chair, on Monday. I asked him some questions about sustainability of the model, how can all the terrific work that was done by the Pollaers taskforce – is that Council of, albeit, very well motivated, committed CEOs and other representatives – is that a sustainable model in the years to come to achieve the various strategic actions, including some very significant ones identified in Pollaers; as a member of the Council, what's your view about that?

MS HILLS: So the Council's been meeting formally since May, monthly. We have a big body of work to do – there's no doubt about that – implementation of the 14 strategic actions, 10 with, I think, specifically sit with the industry. As with – when any new groups get together, you've got a whole lot of people who haven't worked together before ever. So we're getting to know each other and getting to work with each other, and, obviously, setting the culture of the new Board is really important, but when you look at the work we did – we have spent some time, our recent meeting, trying to finalise our strategic plan and all its actions. It is without doubt that – well, to date we've received funding to fund the secretariat from the federal Government, but there is a lot of work to be done.

And we now form the view that – and I am supportive of that – that we do need to ask for additional resources to undertake not only individual pieces of work but to actually fund a CEO or a similar role, because whilst, as you say, we're all well-meaning, we all have day jobs, and it does involve a lot of work, and each of us will take on one or two – spearheading one or two of the strategic actions, and that's still a lot of work in itself. So I think issues around resourcing – clearly, Kevin stepped up, but he's got a big role in his day job, and I could absolutely understand why people would – a number of people would look at it and say "Is it sustainable?", because I think it does need, certainly, the peaks, and my understanding is how the group got together was in fact – it was the three peaks, the provider peaks, who came together and spoke to Government about that. They, as you would know, are not on the Council, and the Council are still working through how we involve them and how we involve other stake-holders.

But I don't see any point – if there is concern about the sustainability of such an important piece of work and the capacity of this group to undertake and complete that work, then I think anyone with any sense and who provides good leadership and management: we would need to have a look at it again, because I don't want – I want people to feel confidence in what we're doing, that we've got the industry and the Australian community, older people, the community in our line of sight.

MR ROZEN: Mr Hearn, can I just throw to you at this point; you referred earlier to the thousands of well-motivated Australians who work in the aged-care industry and are driven by a commitment to the provision of care to elder Australians. We've heard evidence from numerous witnesses who've told us that they didn't enter the industry to get rich, they are driven to engage with older Australians, to care for them, they love that work. So there's a real well of good will that's there. I guess the question, given that we know that we need to expand the workforce significantly over the next 20 or 30 years – how do we do that? How do we get more people to want to work in aged-care, to jump out of bed and say "I'm off to work at Resthaven", the way we do with the Royal Commission; really want to get out of bed and get to work? How do we do that as an industry? How do you do that as an industry?

MR HEARN: Well, I think the first thing I'd say is that – in terms of being removed from the Council but supporting the work those people are trying to achieve – is it

doesn't seem, Governments were there, and I think Government's such a critical player in terms of the outcomes that will be achieved. It's difficult, to see how that will succeed and be sustained unless Governments actually a standing member of that group and a key member of that group.

In terms of other matters that, I think, impact then on moving forward and not only current but the future demand – I think the overall community image of older people, the way the community respects older people, actually understands older people – I think we need to do more in that area. We try and make our contribution to improving the image of how we talk about older people, where – about our respect for older people and what they've contributed. We do things ourselves, but I think there needs to be a national approach that really takes this on board and embeds this in the community. And I think in relation to that – maybe it's a COAG-type approach, where someone's really got to come – the – all Governments got to come together and move forward on, I think, a targeted view on the positive elements of aging and the nature of aging in society and embed that across all parts of society.

Having said that, I think the issue of those really important staff, those people – I think remuneration is a key issue, and that's a resourcing issue that, I think, then brings Government back into the process, and I know you've been reflecting on that here in the last few days. I also think supply of staff, the actual numbers of staff – they are all critical issues that then impact on people and their good will. And so we need assistance, and I think it is needing to have Government at the table. We need assistance to actually improve those outcomes for older people and for those staff that are committed to those outcomes.

What I would say is in many things in aged-care – and I think one of the challenges of the Commission is there so many important topics, and there's always the danger that you look at one particular topic and you think "We've solved that", but every one of those topics then impacts on the other topics. It's a system element; so in all these significant topics we're dealing with, we have to try and understand what the overall impact is.

MR ROZEN: So funding is related to remuneration levels.

MR HEARN: Funding's related to staffing, and it's difficult, to see how you can talk about staffing-remuneration without talking about staffing-levels, because the danger is you'll get caught on thinking we've solved the significant thing, but the other element will have a significant impact.

MR ROZEN: Ms Rivett, can I ask you the same question but ask you to particularly focus on initiatives that Shepparton has tried to put in place to develop its workforce. I know there's one that you refer to in your statement that wasn't ultimately successful. Can you relate that to the Commission, please?

MS RIVETT: Yes. At Shepparton's we try to do all sorts of things. If you take a look at our workforce – our workforce is actually over 40. So if we don't start

attracting young people into our workforces, we're going to be into trouble into the future. So some of the stuff we've been working on, Shepparton, is how do we – and there's also – one of the big things is also, I believe, there's a disconnect between what actually happens in the workplace and what actually is taught in a TAFE college or a university.

So what we try to do is actually – I was looking at developing a traineeship model, and we have developed the traineeship model, and we implemented it in an abridged version, but what I was looking at is employing a group of young people, and they'll be – like becoming apprentices in the workplace, and that – we actually bring the TAFE colleges into the workplace to do the training, and they would be supernumerary for six months, and then they would actually go into the rosters for six months. The course would be over a nine-month period, the PCW course, and then at the end they would be trained and work-ready to fully go into the workplace.

Now, we have initially done the first round and the board approved the funding of some of that and I know Sandra does some of this, and all nine kids have actually been fully employed and are actually happy in the workplace and are fully work-ready. But we were after around 1.7 million to actually implement, you know, having 56 young unemployed people employed and over a three-year period. And we were unsuccessful in getting some of that funding, and I tried multiple, multiple areas to try and attract that kind of funding, yes.

MR ROZEN: Would a Commonwealth Government fund that was available to support appropriately evaluated proposals like that be something the industry would welcome?

MS RIVETT: Like a HR innovation fund would – yes, I think that would be extremely beneficial to the industry, yes.

MR ROZEN: And picking up on that general sort of idea – and perhaps if I could start with you, Ms Hills, this is one of those opportunities of a lifetime moment, what would you like the Royal Commission to recommend in relation specifically to workforce matters that we have been looking at this week?

MS HILLS: Well, look, I mean, you've got the 14 strategic actions and I just think we need to get moving on those. We already have started moving on many of them but I just – I think what I said about the workforce and – you know, the answers are there. I mean, the hard work lies ahead but implementation and resourcing to implement the 14 recommendations in the Pollaers report.

MR ROZEN: So I understood in all that, that a request for resourcing to be able to achieve the 14 strategic actions would be a good start.

MS HILLS: Correct. Resourcing, but also – I would also like to talk about our relationship and the support from the Federal Government as well.

MR ROZEN: Yes.

MS HILLS: Okay. Because clearly, you know, 70 per cent of the funding that they – you know, most organisations receive 70 per cent of their income from the government and then they in turn spend it on staff salaries and wages. So government clearly has a huge investment in this for – if not – well, even the fact, of course, the important fact that they have a role in the health and wellbeing of older people.

So I think that I would like – I'm not sure how the Federal Government, the Department of Health have set themselves up in regards to internally to actually work with the council and others in implementing the 14 initiatives but I would hope that they are setting themselves up and they are selecting people to be engaged and to have got the skills and obviously the right leadership but that is absolutely crucial and they also need to have a plan that marries – that synchronises well with our plan; we need to work together.

MR ROZEN: From your perspective, both of Benetas as a major provider and also in your role wearing your hat of the council, is the Commonwealth Government through the Department of Health, providing leadership on questions of the aged care workforce, enough leadership?

MS HILLS: No. I would have to say no.

MR ROZEN: And I suppose implicit in that answer is that more leadership would be welcomed but why, what do you see the Commonwealth Government as ideally doing in relation to - - -

MS HILLS: Well, I think as a start, it's a disappointment to me and I know many others, that you have a Minister who has two other portfolios as well as aged care. So having a Minister for Ageing, and that's his sole portfolio, his or her sole portfolio, who is in the Cabinet would be hugely powerful, I think.

MR ROZEN: Mr Howie, I hate to use the expression "wish list" but what would you like to see this Royal Commission recommending that would address some of the issues we've been discussing here today?

MR HOWIE: I have a different view, I think, to some my colleagues. I think a lot of our workforce issues can actually be sorted out within organisations with the appropriate level of innovation and leadership and so on. What we really need is an environment to be created where we have got enough clear air in front of us to be able to address the challenges that we have got as a business. Now, just to give you some context around that, if you consider what we are having to face as an organisation at the moment; we are in the middle of a major transformation program from a business to government to business to consumer model with all the investment that that requires.

We are in the middle of a Royal Commission. We are in the middle of an upgrade to the Quality Standards across the industry. And now just in the last few days we have got changes being proposed to payment arrangements which are going to have the effect of stripping four to six months' worth of funding out of the industry over the course of the next two years. So in effect we are going to have to operate for 20-odd months, sorry, for 24 months on about 18 to 20 months' worth of funding. So having some transparency and some predictability around the funding, the cash flow that we are receiving, information being published around where packages are being released and how we're going to be able to – so that we can plan our workforce skills and so on around demand management.

We don't have a transparent marketplace at the moment. You know, a precondition of a marketplace is fully informed buyers and sellers, and we don't have enough information in the marketplace at this point to be able to say that we've got a genuinely functioning marketplace. So creating the conditions for the home care industry to really thrive, I think, is probably the major role of the government.

MR ROZEN: Ms Rivett, you have got a bid in for the fund, but you don't have to stop there. What else would you have the Commission recommend?

MS RIVETT: I think it's imperative that we get John Pollaers' work done fairly quickly, really, really quickly and not stall it whatsoever. What I'm really, really concerned about is rural and remote Australia, and how do we provide a workforce in rural and remote Australia to keep residential care beds and community programs in their communities. You know, in a lot of rural and country areas, the ageing population is expanding a lot faster than in metro areas, and there's not young people there to actually look after them.

So – and the housing prices in rural and remote areas are much less than in the cities. So how do we keep residential care programs and community programs in rural and remote Australia where people actually live. I know the government is discussing how they do that, but I think that needs to be done fairly quickly as a lot of rural and remote areas are actually in trouble right now.

MR ROZEN: I'll just take you up on your observations about the Pollaers report, it's certainly consistent with the evidence we have heard about the importance of the strategic actions. From your perspective in the industry, what's needed to advance that work?

MS RIVETT: There needs to be – look, I think it's around defining the models of care and linking those with the universities and the TAFE colleges and making sure that whatever model of care there actually is, that the staff are actually prepared for what actually happens within the workplace and how that's delivered, and that there is enough people to be able to deliver that model of care in the workplace. I know at Shepparton Villages we have done lots of work around that model of care but when you can't attract staff in rural and remote areas your model of care actually gets compromised. If you look at our – we do very similar staff surveys to Sandra, and

we have high engagement. But what the consistent theme that comes through our staff surveys is the inability at times to actually fill shifts when people are sick because we don't have that workforce out in the community. Yes.

MR ROZEN: Mr Hearn, I haven't forgotten you at the end there. What would you like this Royal Commission to recommend?

MR HEARN: I've made comment earlier. I think there is an important need to develop a broader national focus on the community understanding ageing.

MR ROZEN: Yes.

MR HEARN: And the 30 to 40 years that that represents to many younger people and to those who are in those age groups, and the various differences of that. I think it needs to be very focused on all of government and I think there are elements to building that and actually contributing resources to build that across government and presenting really positive acknowledgements and celebrating aspects that really show that. We did a little Unley Council legends project where for a few years we were taking individuals and celebrating particular individuals for how they have engaged life and how they're managing their life, and that included people in residential care aged care homes. So I think celebrating and giving that to the community.

It all relates to in terms of supply, quality of staff and resourcing, and I think we've talked about that as critical outcomes, and I think the Commission is very aware of that and those related matters. Within the attraction of staff, the actual right staff, the aptitude and empathy of staff is really important. And in terms of one of the topics the Commission is dealing with in mandatory qualifications, cert III, what I would be concerned about is there's not a clear pathway for people who do not have a cert III mandatory qualification to enter the workforce because there are a number of people who enter aged care at a later time in their working career, and it's less likely they will commit themselves to a period of study or qualification attainment without working. I think we must keep flexibility.

In moving towards cert III as mandatory concept, I think we must keep flexibility and acknowledging people have skills and experience that are very relevant to working with older people, and in the context of the demands we have in front of us, we couldn't – we can't afford not to have those people as part of who is available in the workforce. I would like to reaffirm our colleague's comments about regional, rural and remote. Whatever we talk about here as of critical importance, it's amplified in those environments. Another area I know is awkward in reform processes but people who are attracted to aged care are attracted because of the relationship. And one of the dilemmas about how sophisticated the sector gets is they're still overall attracted to the relationship and making a difference.

One of the dilemmas of increasing regulatory outcomes and the way they are implemented is people get very frustrated, and that comes back to that disconnect you mentioned earlier about staff and management because management have to

implement the regulatory outcome. I'm not saying the regulatory outcomes are inappropriate but often they seem to be excessive in their scope when introduced. They go – they go to the full extent as against a build-up. Thank you.

MR ROZEN: Thank you. Commissioners, they're the questions that I have of the panel.

COMMISSIONER BRIGGS: Could I thank the panel very much. These issues are incredibly interesting. You've touched on the issues of staff feedback, and you've also broadly touched on the issue of leadership. I'm very conscious that a lot of success depends on leadership both at the higher level but also at the local level. But my question is not so much about that. It's about the broader issue because I've seen the fragility of leadership. If a good leader goes, the thing falls apart. So the real question is – you would expect that when we write our final report we will be making quite significant changes and you've expressed concern about that. So the question is: how do we, effectively, systematise reform across an organisation? And, as three CEOs, I'm sure you have got views about that.

MR HOWIE: I'm not sure I completely understand your question - - -

COMMISSIONER BRIGGS: Well, it means how do you embed change, both introduce, embed and be guaranteed it's going to stick.

MR HOWIE: Within an organisation?

COMMISSIONER BRIGGS: Yes, within an organisation.

MR HOWIE: That's a very big question.

COMMISSIONER BRIGGS: It's a whopper.

MR HOWIE: I'm happy to take a crack at it.

MS HILLS: Go for it.

MR HOWIE: The – it does, it requires a really deliberate and strategic approach to whatever change you put in place in an organisation. There are very well-established change management frameworks which you would expect professional organisations and professional leadership teams to be accessing. There's no question that the leadership – or leadership of this nature starts with the board and the governance structures. The selection of the CEO makes a huge difference to an organisation. And at every layer then throughout the organisation, the quality of leadership that we have in place makes a big difference to the results that we get.

So we've seen in our own organisation if we've got a group of service delivery team leaders across the organisation, it doesn't take very long to work out which ones are high performers and which ones aren't. And so a lot of focus across the organisation

is needed around building the right culture and the right staff selection and training processes, particularly around those leadership levels, and ensuring that you have got a culture of accountability in the organisation so that when things do go wrong, they get responded to quickly and that people aren't there just trying to be nice instead and settle everything down but to actually resolve the problems and weed them out at the root.

Ultimately, the only thing that is going to work long-term, or even medium term, in an organisation is a really strong culture around customer safety and experience-related issues and so you want to embed that as deeply as you can in the organisation. But you're absolutely right. Even that remains incredibly fragile. You put a different CEO in place in an organisation and that can change within weeks. So it is going to be a constant challenge. I think the reforms that we have seen in the home care sector around consumer choice are having a big impact across the industry and will continue to because it's changed the economic drivers in the industry to the point where, in my view, you will only be successful in the longer term now if you've got these things right.

At the moment we have still got quite a large overhang from our business to government model days, which we're still dealing with through a transformation process across the industry but I think we will see consolidation around those organisations that are getting the customer service, the customer experience, the technical parts of the service delivery right and aren't damaging their reputations through poor service delivery. So that's a context, I guess, in the home care sector. The residential care sector is obviously in a different place at the moment in terms of their reform journey.

MS RIVETT: Change is always difficult. I think you've got to use clear and simple messages and you've got to be clear about your direction and you also need to engage the coalface, because if you don't get buy-in – if you don't get buy-in from the coalface you are sort of fighting a losing battle, so you really do need the ability of your leadership team to be able to go down and up in the structures. So – and making sure you are out there in the coalface delivering that simple single message and just being persistent like a little bulldozer, just being persistent and listening; listening is a huge skill. And being open; open disclosure and listening and hearing the truth, hearing warts and all about what is actually happening, and some of the results as well.

MS HILLS: I would like to add that if you go back to the voluntary code of practice, which is one of the recommendations in the Pollaers report, that sets out a number of principles. So if you're looking at how you would implement something across the sector, a big job; I think you've got to agree on a starting point. There has to be an agreement there. I think increasing the capacity of the leadership, the leadership capacity in the industry. And looking at succession planning in that area is crucial because if you don't have the people with the skills, you are going to get nowhere. And yes, I mean, I think there are lots and lots of examples of organisations doing good things, but it's not shared very well.

So going back to one of the recommendations in the Pollaers report that talks about the Translational Research Centre; that gives a really good – and there is money allocated for that, that gives a fantastic opportunity to actually look at new models of- business models, models of care, approach to service delivery. Go outside the sector. Look to see what's happening internationally, nationally in other sectors, etcetera. There's some fantastic opportunities there because we need trailblazers and people who are going to be those out there who are the sort of expert – subject matter experts.

COMMISSIONER BRIGGS: I suppose my follow up question to that is: is there the energy and excitement and will to make these kind of changes, and is it apparent from where you sit that people are looking at the evidence from the Royal Commission and saying, "What does that mean for us and how do we improve this industry as a whole"?

MR HOWIE: I think, yes, certainly the industry is watching the Royal Commission very closely and – or certainly organisations that I'm speaking to are taking a very good look at themselves as part of this process. I think it has been very valuable. So even the process of producing the initial package of information, I think was very useful for organisations, if somewhat expensive and time-consuming. But it's provided us with a great set of data that we can work our way through. So yes, I do think that there's a lot to be gained.

MS RIVETT: I think there's a lot of passion out there in the industry. I know I'm passionate about – I think I've been working in this industry for a while, and I'm extremely – and what drives me is that one day I'm going to be old, and I want to be able to design a system where I want to live in, and I've got some choice and control about my life. And I think a lot of my staff are actually excited and driven about what they can do in this industry as well. I think what frustrates them is that, you know, work has changed and we can't get people into the industry with that same passion that, you know, 80 per cent of my staff actually have.

So look, I think I've seen over the years – and I've been working in health for a long time and I come out of the mental health sector, and that has been through massive amounts of change, I've seen – I actually have seen things improve over the 20 years that I actually have been in aged care. Things have improved. There's some awful things that happen. They're shocking. But I have seen some very innovative and exciting things actually happen.

MR HEARN: I think a related comment that I would add – so thank you for my colleagues' comments and I agree with many of those. I think a related matter is I think there are very committed people in the community. I think they're tired, though. I think the current workforce and leadership team is tired and maybe the Commission is picking up on that to some degree, and I just do believe it's very important for the Royal Commission to identify that vision and make that leadership statement. I think we should then try and fix some of the issues that you are hearing as being part of the ingredient to move forward in some of that change.

MS HILLS: And I would say that I think the view from the coalface is quite mixed. I think that there are many – some leaders who are quite – who are tired. I mean, their teams are tired. I think if we look at the results of the survey, I mean, the John Pollaers report, that actually told us that there was dissonance between what the staff said and I think we've got to be, you know, take the rosy glasses off. But there is huge commitment in this industry and I think that perhaps there are some – well, there are some providers that shouldn't be in the industry and perhaps will choose one way or the other to move on because hopefully your recommendations will be such that it will be very clear that this is the way going forward and if you are not on the boat, there's the sea.

COMMISSIONER BRIGGS: Thank you. That's very helpful.

COMMISSIONER PAGONE: Well, thank you very much to each of you. What you have had to say has been very, very informative. You've got a real stake in what we are doing; I mean that from every conceivable point of view, good and bad. We've been, I think, greatly enriched in our knowledge by hearing what you have to say and I am sure that if you have any other comments you would like to make, we, I am sure, have the means and process by which we can receive those comments. Certainly the one message, or one of the many messages that we have got today is that the Commonwealth really does need to be a big player and that it needs to be a big player explaining itself and explaining the extent to which it is playing and the extent to which it is not playing and why and what is proposed to do about it all. Thank you again. And we'll adjourn until 2 o'clock.

MR ROZEN: Thank you.

<THE WITNESSES WITHDREW

ADJOURNED [12.54 pm]

RESUMED [1.59 pm]

MR BOLSTER: Commissioners, the next tranche of evidence concerns higher education and the issue of geriatric training. The first panel deals with the basic issue of higher education, and I call Professor James Clement Vickers, who is seated in the witness box closest to you. I also call Rachel Yates, who is the policy director for health and workforce on behalf of Universities Australia, and then I call Adjunct Professor Kylie Anne Ward, who is associated with the Australian College of Nursing.

<KYLIE ANNE WARD, SWORN [2.00 pm]

<RACHEL YATES, AFFIRMED [2.01 pm]

<JAMES CLEMENT VICKERS, AFFIRMED [2.01 pm]

MR BOLSTER: Professor Vickers' statement – WIT.0462.0001.0001 – could be brought up; see in front of you, Professor Vickers, a copy of your statement. You recognise that?

PROF VICKERS: I do.

MR BOLSTER: Are there any changes you wish to make to it?

PROF VICKERS: No.

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

PROF VICKERS: They are.

MR BOLSTER: Ms Yates, in a minute we'll see your statement, which is WIT.0461.0001.0001. You recognise that as a copy of your statement?

MS YATES: I do.

MR BOLSTER: Are there any changes you wish to make to it?

MS YATES: No.

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

MS YATES: They are. They are.

MR BOLSTER: And finally, Professor Ward, WIT.0483.0001.0001 should appear in front of you; are there any changes you wish to make to that?

PROF WARD: Yes; we have submitted the changes.

MR BOLSTER: And they've been incorporated in that document, and are you able to indicate what those changes are now?

PROF WARD: Yes. Thank you. The – in my statement, I note on page 7, at paragraph 28 – I said all other clinical degrees registered with the Australian health-practitioner-regulation agency are four years or more to complete. But I note that para-medicine has a three-year degree and was registered nationally in December

2018; so I would like to correct my statement to begin with "most" instead of "all". Also in my statement on page 12, at paragraph 53, I said the scope of practice of RNs is being limited in residential-aged care facilities by some employees. That is meant to say "employers". And on – in my statement on page 1, paragraph 5, "residential-aged care facility" acronym is incorrect, and it should be "RACF" instead of "FACF". Thank you.

MR BOLSTER: Thank you very much. Other than that, is the statement true and correct?

PROF WARD: Yes.

MR BOLSTER: I'd like to begin by discussing or getting an overview of the undergraduate programs that are available for medicine in Australia. It's, essentially, a four-year course, Professor Vickers?

PROF VICKERS: Yes; there are two variations. There's actually a – five-year versions, which are more undergraduate entry, and four-year versions, which are more at the postgraduate level.

MR BOLSTER: To what extent in that period is there a clinical placement?

PROF VICKERS: Generally speaking: the expectation is that medical students will have the equivalent of two years of patient exposure as defined by the standards.

MR BOLSTER: Is that a full-time exposure or a part-time exposure?

PROF VICKERS: That's full-exposure time within the confines, obviously, of their academic year.

MR BOLSTER: Your university, the University of Tasmania – what's the model you work with?

PROF VICKERS: We have a five-year MBBS degree, which is an undergraduate-entry program. The great majority of students that come into that degree are out of year 12, but we also have a minor component, which – graduates can then enter the course.

MR BOLSTER: Professor Ward, on the nursing-side, the standard bachelor's degree in nursing is a three-year program.

PROF WARD: Correct.

MR BOLSTER: To what extent does it include a practical placement component?

PROF WARD: It – in the undergraduate, bachelor degree for registered nurses there is 800 hours in the practical or clinical setting; that does not include simulation, and a diploma in nursing for an enrolled nurse is – 400 hours are required.

MR BOLSTER: Ms Yates, is there anything you wanted to add to those brief description, or have we got it about right in your experience, those answers?

MS YATES: Yes. For medicine and for nursing and – again I know we've referred in our submission to allied health, and the clinical-placement component for allied health is extremely varied across multiple disciplines; yes.

MR BOLSTER: All right. Accreditation in the two key courses we're talking about, medicine and nursing, both – they're accredited by different bodies, aren't they? ANMAC in the case of nursing.

MS YATES: Correct.

MR BOLSTER: And what's the body for medicine?

PROF VICKERS: The Australian Medical Council or AMC.

MR BOLSTER: And you make the point, Professor Vickers, that there's a degree of autonomy associated with what an individual university chooses to teach in a degree.

PROF VICKERS: That's right. Yes. So the accreditation guide-lines for medical programs provide the broad expectations of what a medical graduate should look like at the end of that program, and really they should be fairly similar between all the different programs in Australia. It's not explicit about particular curricula elements, but it does have commentary in the guide-lines about focussing on diseases and conditions that are common in the Australian population.

MR BOLSTER: Leaving aside the accreditation agencies – does the college of medical deans become involved in curriculum-related issues as a matter of course?

PROF VICKERS: Medical Deans, clearly, take an interest in what's in medical curricula. They tend to largely though reflect off those standards, and I guess there's two particular examples; the standards do talk about making sure medical students have a robust experience in rural practice and have exposures in rural and regional Australia, and another area is working in areas related to Indigenous peoples' health, both – Maori, Aboriginal and Torres Strait Islanders. So Medical Deans does have a keen interest in those domains, and there are committees and groups that are very interested in the curriculum in those particular areas.

MR BOLSTER: Professor Ward, the ANMAC, the – which stands for - - -

PROF WARD: The Australian Nursing and Midwifery Accreditation Council.

MR BOLSTER: It controls the curriculum for nursing?

PROF WARD: It accredits the curriculum and the Australian Nursing and Midwifery Accreditation Council approves the accreditation requirements.

MR BOLSTER: Now, although it's a three-year course at the moment – I understand that there is impetus within the sector to do something about that and make it a longer course.

PROF WARD: Correct. The Australian College of Nursing, along with other key stake-holders, would like to see an extended undergraduate degree, and we're asking for four years or more.

MR BOLSTER: Is there a deficiency in relation to aged care that lies as part of that move for change?

PROF WARD: Well, we would see that there would be more opportunity to extend the experience in clinical settings, including residential-aged care facilities, and that there would be more opportunity to assimilate in a fourth year or more and with other professionals, including inter-professional learning. So, yes, there would be far more opportunity.

MR BOLSTER: Each of you talk about the critical nature of placement in all of the courses that we're talking about, allied health, medicine or in nursing. Where does placement go wrong in this country? How do placements for each of the courses generally tend to produce negative outcomes, Professor Ward?

PROF WARD: Yes. I'm happy to start. It is still dependent on the experience of the person in some ways or the culture of the facility that a student is allocated to. It is a compounding and complex issue, because the pressure on – I'll speak on behalf of nurses – on registered nurses is so high in demand in areas, including residential-aged care facilities, where there's either no registered nurse or one registered nurse with, potentially, on an evening shift, up to hundreds of residents.

So the requirement then to support somebody in a learning-phase through university is increasingly demanding. There are issues with – it's a supply-and-demand issue. So there's many placements after those clinical – in the clinical environment. So there's a cost factor that's now considered. There is how is the nursing workforce in an undergraduate placement supported on a – whether that's 24-seven or around the clock; you can't do everything Monday-to-Friday, and the reflection and critical thinking that's required of undergraduate nurses needs to be supported with some clinical supervision.

MR BOLSTER: Have you got any stats on the extent to which placements, nursing-placements during tertiary education, are in residential aged care as opposed to geriatric primary-healthcare units?

PROF WARD: No. I – and the reason that I couldn't give you those statistics is the 36 universities or higher-education providers that offer an undergraduate, bachelor's degree have a little bit of flexibility in how they deliver that, but they need to show evidence to ANMAC that they meet the accreditation requirements. And so there isn't a mandated amount of time in a residential-aged care facility or in aged care at this stage. So I don't even know that that information exists.

MR BOLSTER: Is that satisfactory, that nurses will graduate without a practical – a requirement that they be embedded in residential aged care for at least some part of their 800 hours?

PROF WARD: A registered nurse who graduates is graduating to meet the needs of the curriculum and the requirements, and it's at a foundational level of general knowledge. It – if the resident – if for example, it's residential-aged care facilities, it would only be beneficial, if the experience was good; otherwise we fall into a place that people wouldn't want to go back to. Industry is very supportive, the aged care industry, in providing placements. It is how that then links to the curriculum. So that's inconsistencies in what it offers - - -

MR BOLSTER: We'll come back and talk about the curriculum shortly. Professor Vickers, at the University of Tasmania, you do placements slightly different from other medical schools. Can you tell us what the – how applicable your placements are in the geriatric setting.

PROF VICKERS: Certainly. Yes. So I guess also to note also that I'm the director of the Wicking Dementia Centre – so I have a particular interest in dementia-education services et cetera. But it was 10 years or so ago, that the Wicking centre, in collaboration with the school of nursing and the school of medicine, decided we needed to provide high-quality placements to a range of health-professional students in the residential-aged care sector, and that was really borne out of research that we had conducted that showed that many of these health-professional students have a negative view of aged care and that might be because they've had an unsupported placement in residential aged care or, probably, more so that they've had very little experience of that domain in their regular curriculum.

So we set about developing the teaching-aged care-facilities program, which then led to a number of facilities coming on board, and they were modelled briefly on teaching hospitals. Teaching hospital is a good place to be, if you're sick, because there's lots of medical and nursing and other students there who are being trained but also keeping everybody else on their toes; so we needed to think about how could a residential facility become a learning-facility where you would get high-quality placements for students.

MR BOLSTER: Well, I expect there's plenty of support at Tasmanian hospitals when people go to a geriatric placement there. What about when they go to a nursing-home?

PROF VICKERS: Well, I think in our state it's – the standards are very high, because again we still – we've had funding off and on from the Commonwealth, but we've always maintained that that program was vitally important. So we have – our pharmacy students, our nursing students and our medical students go on very supported placements, very structured supported placements in residential aged care.

MR BOLSTER: So what's the key to a supported placement in a nursing-home? Does that mean your staff have to – your teaching staff have to be engaged with the provider and attend and - - -

PROF VICKERS: That's right. At one level you, certainly, need senior experienced clinicians who take responsibility for those students on placement. But then in these particular facilities there was a lot of work that was done to bring up to speed or to train up the nurses and the aged care workers, get management on side, to buy into this idea that a learning-environment is a higher-quality environment for everybody, including the residents.

MR BOLSTER: Commonwealth funding for that sort of program: how wide-spread is that across the country?

PROF VICKERS: Well, there isn't at the moment. There was for a period of time the teaching, research and education - - -

PROF WARD: Aged care services. TRACS.

PROF VICKERS: TRACS – did provide funding for a range of different models across the country, and that allowed us to expand our model actually to Western Australia and Victoria. But the unfortunate thing is that funding ended, and so it was a retreat back to Tasmania.

MR BOLSTER: How much – could you take us through the numbers? What sort of funding and how many places were we talking about?

PROF VICKERS: I have got the actual figures on hand and can provide them, but it wasn't a substantial amount of money; mainly it was – most of the money really was directed at making sure that we had a very good evaluation-and-research frame-work that sat around all of that work, because – we could do good work, but if we don't make sure that it is of the highest standard and we don't communicate that, then it's of little value.

MR BOLSTER: What difference does that sort of program make, when you – when the doctor, two, three years down the track is – may be a GP in a regional setting in Tasmania? What difference does that sort of program make to outcomes and the ability to deliver?

PROF VICKERS: It – yes. At one level it is giving them, I guess, particular education around the older frail individual who might have multiple conditions and,

as we know, in residential aged care, the majority of people also with dementia. The students report that it is of high value, because, unlike the hospitals, which can be very busy places – and they're rushed through various placements – they get to spend a good period of time with an individual and understanding of them as a person as well as the various conditions. So as part of this one-year – one-week placement in fifth year of our program, they have to do a comprehensive assessment of that older individual. The particular tasks would vary between those different disciplines, the nursing and the pharmacy students. Pharmacy students are involved in things like medication reviews.

MR BOLSTER: I take it, the philosophy behind that placement is equally applicable to physiotherapists, speech pathologists, pharmacists.

PROF VICKERS: Absolutely. Yes. So we're keen for example for our students who are doing their psychology training to come on board as well – too, and that's being shaped up. What the TRACS funding also gave us too at the time was also that opportunity to be a bit more interdisciplinary. So at the moment fairly much our students are going on separate placements, but when we had more resources, they were able to do some activities together, and that's when health-professional students start to learn about what other groups of health professionals think and their attitudes towards older people, so forth.

MR BOLSTER: Presumably involves engaging with geriatricians as well and learning from geriatricians.

PROF VICKERS: Actually less so in our model; we have a very good relationship with our geriatricians, but they – they're mainly supporting our hospital placements. This has largely involved general-practitioner academics, some with extra qualifications in palliative medicine as well. But it's been very well supported by those general-practice academics.

MR BOLSTER: Ms Yates, from a broader perspective, the universities across Australia – what's the lesson to be learnt from the placement process?

MS YATES: I think there's several. I think – to pick up on your first question – I think one of the areas that could be improved in relation to placements is that – currently many placements occur in the acute setting, and while that's important, it's not – it isn't, in fact, a match with where our workforce need is in many areas, including aged care; so that's one area it could be improved.

MR BOLSTER: Who funds those placements, the clinical-care placement? Is that through the state system, or is that Commonwealth funding?

MS YATES: That's a very good question. There is funding that goes from the Commonwealth and the states. It's called the teaching, training and research block funds, and that covers in acute settings. So – in hospitals. And those figures are available through the independent hospital-pricing Authority or through the public-

funding-pool administrator, and that funds teaching, training and research across all levels. So – not just university students but across all levels. But some of the costs of that are actually levied on universities. Sometimes universities are required to pay for placements.

MR BOLSTER: What about aged care placements: is that funded by the Commonwealth?

MS YATES: Sometimes – not that I'm aware of. Not that I'm aware of, and again it's variable, but sometimes universities are required to pay to place students in aged care settings, not always. To pick up on one of your other points though, and that James and Kylie have made as well, is you asked a question about what the impact of having those placements in an aged care setting might be further down the track. I would say there are immediate benefits of having placements in aged care. They are very well documented through TRACS and also through Wicking and through some of the case studies that we've provided from our individual universities. But also, what it does is it makes – we know that the proportion of older people in the population is increasing.

So irrespective of whether a health professional chooses to work specifically in aged care, they will be encountering older people in their practice more and more, and so it gives health professionals a really good experience at working with older people. It teaches them how to care because often when you are working with older people and the frail elderly, it's more than just clinical skill. I mean, it is clinical skill as well but it's about caring for that person and it also gives inter-professional education experiences and it also just gives that whole experience of working in that setting as well.

MR BOLSTER: If there's funding for placements in the acute system and a lack of funding from the Commonwealth for placements in residential aged care, is that a disincentive for universities across the board to do the right thing and engage with the residential aged care sector?

PROF VICKERS: I think the distinction needs to be clear with teaching hospitals; they certainly do get money or funding from the Commonwealth as part of their overall structure of funding to be teaching hospitals. Whereas what we have for residential facilities they get funding to have residents through ACFI and other funding instruments. So there's nothing built into the funding of residential aged care to help support this. So if a tertiary institution decides or not to engage thoroughly with a residential aged care sector is really those - - -

MR BOLSTER: They've got to pay for it.

PROF VICKERS: They have got to pay for it and they've got to support it which – for us, we were very keen to keep doing despite the fact that TRACS money ended because of the outcomes. The outcomes for the students were terrific and the outcomes for the residents and the staff were really good as well.

MR BOLSTER: Professor Ward, did you want to say anything about this, about the funding dynamics in your sector?

PROF WARD: Yes, look, firstly, I would like to say that I think it would be really good to speak or get information from the council, because Nursing and Midwifery has a Council of Deans of Nursing and Midwifery, and certainly they would have a better viewpoint or understanding. But one of the compounding challenges that we face as a higher education provider is the charges to clinical placements that can be up to $150 a day for a nursing student. So whilst there may be funding, it's certainly – there's an opportunity from the public system to charge as revenue. I don't know that the aged care is doing quite the same, but it is in the funding model through the ACFI that there is not enough staffing, let alone within the staffing establishment to support – and that's not in every case but that's certainly in some facilities. So it's very inconsistent in the experience and that would be our concern as a professional body.

MR BOLSTER: Is it the same that a nurse with a placement in a public acute geriatric setting will be funded at least partially by the funding that Professor Vickers has been talking about?

PROF WARD: I'm not in a position of authority to actually say on that but my understanding, in speaking to Deans is that the – particularly the public is actually charging universities, but I would need to clarify that statement by saying I'm not authorised.

MR BOLSTER: But who pays for a placement in residential aged care for a graduate nursing student?

PROF WARD: We find that – in my understanding, residential aged care facilities are far more generous in not seeing that as a revenue stream and welcoming students, undergraduate students. So that's not an issue that has been presented to us as a college but what the issue is – is the lack of registered nurse. So if you have got an enrolled nurse, an undergraduate registered nurse and somebody doing their diploma in nursing there is only so much capacity you have to take the students.

MR BOLSTER: All right. We will change topic now. Professor Vickers, at paragraph 18 of your statement, you seem to be suggesting that teaching related to the care of older persons is not a dominant influence in medical curricula. Have I got that right?

PROF VICKERS: That would be accurate. I think I would – I'd first say that most medical programs – all of the medical programs in Australia would be of a very high standard but they would be rather historically bound, and what I mean by that is that some of the things that they have been teaching medical students and the way they have been teaching them, are what they've been doing for decades. So then along comes a new issue which is accelerating rapidly which is the ageing of our population, growth in multimorbidity, frailty, and I think the biggest one of all, the

rates of dementia; it's hard for a tight medical program to reorient towards what should be of significant, I guess, public health interest.

MR BOLSTER: You also seem to suggest that the teaching in this area is primarily occurring during clinical rotations and clinical placements at the end of the degree course. Is that right?

PROF VICKERS: Yes, that would be right. So most exposure medical students would have to issues affecting older people would be on placement. But again, it's important to note that even in our acute sector, the average patient coming through for surgery and other indications is getting older and older. And this is, I think, one of the real conundrums is that that student might be presented by condition A, B or C in front of them, but behind it there's four or five other conditions; they may have dementia and so forth. And so I think again, it's – it's – I know a lot of colleagues are struggling with this idea, is this model where we're teaching medical students to attend to one thing, is not going to be enough when it's an older population who has got multiple conditions.

MR BOLSTER: Well, let's talk about the younger population; paediatric teaching is a core course, well taught before one gets to clinical placement; correct?

PROF VICKERS: Yes, it is. Yes.

MR BOLSTER: In every university in Australia you will have a core course in paediatrics - - -

PROF VICKERS: Certainly.

MR BOLSTER: - - - but you won't have a core academic course in geriatric medicine; is that right?

PROF VICKERS: No, you wouldn't. No, you'd have an expected core content and rotations, clinical rotations in paediatrics. On other rotations such as medicine and surgery, again, you will probably be exposed to older adults with all of those conditions as well as the one in front of you but it would be very patchy across medical programs; I think medical deans would accept that. It would be very patchy as to what degree, what engagement they have with programs that are specifically related to geriatric medicine.

MR BOLSTER: I just picked up some stats from the ABS. They project that by – assume this is correct – that by 30 June 2050 the population aged 1 to 15 will be 7,833,000, and the population, 65 and over, will be just shy of that. At the moment there's a bit of a gap. It's 5,562,000 for the under 18s, as opposed to 3,912,000 for the over 65s. So there's definitely a major demographic change happening. Has there been any movement on a broad curriculum level that you are aware of across the country to match that movement?

PROF VICKERS: No.

MR BOLSTER: Could we bring up, please, tab 237 from the general tender bundle, please. Professor Vickers, you're, I take it, familiar with this paper by the Australian Society for Geriatric Medicine, first published in – I think in 1996 and then revised in 2006, and I think there will be some evidence that it's going to be further revised shortly. This effectively calls for curriculum development along the lines that we have been discussing, doesn't it?

PROF VICKERS: Yes, certainly. Yes. But I think it's, again, important to note that while a lot of historic – a lot of the medical curricula are again historically bound. There are also lots of other emerging conditions and changes in medicine and practice too. And so as things come – arise, if you like, in terms of their urgency, it is very hard then to fit them into crowded curricula. Personally, I'm very much in sync with this document and I would love to see more on curricula related to older people, multimorbidity, frailty, dementia which is picked up again in this document. But then it's about what do you adjust to make that possible. And so for us the way of doing that was to – again, to develop this teaching aged care facilities program which gives substantial experience for those students, not the medical students, all kinds of students and those exposures in areas related to this document.

MR BOLSTER: By way of comparison, can you think of another burgeoning or developing area of medicine and public health that has the consequences of the sorts of issues we're dealing with here?

PROF VICKERS: I think, and again I will reply under the prism of dementia, if that's okay. So, and also, as you note, there is an ageing population and the fastest segment of our population in terms of demographic change, fastest growing segment is the old, and particularly those over the age of 80. But I think about dementia and dementia, as you might know, is currently listed as the second leading cause of death in this country, just after ischaemic heart disease. In around about five year's time, it will be the leading cause of death of Australians in this country, and it is the leading cause of death of women. So, again, I think it's really – there's a high priority to start thinking about how we reorient our programs to make sure that these important emerging areas are covered sufficiently.

And yes, that might involve a bit of an adjustment of what we teach in different parts of our medical curriculum but there's also flexible ways of doing it that you don't necessarily need to chop things to make space for the new things, and so online learning is something we're particularly interested. We have developed short online courses on dementia and it's the intention of our College of Health and Medicine to make sure that this online course or parts thereof are in all of our health curricula, and that doesn't necessarily take away from other content.

MR BOLSTER: Professor Ward, from the nursing perspective, your statement is essentially to the effect that at the end of the three year course a graduate comes out

as a general nurse, is unlikely to have had any specialist training in aged care-related matters. Is that correct?

PROF WARD: Yes, because we wouldn't expect them to, on a foundational degree. And if there's any opportunity to expand the undergraduate degree, we would strongly advocate that it would need to be extended. So we are very supportive that's what is in place meets the requirements that are in place. Moving into the future, I think that there's an opportunity to look at what happens, but we then advocate for lifelong learning and certainly for nurses to consolidate in – up to their first year and then move very quickly into postgraduate studies and look at specialty areas, and we offer 21 graduate certificates, one of them being aged care and another palliative care.

MR BOLSTER: Is that a one or a two year program?

PROF WARD: One year.

MR BOLSTER: And how many hours are we talking about?

PROF WARD: It's part time. It's over four 10 week blocks to help people working full time. They need to be working in the specialty area and then there's a significant online capacity but then they're getting their learning in that environment, and we have expert nurse educators who work then with all of the students around the country.

MR BOLSTER: The first year graduate whose first job is in a difficult residential aged care facility, and we have all, we've heard plenty of evidence about difficulties - - -

PROF WARD: Yes.

MR BOLSTER: "Is the first year graduate skilled enough to walk into those sorts of facilities and be able to meet their scope of work?"

PROF WARD: As a beginning or a novice practitioner they shouldn't walk into any environment. So there is a challenge in primary and community acute care and in the residential aged care sector that not everybody gets a transition program, so to speak. And maybe a few years out, so some people if they don't get a job on a graduate program how do they find their way into the profession so that's something that we have to look at within the profession. If you are asking me can somebody come out as a new graduate and take care of a ward or a unit, I would say that no, absolutely not, not in any setting.

MR BOLSTER: What are the skills deficits that you think are there? What's missing?

PROF WARD: Certainly, the consolidation of the theory. They are a licensed professional and this is where I feel that the nurses and graduate nurses need more support because they are being utilised in areas where there are staffing deficits to fill the staffing gaps and the funding gaps or to meet funding needs without, in every setting, not all settings but being given enough supernumerary or support to shadow a more senior nurse. There's very senior and experienced registered nurses who are feeling completely stressed with 50 plus residents. You would never want that for the resident, their families or an early career registered nurse.

MR BOLSTER: We have seen numerous instances of rosters that involve one registered nurse being responsible for one enrolled nurse, two personal care workers and 20, 30, even more, high-care dementia patients.

PROF WARD: Yes.

MR BOLSTER: How could a recent graduate from any – even the best nursing school manage with that?

PROF WARD: Even a nurse with experience who has postgraduate qualifications and highly experienced knows that that is too much on the professional licence because as nurses, we go into this profession and this industry because we love the thought that we can make a difference and we can help people. So what I'm finding and getting messages almost daily is how compromised even senior nurses are feeling in this work environment. The other challenge that we hear anecdotally from our membership and nurses all around the country is that there are some providers who have more like a token or a legislative requirement for a registered nurse, but they might be the facility manager and the DoN and not actually in the area where the residents are providing direct care.

So while somebody has nursing in their licence it's not always applicable that they're in the area. So what we're hearing more and more is that enrolled nurses who should be under the direct care and supervision of a registered nurse, there might be somebody in the office or somewhere around or running there but even not actually able to – so I don't think it's appropriate for an experienced registered nurse. I could not advocate, and this is part of the challenge, is how do we attract people? There are organisations that have great transition programs and great support and are pipelines for early career nurses to have a wonderful career. It's just not consistent.

MR BOLSTER: What would be wrong with legislating for a supervision period and requirements that newly graduated nurses are effectively supervised by experienced nurse practitioners or Division 1 nurses?

PROF WARD: Yes, so Division 1 is a term that no longer exists. You will hear it here because it was based here. But, actually, many years ago now we went to national registration. So Division 1 and Division 2 no longer exist and it's registered and enrolled nurse. And the three authorised nursing categories, I guess, is nurse

practitioner, you're right, registered nurse and enrolled nurse. We, the supernumerary context, would be fabulous. That requires a commitment for funding.

And what we would expect to see, and this can happen in any setting, is that then if there's sick leave or short staffed that it's not conveniently, "Well, we do have one RN who will do – or pick it up this shift," because this is an epidemic that just creeps in and burdens. So how would you support that within the existing workforce? Nurse practitioners are absolutely key in aged care as they are in primary and community and the acute setting and all the interfaces, and to be able to give a registered nurse supernumerary time to shadow those who have mastered our professions would be phenomenal.

MR BOLSTER: By way of comparison, I expect that the new graduate nurse in a large public hospital, whether it's geriatrics, whether it's any other particular area of practice, would get the sort of support that we're talking about? Correct?

PROF WARD: Yes, there's a couple of things, though. They should and do get programs and it's very, that's very well embedded now. The quality of their experience still depends on the leadership, and so we strongly advocate investing in leadership capability development. What somebody has a sense of comfort in in an acute care facility as opposed to in a residential aged care facility is that even if I'm the only registered nurse on in a particular area, there's all the other wards and units with somebody else I can ring up and call.

In a residential aged care facility and those that are very – skimp on the staffing, where there's one registered nurse, the emerging or early career registered nurse is really potentially compromised, and so is the experienced registered nurse or the more familiar because you've got such extensive patients. The staffing is staffed to beds, unfortunately, and generally, not to the patient complexity.

And so with that, if occupancy decreases, quite often so does staffing, it contracts but we never really hear that it expands. And often – so if, you know, occupancy is not full, they might not staff on a shift. So there's not the capacity for the time for teaching and learning generally. There are some areas that are doing it really well and certainly investing but that is probably the exception rather than the rule.

COMMISSIONER BRIGGS: Might I just interrupt for a moment and ask what would you see the ideal number of people in an aged care facility that a registered nurse with a trainee nurse would be looking after?

PROF WARD: It's so dependent, and Kathy Eagar said this earlier, we understand there should be a reasonable workload or a methodology, and so we have said in our position statements a minimum of a registered nurse and that was in 2016, and then we saw that that was being used from a token perspective. So there's a couple of things that I would see is that it really should be looking at the skill and skills mix. An enrolled nurse, we are seeing enrolled nurses get substituted or replaced with a certificate IV worker and carers; they have a role to play but they're very different

abilities of public protection and regulation. And so I would say that it's not even a blunt figure that you can say, you know, one to X number because it's still on a bed based model.

And what we would really need to consider is the values based approach to care of the complex needs and the chronic conditions; that the staffing is to the residents but then there's always family. And so the family generally want to speak to a registered nurse. Of course, they will speak to the carers and everyone else but they're looking for that oversight and governance of care. And so the model can change and I think that nursing directors and leaders are looking for a little bit of innovation and flexibility, depending on workforce supply. But at a baseline there must be more workers now because it has been transactional and tasked to a minimum and – to functional decline, not maintaining functionality for residents.

COMMISSIONER BRIGGS: I think in the end I would like you to say at a minimum we would expect. So you might have a think about that, Professor Yates, if you wouldn't mind.

PROF WARD: Yes, I can.

COMMISSIONER BRIGGS: Sorry, Professor Ward.

PROF WARD: Ward.

COMMISSIONER BRIGGS: I beg your pardon.

PROF WARD: No, that's all right. Look, I would – in a dream world I would like to look at, you know, one to 10, one to 15 with then a team. One on a shift is just now unrealistic, even a few years later. And so one registered nurse to 10 or 15 residents with support in a tiered layered workforce would provide satisfaction. I started nursing when I was 25 in aged care, from intensive care, and I loved it and it was a supportive environment. And now I know it's not the same, having done shifts in more recent years in aged care.

MR BOLSTER: What has changed?

PROF WARD: When I started, I was on maternity leave and I thought I would do aged care for a while. I was a registered nurse. I worked with enrolled nurses. They really were amazing and we also had a nurse unit manager. There was four wings at this particular facility, and it was old-fashioned so the accommodation wasn't as it is now. But you had a registered nurse on each area, and then a nurse unit manager, and then oversight of a director of nursing. So you always had somebody to link in and liaise with. And after-hours we also had a supernumerary registered nurse so you had your dementia, and we did palliative care and specialty, so you felt supported. Now, it's very isolating and very lonely.

MR BOLSTER: Let me ask this question: we've heard some evidence about graduate or first year nurses coming in and being expected to run or be in charge of facilities, some even being referred to as clinical care managers.

PROF WARD: Yes.

MR BOLSTER: Does the undergraduate degree prepare a nurse in any way, shape or form, to run a facility or to be responsible for it, to engage with the enrolled nurses and manage them, to engage with the personal care workers and manage them?

PROF WARD: Intrinsic in a registered nurse's professional licence is the governing and the supervision of care of enrolled nurses and other care staff, and in the team, so it's certainly intrinsic and implied in the training. However, what I would say is that we all need time when we graduate to then get a sense of understanding and experience in the area. So I would definitely not suggest that any new graduate should be running any area, especially when you've got human lives and human experience and they should be supported so that they acquire the skills and have the role modelling so that within a few years, perhaps around five years, they're quite capable and should then have, you know, love a career in a that area.

MR BOLSTER: I have reached the end of the main questions I want to ask you. It's now the opportunity for each of you to sum up and indicate what your priorities are.

COMMISSIONER BRIGGS: Might I intervene before then. Ms Yates, I really do want to hear a little bit more about allied health if we could, please. Over the course of the Royal Commission, it has been very apparent to us that allied health services are underdone, that is probably the quickest way to say it; that whether you are an elderly person receiving home care or whether you are in residential care, those services aren't sufficient.

And I've been reflecting on this and wondering about many things, the adequacy of supply of the workforce, the importance of attracting people into the workforce, the effective utilisation of the skills of allied health professionals, and support of them working as part of a team. So you've got licence now to just tell us what you think really should be happening to address those classic workforce issues if we are to switch the focus to reablement, rehabilitation, enhancing capacity, preventing decline and so on.

MS YATES: Thank you. I think we would, well, we would agree that there is definitely room for more allied health professionals and allied health professional students to have experience in aged care and ideally to be employed in aged care, to work with both medical practitioners and nurses as part of multidisciplinary team. I think there's various reports have actually identified that need as well. I guess one of the issues is that as staffing levels have diminished, it can be very difficult to find adequate supervision and also if a discipline stipulates in the accreditation standards

that they must be supervised by someone of the same discipline, that can also lead to some issues.

But we do have examples including in the TRACS, the Teaching and Research Aged Care Services pilots and evaluation including in the Wicking work, including in the case studies that we have submitted to the Royal Commission, of where if there is policy support for university aged care service partnerships, they can work very closely together to customise models that work to get a whole range of health professionals in – or health professional students in with adequate and relevant supervision.

And when that happens, depending on the programs that are applied or implemented by these students, there are a variety of benefits and outcomes to clients that occur as a result of that, that's absolutely the role of allied health professionals – physiotherapists, occupational therapists, psychologists – a whole raft, podiatrists, in working within aged care settings and services to produce outcomes such as mobility, functional independence, falls prevention programs, cognitive stimulation therapy.

Even sort of oral health programs, speech therapists working on dysphagia and swallowing, they really do make a difference and we would definitely see that that is an area where there is potential to increase that type of partnership approach. It's just that as we have sort of referred to previously, unfortunately, policy support and funding for that is not currently available.

COMMISSIONER BRIGGS: Should the system receive wider Medicare funding?

MS YATES: Well, a lot of allied health professionals aren't really funded through Medicare. So it's not necessarily that that is the answer. And again, I think we have to differentiate here between the health professional students – allied health professional students going into a facility and finding ways that we can support that, and then what the ongoing funding mechanism for allied health professionals in an aged care facility might be.

I mean, obviously, there is the Aged Care Funding Instrument. I'm not an expert on that instrument but I do understand that previously, certainly in the past there have been limits on how that can be used which has difficulty limited the types of services that could be delivered by allied health professionals, for example, I think physiotherapists at one stage were only able to provide things like massage therapy and TENS therapy under the ACFI.

I believe there were some changes that were introduced to that funding in July this year so it may not be as restricted as it used to be, but that does limit what – you know, if you are operating in that type of environment and there's limits on what can be provided you can't necessarily match the allied health professional service to the client need. So there's scope to explore funding mechanisms for the allied health

professionals and also then what the mechanism would be to support those aged care university partnerships for health students to go in.

COMMISSIONER BRIGGS: Would you agree that allied health is almost like an add-on that you clap on at the end once you have done the other medical sectors?

MS YATES: That is not my personal view, and I think in an ideal world it is about multi-professional, multidisciplinary care, particularly with complex and chronic situations like we're dealing with, with many aged care clients. Whether or not that happens in reality, I can't really say. But in an ideal world, it is about the multi-professional, multidisciplinary approach.

COMMISSIONER BRIGGS: Thank you.

MR BOLSTER: Before we do the wrap-up and get you to indicate what your wish list is, Professor Vickers, there was some criticism of the Wicking online courses earlier this week by some of the witnesses, in the VET sector. The criticism effectively was to the effect that, well, VET is about fitting people for a job and task-oriented training, and it was thought that your courses didn't do that. What's your response to that?

PROF VICKERS: I noted those comments and I was concerned by those. I think we all wouldn't be here if the VET sector and the industry were doing such a great job. The comments, I guess, were related to the development of these new undergraduate courses, diploma, associate degree and bachelor of dementia care which is largely designed for aged care workers. And I think the comments – I should note the comments were incorrect because, in fact, when we developed these courses we did do them with industry at that time, ACSA New South Wales and ACSA Tasmania.

But I think with a lot of the work that we do, be they the formal courses or the informal MOOCs on dementia that we do, our orientation really is to people at the coalface. It's the aged care workers, the nurses who are doing that job every day. It's the person who has lots of conditions and our interest particularly, obviously, is in dementia so people with dementia need to be part of the equation, and their carers. And I guess - - -

MR BOLSTER: Does it really pick up the defect in training across - - -

PROF VICKERS: Absolutely.

MR BOLSTER: - - - courses in both medicine - - -

PROF VICKERS: Yes.

MR BOLSTER: - - - nursing and the carer VET course.

PROF VICKERS: Yes. So the catalyst for us to developing these educational program was work that was done by the Wicking Centre led by Professor Andrew Robinson that showed that if you were a family carer, an aged care worker, a nurse, a GP, the chances were that your knowledge of dementia was not up to scratch, it was deficient. Now, you could understand that for family carers who were confronted with dementia for the first time, and they certainly need to be supported. But we've really got a massive problem in what we're doing in our health professional training and in what we're doing in the VET sector and then what we're doing to support people once they're working in the industry to make sure that they know enough about dementia so they can do their job properly.

MR BOLSTER: All right. And your final message to the Commissioners.

PROF VICKERS: Well, back on medical curricula, it's very difficult to shift the direction of a curriculum ship, especially when it comes to medicine. I think what does work is incentivisation. And again, when we had Commonwealth funding to support the development of these teaching aged care facilities, again, to try and make – and it doesn't have to be every residential facility but certainly sentinel facilities throughout the country. If we had funding to make those robust teaching and research-orientated facilities, a subset of them, and support high quality placements, I think that that would do a marvellous job for our health professionals in training and also improve the quality and safety for the people who are resident in those facilities.

So something akin to what we already do in terms of our strategic focus on rural health, with the rural health multidisciplinary training program run by the Commonwealth which has rural clinical schools and university departments of rural health; then we really need to have something like that in the residential and community aged care sector. My other point is just really related to dementia. I think, again, one of the big reasons that we're all here today is that we've got a national emergency around the understanding of dementia. Dementia is the condition that brings the complexity to aged care, and universities haven't probably done the best job that they could in terms of preparing graduates to work with people with dementia. The vocational sector, it is true there as well. It's true when it comes to various service providers as well.

So I think we need a blitz. We really need an emergency reaction to upskill the current health workforce working in aged care in dementia, and then we also need to make sure that we have relevant content in those health professional programs for people who will end up working with older people. And just finally, I guess the point that I make when I have my single lecture on dementia – a single lecture on dementia in a five-year program because of a very tight curriculum – the point I make to medical students, unless you choose very specifically your future career options to go into paediatrics or obstetrics and gynaecology, there's a very good chance that every day that you will be working with older frail people with lots of conditions and, into the future, a lot them with dementia.

MR BOLSTER: Thank you. Ms Yates do you have a message for the Commission?

MS YATES: Yes, there's a few points. I'll make them quickly, though. One is I just want to reiterate that it is universities' role to produce and educate and train beginning practitioners, and they are broad in their understanding and skillset and that generally specialisation comes after that, but they do include the whole lifespan, so they do get exposure. However, there are definitely, as I've already said, opportunities to augment our – and better match our workforce need with some of the placements because we know that placements act as workforce distribution leaders and they give people the skills and experience in the settings of need, and we know that, based on evidence, university aged care service partnerships are an important way of achieving that and they have worked in the past and there is really good benefits that come to clients, to aged care providers and to students in those partnerships.

And I would also say that there's definitely an increased role for allied health to be included in the mix and finally I would say that I think one of the things that we haven't touched on actually today is the need for some guiding agency around the aged care workforce to take some sort of carriage of this and drive it. Whether that's sort of planning agency – I'm not quite sure what you would call it but an agency that is dedicated to looking at the aged care workforce as part of the broader health and disability workforce because those three areas are so intimately related and draw on the same health professional workforce and care workforce.

MR BOLSTER: Thank you very much. Professor Ward.

PROF WARD: Thank you, counsel. Dementia is absolutely a priority but so is palliative care and end-of-life care. We have released earlier this year a white paper, Achieving Palliative Care for All: The Essential Role of Nurses outlining for most people, and particularly in remote and rural and isolated areas, it will be a nurse who is the most familiar member of the community and probably a first port of call.

So I would reiterate that dementia is one part that is definitely – a few elements in specialisation. Nurses – we mentioned allied health and it was a really good point to make around access to MBS, but nurses do not graduate with a provider number and so for registered nurses and nurse practitioners it is just a continuingly relentless issue that there is such limited access to MBS numbers, and that has a detrimental effect on access and equity for Australians or for people living all throughout different areas of Australia, in how they can get to a health professional or the old-fashioned and traditional systems that we have to work in.

Nurses don't come to work to chase paperwork. So when we're talking about undergraduates, any nurse, anyone who chooses to be a nurse – it's in our heart, to want to make a difference to vulnerable populations and people in communities. And in some of the residential-aged-care facilities the role – there's just so much pressure around ACFI and funding and chasing that it's pulling people away. And with that that in mind, we really feel for that public safety – the nurse, registered nurse, if there is one, or enrolled nurse is getting so stretched that we have called in a

white paper for the regulation of the unregulated healthcare worker. It is, probably, the only way that we can get a sense of feeling that we're not compromised.

A lot of times I will hear families and communities refer to care staff as nurses; it is a protected title, but people, of course, don't understand always who's looking after their loved ones. And I think with increased – disproportionately and significantly increased certificate 3 or – that third-tier worker is being considered a nurse, when they are not. They do a very important job. We don't discount that. There is an important place for all of us, but really we're moving into a world where the nursing profession wants to see the regulation of the unregulated healthcare worker now for – because we're governing and providing nursing-duties and for public safety.

And I think that the pride in our profession would be lifted in aged-care. We do need to do a lot to support the nurses. We need social change. There's so much stigma from an undergraduate level about how people age in society and the people that care for them. I received a text late last night from a very experienced registered nurse that I worked with years ago, and she said, "Kylie, I hope I'm not too late to tell you" – and this is – Maria said "I hope I'm not too late to tell you. I've just come off a shift". Two registered nurses, 114 residents in aged-care – they've had to provide all the care and the medication, and she said that one of the residents tried to commit suicide. This is someone experienced who is completely stressed and desperate.

Why would we want – now, Maria's an excellent nurse; imagine if she had a student in that environment. And I am getting texts and messages and people talking to me almost daily as the CEO of the Australian College of Nursing, and we're absolutely reliant on change and grateful to be here. So we're very proud and honourable profession and are hoping that the aged care industry providers will regard us as such and stop focussing only on accommodation and on the role that nurses play. Thank you.

MR BOLSTER: Thank you very much. I have no further questions, Commissioners.

COMMISSIONER PAGONE: Thank you to each of you. We're listening, and I thank you for having shared your various experiences. It's very important, for us to hear it. And we've heard it. Thank you.

PROF WARD: Thank you.

PROF VICKERS: Thank you.

MR BOLSTER: Might the witnesses be excused now, Commissioners.

COMMISSIONER PAGONE: Yes. Now - - -

MR BOLSTER: I need to tender some statements.

COMMISSIONER PAGONE: Well, I was going to remind you.

MR BOLSTER: Do apologise; it's a bad habit I have, Commissioner. If I tender Professor Vickers statement - - -

COMMISSIONER PAGONE: Yes. All right. Professor Vickers' statement will be 11–63.

EXHIBIT #11–63 PROFESSOR VICKERS STATEMENT

MR BOLSTER: I tender Ms Yates's statement.

COMMISSIONER PAGONE: That'll be 11–64.

EXHIBIT #11–64 MS YATES STATEMENT

MR BOLSTER: I tender Professor Ward's statement.

COMMISSIONER PAGONE: That will be 11–65.

EXHIBIT #11–65 PROFESSOR WARD'S STATEMENT

COMMISSIONER PAGONE: They may now be excused.

<THE WITNESSES WITHDREW [3.04 pm]

MR BOLSTER: Thank you. And I call Dr John Brian Maddison.

<JOHN BRIAN MADDISON, AFFIRMED [3.04 pm]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: Dr Maddison, a statement's going to appear in front of you. WIT.0484.0001.0001. Hopefully you'll recognise it.

DR MADDISON: Yes.

MR BOLSTER: That's the statement you prepared on the – for some period up to and including the 8th of October.

DR MADDISON: It is; yes.

MR BOLSTER: Is there anything you want to change about the statement?

DR MADDISON: No.

MR BOLSTER: And is the statement true and correct to the best of your knowledge and belief?

DR MADDISON: Yes.

MR BOLSTER: Can I thank you for a very comprehensive and very helpful statement at least from the Counsel Assisting team. It will mean that I have fewer questions to ask you than I might otherwise have. You're the President of the Australian and New Zealand Society for Geriatric Medicine; correct? And is that a yearly role or a two-yearly role?

DR MADDISON: So all of our members are volunteers, and in our – as office-bearers of the society, we're volunteers; the presidency is for two years, but we spend a year as president-elect and a year as the outgoing president. So it's a four-year commitment.

MR BOLSTER: So you're new to the job?

DR MADDISON: New to the job, but I've been involved with the executive of our body since I was registrar in 2005.

MR BOLSTER: 2005. Your experience is in South Australia, where you are – you have a private practice as well as a hospital practice; correct?

DR MADDISON: I've formerly been in private practice. At the moment I'm full-time in public practice, half-time as a clinical geriatrician, seeing patients, and half-time managing my service in a public hospital, in a local health network, and I oversee geriatrics, palliative care, rehabilitation medicine, chronic-pain medicine and a clinic that specialises in looking after intellectual disability.

MR BOLSTER: Your role: how often does it take you to a residential-aged-care facility?

DR MADDISON: My personal role – not as much as it used to. I do support some nursing homes where we have programs after hours and on weekends. But my service itself – not through people who are in permanent residential aged-care but through a variety of programs such as transitional-care packages and through programs which are hospital run, we have intimate dealings with a number of

facilities where we run – and of course we do see patients on consultative basis in nursing-homes in our area.

MR BOLSTER: It's not in your statement, but would you like to give the Commission an overview of your experience, your recent experience of what's wrong with residential aged-care?

DR MADDISON: It's a good question. I'm sure the Commission's heard a lot more direct evidence from direct lived experience. So really my expertise is really commenting on how we might better provide the medical element to that care. One thing which, I think, is often missed or overlooked or not emphasised enough in these types of deliberations is getting back to – the question, which I have made reference to in my statement, is that – why do people enter into residential aged-care, and entry into residential aged-care is not an inevitable part of aging. Most people, in fact, don't go into residential aged-care. They live and die in their homes.

The reason that some people do have to move into residential care is not driven by choice or really by social need but by medical needs. So it's the accumulation of medical problems throughout the life, that gets to a point where people's function is so impaired that they need to go into a nursing-home or into care of one type or another. So for me – often that isn't stated. The fundamental reason that people move into residential aged-care is because they have medical problems. So for me, central to any solution in terms of how we might improve care, we must be addressing the medical needs of residents in aged-care or in home-care packages.

In terms of the medical care – the bedrock of delivering medical care in residential aged-care must be the general practitioner and having an adequate general-practitioner workforce. So the first problem I see from medical perspective is how general practice operates within the residential-aged-care sector. It's fragmented. There's, clearly, issues of remuneration which other – which the general practitioners themselves can speak for. But that's – the first challenge when we're running our programs in nursing-homes is actually – is trying to secure consistent general-practitioner input into the patients that – we're facilitating their care.

MR BOLSTER: We hear evidence and we've heard a lot of evidence about the difficulty for a person going into care with their own GP, losing that GP when they go into care because of a geographical dislocation or because there's a particular GP associated with a nursing-home. How big a problem is that?

DR MADDISON: We see both – there's pros and cons to both models. So you can imagine, if you are at an aged-care facility and you've got 40 residents, it's not necessarily great, if you've got 20 or 25 general practitioners coming to provide care. Of course, the corollary of that is having a – losing that longitudinal relationship with a general practitioner has got consequences as well. So I don't – that's not an easy question to answer. I think one of the challenges for the residential-aged-care sector would be in trying to deal with the whole different – the vast range of general practitioners who may come in.

The second model which I've seen – the second one of the problems I've observed directly in our area is also – some of the general practitioners will provide a service to a nursing-home, but they're fairly regimented in what they can provide. So if you have a problem on a Tuesday morning and that's the day they come, then that's okay. But if they have a problem Tuesday night or – it has to wait until the following Tuesday, or an ambulance has to be called. So – I'm not a general practitioner, and we do see some of the issues that come of it. I support my general-practitioner colleagues in the evidence, I'm sure, they've already given.

MR BOLSTER: Going back to that process whereby there is an admission because of a medical need, in your statement, at paragraph 27 and 28, you deal with a looming problem in that area concerning the – effectively, the removal of the geriatric portion of the assessment process under ACAT. Why is that happening, and why is it a bad move?

DR MADDISON: Well, this has been a part of the broader Commonwealth aged care reforms that've been ongoing for some years now, as I understand it, and there was a review, which, I think – which I reference, led by David Tune, I believe, who based on feedback from a wide range of stake-holders formed the view that there should be a single assessment process for access into all Commonwealth aged-care services. At the moment it's really divided into two separate assessment processes, one being the regional assessment service, which would tend to look at lower-level-type programs, and then ACAT, which is reserved for the higher-level more-expensive programs, such as receipt of a care package or your ticket to enter a nursing-home basically.

And I'm sure there's some sound reasoning for why those things might be coalesced into one body. One of the consequences of that though is currently in a large number of places across the country those ACA teams are embedded or very closely associated with public-hospital departments of geriatric medicine. So as a consequence of the move to centralise all of these services under a regional-assessment model, that association, that close association will be lost. So that is one fairly key part in our system where an older person can access a geriatrician or more the assessors who identify the need for a geriatrician can readily access one.

MR BOLSTER: Given the sorts of defects in geriatric knowledge that we've heard of today – you were here for Professor Vickers – how confident would you be, if that assessment process was carried out without geriatric-specialist involvement?

DR MADDISON: I think the ACA teams as they are structured have been working closely with geriatricians, and in fact, going back to the 80s, when the whole process was established, geriatricians were involved from the outset. So those teams and those staff members themselves are very expert at what they do. So – I do run an ACA team as part of my public hospital profile, and the assessors we have, which are multidisciplinary nurses and allied health, are extremely good at assessing an older person and the older person's need and are very astute with identifying when a

geriatrician might need to be involved, and we can then get involved. How that level of expertise will be maintained under alternative model is not clear.

MR BOLSTER: Just going back a step – when you see an intern for the first time in your work, how well equipped are they when it comes to geriatric health?

DR MADDISON: I think, having listened to Professor Vickers testimony, I agree with everything he said really. There is – the university curricula for teaching medical students is extremely crowded, and it's almost – very competitive in terms of that – every specialty believe they need more time to teach the students about what they do, and I do think in general geriatric medicine – taking a sort of view across the whole country – is relatively short-changed for want of a better term in terms of time we get to spend with the medical students and educate them about dementia, and an even greater deficiency has already been alluded to as well; the teaching-opportunities outside of acute hospitals or even subacute hospitals are more limited.

MR BOLSTER: Paragraph 54 of your statement – you refer to a survey of Australian medical schools which is to the effect that, of the 18 medical schools responding, rotations in geriatric medicine were not mandatory in seven. When we're talking about rotations there, what are we – are we talking about a clinical rotation of the kind that seems to be - - -

DR MADDISON: Yes, that's right. Where a student would come out and attach to a geriatric-medicine unit for a period over time.

MR BOLSTER: So if – in those medical schools, if a student does not elect, doesn't even have the ability to engage in a geriatric-medical rotation, their exposure to Alzheimer's learning, BPSD, even pharmacology associated with dementia, is likely to be very limited, isn't it?

DR MADDISON: It is, and it's likely to be much less structured. So they'll of course encounter older people with complex problems in other rotations, but they won't have that structured learning focussing on those areas, which, as you said, is quite bizarre when you talk about what is the prevalence of dementia in our society.

MR BOLSTER: Can I turn to the number of geriatricians, which you deal with in some detail in your statement. I won't repeat here. But has there been any study carried out longitudinally about whether that trend is going to continue? There seems to have been an increase over the last 10 years. Are we going to see those numbers replicated over the next 10 years?

DR MADDISON: Yes. Workforce data is very difficult, and I think – as previous people have alluded to, there doesn't seem to be a really central focus on understanding medical workforce, although the Department of Health may disagree. The Health Workforce Australia doesn't exist any longer, as I understand it, and its function's been picked up by the Department of Health. The first point about workforce data – it's extremely difficult, to really get a single source of truth. I think

that's demonstrated in my submission, where I've provided a variety of different sources. What they do tell is a fairly consistent story, which is that number of geriatricians has increased and has increased dramatically over the last 10 to 15 years.

MR BOLSTER: What do you put that down to?

DR MADDISON: I think there's two – there's, probably, three main factors: the first thing has been the recognition by jurisdictions, and Victoria has been at the fore-front of this, by recognising a need in around 2005, that they needed more geriatricians both in the public and in the private sector and making a modest but deliberate investment to develop advanced training in geriatric medicine and support and encourage prospective trainees to consider geriatric medicine as a career, and that really – the numbers speak for themselves. That's been published internationally. It's fantastic model. It's been adopted by other jurisdictions, such as Queensland, and has been expanded into other specialties where the need is perceived, such as palliative care and rehabilitation medicine. So I think that's one factor.

The second factor which was – I think, was a very – was very key was changes to the MBS with the introduction of the geriatric medicine specific item numbers. And I think for the first time you could then articulate to a prospective trainee that there is a business model, there's a remuneration system in place such that you can practise geriatric medicine and make a living that is not completely incomparable to what you can make as another specialty.

One important comment to make there, which I perhaps didn't draw out in my statement, is a lot of geriatricians are actually dual-trained in two specialities. So for example: I'm dual-trained as a geriatrician and a clinical pharmacologist. You may be – a large majority are dual-trained as a general physician and an internal-medicine specialist or as a general physician and an endocrinologist; pretty much every combination you can imagine exists out there amongst my colleagues. So even as an individual, I might choose how much time do I spend, doing geriatric medicine, how many time might I spend, doing clinical pharmacology.

And, of course, financial implications come into which way I choose to spend my time. But the advantage of these item numbers is that it makes it financially viable, to practise as a geriatrician, because it remunerates you for what you actually do, as opposed to perhaps some of the other item numbers, where you'll be more encouraged to have a quicker approach – more task-based, problem-based approach to a patient as opposed to looking at the whole patient.

MR BOLSTER: We might turn to the individual items and get a sense of the way in which they operate. If we could go, please, to page 19 of the statement and you set out a table that shows the prevalence across the country in 2018-2019 of the four MBS items that you refer to. Firstly, in terms of the number of services, 83,566 in

total across the country, what does that tell you about awareness and access to these services?

DR MADDISON: My first reflection on these numbers was I was – and this may surprise you, I was almost pleasantly surprised that there was such a high uptake because although this is clearly not meeting the need, that is still, as I said in my statement, that's still 55,000 patients who have received either a 145 or a 141 which is the full comprehensive assessment within the private sector. So a lot of people will have these kinds of assessments in the public sector as well. But that, for me, is actually pivotal. That's 55,000 older people who have had the benefit of having seen a geriatrician, and this is in the private sector under the MBS.

Now, to contextualise that, we talk about the people on the wait list for aged care packages and I think those numbers run at about 110 to 120 thousand people. That's not a bad dent in that. Clearly, we've still got a way to go, and the idea would be that anyone who is looking to enter into residential aged care or receive a level 3 or level 4 type package would benefit from a CGA. So it does show that moving forward and perhaps the medium term it is not unrealistic to think we would have the workforce to actually do that.

MR BOLSTER: Is there any pressure on that current list of items: 141, 143, 145 and 147?

DR MADDISON: So my understanding is there's currently a review into the Medical Benefits Schedule being conducted by the Department of Health and the first proposed – draft proposal of that was to abolish these item numbers.

MR BOLSTER: Replace them with anything at all?

DR MADDISON: The plan is to – the rationale, as I understand it, is to really simplify the Medicare Benefits Schedule and to largely move everyone who practices as a physician, whether he be a cardiologist or a geriatrician, to a time-based approach, purely a time-based approach. Now, the details of that I don't think have been clarified. Certainly, our Society has strongly opposed the abolition of them for a variety of reasons and we'd be happy to provide a copy of our submission to the Commission. But I understand also the AMA and the Royal Australasian College of Physicians have opposed the removal of those item numbers and I think we've got a strong case, particularly because, for example, in paediatric medicine these types of item numbers have been preserved.

MR BOLSTER: So how does that – can you give us an idea of the comparable paediatric item numbers.

DR MADDISON: The actual MBS numbers are in the papers but - - -

MR BOLSTER: Forget the numbers, just the substance of the service and compare it to what happens?

DR MADDISON: Yes, well, really, both the CGA item numbers and the paediatric numbers talk about focusing on the care of the complex group of patients. So complex paediatric patients or complex older people, and assessing the whole patient, not just their medical needs, but looking at future care planning, taking into – you know, social and other factors, with a strong focus on maximising the function of the person.

MR BOLSTER: What's the risk if there's a shake-up of this in terms of geriatric training and the geriatric cohort?

DR MADDISON: Well, our view is with these item numbers they provided two functions; one is it has – the first thing is they really define what is involved in a CGA or comprehensive geriatric assessment and the elements that need to be undertaken based on evidence to effectively complete that procedure, if you like. So it's a very important quality marker for us in terms of what people need to be doing when they're assessing – geriatricians need to be doing when they are assessing complex older patients.

The second point I've already alluded to is I think this was the first time we could actually demonstrate to prospective geriatricians that, you know, although I can't guarantee you're going to get paid as much as, perhaps, another specialty, it's not as bad as it used to be. And it does mean you can – you can go and see people in a nursing home and charge – and be remunerated at a similar rate to what you would be for an office-based practitioner.

MR BOLSTER: Just going back a step, you were talking about the funding particularly in Victoria that enabled the increase in geriatric numbers to occur. To what extent is the Commonwealth behind any moves to increase or incentivise people to go into geriatric training?

DR MADDISON: So the only Commonwealth program – so by and large all training of all specialties is funded by State governments and public health systems. The one – for specialist training. The one exception I can think of for that is the specialist training position or STP program. So the origins of that is – if we look back two decades and workforce planning, it was perceived there was going to be a very significant shortfall of doctors.

The Commonwealth funded a very large increase in the number of medical students and there were a number of new medical schools which opened up. And, as a result we had a lot more people graduating from medical schools. What was required, though, was training pathways to actually turn these medical graduates into specialists and as a result we needed more specialist training positions and the Commonwealth funded a number of those.

MR BOLSTER: That was across all specialties.

DR MADDISON: Across all specialties and different – and they were – as I understand those – the numbers were then administered by the specialist colleges and, as I said, based on the 2017 review of the STP training program, 35 of those 900 positions were in geriatric medicine.

MR BOLSTER: You mention in your statement – you deal with the issue of perception of geriatric medicine and, to be honest, it's regarded lower down in the pecking order. Why is that?

DR MADDISON: I don't know. I think remuneration might be part of it. So even going back as far as a relative value study which I think was, you know, in about the year 2000, my understanding from that report is procedural specialists are more highly remunerated than cognitive specialists, and that's just built into our system. So invariably people draw a link between what you pay somebody and where that profession fits in terms of esteem. We might speculate there's a degree of inherent ageism in all of us. I don't know. It's difficult to say. I don't have an easy answer for you and I'm obviously not in a good position because I chose to go into geriatric medicine.

MR BOLSTER: Well, you say you found it rewarding; what's the rewarding thing for you?

DR MADDISON: Well, it's not just me. Invariably, surveys of different specialties always find that geriatricians have amongst the highest job satisfaction, and I think people are attracted to geriatric medicine for a variety of reasons.

MR BOLSTER: You have said so much in your statement that I have very little to ask you. What is your message to the Commission in closing?

DR MADDISON: I think there were several points I was hoping to illustrate in the statement. The first point is I understand there's – I think geriatricians have a big part in terms of trying to improve the safety and quality in the aged care sector, and we are heading towards a position where we will be more able to do that in terms of workforce. I think there has been a degree of perception that there are no geriatricians out there and I hope the numbers illustrate that that is in the process of changing. And I almost hope to try and educate the Commission and people who have the chance to read my statement as to what geriatric medicine is about.

And in fact, the very origins of geriatric medicine are, basically, working in nursing homes and that seems to have been lost in some of the discussion. There are some immediate short-term threats to the gains we've made in terms of changes to the aged care assessment team process, and to the Medicare Benefits Schedule, but in the medium term there is some cause for optimism and there are – it's been demonstrated across, you know, the jurisdictions such as Victoria that relatively modest investments can dramatically shift people's training preferences and create workforce.

MR BOLSTER: There's one other matter I did want to raise. There seems to be a gap in the postgraduate training in the geriatric field. There's the six-year geriatrician training under the college. Is there scope for some form of graduate diploma in palliative care or in geriatric training, perhaps a one or two-year course to plug some of the gaps to give registrars and GPs perhaps a minimalist way of addressing skills defects in the area?

DR MADDISON: So – as far as I understand it, and – there is no program out there that is designed to give – that's targeted to doctors, people who have a medical degree already, to build on their formal training in geriatric medicine unless you choose to become a geriatric medicine specialist. There are graduate diplomas in palliative care which are administered by the College and in the past, some universities in different places across the country have run graduate programs targeting doctors to upskill them.

Those programs have failed. I don't know why; I wasn't involved. One speculates that there wasn't a high enough demand for them because, I guess, doctors couldn't see the benefit in doing it because it wasn't linked into remuneration. So I think the two things have to go together; if we're going to ask universities or tertiary organisations to develop these programs, we need to work out how and why would we incentivise people to do them to upskill themselves in those areas.

MR BOLSTER: Is there anything else you wish to say before we conclude?

DR MADDISON: I think I've covered my main points in my statement, so - - -

MR BOLSTER: Those are my questions, Commissioners.

COMMISSIONER PAGONE: Dr Maddison, thank you very much, indeed. I think you've managed to increase at least my knowledge of geriatric medicine more than it was before. So thank you very much indeed. It really is very important to hear from people like you. And I know that the public at large probably don't realise just what public service you perform and the amount of hours and time that you spend doing this kind of thing. Your statement is very full and informative. You may have had some help but nonetheless a lot of it would have been done by you and we are grateful for that. Thank you very much.

DR MADDISON: Thank you.

MR BOLSTER: I tender the statement too, Commissioners.

COMMISSIONER PAGONE: I was going to remind you about that, too. If there was a third witness it would be a hat trick, wouldn't it. The statement of Mr Maddison, 11-66.

EXHIBIT #11-66 STATMENT OF JOHN MADDISON DATED 08/10/2019 (WIT.0484.0001.0001)

MR BOLSTER: Thank you, Commissioners. And might the witness be excused, and there is no further evidence for today.

COMMISSIONER PAGONE: Yes. Dr Maddison, you're excused. Thank you. And if you have any last-minute thoughts about what we might be recommending or doing better, you should feel free to add that. Thank you.

DR MADDISON: Thank you.

<THE WITNESS WITHDREW [3.32 pm]

COMMISSIONER PAGONE: Adjourn until tomorrow morning at 9.15.

MATTER ADJOURNED at 3.32 pm UNTIL FRIDAY, 18 OCTOBER 2019

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