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TRANSCRIPT OF PROCEEDINGS

O/N H-985231

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

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

ADELAIDE

10.05 AM, MONDAY, 18 FEBRUARY 2019

Continued from 13.2.19

DAY 5

MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P. BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL

MR S. FREE SC appears with MR CROCKER for the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, the Commonwealth Department of Health and the Aged Care Quality and Safety Commission

COMMISSIONER TRACEY: Please open the Commission.

MR S. FREE: Commissioners, may I announce my appearance for two additional Commonwealth agencies. My name is Free; I appear with my learned friend MR CROCKER and I appear for the Commonwealth Department of Health and the Aged Care and Safety Commission.

COMMISSIONER TRACEY: We had the pleasure of your presence last week. You're welcome back. Thank you, Mr Free. Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. May I deal with an issue arising out of the tenders from last week.

COMMISSIONER TRACEY: Yes.

MR GRAY: In relation to the documents tendered in respect of Ms Butler's evidence, play I add an additional exhibit which is referred to in Ms Butler's statement which is ANM.0001.0001.2102. That is a literature review entitled Ratios Save Lives.

COMMISSIONER TRACEY: Was this an exhibit to the statement that became exhibit 1-16?

MR GRAY: Yes.

COMMISSIONER TRACEY: And what is it you wish to do? Do you wish to add this to the tender or - - -

MR GRAY: Perhaps if it could simply be tendered separately and given, I believe, number 1-22.

COMMISSIONER TRACEY: Well, 1-20 was the National Aged Care Staffing and Skills Report dated 2016. It might help if the document gets called up and we can see what we're talking about.

MR GRAY: Operator, please bring up ANM.0001.0001.2102. Commissioners, I will deal with this at a more convenient time. We seem to have – be having difficulties accessing that document.

COMMISSIONER TRACEY: Well, I'm at a loss at the moment to understand what the problem is. If it's already in as part of the statement or separately tendered, what's the difficulty you're trying to rectify at the moment?

MR GRAY: I just wanted to ensure that it is in the material.

COMMISSIONER TRACEY: Well, that's why we should have it called up so we know what we're - - -

MR GRAY: Here it is. Now, in respect of Ms Butler's statement that went in as exhibit 1-16 and a number of Ms Butler's identified documents, documents went in as exhibits 1-17 through to 1-21. I seek to add this document as 1-22.

COMMISSIONER TRACEY: All right. Well, I think this is a document of significance and probably, at the risk of having it in twice, it's worth giving it a separate marking. Is it dated?

MR GRAY: May 2018, Commissioner.

COMMISSIONER TRACEY: Well, the document prepared by the New South Wales Nurses and Midwives Association entitled Ratios Save Lives, Supporting Research, dated – what was the 2018?

MR GRAY: May.

COMMISSIONER TRACEY: May 2018 will be exhibit 1-22.

EXHIBIT #1-22 DOCUMENT PREPARED BY NSW NURSES AND MIDWIVES ASSOCIATION ENTITLED RATIOS SAVE LIVES, SUPPORTING RESEARCH, DATED MAY 2018 (ANM.0001.0001.2102)

MR GRAY: Thank you, Commissioner. I call Ms Glenys Beauchamp PSM, the secretary of the Department of Health of the Commonwealth.

<GLENYS ANN BEAUCHAMP, AFFIRMED [10.11 am]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Operator, please bring up WIT.0022.0001.0001. Ms Beauchamp, what is your full name?

MS BEAUCHAMP: Glenys Ann Beauchamp.

MR GRAY: Do you have a copy of your witness statement available to you?

MS BEAUCHAMP: Yes, I do.

MR GRAY: Is the document bearing the number I just read out a true copy of that witness statement?

MS BEAUCHAMP Yes, it is.

MR GRAY: Do you wish to make any amendments?

MS BEAUCHAMP: No.

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

MS BEAUCHAMP: Yes.

MR GRAY: Commissioners, I tender WIT.0022.0001.0001.

COMMISSIONER TRACEY: Yes. The statement of Glenys Ann Beauchamp dated 4 February 2019 will be exhibit 1-23.

EXHIBIT #1.23 STATEMENT OF GLENYS ANN BEAUCHAMP DATED 04/02/2019 TOGETHER WITH 10 ANNEXURES (WIT.0022.0001.0001)

MR GRAY: And Commissioners, there are 10 annexures, referred to as exhibits I believe.

COMMISSIONER TRACEY: The exhibit will include the annexures.

MR GRAY: Thank you, Commissioners. Ms Beauchamp, you're the secretary of the Department of Health.

MS BEAUCHAMP: Yes.

MR GRAY: The department administers a range of programs for subsidising the provision of aged care in Australia; correct?

MS BEAUCHAMP: That's correct.

MR GRAY: The Australian Government doesn't itself provide the aged care; it provides the subsidies for its provision.

MS BEAUCHAMP: That's correct.

MR GRAY: The care itself is largely provided by privately owned entities with a minority of State owned entities.

MS BEAUCHAMP: That's correct.

MR GRAY: And the Australian Government pays subsidies to the providers under a number of programs, that's correct, isn't it.

MS BEAUCHAMP: Yes.

MR GRAY: Including – let's identify perhaps the three of keenest interest, the Commonwealth Home Support Program, CHSP.

MS BEAUCHAMP: Yes, that's correct.

MR GRAY: Home care packages.

MS BEAUCHAMP: Yes.

MR GRAY: HCP and, of course, residential care provided under the Aged Care Act.

MS BEAUCHAMP: That's correct.

MR GRAY: And they're the three principal programs I'm going to be asking you questions about today.

MS BEAUCHAMP: Yes, acknowledging that there are a number of other programs.

MR GRAY: There are a number of others. And in terms of an overall funding split, you refer in your statement – this is paragraph 55 – to there being a split of about 70/30 in terms of government funding, that's 70 per cent, and customer contributions, that's about 30 per cent overall.

MS BEAUCHAMP: Yes, that's correct.

MR GRAY: And in terms of where the weighting in that expenditure, that government expenditure goes, the budget is weighted towards residential care and it's roughly, in 2017/18, $12.2 million out of $18 million; is that right?

MS BEAUCHAMP: Yes.

MR GRAY: However, in numbers of people who are receiving the care that weighting isn't reflected in those numbers. In fact, people receiving residential care are something between 18 and 19 per cent of the total numbers of people receiving care; is that right?

MS BEAUCHAMP: That's correct, yes.

MR GRAY: And with respect to those three programs I mentioned, those principal programs, accepting that there are various others, just talking about CHSP first, that's an entry level program.

MS BEAUCHAMP: Yes, that's regarded as an entry level program, yes.

MR GRAY: And it's entry level in terms of the funding that's provided and the sorts of assistance that are provided to people in the home, such as gardens, help with shopping and so forth; is that right?

MS BEAUCHAMP: Primarily to allow aged care people to live at home longer, yes.

MR GRAY: And the average age of accessing CHSP is about 79 years old.

MS BEAUCHAMP: Yes.

MR GRAY: Paragraph 35 of your statement. And when we go to the other programs, next HCP, home care packages, the average age of a person receiving HCP, depending on their gender is between 80 to 81 years old.

MS BEAUCHAMP: Yes.

MR GRAY: Just looking at the table in paragraph 35 which is available to you on the screen, is that age an average age when the person receives their assessment or receives the care package itself and care begins.

MS BEAUCHAMP: That is the average age of the person in receipt of the care.

MR GRAY: Thank you. And with respect to residential care, the average age, depending on gender, is between 82 and 84 and a half years old?

MS BEAUCHAMP: That's correct.

MR GRAY: That's correct. The subsidies the government pays are determined in accordance with the various specific conditions of each program; that's correct, isn't it?

MS BEAUCHAMP: That's correct.

MR GRAY: CHSP is block funded but when we get to home care and residential care there's a specific assessment of the person who's to receive the care and the funding depends on that assessment; is that right?

MS BEAUCHAMP: Yes, that's right.

MR GRAY: And HCP is assessed at four levels.

MS BEAUCHAMP: Yes.

MR GRAY: Funding for residential care is even more calibrated to assess needs using an instrument; is that right?

MS BEAUCHAMP: A subsidy provided to aged care residential services, yes, we do use an instrument, yes.

MR GRAY: And when you say "we do use" it's, in fact, the approved providers who use it, isn't it?

MS BEAUCHAMP: Yes.

MR GRAY: So each approved provider wishing to receive a subsidy in respect to a person to whom they're providing residential care needs to have a number of things in place before that approved provider can get a subsidy. That's right, isn't it?

MS BEAUCHAMP: That's correct.

MR GRAY: One thing is an allocated place.

MS BEAUCHAMP: Yes.

MR GRAY: That allocated place may or may not represent an actual person. It may be operative, in that case the place is filled or inoperative, in that case it isn't filled; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: And in the case of an approved provider seeking to actually provide residential care to a person in respect of an allocated place, the approved provider applies the instrument to assess the person's needs; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: And the instrument is called the Aged Care Funding Instrument, ACFI or ACFI.

MS BEAUCHAMP: ACFI, yes.

MR GRAY: And depending on the assessment made by the approved provider, the application of the instrument results in certain dollar amounts being paid by government to that approved provider in respect of that person; is that right?

MS BEAUCHAMP: For that element of the subsidy which is the care subsidy, yes.

MR GRAY: For the care subsidy. And there are various other forms of subsidy that might be received, for example, in respect of capital investment; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: Now, just thinking further about ACFI, the mix of people's needs catered for by a particular approved provider in a residential setting can vary from approved provider to approved provider; is that right?

MS BEAUCHAMP: Yes.

MR GRAY: For example, some providers are caring for greater numbers of people with more complex needs such as perhaps care of people living with dementia; is that right?

MS BEAUCHAMP: That's correct and even within one service you might have significant variability in terms of needs of clients.

MR GRAY: And the approved providers are receiving one amount of money or one pot of money in respect of their conduct of their business, aren't they? It's not – it doesn't need to be acquitted in terms of each resident; is that right?

MS BEAUCHAMP: No, it doesn't.

MR GRAY: Yes. I want to ask some questions about the importance of ACFI in the current architecture of the system for funding residential care.

MS BEAUCHAMP: Yes.

MR GRAY: Time permitting I will return to the topic of funding at the end of your evidence, but to begin with, I just want to ask you some limited questions about ACFI. I want to ask you about ACFI in the period prior to the 2016/2017 budget. Is it the case that prior to the 2016/17 budget ACFI amounts were indexed year on year for inflation?

MS BEAUCHAMP: Yes, they are.

MR GRAY: They are, and I'm asking you about the period prior to 2016/17.

MS BEAUCHAMP: So they're generally indexed on the basis of inflation, the care needs of the client and other indices, other parameters.

MR GRAY: Thank you. And is it the case that in the 2016/17 budget there was a suspension on index of certain amounts paid to providers of residential care based on application of ACFI?

MS BEAUCHAMP: Yes, there was.

MR GRAY: Now, Leading Age Services Australia is putting forward a witness, Mr Sean Rooney, and he's going to give evidence later this week including certain paragraphs of his statement which I will ask to be put up so you can read them. Operator, please bring up WIT.0013.0001.0001. Please go to paragraphs 68 to 72. Now, rather than ask you to read all of that Ms Beauchamp, perhaps if I can just ask you to read from paragraph 68 to 72 and then I will ask you in particular about the views expressed in paragraphs 70 and 71.

MS BEAUCHAMP: You would like me to start at paragraph 68?

MR GRAY: Yes, just read it to yourself though, don't read it out. Thank you. Thanks, Ms Beauchamp. Are you happy that you've familiarised yourself with those paragraphs now?

MS BEAUCHAMP: Yes, I am.

MR GRAY: Thank you. In paragraphs 70 and 71 Mr Rooney – and I am paraphrasing his argument – he's contending that certain modelling that was obtained found that the changes that I have mentioned in the 2016/17 budget to ACFI would reduce funding to support older people in care by 11 per cent per resident each year, and for residents with very complex health needs there was an even larger amount of impact extending to approximately $18,000 a year. Do you agree with the views Mr Rooney expresses in that regard?

MS BEAUCHAMP: In answering that there's probably two things to look at. One is the amount of funding the Commonwealth has provided to residential aged care which has been growing annually since that time. The second issue is the funding provided for each client through the ACFI instrument has actually increased. Prior to this happening there was, indeed, anomalous growth without very much change in client profile.

MR GRAY: When you say there was anomalous growth, do you mean that approved providers in aggregate terms were claiming that assessed needs were higher and were claiming more money through ACFI?

MS BEAUCHAMP: In aggregate terms we're looking at a benchmark of two per cent per annum, in aggregate terms; that doesn't get down to the complexities in each service. The two years prior to those reforms which came in, the growth rate was in excess of five per cent.

MR GRAY: When you say we're looking at a growth rate of two per cent, you mean that's just a projection within the department of what the growth rate should be. Is that what you mean?

MS BEAUCHAMP: Even looking back now there has still been a growth rate for residential care and, indeed, subsidies paid through ACFI.

MR GRAY: The cause of the increase could have been increasing complexity or acuity in the needs of residents, couldn't it?

MS BEAUCHAMP: On an individual basis, yes, but I think, as I mentioned earlier, the client profile had not changed all that markedly and there was indeed anomalous growth in the two years prior to those changes.

MR GRAY: Has indexation of the relevant amounts through ACFI been restored?

MS BEAUCHAMP: Indexation is being restored. It's not to the indexation amounts that were provided prior to these changes.

MR GRAY: Has the department formed any view about whether the suspension of indexation on the relevant ACFI amounts impacted on safety and quality outcomes for residential aged care services post the 2016/17 budget?

MS BEAUCHAMP: That's a level of detail I haven't got for each individual person but in looking, as I said, the client profile, it hadn't changed markedly. Our priority is to ensure care recipients are receiving adequate care in residential care facilities, and the audits that we've done of the use of the ACFI instrument appears in aggregate terms only, that there has been a number of providers maximising their revenue through the ACFI instrument.

MR GRAY: I'm not certain that that's a complete answer to my question. Has there been analysis of whether notwithstanding those anomalies there was an impact on quality and safety as a result of that indexation suspension?

MS BEAUCHAMP: There hasn't been a direct assessment of the impact of the ACFI funding changes on quality and safety.

MR GRAY: Thank you. Now, as secretary you're responsible for all aspects of the Department of Health's operation and performance, as you say in paragraph 14. That's correct, isn't it.

MS BEAUCHAMP: That's correct.

MR GRAY: And would I be right in thinking that your responsibility includes making the aged care system work in tandem with other parts of the health system?

MS BEAUCHAMP: Yes.

MR GRAY: Thank you. Now, ageing and aged care is an outcome in the health department's budget; that's correct, isn't it?

MS BEAUCHAMP: That's correct.

MR GRAY: And, in fact, it's outcome 6, is that right?

MS BEAUCHAMP: Outcome 6.

MR GRAY: Yes. Operator, please bring up RCD.9999.0011.0734. Ms Beauchamp, do you recognise this to be an extract from the budget-related papers concerning the Department of Health's budget?

MS BEAUCHAMP: Yes, I do. I'm not clear of the date of those budget papers but that's very familiar.

MR GRAY: In respect of the last budget, 2018 to '19.

MS BEAUCHAMP: Right.

MR GRAY: Could we please go to paragraph 133 and 4. I don't know if you're able to bring them both up on the screen at the same time, Operator? Pages 133 and 134 of the budget papers. Thank you. Ms Beauchamp, do you recognise this to be table 2.6.1, the outcome 6 budgeted expenses for 2018/19 including estimates for three years following 2018/19?

MS BEAUCHAMP: Yes, that's correct.

MR GRAY: Thank you. In your opinion, is the budget allocation including the forward estimates sufficient to discharge the obligations you've outlined in paragraph 15 of your statement in respect of the functions of the department?

MS BEAUCHAMP: I should point out that there's an updated budget paper that was only released last week, the portfolio additional estimates paper and that these figures have been updated in accordance with that. Whether this is a funding envelope that I think you said, is sufficient?

MR GRAY: Sufficient.

MS BEAUCHAMP: Sufficient. The government decides on the funding envelope we're to work within and we determine against the parliamentary appropriations how that is then to be expended. It is sufficient for currently the aged care system that we administer.

MR GRAY: And, of course, I understand, I'm sure the Commissioners understand that you work within the budget you're given but I asked you a different question which was, granted that you have to work within it, is it sufficient now and in the future. I think your answer is that it's sufficient; is that limited to the present?

MS BEAUCHAMP: It is sufficient for the forward estimates period. In terms of the future, there will be some challenges. For example, the number of people wanting to live at home will grow. The level of acuity, for example, the number of people with dementia will also grow. And the number of people accessing the aged care system

in future will grow. So we will have to look at, through the budget process which is an annual process, funding required to meet those needs.

MR GRAY: Thank you. I want to ask you a bit about how the department is structured in relation to aged care. Is the total number of staff in the department about four and a half thousand people.

MS BEAUCHAMP: It's a full time equivalent of about 3970.

MR GRAY: Thank you. And what's the staffing level in respect of people with aged care functions?

MS BEAUCHAMP: So the direct – the direct staffing level within the department would be about 586 full time equivalents, and, of course, there would be corporate support services on top of that.

MR GRAY: And how many of those 586 people are involved in visiting residential aged care facilities as part of their ordinary duties?

MS BEAUCHAMP: In our network, which is a devolved network around Australia, we have over 200 of those 586 staff working in those State and Territory offices. Many of those would be part of our compliance regime which would require visits to a number of aged care facilities.

MR GRAY: Thank you. Has there been any material change in the number of staff within the department working in aged care over the last five years?

MS BEAUCHAMP: I haven't got the exact detail and the exact numbers with me but, of course, as the secretary of the department, you do make sure you can allocate both staffing and departmental resources where it's needed most and so there have been quite a few changes in terms of the aged care program and outcome 6. I've given more responsibilities to some of the deputies and, for example, we have set up a reform area because there have been quite a number of government reforms to be implemented over the last 18 months, particularly since I've been there. So there have been additional resources applied to aged care.

MR GRAY: What's the department's overall budget for its own expenditure on administration?

MS BEAUCHAMP: The department's overall budget would be about $700 million.

MR GRAY: In respect of expenditure on salary for its own employees?

MS BEAUCHAMP: Probably the benchmark you would use is between 60 and 70 per cent are salary expenses, but in departmental cost, you also have contractors, consultants, reviews and a number of other costs associated with that departmental funding.

MR GRAY: And how much of the departmental administration funding goes to aged care or is correlated to aged care?

MS BEAUCHAMP: Approximately between 13 and 15 per cent.

MR GRAY: And has there been material – any material change in that proportion over the last five years in real terms?

MS BEAUCHAMP: I think that's quite a difficult question to answer because responsibilities for aged care and parts of aged care have been going in and out of the portfolio and, of course, when governments change and their administrative arrangement orders, there are many changes in the department so it's hard to compare overall staffing with previous staffing levels and resources.

MR GRAY: I won't press you.

MS BEAUCHAMP: All right.

MR GRAY: Ms Beauchamp, as you've said in your statement, the department currently has what we can call regulatory functions in relation to aged care as well as having policy including system design and funding functions. That's right, isn't it, currently?

MS BEAUCHAMP: Yes. That's correct.

MR GRAY: And it's intended by government that from 1 January 2020 the department will not have regulatory functions but will be left with the policy and funding functions. Is that a correct summary?

MS BEAUCHAMP: That's the intention, yes.

MR GRAY: Yes. And those regulatory functions are intended to go to the new Aged Care Quality and Safety Commission; correct?

MS BEAUCHAMP: That's correct.

MR GRAY: Now, I want to ask you about transitional arrangements. What specifically in concrete terms are the transitional arrangements with regard to transferring the department's regulatory functions to the Commission by 1 January 2020? What has been happening in that regard?

MS BEAUCHAMP: So the department has been looking at exactly what functions do need to be transferred and the normal transition arrangements would be that staff and resources follow those particular functions. So there's a number of things that we're doing is looking at the – making sure we've got the legislative provisions to meet those transfers and also that we're very clear about roles and responsibilities between the Commission and the department, and so putting in place formal

arrangements around the transition of those functions to the new commission is something that we haven't formalised yet, although we do have ongoing discussions, both within the portfolio and with the commission.

MR GRAY: I just want to ask you about the transfer of staff and resources. With respect to the transfer of staff, do you mean that the staff who are currently doing – departmental staff, that is, who are doing visits to residential aged care facilities and who are considering notices of intention to consider the imposition of sanctions and so forth, that those people are going to be re-employed by the commission?

MS BEAUCHAMP: That's correct. The staff on the compliance activities and regulatory activities currently in the department will transfer.

MR GRAY: Right. Is it, as far as the transitional plans are concerned, it's just a matter of transferring that workforce or are improvements going to be made to their capabilities?

MS BEAUCHAMP: I think with the reforms that have already commenced, there's always a process of continuous improvement and upskilling staff, and indeed, our provider functions and compliance functions. So that will be a normal course of business happening between now and 1 January 2020 and will continue beyond that.

MR GRAY: So when you say there's always a process of upskilling and it's part of the normal course of business, are you saying there aren't any special plans out of the ordinary course of business for additional training in respect of investigative capability?

MS BEAUCHAMP: I think ultimately that will be for the Commission on 1 January 2020 to look at the – both the quantum of skills and the mismatch of skills having an end to end compliance process. I'm sure at the moment there's some overlap and duplication of effort. There's also a number of different systems and so I think having the – having those sort of things consolidated in under one Commission I think there will be some efficiencies and effectiveness under the new regime.

MR GRAY: I want to bring up paragraph 111 of your statement. Just focusing on the introductory words; it's quite a long paragraph in its entirety but the introductory words:

> *There is a range of evidence including consumer feedback going to the issue of whether the aged care system currently meets consumer needs.*

And then you enumerate a number of sources of that evidence. Now, what's your view as opposed to whether there are sources of evidence on the question of does the system currently meet consumer needs?

MS BEAUCHAMP: As I mentioned, we do focus on continuing to improve the way we do our business. I think there have been a number of improvements to

ensure that we are gaining consumer feedback and it's meeting the needs. As I've mentioned in those paragraphs, there is more engagement with consumers and families now. There's also new standards are being put in place in the regulatory arrangements, and I think more engagement, both with the providers, families and care recipients, will give us more information in the future.

MR GRAY: And again, thank you, you've identified a number of sources of material or information that might go to the question of whether the aged care system currently meets consumer needs, but do you have your own view about whether it does or not at present, or are you able to rate it?

MS BEAUCHAMP: Generally, you would look at a range of evidence and in aggregate terms I think commentators that are more skilled and have expertise more than I have commented in the past, for example, under the Carnell Paterson report that the quality of care is of a good standard. In terms of extrapolating that comment you would think in general it's sufficient to meet the needs. That's – of course, I acknowledge there may be considerable hot spots, and indeed areas of special needs where we need to improve the services that are being provided.

MR GRAY: Let's go to the Carnell and Paterson report. Operator, please bring up RCD.9999.0011.1833. Thank you. Ms Beauchamp, following the Oakden incidents and the closure of Oakden, the regulatory framework for complaints, compliance monitoring, compliance action and sanctions in the period before 2017/2018 were the subject of scrutiny by Ms Carnell and Professor Paterson and then were the subject of this report from them in October 2017; correct?

MS BEAUCHAMP: That's correct.

MR GRAY: Commissioners, I omitted to tender the budget paper that was RCD.9999.0011.0734. I tender that document.

COMMISSIONER TRACEY: Now, it's best described, is it, as a budget paper? And it, I think, probably needs a date given that Ms Beauchamp has indicated that there has been an even more recent budget paper in this area.

MR GRAY: Ms Beauchamp, can we say May 2018? Is that correct?

MS BEAUCHAMP: Only last week there has been an update of those figures in what we call the portfolio additional estimates process and that follows a midyear and economic forecast process the Department of Finance and Treasury undertake.

MR GRAY: Yes, but in respect of this one, the original budget paper, was it dated May 2018?

MS BEAUCHAMP: Last year's budget paper, yes.

MR GRAY: May 2018, Commissioner.

COMMISSIONER TRACEY: All right. Well, the extract from the May 2018 budget paper bearing the identifying number which counsel has read, will be exhibit 1-24.

EXHIBIT #1-24 EXTRACT FROM THE MAY 2018 BUDGET PAPER (RCD.9999.0011.0734)

MR GRAY: Thank you.

And now if we go back to the Carnell and Paterson report, RCD.9999.0011.1833, I tender that document.

COMMISSIONER TRACEY: Yes. The document entitled Review Of National Aged Care Quality Regulatory Processes by Ms Kate Carnell and Professor Ron Paterson dated October 2017 will be exhibit 1-25.

EXHIBIT #1-25 REVIEW OF NATIONAL AGED CARE QUALITY REGULATORY PROCESSES BY MS KATE CARNELL AND PROFESSOR RON PATERSON DATED OCTOBER 2017 (RCD.9999.0011.1833)

MR GRAY: Thank you.

Ms Beauchamp, that report was published a month after you were appointed secretary of the department?

MS BEAUCHAMP: That's correct.

MR GRAY: And I expect that you gave it a lot of attention at the time and have been continuing to give it attention; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: And in your statement you've attached a table of summarised notations of implementation progress in respect of the recommendations contained in this report. That's at CTH.0001.1000.4510. I will just have that brought up for you. Are these notes on implementation progress that you say are true and correct statements of what the department's progress or the government's progress in respect of the implementation of various recommendations in the Carnell Paterson report is?

MS BEAUCHAMP: Yes, they are.

MR GRAY: Thank you. Now, Operator, I'm going to go between the Carnell and Paterson report and the table setting out implementation progress. Firstly, Ms

Beauchamp, did you note at the time – I'm referring to pages 47 and 8 of the report – that Carnell and Paterson found that the regulatory system design was flawed. In particular, they found that it was flawed in that there was a focus on maintaining a cycle of three year accreditations for all residential aged care services? No, Operator, I'm sorry, I'm referring to – yes, sorry, that's right. Are you able to bring up pages 47 and 8? Think you. Do you see at the end of the passage under the pie chart on number of accreditation periods on page 48, there's a statement:

> *Three year accreditation is inefficient and not risk based. The Oakden case demonstrates that it can place higher risk services and vulnerable consumers at unacceptable risk. It should be replaced with ongoing accreditation and a risk based system with more rigorous monitoring under updated standards. This is discussed further later in this report.*

Did you note that finding at the time?

MS BEAUCHAMP: I have noted that finding, yes.

MR GRAY: Does the three year accreditation cycle remain a feature of the current regulatory design?

MS BEAUCHAMP: A three year accreditation cycle does, with the added avenue now that they're unannounced.

MR GRAY: That is, the accreditation visits are unannounced?

MS BEAUCHAMP: Yes.

MR GRAY: Thank you. With respect to risk profiling, there's an explanation of this concept in more detail at pages 86 and 87 of the report. I will just ask the operator to go to pages 86 and 87. In a nutshell, does risk profiling involve considering a range of data that could inform a more targeted process for conducting visits, reviews, audits and other compliance monitoring?

MS BEAUCHAMP: The risk profiling will be a key factor under the Commission in terms of both preventing and detecting substandard care. I think the – without disrespect, if I can refer to the Carnell Paterson report did raise a number of findings about the risk profiling strategy. Access to data will be a key reform that we need to look at, particularly at the local level, an aggregate level and that has been acknowledged by both Health Ministers and aged care Ministers and across the Commonwealth and States and Territories. Also sharing information at the local level with local health networks and other independent sources of advice, and information. So data is critical to that. I think at the Commission now, the independent Commission being set up having end to end compliance functions will be able to draw on the regulatory information the department holds, but also more information that now the Commission has access to from review audits, accreditation processes and the like.

MR GRAY: At present, is there – until that work is done on a risk profiling system, is there some sort of interim measure in place for more targeted compliance and monitoring action by the department, so it will be transferred to the Commission?

MS BEAUCHAMP: So just to clarify, the commission does have compliance and monitoring responsibilities for quality and safety. We do have a number of compliance functions around, as you mentioned earlier, the funding instrument and the approval of providers. And also we are in receipt of information about reportable incidents. Combining those with the datasets that the commission currently has will be of great benefit in future risk profiling under one umbrella.

MR GRAY: In your response table at page 4510, in respect of recommendation 2, you say:

A risk profile model is being developed for implementation by 1 July 2020.

Is that the best information you have that we can't expect to see a risk profile model implemented before 1 July 2020?

MS BEAUCHAMP: There's risk profiling that occurs now. I think the risk profiling model sitting under one regulatory – independent regulatory agency will need to draw on additional sources of information that I just mentioned, for example, the interface and information that's available at the local level.

MR GRAY: Well, perhaps this is within the province of the new commission, but are you able to say without revealing any operational detail, are there improved systems in place now, never mind 1 July 2020, but now to vary the program of monitoring so that it's not bound to an accreditation cycle?

MS BEAUCHAMP: I think with – following the Carnell Paterson report and a number of other reviews, of course, the department works closely with the commission in sharing information and making sure that our oversight and monitoring doesn't just include the accreditation process, that there are review audits, there are contact assessments. Each time our officers might go out they will share information with officers going out from the commission. So we do have formal arrangements in place between the department and the commission. But, of course, then we have a range of informal mechanisms in terms of weekly meetings and sharing of information.

MR GRAY: I want to ask you about the current accreditation framework which is coming to an end on 30 June 2019. Now, the – in respect of residential care, that accreditation framework involves 44 expected outcomes across four standards; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: And is it correct that in the past and now, and at any time up to 30 June 2019, if an approved provider fails any one of those 44 outcomes they will not be reaccredited?

MS BEAUCHAMP: That's one of the sanctions available at the end of the process. In terms of the accreditation process, that is in the bailiwick of the commission. If there's a service that fails one of those 44 standards, then the service will be given an opportunity to rectify and then if that service does not rectify that outcome, then a number of processes are put in place to escalate that – that outcome.

MR GRAY: I want to ask you about the detail of how outcomes are assessed at present, accepting that the currency of that information may be of limited duration after five months or so; it's not going to be as important as it once was. In your statement at your own exhibit number 3 you have a copy of the quality principles, 2014. Operator, that's CTH.001.1000.4676. And the quality of care principles 2014 is the document which, in two of the schedules, sets out accreditation standards in respect of residential care on the one hand and common standards for home care on the other; is that right?

MS BEAUCHAMP: That's correct. There are four groups of standards sitting under the quality principles.

MR GRAY: And there are four groups of standards in respect of residential care; is that what you mean?

MS BEAUCHAMP: No, there's – there's residential care standards, home care standards, transitional care standards and, indeed, separate standards for national Aboriginal and Torres Strait Islander – the flexible services.

MR GRAY: Thank you. I'm just going to ask you about the accreditation standards in relation to residential care. I take you to page 4700. There are four sets of standards in respect of accreditation of residential aged care services; correct?

MS BEAUCHAMP: Yes.

MR GRAY: And the second of them is entitled Health and Personal Care.

MS BEAUCHAMP: Yes.

MR GRAY: And there are a number of expected outcomes. One of them, just to take an example, is 2.10, nutrition and hydration. And the expected outcome is:

Care recipients receive adequate nourishment and hydration.

It has been suggested, in information that the Commission has available to it, that this could be quite a subjective matter of whether that outcome is met. How is it actually to be assessed in practice? For example, is it required that assessors should

actually observe whether meals are left with residents for a sufficient time for them to eat the meals or whether residents get the assistance they need to eat the meals? Does the department have a view on that?

MS BEAUCHAMP: The department does have a view which I will express in one moment. But the actual detail of what's looked at is done by the Commission as part of their processes. So they've got a separate workforce looking at that. I would expect that care recipients receive adequate nourishment and hydration is not only the number of meals and the food that's provided, but also ensuring that residents are given enough time to eat that food but also there's certainly residents with high care needs that do require assistance with feeding.

MR GRAY: All right. But those matters are not prescribed in the standards but they're a matter of the practice of the – previously the agency, now the commission; is that right?

MS BEAUCHAMP: They would be a practice that's, from my understanding, included in a manual in terms of number of meals and adequacy in terms of assisting residents with feeding.

MR GRAY: I just want to ask you now, perhaps it's similar to that question I asked you about what happens if an approved provider fails one expected outcome. Up until 1 January 2019, the responsibilities for assessment of whether an approved provider met the accreditation standards in a residential care setting, those matters were the responsibility of the Australian Aged Care Quality Agency, weren't they?

MS BEAUCHAMP: That's correct.

MR GRAY: And the agency was required to notify the department, wasn't it, if it became aware of any evidence of a failure to comply with the accreditation standards?

MS BEAUCHAMP: Yes.

MR GRAY: How many such notifications did the department receive in 2017/18 approximately?

MS BEAUCHAMP: I haven't got the precise detail in front of me. I will have to get back to you on that.

MR GRAY: Okay. Can I just ask this then: no matter what the precise number was, what's the process that applied for the department to take in relation to such reports when they were received? I'm talking about the period before 1 January 2019.

MS BEAUCHAMP: So for the period there would have been a number of referrals from the quality agency, and indeed, we provide – we would have provided referrals

also to the quality agency about any service provider that had not met one of the 44 standards. In a normal process it would be up to – it would have been up to the quality agency to rectify that through talking to the provider, going out, having a look and making sure that they bring their standard up to scratch. In – if that wasn't the case, then it would be further escalated to the department.

MR GRAY: I want to ask you now about the standards that will apply from 1 July. They've already been incorporated in a statutory instrument but it's yet to commence; is that right?

MS BEAUCHAMP: That's correct, a statutory instrument in September 2018 for commencement on 1 July 2019.

MR GRAY: And you've extracted the text of the single quality framework that will apply to both residential care and home care.

MS BEAUCHAMP: Yes.

MR GRAY: And you've extracted that at CTH.1000.1012.2385. That was an attachment to your statement.

MS BEAUCHAMP: Yes, yes.

MR GRAY: Thank you, Ms Beauchamp. Now, if we just go, please, to page 2387, the consumer outcome under the heading Personal Care and Clinical Care is:

> *I get personal care, clinical care or both personal care and clinical care that is safe and right for me.*

And then there are certain matters under the requirements that are a little more explicit in terms of what the organisation must demonstrate. But it has been suggested that the new standards are still expressed in quite subjective language. What do you say to that?

MS BEAUCHAMP: I would say that the new standards provide much more of a person-centred approach by asking the initial – articulating the consumer outcome upfront. Of course, the – there's much variability in the range of care recipients, both in residential care and home care, and there will be an element of judgment depending on the needs of that particular consumer, and so I don't think they're too subjective. Of course, there will be guidance provided underneath each of those organisational requirements, but I think the headline is, it does need to meet the needs of the consumer, which varies greatly.

MR GRAY: Just with respect to the Carnell and Paterson recommendations, this was in recommendation 9, and you've addressed it in your response document at page 4514. You say that there needs to be – the chief clinical adviser within the commission involved in a process of establishing a clinical care document, a clinical

governance framework, and you say that won't be in place until the beginning of next year; is that right?

MS BEAUCHAMP: If I can just elaborate, in terms of the reforms that have been put in place, the Commission now has access to an interim clinical adviser. That clinical adviser will be working with service providers to make sure they've got appropriate clinical governance standards in place. In addition to that, and our quality – new quality standards, the commission is also looking at the level of clinical care within each of the service providers and the Minister has also announced a separate advisory committee headed by our chief medical officer in terms of what needs to be done to administer that most effectively.

MR GRAY: And the adviser you mentioned, who is that? The chief adviser or the chief clinical adviser? Who's that person?

MS BEAUCHAMP: Dr Murray who provides guidance to Ms Anderson in the commission.

MR GRAY: And - - -

MS BEAUCHAMP: And that will be supported and the commission will be supported by an advisory quality expert group.

MR GRAY: And when did the Minister establish that committee that you mentioned?

MS BEAUCHAMP: The chief medical officer one?

MR GRAY: Well, the committee which will be assisting in the establishment of the clinical measures? I think you mentioned that the Minister had just established a committee in that regard as well.

MS BEAUCHAMP: The advisory committee the Minister just established, was for the chief medical officer and a number of other advisers to look at clinical care more broadly, particularly misuse of medicines, and the advisory committee that Ms Anderson has in the commission is the transfer of functions from the quality agency from an already expert committee that now is being rolled into the commission. That will provide support and assistance to the commissioner, along with a new clinical care adviser.

MR GRAY: It has been suggested that in some ways the new standards, that is, the single quality framework to commence on 1 July this year, are less prescriptive than the current standards. For example, I will just note that standard 2.15 of the current standards requires that a care recipient's sensory, oral and dental health is maintained, but if we go back to the new single quality framework, there doesn't seem to be any mention of – that's at 1000.1012.2385 – there doesn't seem to be any

mention of oral and dental health. Is that right? There's no mention of oral and dental health in the new single framework quality standards?

MS BEAUCHAMP: I think that's more broadly rolled up into the clinical care – the personal care and clinical care standard.

MR GRAY: All right. You would accept that oral health is very important because poor oral health can lead to a number of consequential health problems. Do you know that?

MS BEAUCHAMP: I agree with that, yes.

MR GRAY: Given its importance, why isn't it explicitly mentioned in the new standards?

MS BEAUCHAMP: I think, as I mentioned earlier, each individual is different in the aged care system. So oral health is one part of the health and clinical care required for each care recipient. So just focusing on one area of health and not a range of others, I think would be singling out unnecessarily that the clinical care and health care needs to look at all health care.

MR GRAY: Operator, please bring up exhibit 1-10 or 1.010 which is RCD.9999 – thank you. I won't read out the entire number. It's already an exhibit, Commissioners. Ms Beauchamp, please look at that document. It's a one page document. Is that an authentic Department of Health document?

MS BEAUCHAMP: Yes, it is.

MR GRAY: And when was that prepared?

MS BEAUCHAMP: That would have been prepared probably August/September last year.

MR GRAY: For what purpose was it prepared?

MS BEAUCHAMP: It was primarily to consolidate what we were seeing around complaints, quality care leading into the decision about providing additional resources for compliance and monitoring, and also it provided some supporting documentation in the government's consideration of establishing the Royal Commission.

MR GRAY: Thank you. If we go down to the data reported under the bolded heading Department of Health, do you see there there's a row Reportable Assault Reports, and, for example, in respect of the year 2017/18 the figure is 3773 reportable assaults. What is a reportable assault in that context?

MS BEAUCHAMP: A reportable assault is where there's allegations or suspicions of what is generally known as assault – physical, mental assaults on either residents or staff.

MR GRAY: And is it the case that it doesn't include assaults by residents on other residents in certain situations, for example, if there's satisfaction by the approved provider that the person who perpetrated the assault was cognitively impaired and certain other conditions are met?

MS BEAUCHAMP: Yes, in certain conditions those are exempt from those assault figures.

MR GRAY: Okay. What action does the department take in respect of the report it receives of reportable assaults?

MS BEAUCHAMP: So reportable assaults, we do make sure that there's follow-up in terms of the assessment of what those – at that stage, they're allegations, so we would undertake and do more work where there were allegations and refer them to the appropriate authorities, whether it be the police or other providers.

MR GRAY: In Carnell and Paterson, there was a recommendation that the obligation to report assaults be broadened in the context of a thing called a serious incident response scheme. And this is recommendation 6 and also page 114 of the report. Perhaps to save time I will just ask you to go to your response table at page 3, page 4512. Thank you. Maybe I will just ask you, Operator, to stay on page 114. Do you see there's reference at the top of that page to:

> *Overall we consider the ALRC extended definition of "serious incident" appropriate.*

Next:

> *We also agree that all –*

I will skip the rest of that paragraph and the next paragraph:

> *We also agree that all incidents of assault, including those committed by a resident with a cognitive impairment should be reported.*

Etcetera. What's the government's position on the expansion of mandatory reporting of assaults to include residents with cognitive impairments?

MS BEAUCHAMP: The serious incident response scheme is something that's being developed at the moment. It will require legislative changes. We're looking at broadening as per the Law Reform Commission recommendation and, indeed, the Carnell Paterson to include resident on resident assaults without exception, and

looking at broadening the definition in terms of some of the recommendations of the Law Reform Commission.

MR GRAY: So you're looking at it but there isn't yet a position?

MS BEAUCHAMP: The scheme is absolutely being developed, yes.

MR GRAY: So, sorry, is it a matter of deciding in the future about whether the definition will be broadened or that has – that decision has been made and the scheme is being designed accordingly?

MS BEAUCHAMP: So that decision hasn't been made. We're in the process of consulting with the sector as the response says, and we will be putting advice to government in terms of how broad that they would like the serious incident response scheme to extend.

MR GRAY: All right. Now, at any rate, presently and it follows in the years that are in that one page document, exhibit 1-10, those reportable assaults don't include resident on resident assaults involving cognitive impairment and meeting the other conditions; correct?

MS BEAUCHAMP: Just to confirm, there are some that are accepted in certain circumstances, yes.

MR GRAY: In certain circumstances. If there isn't cognitive impairment or if the approved provider hasn't done certain things, there is a mandatory reporting obligation?

MS BEAUCHAMP: Yes.

MR GRAY: Now, does the department know the extent of underreporting of assaults? Has it done any studies on the extent to which assaults are underreported in the nature of things – there's usually some sort of degree of noncompliance with reporting obligations, isn't there? Do you know the extent of it in this case?

MS BEAUCHAMP: I wouldn't be aware of the detail in terms of the extent of underreporting, but all of these issues are followed up and in terms of underreporting, I guess I should – I would like to say that we do need to be attentive, both in government, providers and certainly families and carers, to any allegations or suspicions of assault. So we do make sure it is all included in the reports.

MR GRAY: Even on those figures, taking the 3773 reportable assaults in 2017/18, that's a reasonably – reasonably significant proportion of the total number of people in residential care, isn't it? Where there are about two thousand – I beg your pardon, about 240,000 people in residential care, so it's something between one and two per cent.

MS BEAUCHAMP: Yes, a little over, yes.

MR GRAY: And if you included – well, we don't know, do we, how many more assaults would be perpetrated by residents on other residents in circumstances of cognitive impairment and meeting the conditions absolving approved providers from making reports. So the percentage could, in fact, be higher in terms of people actually assaulted in residential aged care; is that right?

MS BEAUCHAMP: I think – I haven't got the exact detail but broadening it out to include assaults from one resident to another in those exceptional circumstances would increase that number.

MR GRAY: In your statement – this is paragraph 111 at sub-paragraph (a) – you refer to data coming from consumer experience reports, and are they reports that are mandatory? They have to be collected by approved providers; is that the case? Or are they not mandatory?

MS BEAUCHAMP: No, they are not mandatory and it was the quality agency that put these in place.

MR GRAY: Okay. Do you know what the participation rate is in approved providers who actually do obtain consumer experience reports and provide them to the – provided them to the agency, or now the commission?

MS BEAUCHAMP: I did mention with this particular one there, the consumer experience report involved over 15,000 interviews.

MR GRAY: And that – was it just a one-off or is it going to continue at about that level?

MS BEAUCHAMP: My understanding is that the commission is endeavouring to continue this.

MR GRAY: And how – so how many approved providers were covered by the 15,000 interviews, if I can put it that way? Do you know roughly what percentage of approved providers were the subject of at least one consumer experience report?

MS BEAUCHAMP: I have – my apologies, I haven't got that detail in front of me but I can get back to you on that.

MR GRAY: Okay. Now, in respect of this information that you've summarised, you've referred to a metric of whether people feel safe and you say that a fairly high percentage say they feel safe most of the time or always; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: Do you know what the statistical significance of that finding is?

MS BEAUCHAMP: I beg your pardon, I didn't hear that.

MR GRAY: Do you know whether that's a statistical valid finding that covers the gamut of approved providers?

MS BEAUCHAMP: I would have to look at that and ask my statisticians but just in terms of your previous question I notice my footnote there says the interviews were in over 1100 residential aged care services and it was a 10 per cent sample of residents.

MR GRAY: Thank you. I just want to ask you about exhibit 1-10 again, please. In that table there's also a reference to – this is under the heading aged care – Australian Aged Care Quality Agency. There's a reference to serious risks found. That's at the third last row under the bolded heading Australian Aged Care Quality Agency. Do you see that?

MS BEAUCHAMP: Yes.

MR GRAY: What is serious risk?

MS BEAUCHAMP: Serious risk is a term that's used by the now commission, the quality agency, to identify where there was substandard care that would impact on the health and wellbeing of a care recipient.

MR GRAY: Thank you. When you look at the year 2015/16, that's the first row of numbers, there's only two serious risk findings in that year. Is that credible, that there would have been only two approved providers that fell into that category of serious risk in that year?

MS BEAUCHAMP: I just should go back. They're not necessarily approved providers. These are at the service level so we're talking about services. I think I would have to go back to the figures beforehand to see what the longer term trends are there but I wasn't there at the time in 15/16 so whether that was a credible figure or not is something that needs to be determined. I can say, my personal view would be that given some of the failures that have occurred around that time, that may have been what I would call on the low side.

MR GRAY: It might have been on the low side. Could that indexation of ACFI funding, which occurred up to 2016/17, be part of the reasons why there might have been lower incidents of serious risk in 2015/16?

MS BEAUCHAMP: I don't think you could extrapolate that. I think this is – this area of focus is directly on quality and safety in terms of meeting those 44 standards that you spoke about earlier.

MR GRAY: Then when we go to the next year there's quite a marked increase – a factor of 10 – in serious risk findings in 2016/17, there are 22; and then a further

large increase in 2017/18 to 61. Could it be that the frequency of findings of serious risk wasn't actually attributable to a falling off in standards, but because – but rather, attributable to the regulators applying a greater degree of scrutiny?

MS BEAUCHAMP: It probably reflects a number of things. One, in terms of looking at the activity there, there has certainly been an increase in activity levels around both audits and reviews. I think, having the failures that occurred like Oakden in the past and the reports and reviews that have been undertaken since, there has certainly been a much greater level of scrutiny by all involved in the care of our older Australians around being more attentive to areas where there may be risk. There has also been legislative changes that have been put in place with the creation of the new commission as well. So there has been a number of reforms, plus also the heightened level of scrutiny and activity levels that have resulted in an increase in serious risks found. And I probably should comment that it is a relatively limited or low proportion of the total number of services in the system.

MR GRAY: All right. Let's just go to hopefully, if it's convenient, Commissioners, I think I can deal with this topic in less than five minutes.

I will go to the complaints function which, as part of those legislative changes you mentioned, has been consolidated with the accreditation function in the hands of the new commission.

MS BEAUCHAMP: That's correct.

MR GRAY: That's right. Now, that complaint function is the subject of recommendation 10 by Carnell and Paterson. And if I could just take you to your response table on that, that's at page 4514 of your response table. Just as part of the background here, it's the case, isn't it, as Carnell and Paterson recognised, that the fear of reprisal is a very important thing that a proper complaints process has to be able to address.

MS BEAUCHAMP: Yes.

MR GRAY: And are you aware of any steps that have been taken to improve the current complaints position to address that topic of fear of reprisal as a deterrent to people making complaints?

MS BEAUCHAMP: One of the proposals, as the response says in my statement, is that the new commission will have the power to name residential aged care providers who obstruct the resolution of legitimate complaints. Of course, any complaint should be firstly endeavoured to be resolved at the local level, initially, before it's escalated. And so that response is being progressed as one of the reforms to the commission from 1 January 2020. I think having transparency around complaints, both the types of complaint and the providers, the service provider should go some way towards influencing the behaviour of providers.

MR GRAY: One of the actions recommended by Carnell and Paterson was that the complaints commissioner – that's an office now within the commission, of course – will develop an online register of all complaints received in their handling. Is it the department's position that that will be implemented and it will be transparent to the public?

MS BEAUCHAMP: Yes.

MR GRAY: What do you attribute the increase in aged care complaints to? That is, the increase in recent years. You refer to this at paragraph 111, sub-paragraph (c).

MS BEAUCHAMP: I will just reiterate, of course, those things I mentioned previously: added scrutiny coming out of the various reviews, the government also provided additional funding for compliance purposes, including complaints assessors on the ground. My observation is that the previous complaints commissioner endeavoured to resolve complaints at the local level as early as possible with an early intervention approach. I think in my conversations with her at the time, I think she was more inclined towards the end of that period where these statistics are shown, to refer matters to the quality agency and, indeed, to the department.

MR GRAY: Would there be a process for reporting back to the complainant, or is there already a process for reporting back to the complainant?

MS BEAUCHAMP: I'm obviously not across the detail because that's something that's in the complaints commission but I would expect that there would be a feedback loop, yes.

MR GRAY: There has been a suggestion, in particular in the evidence of Mr Yates, that the process for complaints to the commission should be expanded to encompass pre-service delivery matters, such as matters concerning the My Aged Care portal or other issues concerning navigation of the system before one actually gets to receive aged care services. What's the department's position on that?

MS BEAUCHAMP: I think having more transparency and visibility about the level of complaints anywhere in the aged care system would be of benefit.

MR GRAY: So the complaints function of the new commission should be expanded to encompass issues about My Aged Care, for example?

MS BEAUCHAMP: My Aged Care is something that's administered through the department. I think whether we provide that transparency or the commission is something that we will need to sort through with the commission.

MR GRAY: Right. Is that a convenient time?

COMMISSIONER TRACEY: Yes. The Commission will adjourn until a quarter to 12.

ADJOURNED **[11.27 am]**

RESUMED **[11.48 am]**

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioners.

Ms Beauchamp, I want to return to the evidence you gave about the consumer experience reports and the fact that 98.3 per cent of respondents to those reports were saying that they felt safe most of the time or always. Operator, please bring up CTH.2000.1000.5400. Is this the document you based that statement on? Your footnote on page 25 of your statement refers to Consumer Experience Reports In Residential Aged Care Services: What Are Consumers Saying About Aged Care, Australian Aged Care Quality Agency 2018.

MS BEAUCHAMP: Yes. Yes.

MR GRAY: If we go to the next page and we go down to item 2, the bar graph, Do You Feel Safe Here? You will see that once you break down the two categories of answers:

Do you feel safe here – most of the time and always

then one can see that some of that total of 98.3 per cent is made up of 17.21 per cent respondents who answered "most of the time". Do you agree with that interpretation of the graph?

MS BEAUCHAMP: Yes, I do.

MR GRAY: So in effect, lying behind the 98.3 per cent is the fact that 17.21 per cent of respondents to the consumer experience reports only feel safe most of the time in their residential aged care service. Do you agree with that?

MS BEAUCHAMP: That's correct.

MR GRAY: And that's actually of significant concern, isn't it, because if you don't feel safe most of the time in your own home, that's a very significant matter.

MS BEAUCHAMP: I think anything less than 100 per cent wouldn't be acceptable. I think as I've indicated in my witness statement, I did combine most of the time or always, and, of course, I would like to see that up at 100 per cent.

MR GRAY: All right. Now, I just want to ask you a couple of questions about visits by the regulator. Currently that's split between the new commission and

departmental staff, and as from January 2020 it will be only the commission who is making those visits; correct?

MS BEAUCHAMP: All regulatory and compliance activities will be undertaken by the commission. The regulatory activities that relate to quality and safety are already the responsibility of the commission.

MR GRAY: We've gone over some of this ground already. I've already asked you about visits and you've referred to unannounced visits. I want to ask you about a statement you made in paragraph 163 of your witness statement – if we can just have that brought up for Ms Beauchamp, please, Operator. You say, in paragraph 163 – perhaps you've got your hard copy there anyway:

> *It's clear that with increased monitoring of quality over the course of 2018 including the introduction of unannounced re-accreditation visits, a higher number of incidents of care not meeting quality standards has been identified than in previous years. This both demonstrates the benefit of increased monitoring which has been introduced and reinforces the importance of identifying the full extent of non-performance in all aged care settings.*

And then you say this:

> *Based on the evidence and information available to the department and bearing in mind that any incidence of failure of care must be addressed, serious instances of substandard care do not appear to be widespread or frequent.*

I just want to ask you about that conclusion that you've reached and the extent to which it's a safe conclusion based on the fact that there are unannounced visits. If we go back to the exhibit 1-10, one page summary document, do you have that – yes. Thank you, Operator. Do you have that on the screen in front of you, Ms Beauchamp?

MS BEAUCHAMP: Yes.

MR GRAY: Yes. I will just ask you about the unannounced visits row which appears to be under the heading Australian Aged Care Quality Agency unannounced review audits; is that right? Are they the unannounced visits? And unannounced assessment contacts, I see, so there are two forms of unannounced visits. Is that right? They're in italics.

MS BEAUCHAMP: That's correct, in addition to the unannounced re-accreditation process.

MR GRAY: Thank you. These footnote 2. Could we just have a look at footnote 2, please. Right. Thank you. Now, is it the case that with the exception of review audits, of which there haven't been a great number – 55 in 2017/18 – all of these other visits occur within a 90 day window prior to re-accreditation?

MS BEAUCHAMP: If I'm understanding you correctly you're saying the audits happen within 90 days of the re-accreditation visits. Is that your - - -

MR GRAY: No, the unannounced visits. With the exception of unannounced review audits, they all happen within 90 days of the date for re-accreditation at present; is that correct?

MS BEAUCHAMP: I would have to ask the commission that. I am not sure when they are actually undertaken.

MR GRAY: All right. Okay. Commissioners, going back to the document with the breakdown of survey figures in respect of consumer experience reports, CTH.2000.1000.5400, I tender that document.

COMMISSIONER TRACEY: Yes. Could the operator please call up the front page of that document so that I can get the title correct?

MR GRAY: That is the front page, I believe, Commissioner.

COMMISSIONER TRACEY: This is a document prepared by the Australian Aged Care Quality Agency entitled What Are Consumers Saying About Aged Care, and that will become exhibit 1-26.

EXHIBIT #1-26 DOCUMENT PREPARED BY THE AUSTRALIAN AGED CARE QUALITY AGENCY ENTITLED WHAT ARE CONSUMERS SAYING ABOUT AGED CARE (CTH.2000.1000.5400)

MR GRAY: Thank you.

Ms Beauchamp, ABC aired a program on Four Corners on 24 September 2018 including an account of a Mr Steve Wood, a former police officer who was described as having worked in aged care complaints for the department. Are you aware of that program?

MS BEAUCHAMP: I'm certainly aware of that program, yes.

MR GRAY: Yes. And Four Corners said that when Steve Wood worked in the department a decade ago there were over 3000 visits a year. Did you note that being said and is that accurate?

MS BEAUCHAMP: I noted that being said.

MR GRAY: Is that accurate?

MS BEAUCHAMP: I would have to investigate and have a look at that myself.

MR GRAY: All right. And Mr Wood said during the program:

> *I'm really disappointed that we think so little of our residents that the commissioner's office send out officers on only 50 visits from the thousands of complaints that they've had. You cannot get that feeling for what an aged care service is doing over the phone and you can't get that feeling by sending an email to the provider saying "We've had a complaint about A, B and C, tell us what you're doing".*

Is that accurate as a depiction of the limits in what the commissioner's office is doing?

MS BEAUCHAMP: Can I just clarify. The commission is independent of the department, and so those operational matters would be a matter for the commission. But I can certainly follow up and find out for you in terms of what happened 10 years ago.

MR GRAY: It seems to be a statement made in response to responses to complaints. That seems to be the gist of what Mr Wood was saying in that interview. I've already asked you about the serious incidents response scheme and you've said that there are consultations under way about what might be included in it, but that's as far as things have gone at present.

MS BEAUCHAMP: Yes, taking into account the Carnell Paterson report and the Law Reform Commission report, yes.

MR GRAY: All right. I will bring the Law Reform Commission report, RCD.9999.0011.0302. Is this the Law Reform Commission report to which you refer?

MS BEAUCHAMP: Yes.

MR GRAY: I tender that document, Commissioners.

COMMISSIONER TRACEY: Yes. The report of the Australian Law Reform Commission entitled Elder Abuse – A National Legal Response, being ALRC report 131 dated May 2017 will be exhibit 1-27.

EXHIBIT #1-27 REPORT OF THE AUSTRALIAN LAW REFORM COMMISSION ENTITLED ELDER ABUSE – A NATIONAL LEGAL RESPONSE, BEING ALRC REPORT 131 DATED MAY 2017 (RCD.9999.0011.0302)

MR GRAY: Now, Ms Beauchamp, I want to ask you about the use of what are called restraints, both physical and chemical, and you understand what I mean by that in the context of aged care, do you?

MS BEAUCHAMP: Yes, I do.

MR GRAY: Yes. And the Law Reform Commission referred to the matter of the use of restraints, didn't it, in its report? Have you familiarised yourself with chapter 4 of - - -

MS BEAUCHAMP: Yes, I have.

MR GRAY: Yes. When did you first hear concerns about the use of restraints, be they chemical or physical, in the context of aged care? I ask because at paragraph 111(e) you only footnote a report dated January 2019, but I assume that you must have known about concerns relating to restraints earlier than that?

MS BEAUCHAMP: I knew about concerns about restraints after having read a number of reports when I first came into the department.

MR GRAY: Yes. And just let's take physical restraints first. What are physical restraints?

MS BEAUCHAMP: I'm – I'm not an actual clinician, but I think they're restraints used to physically restrict somebody's movement.

MR GRAY: And did you form a view that that was appropriate, inappropriate, in the context of provision of aged care?

MS BEAUCHAMP: My understanding physical restraints covers many things, bed rails, people being assisted with feeding and the like. I think it has been a concern that has been acknowledged by the department and the government and I think we've instituted and will be putting in place mandatory reporting requirements around the use of physical restraints.

MR GRAY: Those various reports that you received on the topic, did you receive such reports as soon as you came into the job in September 2017, as secretary of the department?

MS BEAUCHAMP: Not – not specifically on physical restraints, no.

MR GRAY: How long after coming into the job do you think you first became aware of this issue?

MS BEAUCHAMP: I probably first became aware of it after reading a number of reports related to the serious failures of Oakden and others.

MR GRAY: All right. And did you take immediate action to get some regulations up preventing or at least restricting the use of physical restraints?

MS BEAUCHAMP: There are a number of regulatory arrangements in place, not just the Commonwealth but also the States and Territories and the States and Territories have different arrangements, depending where you live. I think what we have now in place – and obviously physical restraints are to be used as a last resort and providing what we've done in the aged care areas, provide some guidance in terms of how to better educate and train both the providers and caregivers around behavioural management and the like, and as I mentioned earlier, the introduction of a formal mechanism about reporting the use of physical restraints is something that's going to be put in place.

MR GRAY: Operator, please bring up RCD.9999.0011.2033. Now, this is a media release by the Minister on 17 January 2019, and do you see there there's reference to the topic of minimising restraint, and there's reference to both chemical and physical restraint. And the Minister begins by saying:

> *Chemical and physical restraint in aged care homes will be better regulated following extensive examination of this important issue over the past 18 months.*

Then there's a foreshadowing that there will be regulations. Why did it take 18 months for government to form a position on the need to better regulate the use of not only physical restraint but chemical restraint?

MS BEAUCHAMP: As I mentioned, it's to be used as a last resort. So there were already a number of – as this media release indicates – advisories and education tools that were used for services. I think given some of the incidents that have occurred and which were seen on television, I think now we're making sure that we can strengthen the regulatory framework around the use of both medical and physical restraints.

MR GRAY: And I should have asked, what's chemical restraint or medical restraint. I think you just referred to it as medical restraint?

MS BEAUCHAMP: I think commonly – like I said, I'm not a clinician but it commonly refers to the use of psychotropic medications to restrict, again, the movement of care recipients.

MR GRAY: And you would agree, wouldn't you, with the views expressed by the ALRC amongst other people that both physical and chemical restraints raise serious human rights issues?

MS BEAUCHAMP: As I said, I think it needs to be used as a last resort. I think the care environment, particularly in residential aged care, is the protection, of course, of the care recipient but also other residents and workers. And I think in terms of the

medical restraints, then that certainly is something in terms of doctor/patient privilege that I wouldn't want to intervene. As I said, it's a – it's a last resort. What we want to try and do is minimise the use of both forms.

MR GRAY: When can we expect to see the regulations that the Minister refers to later in this media release?

MS BEAUCHAMP: We're currently working on the mandatory quality indicators that are currently voluntary. We're also looking at extending those to include, at the moment it's – physical restraints are on the program but also extending those to medication management so I think the broader issue of medication misuse and medication management is to be included in those mandatory quality indicators.

MR GRAY: Are there going to be regulations?

MS BEAUCHAMP: We will look at, as the Minister has said, whether we need to strengthen the regulations under the Aged Care Act.

MR GRAY: In the second paragraph of the media release, the Minister says:

> *Incidents of overuse of physical and chemical restraint will not be tolerated and draft changes to regulations are expected to be released within weeks.*

Now, that was said on 17 January 2019. Have they been – has an exposure draft been released?

MS BEAUCHAMP: No, an exposure draft hasn't been released and the department is working on options to put to the Minister.

MR GRAY: I tender that document, Commissioners.

COMMISSIONER TRACEY: Yes.

MR GRAY: That's RCD.9999.0011.2033.

COMMISSIONER TRACEY: The media release by the Honourable Ken Wyatt AM, MP, Minister for Senior Australians and Aged Care dated 17 January 2019 will be exhibit 1-28.

EXHIBIT #1-28 MEDIA RELEASE BY THE HONOURABLE KEN WYATT AM, MP, MINISTER FOR SENIOR AUSTRALIANS AND AGED CARE DATED 17/01/2019 (RCD.9999.0011.2033)

MR GRAY: Ms Beauchamp, another matter of great concern that you advert to in your witness statement, at the same place, paragraph 111, subparagraph (e), is medication management in the context of aged care.

MS BEAUCHAMP: Yes.

MR GRAY: And, again, I suggest you must have heard concerns about that topic well before January 2019. Do you remember when you first were briefed about concerns relating to medication management in aged care?

MS BEAUCHAMP: I can't recall the exact date but yes, there were a – there have been a number of issues raised about the use of medicines and mismanagement of medication.

MR GRAY: And did you hear or were you briefed on evidence from Associate Professor Strivens, the - - -

MS BEAUCHAMP: I'm aware of it, but in terms of medication misuse or medication mismanagement, they also come through in terms of both re-accreditation visits and also through complaints.

MR GRAY: There's just one aspect of Associate Professor Strivens' evidence I will just summarise for you and ask whether the department is taking any specific action on it. In his evidence he said that, in the context of dementia, some 80 per cent of people in residential care are being prescribed psychotropic medication, or there's evidence to that effect, with only about a 10 to 20 per cent efficacy rate and with huge attendant risks. Are you aware of that issue?

MS BEAUCHAMP: I'm aware of that claim. In terms of being clear about the efficacy of those figures, I think I would need to draw on specific clinical advice and evidence.

MR GRAY: And have you set in train a process to obtain that advice and evidence?

MS BEAUCHAMP: What we have put in place and what Minister Wyatt has put in place is under the chief medical officer a committee looking at medication mismanagement and a number of clinicians, nurses and others will be involved in that process to look at what that means within an aged care setting.

MR GRAY: And when can we expect the results of that process?

MS BEAUCHAMP: The results of that process won't be for many months. I think the first meeting of that group is occurring this week.

MR GRAY: So that group was only convened very recently.

MS BEAUCHAMP: Yes.

MR GRAY: Is that a fair inference?

MS BEAUCHAMP: Yes.

MR GRAY: When?

MS BEAUCHAMP: Probably in the last couple of weeks, yes.

MR GRAY: All right.

MS BEAUCHAMP: But I just probably should add, in addition to that, the commission is also undertaking as a standard procedure now a requirement that they gather information when they do go into service providers about the use of medication and psychotropics.

MR GRAY: I want to ask you about the National Quality Indicators Program. Carnell and Paterson recommended that it be made mandatory.

MS BEAUCHAMP: Yes.

MR GRAY: What's the government's position in response to that recommendation? Should it be made mandatory? In your response table at page 2, it's recommendation 3, I'm not certain that there is a clear position stated. What is the government's position? Should it be made mandatory?

MS BEAUCHAMP: The government has announced that participation in the National Quality Indicators Program will become mandatory from 1 July 2019, and in addition to those indicators around pressure sores, weight loss and physical restraints, another two are being looked at. The Minister has asked us to look at also medication misuse and falls to be made mandatory.

MR GRAY: Will the expansion of the indicators that have to be reported on as part of the NQIP, the National Quality Indicators Program, to cover medication misuse, will that be intended to cover chemical – the use of chemical restraint?

MS BEAUCHAMP: Yes.

MR GRAY: Yes. Now, Operator, please bring up RCD.9999.0011.0027. This is a media release – it should be – I beg your pardon. I possibly read out the wrong number, Operator. Just give me a moment.

COMMISSIONER TRACEY: I think you might have said 1027 and this is 2027.

MR GRAY: Thank you, Commissioner. The suffix should be 0027, 0027, the last four numbers should be 0027. Thank you. I thought I read out – sorry, yes, I read out the wrong number. Thank you, Operator. The correct number is 2027. Now, in this media release there's reference to a $4.2 million approval of expenditure on the

NQIP, if we go to the second page, please. It's the third dot point. Is this the announcement to which you referred a minute ago when you said the government has approved making the NQIP mandatory?

MS BEAUCHAMP: That's correct.

MR GRAY: Right. So it's just – the decision to make it mandatory is, in effect, conveyed by this dot point and the approval of $4.2 million funding?

MS BEAUCHAMP: I would have to look at what other material has been released. Of course, we've been working with the sector and participants in the sector about making the voluntary program mandatory for some time.

MR GRAY: Okay. And there's further reference to it in the – at the foot of that page and it's described as mandatory in words attributed to the Health Minister. Now, is $4.2 million sufficient to convert the program into a mandatory system? At present it's voluntary and it has only got a 10 per cent participation rate; is that right? Is $4.2 million sufficient?

MS BEAUCHAMP: So $4.2 million is a start to develop the systems and reporting we need to do that, plus also the tools and performance indicators as part of that program.

MR GRAY: I'm sorry, I asked you two questions at once, but it is presently voluntary and only has a 10 per cent participation right; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: Yes. So how long before we can expect that there will be a mandatory NQIP up and running?

MS BEAUCHAMP: The first phase of the mandatory program will start on 1 July 2019 and cover physical restraints, weight loss and pressure sores.

MR GRAY: And then, what, the next phase will add the additional two metrics.

MS BEAUCHAMP: Yes.

MR GRAY: Of misuse of medicine and unexplained falls?

MS BEAUCHAMP: Yes, we're working as hard as we possibly can to see when they might form part of that mandatory regime.

MR GRAY: Are you aware of the 12 indicator system in place in Ontario? Will that be considered?

MS BEAUCHAMP: Yes, I am, not in detail, but yes, I am aware of it and we're drawing on that in terms of some of those – the supporting information that they use.

MR GRAY: Any idea of the timeframe before we can expect that it will be up and running?

MS BEAUCHAMP: As I mentioned, 1 July 2019 is the first three mandatory indicators. And we're working as hard as we possibly can to ensure the other two either form part of that process or a little later on.

MR GRAY: Okay. Now, I'm not sure whether this is in effect the same topic but I want to ask you about public ratings performance. Do you see a connection between making the NQIP mandatory in either the July form with three indicators or at some subsequent time with a broadened set of indicators; do you see some connection between that program and a public star ratings program?

MS BEAUCHAMP: I think there will be connections between a lot of the indicators and information we use to contribute to the, as we call it, the differentiated performance regime. I think from a consumer perspective they will want to know the level of complaints meeting the quality standards that will be in place from 1 July. So having transparency and reporting on that will certainly add to the consumers' assessment of a particular service.

MR GRAY: There's a transparency framework under consideration; is that right?

MS BEAUCHAMP: Yes.

MR GRAY: And under that framework is it proposed that the sort of information which we saw tabulated in the graphs in the agency document relating to consumer experience reports, that that would be made public in respect of specific approved providers?

MS BEAUCHAMP: The actual form of the document is still in development and in development with our stakeholders more broadly. So I would expect it to be more comprehensive and absolutely evidence based. And I think it will include how residents feel, an element of residents' feedback, just like the new quality standards.

MR GRAY: All right. And you say in your response table that:

We can expect that this information –

As you've called it, differentiated performance rating:

...will be published from July 2020 on My Aged Care.

Is that right?

MS BEAUCHAMP: That's right.

MR GRAY: Now, I've omitted to tender the preceding media release that I referred to, Commissioners. It's still on the screen.

COMMISSIONER TRACEY: Yes, it is. I will just get the operator to bring it back to the first page. Yes, you go on.

MR GRAY: Thank you, Commissioner. It's RCD.9999.0011.2027. I tender that document.

COMMISSIONER TRACEY: Yes. The media release from the Prime Minister, the Minister for Health and the Minister for Senior Australians and Aged Care dated 10 February 2019 will be exhibit 1-29.

EXHIBIT #1-29 MEDIA RELEASE FROM THE PRIME MINISTER, THE MINISTER FOR HEALTH AND THE MINISTER FOR SENIOR AUSTRALIANS AND AGED CARE DATED 10/02/2019 (RCD.9999.0011.2027)

MR GRAY: Thank you, Commissioner. Ms Beauchamp, just going back to the star ratings system, is it the department's intention, when you say that it has to be more empirically based that it will pick up objectively measurable clinical performance as well as the more subjective metrics on the customer experience reports?

MS BEAUCHAMP: The advisory committee I spoke to, headed up by the chief medical officer, if that's possible in terms of those measurable indicators, then we will look at whether we incorporate those as well.

MR GRAY: All right. And all that will be done by 1 July 2020, will it?

MS BEAUCHAMP: Yes.

MR GRAY: Thank you.

MS BEAUCHAMP: Sorry, on the transparency framework I should also say attached to not only quality and safety indicators is pricing information, too.

MR GRAY: Thank you. Division 86 of the Act has been raised in evidence before the Commission as an obstacle to transparency in the context of providing sufficient information to consumers to make informed choices about what services they obtain, particularly under HCP. Is division 86 going to be amended as part of these reforms?

MS BEAUCHAMP: I think we would need to look at division 86. I think in the context of personal information and health information and privacy, it's certainly paramount in terms of the release of information. So we would need to look at

whether transparency around both pricing and quality standards are – was not going to traverse the privacy and protection of personal information.

MR GRAY: Thank you. I want to ask you about the concept of an employee screening database. Now, this has been suggested as a useful potential reform in evidence before the Commission, including evidence they've received from Barbara and Clive Spriggs. It's mentioned in the ALRC report as well. I will, just for the record, without asking you to read it, mention recommendation 4-9 on page 135. Does the department have a position on the idea of a national employee screening database for workers in aged care who aren't registered under AHPRA?

MS BEAUCHAMP: I did listen to Mrs Spriggs' evidence last week and personally I think there is some merit in having information about the – about the expertise, knowledge and quality of carers. It's something that we will be looking at as a government in the context of the workforce strategy and working with Department of Education and others around that, noting that it is being used or proposed to be used in the disability area and when you're looking at personal care workers, there's probably a similar quality expertise around looking after people with disabilities and looking after people in the aged care system, so there would be merit in seeing whether we could combine our efforts on the disability side and the aged care side.

MR GRAY: Thank you. Another matter that is been mentioned is expanding the use of CCTV and making it mandatory, at least in respect of some areas in residential aged care services. Does the department have a position on CCTV in that context?

MS BEAUCHAMP: I don't personally have a position and I don't think the department personally has a position. I think this is probably an area of contention and I think Mrs Spriggs spoke about the use in common areas, and I think there would be a need for a substantial amount of consultation, both with care recipients' families and certainly service providers in implementing CCTV.

MR GRAY: I want to ask you about the meaning that the Commission should attribute to the concept of safety in the provision of aged care services. It has been suggested – this is a suggestion of Mr Versteege of CPSA – that the concept of safety should be understood as including access to necessary aged care. Now, this was something that was of particular significance in the context of home care packages. What's your view about that? Does safety include getting access to home care?

MS BEAUCHAMP: That's a very difficult question to answer because you're talking about people living in their own homes and have been living there for some time. In terms of accessing the aged care system, I think it's probably important – it would be absolutely important to look at the safety aspects of applicants and people who have been assessed in the system that their safety and – safety of their environmental conditions, including their home, was safe.

MR GRAY: But you're not going to comment on whether, in effect, the obtaining of aged care is itself a safety issue?

MS BEAUCHAMP: I think when we look at the process of people accessing services, both residential and home care packages, the risk around a person's safety would be taken into account in that assessment.

MR GRAY: All right. Now, on home care packages, I'm going to ask you about the exhibit that you numbered 1 in your own statement. Operator, please bring up CTH.0001.1000.3997. Please go to page 14, table 11. In the context of the national prioritisation process or, colloquially, the queue for home care packages, the department has extracted this information in table 11 concerning wait times for people entering, as at 30 September 2011, by package level into a home care package arrangement. Is that a fair summary, Ms Beauchamp?

MS BEAUCHAMP: I think you said 2011? I think it's 2018.

COMMISSIONER TRACEY: 2018.

MR GRAY: 2018, my apologies.

MS BEAUCHAMP: That's correct.

MR GRAY: And in respect of level 4 which is the level of highest need, if I could put it that way, in respect of people who have been assessed, presumably by an aged care assessment team or the ACAS in Victoria, ACAT around the rest of the country, is that correct?

MS BEAUCHAMP: Yes.

MR GRAY: In respect of people who have been assessed needing level 4, this information seems to be showing that the first package they will be assigned is a level 2 package, or at least they will be offered that, but even that will take more than 12 months. Is that a fair reading of that row, the bottom row of this table?

MS BEAUCHAMP: As at that particular date, yes, that is a fair reading but just to acknowledge, since 30 September 2018 there has been a significant or a substantial number of home care packages released.

MR GRAY: All right. Well, I will just go to – I will go to that issue in a moment, but do you agree this is a view expressed by Mr Craig Gear of OPAN at paragraph 40 of his statement. I won't ask it to be brought up but it's exhibit 1-8. He says that interim packages provided to people that have been assessed at a higher level of need and CHSP are often grossly inadequate. Do you have any reason to doubt his views on that?

MS BEAUCHAMP: I think you need to look at each individual case and what we would look at is ensuring that we can provide access to Commonwealth home support, and other services for that client, while they're waiting for a package to be assigned. So, of course, the individual circumstances are – for that person, there's –

there may be informal and other formal care arrangements in place, but I think our priority is to ensure those that need care and support are provided with that care and support.

MR GRAY: Operator, please bring up exhibit 1.003 or 1-3, that is a document from COTA, COT.1111.1111.0002, and please go to page 8. COTA estimated – and this was somewhat at around the time of the information you've just been referring to, September 2018 – that 30,000 – if we go to page 8 – thank you – that 30,000 high level home care packages are required to ensure older Australians never have to wait longer than three months for the care that matches their assessed needs. So that was an analysis by COTA on the then implications of the size of the queue, if I can use that expression. Is that a calculation that as at that time you would accept was correct or reasonable?

MS BEAUCHAMP: Of course, the department undertakes a fair bit of analysis in terms of the wait times around home care packages and I think when you look at funding for 30,000 more high level home care packages and waiting for more than – not waiting for more than three months of care is something that we will – we need to do further work on. But I think it's probably worthwhile looking at since September again we've had probably – well, we have had an announcement of 20,000 additional places and, indeed, by the end of June 2019 I think there will be about 124,000 packages in the field. So there – there is a substantial increase in the number of home care packages and, of course, we do want to reduce that waiting list. I think also looking at the future is – being – being clear about the levels of support and services around people who are waiting. So yes, we have done some analysis. That figure, I cannot substantiate from COTA but it's in the ballpark. So that number of increases in packages, is several billion dollars.

MR GRAY: Let's go and look at the detail of the additional allocations that you've just mentioned. Operator, please bring up RCD.9999.0011.2022. Now, in respect of this MYEFO-related media release, there is reference, over the page, to – perhaps if we go to the next page, I'm sorry, Operator, and the final page. Under the heading Aged Care there's reference to:

> *We are delivering 10,000 high level home care packages.*

Then there's a paragraph:

> *The government is building on its $5 billion investment in the 2018/19 budget.*

And it says:

> *The additional funding includes $287 million with an extra 5000 level 3 and 5000 level 4 care packages.*

So those care packages, they're not all at level 4, half of them are, but at least both of those allocations are for the higher levels of care package. Is that a correct assessment?

MS BEAUCHAMP: That's correct.

MR GRAY: Now, where does that funding come from? Has that come from the forward estimates in respect of the three years after this current financial year or is that actually new funding that will affect the bottom line of the forward estimates?

MS BEAUCHAMP: So this is additional funding. The money is accorded this program through the proper budget processes of government.

MR GRAY: Okay. And in addition, Operator, could you please go to RCD dot – I tender that document, Commissioners, while it's on the screen if I may. It's RCD.9999.0011.2022.

COMMISSIONER TRACEY: The media release by the Honourable Greg Hunt MP Minister for Health and the Honourable Ken Wyatt AM, MP, Minister for Senior Australians and Aged Care, dated 17 December 2018 will be exhibit 1-30.

EXHIBIT #1-30 MEDIA RELEASE BY THE HONOURABLE GREG HUNT MP MINISTER FOR HEALTH AND THE HONOURABLE KEN WYATT AM, MP, MINISTER FOR SENIOR AUSTRALIANS AND AGED CARE DATED 17/12/2018 (RCD.9999.0011.2022)

MR GRAY: Thank you, Commissioner. Could I ask the operator to go back to a document I believe I've already tendered, RCD.9999.0011.2027. I hope I've got the number right. Yes. I've already tendered that document. Now, in addition to the additional 5000 level 3 HCP places and 5000 level 4 HCP places, am I right in thinking that this media release announces additional funding for HCP?

MS BEAUCHAMP: That's correct.

MR GRAY: And in particular, it refers to an allocation across HCP levels. Do you know – I will just – Operator, if you could please go down the page to the next page. At the very top of that page, 2028, the first bullet point refers to 282.4 million for 10,000 home care packages across all levels.

MS BEAUCHAMP: Yes.

MR GRAY: Do you know how many level 4 packages will be supported out of that amount?

MS BEAUCHAMP: I haven't got that detail with me but I can certainly get that, but it's across all level 4, 3, 2 and 1.

MR GRAY: All right. And same question, that 282.4 million, has that come out of the forward estimates or is that fresh funding that will affect the bottom line of the forward estimates?

MS BEAUCHAMP: These are figures the government has allocated as new money. When you say come out of the forward estimates, I'm not too sure what you're referring to.

MR GRAY: What I refer to there is the issue of whether the 282.4 million has been brought forward to the current financial year from estimated expenditure in one of the three succeeding years, 2019/20, 20/21 and 21/22.

MS BEAUCHAMP: In the budget papers I think there's an indication that we have brought forward the allocation of additional home care packages from the later years. So now incurring the expenditure upfront, which is additional money, that would have been incurred over the forward estimates period. So there's additional money and additional cost to government by bringing the release of those packages forward.

MR GRAY: All right. So is that the case in respect of the other announcement, the one made in December about the additional 5000 level 4 places and 5000 level 3 places? In both cases it's a bringing forward of planned expenditure in future financial years.

MS BEAUCHAMP: I will have to clarify the detail. It was one of those measures that was brought forward. I'm not sure whether it was the most recent release or this one and I will certainly get back to you on that.

MR GRAY: Thank you. I now want to ask you some questions about interfaces with other health services, in particular interfaces with primary health services in the form of, say, GP services and, on occasion, allied health.

MS BEAUCHAMP: Yes.

MR GRAY: Is allied health regarded as primary or is that - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - a referral?

MS BEAUCHAMP: Allied health care and the services provided by allied health care workers can occur in any sort of setting. So when we refer to primary, it's outside of the hospital and institutional care. It's more at the home, at the GP level. So that's correct.

MR GRAY: Thank you. And also at the secondary level which you just mentioned which axiomatically would, say, refer to a hospital – treatment in hospital as I understand it, is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: Now, there are suggestions in the evidence before the Commission that there are problems in respect of transfers between residential aged care services and hospitals. There are problems of various kinds that are mentioned, for example, the transmission of accurate clinical care information. Is the department looking at improving those interfaces?

MS BEAUCHAMP: Just to put it in context, obviously the States and Territories are responsible for the hospital system and the administration. Of course, we acknowledge the issues around transition from tertiary and secondary care to aged care and primary care. What all governments have acknowledged is the need to get better data and improve those transition points. So we're working with the States and Territories. The Commonwealth is working with the States and Territories to get better information. In terms of the record-keeping which is specifically referred to, I would contend that the My Health Record, particularly for aged care clients more broadly, not just those care recipients in the aged care system, is absolutely a key contributor to having all information that health professionals need in one spot.

MR GRAY: Still on the question of the interface between residential aged care facilities or services as they're called, and hospitals, there's a suggestion in the evidence about pressure or decision-making that's not necessarily person-centred, on the part of hospital authorities to have people taken out of a hospital setting, sometimes earlier than may be appropriate, and put into residential aged care. Is this an issue that has come to your attention?

MS BEAUCHAMP: I've heard anecdotally that, but, of course, anyone requiring hospital treatment and medical care should not be denied that in the hospital system as a first instance. I think when you're looking at health care it also extends beyond the hospital so an aged care client coming out of a hospital system may be looking at restorative care or rehabilitation or re-ablement activities before absolutely touching and facing the aged care system.

MR GRAY: Taking it beyond anecdote, has the department analysed any data on this issue to determine whether it is a concrete problem that needs to be addressed with a concrete solution?

MS BEAUCHAMP: In aggregate level, no, we haven't, but we have agreed through Ministers and what's – the Council of Australian Governments Health Council, all the Ministers have agreed under the health agreement to have better access to data so it can be analysed both at the aggregate level and, indeed, at the local health network level, hospital level.

MR GRAY: And what stage is that process at?

MS BEAUCHAMP: We're currently in negotiation still and working on the officer level on how that might happen.

MR GRAY: Okay. So it's some way off, is it?

MS BEAUCHAMP: It's not some way off but I think we will be looking at tranches and so the custodian of such information will be the Australian Institute of Health and Welfare and we're looking at what arrangements we can put in place to have, not only efficacy and robustness around the information being provided but also consistency across a health and aged care system.

MR GRAY: I want to turn now to the interface with primary care. There are suggestions in the evidence that there are inhibitors to free access on the part of residential aged care service residents to GPs and to allied health professionals. Those inhibitors take various forms. Is that an issue that has come to your attention?

MS BEAUCHAMP: It is an issue which has come to my attention and the government has recently announced additional funding for GPs to go into residential aged care services.

MR GRAY: Is that in the form of the Medicare Benefits Schedule amounts?

MS BEAUCHAMP: Yes.

MR GRAY: Any other initiatives that are being taken by the department in that regard?

MS BEAUCHAMP: I think we're continuing to do further work and working with the AMA and others on how we absolutely improve access to primary health care services, including allied health care services to people in residential facilities, yes.

MR GRAY: I want to ask you about navigating the system. It begins with My Aged Care, which is a web platform as well as a call centre.

MS BEAUCHAMP: Yes.

MR GRAY: Mr Yates from COTA said that COTA had always envisaged that My Aged Care should have – or whatever the COTA conception of the gateway into the system was at the time – that it should have a face-to-face component. Why doesn't My Aged Care have a face-to-face component at present?

MS BEAUCHAMP: I think when you're looking at the aged care system and people wanting to access aged care services, people are wanting to prepare for ageing more broadly, and we've got 1.5 million people accessing aged care services at the moment. People receive information in different forms. What we have got is the

website where families and potential care recipients can play around and see what's there in terms of aged care support and services, but we do also have the call centre. If someone is requiring further assistance or assessment, then that does result in a face-to-face meeting.

MR GRAY: Mr Gear, who I referred to a minute ago, of OPAN – again I won't ask you to read this, but I will just summarise some things he said in his statement, exhibit 1-8, paragraphs 37(a) to (c), about criticisms that OPAN received concerning My Aged Care and he said that internet and phone are not ideal for certain clients, and the My Aged Care correspondence can be confusing. Are these complaints that you've heard before?

MS BEAUCHAMP: Yes, they are complaints I've heard before. We're on a process of continually upgrading the My Aged Care service, including the call centre and the website.

MR GRAY: There's a COTA-guided navigation trial in progress - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - which will add on a trial basis in certain locations – it's quite limited as I understand it – but it will add a face-to-face component to My Aged Care; is that right?

MS BEAUCHAMP: People accessing the aged care system already – are already getting some services, not necessarily within the aged care system but it could be the RSL, the Rotary, local community organisations that help people. In terms of the COTA proposal, we're looking at having 30 hubs around the nation and engaging – them engaging with local areas to help potential aged care recipients access and seek information on the system.

MR GRAY: Mr Gear of OPAN also said that screening – that's a threshold process that My Aged Care engages in to determine whether somebody should go to a CHSP stream or the higher levels of care; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: That screening often leads to referral to the wrong assessment services, so presumably to an RAS for CHSP rather than to a ACAT or ACAS for HCP or residential care. Is that a complaint you've heard before, that screening refers people sometimes to the wrong process?

MS BEAUCHAMP: It's not a complaint I have personally heard but I think when people are going through the call centre process and registering at that point, we try and find as much information about the care recipient as we possibly can. And some care recipients are referred to regional assessment services and others are referred to the ACATs as you say. But I guess if there's – well, if there's an issue about not

classifying the potential care recipient properly, then we would correct that and make sure that person has a proper assessment.

MR GRAY: There are suggestions in the evidence and, indeed, proposals from COTA, amongst others, as I understand it, for consolidation of, or streamlining, as I think it might be called, of the assessment process so there's just one assessment process. And similarly for consolidation of CHSP and home care package. What's the department's position on each of those two proposals; and deal with them separately, if you wish?

MS BEAUCHAMP: So I think we're looking at a more streamlined registration and screening process. For example, even a self-assessment and self-registration process, in terms of that continuum of care and understanding people's needs, which are very diverse as I've mentioned previously, we're looking at streamlining the assessment process between the regional assessment providers and the ACATs and just having one assessment process.

MR GRAY: Can I just ask you – it relates to this issue of navigation because it's quite important to get price information, isn't it – could I just ask you about the requirement, as I understand it, that has been in place since 30 November 2018 for home care providers to publish their prices online via My Aged Care; what's the compliance rate with that requirement?

MS BEAUCHAMP: The compliance rate in January was 70 per cent.

MR GRAY: All right. And what follow-up is being applied to the other 30 per cent?

MS BEAUCHAMP: So we're making contact to follow up but also what's being brought in on 1 July is a mandatory schedule of consistent pricing information so consumers can compare one service with another. At the moment the requirement is for each service to put up its own pricing information and how that – how it categorises that information may vary from service to service.

MR GRAY: I want to ask you some questions briefly in the time that remains about funding and sustainability; and it's not to suggest that they're unimportant topics, it's just that we're running out of time. In respect of sustainability issues confronting the aged care system as a whole, is it reasonable to regard the Productivity Commission's report in 2011 as, in effect, the foundational starting point at which the Commission should embark on its consideration of sustainability issues within its terms of reference?

MS BEAUCHAMP: The Productivity Commission 2011 report is a good starting point. Of course, it has made a substantial number of recommendations that governments could consider, in terms of the sustainability of the system going forward. When you look at the level of acuity, the number of people with dementia and just the size of the sector, say, in 2050 or 2055 it will require governments to

look at the allocation of funding for aged care services. And I think in terms of sustainability, I think we do need to be continuously looking at the contribution the Commonwealth makes to care and support and the contribution of clients and families to their ongoing care and support. And, indeed, in terms of sustainability, looking at the different models of care because as you mentioned, much of the funding at the moment goes to residential aged care and many of the clients are accessing more – a greater proportion of the clients are accessing home care packages and Commonwealth Home Support Programs, so looking at that continuing care is going to be important.

MR GRAY: I will ask you another question about that in a minute but I will just tender the Productivity Commission report. Could the operator bring up, firstly, the overview at RCD.9999.0011.0943. And Commissioners, I will tender that document. That's the correct report, isn't it, Ms Beauchamp?

MS BEAUCHAMP: It is indeed.

COMMISSIONER TRACEY: The Productivity Commission Inquiry Report entitled Caring for Older Australians dated 28 June 2011 will be exhibit 1-31.

EXHIBIT #1-31 PRODUCTIVITY COMMISSION INQUIRY REPORT ENTITLED CARING FOR OLDER AUSTRALIANS, OVERVIEW, DATED 28/06/2011 (RCD.9999.0011.0943)

MR GRAY: Next, I will ask the operator to bring up RCD.9999.0011.1031. That's volume 1. I tender that document.

COMMISSIONER TRACEY: I beg your pardon. Is this a separate document?

MR GRAY: It's volume 1 following the overview.

COMMISSIONER TRACEY: So you want me to identify it as volume 1 as part of a title?

MR GRAY: Yes, please.

COMMISSIONER TRACEY: Yes, very well. Exhibit 1-31 will be volume 1 of the Productivity Commission's report dated June 2011.

EXHIBIT #1-31 PRODUCTIVITY COMMISSION INQUIRY REPORT, CARING FOR OLDER AUSTRALIANS, VOLUME 1, DATED 28/06/2011 (RCD.9999.0011.1031)

MR GRAY: And I also have to tender volume 2, RCD.9999.0011.1261. That should be volume 2, and I tender that document.

COMMISSIONER TRACEY: Yes, I see. The Productivity Commission Inquiry Report, Caring for Older Australians, volume 2, bearing the same date, 28 June 2011 will be exhibit 1-32.

EXHIBIT #1-32 PRODUCTIVITY COMMISSION INQUIRY REPORT, CARING FOR OLDER AUSTRALIANS, VOLUME 2, DATED 28/06/2011 (RCD.9999.0011.1261)

MR GRAY: Thank you, Commissioner. Time doesn't permit us to go into the contents, Ms Beauchamp, but do you accept that the recommendations of the Productivity Commission, very broadly speaking, included phasing out limits on residential places and care packages, and that a new Australian Aged Care Commission – that was the name used in the report – would be responsible for quality and accreditation and recommend efficient pricing?

MS BEAUCHAMP: I'm aware of the recommendations, yes.

MR GRAY: And with the exception of that suggestion about a function of recommending efficient pricing, has the trajectory set by the Productivity Commission in effect been followed by government ever since then, very broadly speaking?

MS BEAUCHAMP: I think – if it's as a result of the Productivity Commission, I wouldn't be able to say but in terms of funding that has been allocated to aged care, it has certainly been on the increase and continues to be on the increase over the forward estimates.

MR GRAY: And is government on the path of heading towards an aged care system that's one characterised by there being removal of limits on residential places and care packages and more of a consumer-driven demand model, coupled with safety and quality regulation?

MS BEAUCHAMP: The government has said it wants a more consumer-directed model of care. There has been a bit of a re-calibration from residential care to home care packages already in terms of some of the evidence I drew on in terms of number of packages being released. I think the overall concept about having a continuum of care and the person determining what sort of setting they would like to receive that care is certainly a trajectory that we're on. Whether we're on that in the next few years is questionable, but certainly over the longer term because, of course, any transition – and we've seen it in the National Disability Insurance Scheme – would require careful management of both the service system, consumers and others that are involved in the delivery of services.

MR GRAY: When it comes to considering the economic sustainability of the system going forward, is analysis of that topic the preserve of the Aged Care Financing Authority or is it done within the department or is it done somewhere else altogether?

MS BEAUCHAMP: I think in terms of the advice government receives, it can come from a number of sources including the Aged Care Financing Authority. So this is really for governments to look at the longer term implications of that, and indeed, Treasury occasionally puts out what they call the Intergenerational Report which does do that medium to longer term planning beyond what's included in the budget papers which is just the initial four years of funding.

MR GRAY: Is the most recent Intergenerational Report that is of relevance to aged care, the 2015 report?

MS BEAUCHAMP: I thought there was one later but I – look, I would prefer not to speculate. I would have to come back to you on that.

MR GRAY: When it comes to the Aged Care Financing Authority – I will ask the operator to bring up the following document, RCD.9999.0011.0120 – is that the most current report of the ACFA?

MS BEAUCHAMP: Yes, it is.

MR GRAY: I tender that document.

COMMISSIONER TRACEY: The Aged Care Financing Authority document entitled the Sixth Report on the Funding And Financing of the Aged Care Sector dated July 2018 will be exhibit 1-33.

EXHIBIT #1-33 AGED CARE FINANCING AUTHORITY DOCUMENT ENTITLED THE SIXTH REPORT ON THE FUNDING AND FINANCING OF THE AGED CARE SECTOR DATED JULY 2018 (RCD.9999.0011.0120)

MR GRAY: Just quickly, Ms Beauchamp – thank you, Commissioner – just quickly, Ms Beauchamp, in the time that remains – Commissioners, is it all right if we go a little past 1 pm? I think I need another – probably need to take us to about five, five or so past 1 pm. I'm sorry about that.

COMMISSIONER TRACEY: I'm sorry, I was busy writing down the name of this document.

MR GRAY: I'm sorry, Commissioner. I was just asking for permission to go over the 1 pm time.

COMMISSIONER TRACEY: Yes.

MR GRAY: Thank you. Because it's possible that I can then finish Ms Beauchamp's examination.

COMMISSIONER TRACEY: Take your time.

MR GRAY: Thank you. The Commission has heard about the Aged Care Sector Committee roadmap, so I won't ask you about that, but the Commission has also heard about the Tune review, the Legislated Review on Aged Care 2017. That came shortly after the roadmap, as I understand it?

MS BEAUCHAMP: That's correct.

MR GRAY: And does the Tune review, in effect, also consider, amongst other things, sustainability issues and the reform agenda in relation to funding and sustainability?

MS BEAUCHAMP: Yes.

MR GRAY: For the aged care system.

MS BEAUCHAMP: Yes.

MR GRAY: Thank you. Operator, please bring up RCD.9999.0011.0746. Thank you. Now, there's not much information on that page apart from the title but is that the Tune review, Ms Beauchamp? Would you like to go to the next page? And perhaps the next page, please, Operator.

MS BEAUCHAMP: Yes, it is.

MR GRAY: Thank you. I tender that document.

COMMISSIONER TRACEY: It is the Legislated Review of Aged Care 2017, and it will become exhibit 1-34.

EXHIBIT #1-34 LEGISLATED REVIEW OF AGED CARE 2017 (RCD.9999.0011.0746)

MR GRAY: Thank you, Commissioner. Ms Beauchamp, is there anyone within the department, or to your knowledge within the ACFI, the Authority who monitors the costs of approved providers in providing aged care and compares that with their financial performance under current funding arrangements and considers the adequacy of funding?

MS BEAUCHAMP: I don't think we've done, and we don't do on a regular basis, monitoring the costs of care because the costs of care would change over time. But it's certainly something I've raised as well in terms of getting that correlation between cost of care and what both government and consumers contribute to that cost.

MR GRAY: Because in terms of that 70/30 split that you spoke about at the outset, it's a very important contribution to the stability that the system which is used to provide care to our older Australians, isn't it, and you've got to get the funding right, it has got to in effect cover the costs. Would you agree with that?

MS BEAUCHAMP: Indeed, it should cover the costs in terms of the Commonwealth's contribution but that 30 per cent that you refer to in terms of client contributions and other private contributions is a key factor of that.

MR GRAY: Is there work being done at the moment called a Resource Utilisation and Classification Study, which I believe might be based at the University of Wollongong?

MS BEAUCHAMP: That's correct.

MR GRAY: And what stage has that work reached? I will ask the operator to bring up RCD.9999.0011.2021 which is a communique from a forum in November 2018, but I'm asking about any steps since this communique.

MS BEAUCHAMP: So I think the announcement and the press release, you may have referred to on 10 February previously, indicated that we're now going to – in a position to trial this new Resource Utilisation and Classification Study. So this is what we're looking at in terms of providing much more efficacy, easier to use and understand process of funding, of providing subsidies to residential aged care facilities.

MR GRAY: Right. I tender that document.

COMMISSIONER TRACEY: Yes. The Department of Health document entitled Resource Utilisation And Classification Study and Residential Aged Care Funding Reform, Stakeholder Forum Communique dated 19 November 2018 will be exhibit 1-35.

EXHIBIT #1-35 DEPARTMENT OF HEALTH DOCUMENT ENTITLED RESOURCE UTILISATION AND CLASSIFICATION STUDY AND RESIDENTIAL AGED CARE FUNDING REFORM, STAKEHOLDER FORUM COMMUNIQUE DATED 19/11/2018 (RCD.9999.0011.2021)

MR GRAY: And Ms Beauchamp, is that in effect at the stage of considering the parameters of a study as opposed to actually already collecting data? Is that what I take from your earlier answer?

MS BEAUCHAMP: We are, of course, already collecting data and this is one element of the sustainability issue that you've spoken about. Of course, there are many other elements in terms of sustainability, the aged care system going forward.

MR GRAY: All right. Well, time doesn't permit me to ask about all of them but can I just ask you about a matter raised in paragraphs 57 and 8 of your statement. You refer to something called the aged care provision ratio, or the ratio. You refer to that being, in effect, something used by government to work out the expenditure on aged care, and it's based on a national target of operational places for every 1000 people aged over a certain age. And the age in question is 70 and over at present.

MS BEAUCHAMP: Yes.

MR GRAY: Now, the average age of people taking up aged care as referred to in your statement is actually a bit older than 70. It's 79 for CHSP and then a little older again for home care packages and older still for residential care. Shouldn't, if the ratio is going to be used in the future, it track the cohort of Australians based on the average age of taking up aged care services? Because then it would more accurately reflect changes in the profile of that cohort.

MS BEAUCHAMP: Changing the ratio – these targets are in place until 2021. So we're not looking at changing those targets before then. But Mr Tune also recommended not just changing the age, but the number of places per thousand population, which would, as in his report, indicated it would have a substantial cost to the system.

MR GRAY: All right. So I don't think you're agreeing with me that the age cohort should more closely reflect the average age at which people are actually taking up aged care?

MS BEAUCHAMP: I think we should be looking at beyond 2021 what is an appropriate age cohort.

MR GRAY: All right. And you also say, in 58, that when it comes to home care packages, because they're now allocated to the actual people receiving the care as opposed to being allocated to a particular approved provider, that the number of packages is somehow now excised from or taken out of the calculation or the application of the ratio; is that right?

MS BEAUCHAMP: So the planning ratio is currently set at 125 places.

MR GRAY: Across all - - -

MS BEAUCHAMP: Per thousand of population across all forms which includes 78 for residential care facilities, it includes 45 target per thousand population across home care packages and another couple for what we call restorative care. So in that context, looking at aged care packages on a regional basis doesn't make much sense when you've got a national system of allocation but it's certainly used as a planning and funding tool around the 45. So we're definitely on target to reach that 45 for home care packages this year, so earlier than the 2021 year.

MR GRAY: Thank you. Now, there's more explanation of the ratio and its application in documents called Report on the Operation of the Aged Care Act. The most recent one of those is for 2017/18; is that correct?

MS BEAUCHAMP: That's correct.

MR GRAY: Operator, please bring up RCD.9999.0011.0001. Is that the most recent report on the operation of the ACA?

MS BEAUCHAMP: Yes, it is.

MR GRAY: I tender that document.

COMMISSIONER TRACEY: The Department of Health document entitled 2017/18 Report on the Operation of the Aged Care Act 1997 will be exhibit 1-36.

EXHIBIT #1-36 DEPARTMENT OF HEALTH DOCUMENT ENTITLED 2017/18 REPORT ON THE OPERATION OF THE AGED CARE ACT 1997 (RCD.9999.0011.0001)

MR GRAY: Finally, I want to refer to a document called the workforce strategy report, the Aged Care Workforce Strategy Taskforce report. That's already in evidence, Commissioners, at UVH.0001.0007.0001. Does the department concur with the recommendations, or strategic initiatives as they're called, in the Aged Care Workforce Taskforce Strategy?

MS BEAUCHAMP: Primarily, the recommendations and the actions that you mention are ones for the industry to look at. But yes, in terms of doing this piece of work through Professor Pollaers, we're asked actually the Department of Education and also a new workforce, Aged Care Workforce Industry Council to see what that would require in terms of progressing and implementing those recommendations.

MR GRAY: Now, there are recommendations about having the Australian Industry and Skills Committee through a new reference committee work on improved qualifications for the workforce.

MS BEAUCHAMP: That's right.

MR GRAY: Is that something the department supports?

MS BEAUCHAMP: Yes, we do and we're working with the Department of Education and the committee looking at that.

MR GRAY: That's strategic action 3 on page 26. I will now turn to remuneration deficiencies. Does the department accept the views in this report that there are remuneration deficiencies; that's strategic action 13 on page 88 to 94?

MS BEAUCHAMP: So the department would agree in terms of the health professional side of aged care services that the people working in the aged care system are being paid less. That may reflect more the profile of the workforce, mostly. Mostly women, mostly permanent part-time. It has moved from a casual contract basis to permanent part-time, but, of course, under the industrial relations framework pay and conditions form part of local enterprise agreements.

MR GRAY: And finally, staff ratios, and skills mix ratios, are you aware that the ANMF has contended, on the basis of evidence that it refers to in a number of reports, for the imposition of mandatory staff and skills mix ratios in the aged care setting?

MS BEAUCHAMP: Yes, I'm aware of the evidence that was provided last week.

MR GRAY: And this workforce strategy report doesn't take up the proposal of mandatory ratios of that kind. Is that a position that the department concurs with, or is the department simply agnostic on ratios?

MS BEAUCHAMP: I don't think we're quite agnostic; I think more principled around – given diversity of aged care systems, making sure there's sufficient adequate both skills and numbers of people to take care of people in both the home care setting and also aged care residential facilities. Even within services, there's a very large diversity of the types of clients in residential care settings. These are people's homes. They're not a medicalised model as such, but our view would be to making sure there's the appropriate mix of skills, knowledge and, indeed, are attitudes and support for workers to provide the level of care needed.

MR GRAY: So do I understand your answer to be that the department would be open to supporting the imposition of mandatory skills mix ratios?

MS BEAUCHAMP: My personal view is the allocation of ratios is a very blunt instrument for a service system which is very diverse, and is also reflecting the diverse nature of the care recipients and also the diverse nature of the care needs. So having a blunt instrument on numbers, I don't think on its own would suffice.

MR GRAY: Commissioners, I'm very grateful for the extra time. Subject to anything that you may wish to ask Ms Beauchamp, that concludes my examination of Ms Beauchamp today.

COMMISSIONER TRACEY: Thank you, Mr Gray. Ms Beauchamp, would it inconvenience you to return at 2 o'clock for about 10 minutes or a quarter of an hour?

MS BEAUCHAMP: No, it wouldn't inconvenience me.

COMMISSIONER TRACEY: Very well. The Commission will adjourn until 2 o'clock.

ADJOURNED **[1.12 pm]**

RESUMED **[2.01 pm]**

COMMISSIONER TRACEY: Ms Beauchamp, the Commission has a number of questions we would like to invite your response to. The first relates to the funding of these aged care packages, be they in homes or in institutions. The money, as you said in evidence, at least the Commonwealth's contribution, substantial as it is in most cases, is payable in respect of a particular recipient, but is payable to the institution that is providing the care services. Is there any auditing or other arrangements, pursuant to which the Commonwealth satisfies itself that its funds, in respect of recipient A, is used for recipient As care and welfare, as distinct from simply disappearing into a pool that the provider has for the purposes of operating the facility?

MS BEAUCHAMP: Yes. Yes, there is, and it takes the form of auditing but also responding to the oversight and accreditation processes as well. So, for example, we do do auditing around the funding instrument that we spoke about earlier and, of course, there are – sorry, I was just going to say there are other auditing mechanisms that are used external to the department like the Australian National Audit Office as well.

COMMISSIONER TRACEY: And what if the audit in relation to a particular institution discloses that the whole of the Commonwealth money allocated in respect of a particular recipient has not been used for the benefit of that recipient, but has, for example, gone into consolidated revenue and lingers there?

MS BEAUCHAMP: Has gone into consolidated revenue?

COMMISSIONER TRACEY: I'm sorry?

MS BEAUCHAMP: Sorry, I'm not sure - - -

COMMISSIONER TRACEY: What I'm putting to you is this: the Commonwealth allocates $1000 for the care of a particular – I'm talking about a recipient, but an

elderly person who is having services provided for him or her by a particular institution.

MS BEAUCHAMP: Yes.

COMMISSIONER TRACEY: The audit is done and it finds that only $700 of that 1000 has been utilised - - -

MS BEAUCHAMP: Yes.

COMMISSIONER TRACEY: - - - for the purpose of the care and the assistance of the elderly person. The other 300 is sitting in consolidated revenue on the balance sheet of the institution.

MS BEAUCHAMP: Yes.

COMMISSIONER TRACEY: My first question is: have audits from time to time thrown up such situations, and if so, what does the Commonwealth do about it?

MS BEAUCHAMP: So, thank you, and I'm sorry about asking for clarification. Under the home care packages, for example, there is auditing and also reporting required. So if the recipient is not receiving all of – or not spending all of the money under the aged care package it would be notionally allocated into what we call unspent funds. So they're still allocated to that recipient but they're actually not yet spent. So we've got a pretty good handle on those funds. In terms of the residential aged care facilities, of course, we look at financial statements and where the subsidies and the money goes.

COMMISSIONER TRACEY: Well, my question is directed to the situation where the audit discovers the money hasn't gone to the full extent to the benefit of the patient. What does the Commonwealth do about it?

MS BEAUCHAMP: There are a number of avenues we can take. For example, the funding instrument I spoke about, if there's ongoing noncompliance in terms of are the allocation of those subsidies, we can take notices of noncompliance. So in terms of the money spent, audits required, it requires under the Act that it be spent in accordance with care plans and arrangements in particularly residential aged care facilities but also for home care clients, and it would be part of our oversight and monitoring process.

COMMISSIONER TRACEY: And do I take it from that that it is a legal condition of the payment of the money to the institution that it applies it in the way that the Commonwealth intends?

MS BEAUCHAMP: Yes, indeed, and we look at both overheads, case management costs and other arrangements and, as was said earlier, making those more transparent,

both to the consumer and for the general public will improve, we think, the efficacy of how that money is being used.

COMMISSIONER TRACEY: Thank you.

COMMISSIONER BRIGGS: Picking up on the point by Commissioner Tracey, if you've got detail about how the money that goes towards aged care is ring fenced so corporate and other providers don't use it for other purposes, that would be of interest to the Commission. Let me go back to some of your earlier evidence today. You gave us several examples of where the government or the department, call it what you will, has invited providers to comply, but then has moved to make those arrangements mandatory and the most obvious one of those is the quality indicators. We've noticed a similar reluctance by providers to voluntarily provide this Royal Commission with data on quality and safety, and their views about the current state of the industry and what needs to change. What do these practices tell us about the willingness of the industry to be open and transparent about their caring and pricing arrangements?

MS BEAUCHAMP: I think we've all got a responsibility to be more attentive to how the sector treats elderly clients. And that's not only just the provider, but also the care recipient, families and, indeed, us as regulators. Mentioning "us" through the commission primarily. I think we need to look at more transparency in the system and I think there's proposals which I mentioned earlier about putting pricing and performance information and making that more publicly available. And there's nothing like shining a light and making things publicly available in terms of both competition and choice for consumers, but also ensuring it encourages the right behaviours of the sector.

COMMISSIONER BRIGGS: How much confidence can the community have that providers will willingly provide the level of qualified staffing to deliver the highest standards of care, without, to use your words, the blunt instrument of mandatory staffing arrangements?

MS BEAUCHAMP: It is a requirement under the current standards and indeed it's a requirement under the new indicators that are going to be in place. I think, as I mentioned, the care needs of individuals change and will change over time, and indeed, they change within that organisation. I think having a blunt instrument, for example, like ratios refers to numbers rather than quality, necessarily, or indeed looking at what's required 24/7, particularly in residential aged care facilities. So it's very different than an acute system as well, and I think we need to be looking more at training, education, knowledge and, as I said in my witness statement, some of the attitudes of compassion and empathy for caring is really important. We've got most of the workforce profile in terms of lower – lower paid non-health professionals and it's the quality of care that they're giving to each individual that is hugely important, in addition to the other health and clinical care.

COMMISSIONER BRIGGS: What are your reflections about the governance arrangement in the sector?

MS BEAUCHAMP: In?

COMMISSIONER BRIGGS: In the sector.

MS BEAUCHAMP: I think the governance arrangements can be improved at the operational level. I think we're looking at putting in place – having in place clinical governance arrangements. When we do apply sanctions, for example, one of the sanctions – suite of sanction actions available to us is to look at what's termed administrators, but putting what I would call improvements around both clinical governance and management governance. S I think the leadership and the governance is really important to not only the provider but the service that's being delivered underneath those providers and I think the leadership in governance is – is particularly important.

COMMISSIONER BRIGGS: Did the department have a role in the development of the workforce taskforce strategy?

MS BEAUCHAMP: Yes, the department supported Professor Pollaers in the development of that strategy.

COMMISSIONER BRIGGS: What responsibilities does the department have in terms of the implementation of that strategy?

MS BEAUCHAMP: Depending on what comes out of the implementation group that the Minister has announced, the workforce industry council, there may be some requirements more broadly for the Commonwealth to look at. I think we've heard today about having some sort of register or database or screening of people working in aged care facilities. Of course, that may require a regulatory response, it may require a code of conduct response. I think when you're looking also at workers and the skills they need, training and education and knowledge and the vocational education training system is going to be a key part of that, and that's a responsibility of the Commonwealth, too. So there will be, I anticipate, some actions coming out of that implementation group more broadly for the Commonwealth.

COMMISSIONER BRIGGS: You said in your witness statement at para 159 that you're confident that a service that met or exceeded the new quality standards would be one that you would want for yourself or your loved ones.

MS BEAUCHAMP: Yes.

COMMISSIONER BRIGGS: Would you have the same confidence in relation to a service that met the current standards?

MS BEAUCHAMP: I think the big difference in the change of standards is focusing on the care recipient. How do they feel? What are they experiencing in terms of the care and support that's provided? And, of course, that can be based on clinical health professional care but it's also being looked at, the living environment, the emotional support, particularly for people who are isolated and vulnerable, and for me, I guess it doesn't cost anything to be friendly and show empathy and compassion for the people we're caring for. So I think not only having the regulatory arrangements in place but I think there's also a culture we have to encourage within the sector around caring for our elderly.

COMMISSIONER BRIGGS: You've described in your witness statement substandard care as care that doesn't meet the relevant quality standards in the aged care legislation. Do you agree that care that meets the standards may not meet community expectations?

MS BEAUCHAMP: I think with the introduction of the new quality standards, I think the government wants reassurance that, indeed, the standards reflect what the consumers want and feel about how they're being treated. I think the current standards require a subjective assessment, not necessarily based on how the client feels and what the client is experiencing but I think the new standards absolutely put the care recipient at the centre.

COMMISSIONER BRIGGS: You mentioned a little while ago about the importance of leadership in this sector, and I certainly believe it's terribly important in terms of cultural change. I think you would agree that cultural change is quite necessary in terms of moving to person-centred care. So my question is: do you have confidence that the current Commonwealth, State and Territory leadership can deliver on that person-centred care outcome when, after 10 years of discussion about putting consumers at the centre of everything we do, all we're doing now is still talking about collecting data to determine whether that's the right way to go or how we should go about it?

MS BEAUCHAMP: I think there are probably a number of avenues and – in terms of the actions that we have. Obviously the regulatory response is important and I think there has been a number of regulatory reforms, not just the quality standards but having an end to end compliance organisation through the commission is going to be part of that. I think training and education is also important. And I think making sure we've got people in the care system with the right skills and qualification. I think also as the new standards indicate, there is – it is putting the person at the centre and will have more transparency, not just about pricing but performance standards based on how the consumer feels. I agree in terms of leadership and governance. It does take time to change the culture of organisations, particularly large organisations. But I think if we're all attentive to that, not just care recipients, that the community more broadly, carers and families, then I think we've got the building blocks to make it happen.

COMMISSIONER BRIGGS: I think you just dodged the question. The question is really – really asking you is – are you confident that State and Territory and Commonwealth leadership can deliver on a better integrated care model to provide properly person-directed care?

MS BEAUCHAMP: Yes, I do, and I'm sorry you thought I've dodged the question but I didn't realise you were getting at the integrated care model. And just being the secretary of the department, looking at the primary care, hospital, disability, the pension system, they are all interrelated in terms of how a person feels about how they're being cared for and supported, particularly those most vulnerable and that need most of the care to come from government. So I think we're on the path of ensuring much more focus on integrated care and I think you spoke about data earlier and I wouldn't dismiss how important that is. So sharing the data, not just between governments and levels of government, but I think also with care recipients and providers.

COMMISSIONER BRIGGS: I would agree with that in terms of transparency. That's all from me.

COMMISSIONER TRACEY: Anything arising, Mr Gray?

MR GRAY: Just one question, thank you, Commissioners. Ms Beauchamp, in answer to a question from Commissioner Tracey, you referred to a process by which, as I understood your answer, the department does obtain audit-type information in relation to whether funding in respect of a particular aged care recipient is spent for the benefit of that aged care recipient. Is that in the context of both residential care and HCP?

MS BEAUCHAMP: As I mentioned earlier, the Commonwealth makes a contribution to care. We've already had a discussion around the costs of care. However, there are a number of oversight and monitoring tools that we can use to ensure the Commonwealth and, indeed, the taxpayers and the care recipient is getting value for money. So that's primarily through the accreditation process but also - - -

MR GRAY: Ms Beauchamp - - -

MS BEAUCHAMP: - - - compliance around funding.

MR GRAY: Ms Beauchamp, I'm just asking whether the answer you gave earlier relates to both HCP and residential care.

MS BEAUCHAMP: Yes.

MR GRAY: It does.

MS BEAUCHAMP: Yes.

MR GRAY: Thank you. Now, in respect to residential care, I think earlier in answer to some questions I asked you, you said in effect, evidence to the effect that there isn't a – an analysis yet of what are the cost inputs of particular approved providers to meet certain levels of care, but there will be some work done in that respect in the future; is that right?

MS BEAUCHAMP: That's correct.

MR GRAY: So how could it be – how could there be an audit process relating what is spent on a particular person without that critical input of working out what the cost of care for that person is?

MS BEAUCHAMP: As I mentioned, the cost of care is a very complex piece of work to do. What we're required to do is look at whether the Commonwealth is getting value for money. So the pricing information that will be more transparent will allow some benchmarking and indeed, as the Productivity Commission has mentioned, having more choice and competition in the field is also putting added pressure on the appropriate price. So there is a difference between the costs of care and the prices being paid.

MR GRAY: I have nothing further. Thank you, Commissioners.

COMMISSIONER TRACEY: Ms Beauchamp, we're most grateful to you for having continued your evidence beyond the originally planned time. At various points when you gave evidence you kindly undertook to provide the Commission with additional material. I'm sure you didn't have time to write down every occasion on which you did that, but the solicitor advising the Commission will, in due course, provide you with a list of the matters that you have indicated you're happy to provide additional information in relation to, and we would be most grateful to you to respond when you're able.

MS BEAUCHAMP: I will do that and we're happy to help the Commission wherever we can.

COMMISSIONER TRACEY: Thank you very much and thank you for your evidence.

MS BEAUCHAMP: Thank you.

<THE WITNESS WITHDREW [2.22 pm]

COMMISSIONER TRACEY: Dr McEvoy.

DR McEVOY: Commissioner, I would call Janet Mary Anderson.

<JANET MARY ANDERSON, AFFIRMED [2.23 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Operator, would you please bring up document WIT.0023.0001.0001. Would you give the Commission your full name.

MS ANDERSON: Janet Mary Anderson.

DR McEVOY: And is the document that has now been brought up on the screen the statement that you have made to the Commission?

MS ANDERSON: Yes, it is.

DR McEVOY: And do you wish to make any amendments to that statement?

MS ANDERSON: So an amendment had been submitted to the exhibits.

DR McEVOY: Yes. Operator, if you could bring up please, WIT.0023.9999.0001. Is that the corrigendum to the statement that you would wish to make?

MS ANDERSON: Yes, that's correct.

DR McEVOY: And there, I understand, is also a minor amendment to exhibit 13 of your statement. I understand you provided a copy of that to the Commission as well.

MS ANDERSON: I have.

DR McEVOY: And we have included that amended exhibit as your exhibit 13. Now, Ms Anderson, are the contents of that statement true and correct to the best of your knowledge and belief?

MS ANDERSON: Yes.

DR McEVOY: Commissioner, I would tender Commissioner Anderson's statement, bearing the document number that I read out earlier, and all of the 13 identified exhibits.

COMMISSIONER TRACEY: Yes. Are you planning to tender the corrigendum separately?

DR McEVOY: Yes.

COMMISSIONER TRACEY: All right. Well, in that event, the statement of Janet Mary Anderson dated 4 February 2019 together with the exhibits thereto will be exhibit 1-38.

EXHIBIT #1-38 STATEMENT OF JANET MARY ANDERSON DATED 04/02/2019 TOGETHER WITH THE EXHIBITS (WIT.0023.0001.0001)

COMMISSIONER TRACEY: If the operator would call up the corrigendum again, please. And the corrigendum to the statement of Janet Mary Anderson dated 15 February 2019 will be exhibit 1-39.

EXHIBIT #1-39 CORRIGENDUM TO THE STATEMENT OF JANET MARY ANDERSON DATED 15/02/2019 (WIT.0023.9999.0001)

DR McEVOY: Thank you, Commissioner.

Commissioner Anderson, so it's, I think, now about six weeks into the job. How is it going?

MS ANDERSON: It's going very well. I'm enjoying it. It's a very steep learning curve in many ways. There's a lot to be done and I have a very capable staff with whom I'm working to get it done.

DR McEVOY: You say there's a lot to be done. I think in your statement at paragraph 19 you also say that there's more to do and I think you say at about paragraph 6 of your statement that you're empowered to set the priorities for the commission and to deliver on its mandate. What are your priorities and what do you regard the commission's mandate as being?

MS ANDERSON: Well, I think the mandate is fairly clearly set out in the Act. It's not something that we had to construct. It has been provided to us by the Parliament. There are six functions in the Act and the first two which are listed are essentially more generically crafted. The first is to protect and enhance the safety, health, wellbeing and quality of life of aged care recipients. The second function is to promote the provision of quality care and services. And taken together I think they encapsulate fundamentally the work of the commission. The four functions which follow go to the specifics in my brief and the brief of the commission and I can go through them in series if you would like, briefly?

DR McEVOY: Certainly.

MS ANDERSON: The first of the list is a new function. The commission was formed from two prior agencies, the – as has already been noted, the aged care –

Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner and neither of them had a specific function in relation to what is called consumer engagement. And the Act sets that out in a very particular way. It talks about the role of the commission working with consumers and their representatives to develop best practice models for providers to engage with consumers in the design and delivery of care. I've paraphrased, obviously. That's a very specific reference. It requires the commission to reach into the broad consumer body and beyond that and work with that group to ensure that providers have available to them and are disposed to work closely with consumers in delivering care.

And this goes to questions of co-design of care, delivering services which are fit for purpose and meet the consumer's expectations and I have in mind Commissioner Briggs' earlier comments about that. So it's a very important power and it's a novel power. The next power in the sequence is the complaints functions and that is brought in from the complaints commissioner. It is largely unchanged but there is work that the commission has to do there as well. Indeed, this Royal Commission has heard evidence from certain witnesses around the difficulties they may have experienced in accessing the complaints service. That's interesting. I find that very important information, very important input. It's clear to me that there's a further body of work that the commission needs to do to ensure that the service we provide in assisting complainants to resolve the issues, the concerns they may have about a care provider is as accessible, as easy to navigate and as unintimidating to use as possible. So there's work to be done there.

You were asking me about priorities. The third of the four specific functions goes to what the Act calls our regulatory functions. It's a little bit misleading because we are a regulator so there's a totality of powers that we exercise but this particular power has to do with accreditation, quality assessment monitoring. And this is where quality assessors go to providers and assess the quality and safety of the services that they deliver. We've already heard from witnesses and, indeed, the commission itself is very aware of the need for further work in this regard. I have come into a reform journey which is already under way in this regard. The predecessor agency, the quality agency had already embarked on a series of strategies and initiatives to ensure that we were moving towards a more risk-based regulatory approach.

And by that I mean that we direct the intensity of our gaze proportionately to the observed and assessed risk and where a provider of aged care is identified through a range of means as presenting a high risk profile, then we would increase the intensity of our review processes and our monitoring of that provider. That's a work in progress. We have more to do there. The Royal Commission has heard about our consumer experience reports, also an area that we're working on further. That consumer voice is a vital input to the commission's understanding of the consumer experience and also where there may be issues in relation to quality and safety. So there are a range of inputs that we need to further harness and develop.

There is also a range of outputs that we need to work on further. There is the need to publish more about what we as a regulator observe. We have committed to making

available to the public domain information about provider performance beyond that which is already published. And this is something which has been sought for a while. Similarly, the complaints base, there has been an expectation that additional information is available around the complaints we receive and the way in which they're resolved and the way in which providers respond to those complaints, actively looking at that as well. So the commission's ability to make information available to consumers and to providers in the sector is going to be further explored and that's a priority that we have.

DR McEVOY: Let me come back to a couple of the things that you mentioned in a few minutes. But can I just take up an aspect of what you said there in terms of the role, the change role that you now have. Could you say something to the Commission about the additional compliance functions that will adhere to the commission in 2020?

MS ANDERSON: Certainly. The expectation, which is actually reflected in the legislation, is that in January 2020 the functions relating to compliance and provider approvals which are currently exercised by the department will transfer to the commission. Now, this is subject to further legislative amendment which is complex in its own right because it, in fact, involves looking with fresh eyes at the Aged Care Act and carving out sections of that Act which is no mean feat. But there's a piece of work already well under way to look at the way in which that would occur and these functions, the compliance function which is the applications of sanctions to nursing homes which have been identified or providers who have been identified as falling well short of the standards and persistently underperforming, the application of sanctions will be a function that the commission takes on.

In relation to the approvals process, that's more an administrative process but it entails looking closely at the various characteristics of – of a provider to see whether they pass the test which would enable them to receive Commonwealth funds and become a designated approved provider under the law.

DR McEVOY: Can I take you to the Carnell Paterson report. Operator, you might bring that up. It's RCD.9999.0011.1833. Can I ask you really by way of introduction whether you agree with all of the recommendations of that report?

MS ANDERSON: There are 10 recommendations and some of them have sub-recommendations.

DR McEVOY: Yes.

MS ANDERSON: I agree with the 10 recommendations. Some of the sub-recommendations are less able to be implemented.

DR McEVOY: Well, let me ask you, for example, about recommendation 9 which is on page (xiii) of the report. That, in fact, has five sub-recommendations but the principal recommendation is:

To ensure that assessment against standards is consistent, objective and reflective of current expectations of care.

You're aware of that recommendation, of course?

MS ANDERSON: Yes.

DR McEVOY: Can I ask you, in respect of recommendation 1 – strengthening the capability of assessment teams – this is something which appears to be of central importance. What is being done in this respect?

MS ANDERSON: The former quality agency undertook a capability review of the quality assessors as a group, looked at the range of training which was already provided to them, and reached certain conclusions about how that needed to be strengthened. So that work was already under way. I have picked that up and it continues as a particular priority for the commission. If I may briefly just outline what we do.

DR McEVOY: Yes.

MS ANDERSON: There is a prerequisite for quality assessors they must be registered and they must be re-registered annually. And the registration process is effectively a training program that they must pass and not all of them do pass so it's fairly rigorous and there are some who fall by the way. Those who pass are successfully registered. They are then required to engage in continuous professional development which is guided by the commission in terms of their exposure to relevant information to their roles and functions. We also proactively make information available to them around best practice aged care and seek often their views on work that's being undertaken in other parts of the commission so that they're actively involved in an iterative process of developing a better understanding of best practice and how it would be observed.

We've also strengthened their capacity for information gathering in a highly structured way. The previous quality agency introduced the computer-assisted audit tool which is a very structured process for identifying pieces of information which were relevant and drawing it together as evidence which will inform conclusions that a quality assessor might make. In addition, we have given them access to improved information about consumer expectations through the consumer expectation reports. There is – the through line on this is the quality assessors are our frontline staff. We are essentially as good as they are. We value them highly. We invest in them. And we have fairly high expectations of them. We talk often with them about standards of performance and ensuring that they do their best work every time they go out and review a provider.

DR McEVOY: Well, just on the subject of those people, are they people that you've taken over from the former agency on the whole?

MS ANDERSON: Yes. There is some refreshing of the workforce, we do have a turnover but certainly the entire workforce who wanted to come into the commission were given that opportunity.

DR McEVOY: And are they people who work for the new commission exclusively, or do they work for others as well?

MS ANDERSON: There are – the majority are employed full time by the commission. There is a minority who also hold positions elsewhere in the aged care sector.

DR McEVOY: What do you mean, elsewhere in the aged care sector?

MS ANDERSON: Well, it's a diversity of different roles that they hold. Some of them work as advisers to other facilities. Some I understand may also have roles in – in particular nursing homes.

DR McEVOY: So some of them are working for providers as well?

MS ANDERSON: Yes.

DR McEVOY: What proportion, roughly, would you say, fall into that category?

MS ANDERSON: I don't know, Counsel, I couldn't – I wouldn't want to hazard a guess on that.

DR McEVOY: One of the Carnell Paterson recommendations – in fact, it's the first, was that, of course, your commission be established but there were four sub-recommendations to that. The fourth of which was the appointment of a chief clinical adviser for the purposes of guiding the development of clinical outcomes, measures and guidance material. Has a chief clinical officer been appointed yet? I think in your statement you said, as at the end of January, that that had not happened. Is that still the case?

MS ANDERSON: That's correct. We are in the closing stages of a recruitment process. I do, however, have an interim chief clinical adviser.

DR McEVOY: Yes, is that the Dr Murray - - - .

MS ANDERSON: Yes.

DR McEVOY: Yes, that Ms Beauchamp referred to. Yes. In the announcement that Minister Wyatt made on 17 January 2019 about new regulations for the use of restraints, the Minister said that managing and minimising restraints would be a top priority for the new clinical adviser and, of course, this was also an important aspect of why the Carnell Paterson report suggested that there should be such a person. Is

that something that the commission intends to ensure that the clinical adviser is responsible for doing?

MS ANDERSON: Absolutely. And more. I am very ambitious for my chief clinical adviser. I see this role as being an expert in health care for older people. Somebody of standing in the sector, probably drawn from – logically drawn from a health background but with extensive exposure to aged care. Their expertise is going to be material both internally within the commission to provide advice to my complaints officers and my quality assessors when they encounter clinical situations where expertise is involved in reaching a conclusion about what's happening. But similarly, and equally importantly, externally working with providers to ensure that they are aware of evidence-based clinical expertise in relation to particular aspects of the care for older people and indeed on occasions developing best practice guidance for the sector where it's absent or it's outdated or it's subject to misinterpretation.

DR McEVOY: Self-evidently you've assumed responsibility for many of the systems of the predecessor agencies. Can I ask you what your level of satisfaction is in relation to the way the system was working before you took it over, in effect?

MS ANDERSON: I said in an earlier answer that I stepped into a reform process already underway and that's very much my impression, my – my sense of where the commission has started. If I may, the Oakden tragedy was a sentinel event. It sent shock waves through the sector into the broader community and into the regulatory bodies at the time. It was a wake-up call and a number of things flowed from that, including some self-reflection by the regulators who existed then about their own practice and how they may need to, indeed would be required to strengthen their regulatory gaze. That work had commenced before I started. My job is to harness all that has happened and accelerate that journey and amplify it to be – to become a best practice regulator of aged care in Australia.

DR McEVOY: In one of your earlier – in one of your earlier answers to me you touched on the subject of complaints which, of course, is central. When you talk about a complaint, what are you talking about? Where does that definition derive from?

MS ANDERSON: One of the ways we seek to facilitate access to the services that we offer to the public is to not be too doctrinal about our definitions. So a complaint could be a concern or a question or a puzzle that someone has in mind. They ring our 1800 number and the complaints officers are highly skilled in eliciting from the call maker the essence of the difficulty or the issue which has caused them to call and then to – to guide them through, you know, a journey of providing further information or assisting them to take the matter to the provider. So we – we have the – a fairly broad gate through which these calls come and deliberately so.

DR McEVOY: Well, without wanting to be too doctrinal you would be aware, of course, that in the Aged Care Quality and Safety Commission Rules 2018 in rule 11 there's a definition of complaint in the following terms:

A person may make a complaint to the Commissioner raising an issue or issues about (a) the responsibilities of the approved provider of an aged care service under the Aged Care Act or the Aged Care Principles or the responsibilities of a service provider of a Commonwealth-funded aged care service under the funding agreement that relates to that service.

So in a statutory sense - - -

MS ANDERSON: Yes.

DR McEVOY: - - - that's the definition but I think what you were putting to me a moment ago is that you would regard a complaint as being all that and more, in effect.

MS ANDERSON: Yes. Thank you for drawing my attention to those rules and, of course, that is the framework within which the service is offered. I suppose the point I was trying to make was we don't get too hung up on the particulars as long as it is broadly within our capacity to approach a provider to ask questions about it, then we are happy to assist the complainant.

DR McEVOY: So has the new commission made any significant changes in relation to the operation of the complaints function, as compared to what was happening previously?

MS ANDERSON: In the last six weeks, no.

DR McEVOY: In your answer to one of my questions a moment ago you started to traverse what the response to a typical complaint would look like. Could you step through, in an appropriate level of detail, how the complaint process actually works.

MS ANDERSON: Yes, I would be happy to. There's actually an exhibit which we could probably bring up at this point, if we could.

DR McEVOY: Yes. Exhibit 2 perhaps.

MS ANDERSON: I think it's 1.

DR McEVOY: 1. This is 0001.4000.2132.

MS ANDERSON: Okay. As the exhibit indicates, the initial contact is key to determine whether it, in fact, falls within that broad definition that we just discussed in relation to complaint. We also get matters which are out of scope for the commission. We sometimes get calls about telephone services and so on. We do our best to guide those individuals to the appropriate contact point. We also get what we call inquiries which are not specifically around a complaint but have more to do with the question about where to go to find a piece of information. So once we've done that initial triage, is this a complaint that we can assist the individual with through

the complaints process, we then ask whether the individual has raised the issue with the provider.

And I might also make the point here, Counsel, that we also are not at all narrow in our view about who can complain. In some other jurisdictions they take a fairly narrow view of the definition of complainant. We are happy for the care recipient, any family member, a friend or even a member of the public or a staff member to ring our phone line and log a complaint. So we ask whether, if it's a care recipient or a family member of somebody in care, we say, "Have you raised it with the provider?". If they're at all diffident about that, that's fine. If they haven't thought about it we might say, "Would you like to? Can we assist you in doing that?". Once we move past that question - - -

DR McEVOY: Well, if you did – let's come back in a moment to where you were. If you did do that, if you did say to them, "Have you raised it with the provider?" and they said, "Well, no, actually not", you would presumably encourage them to raise it with the provider.

MS ANDERSON: That's correct, but not in an insistent way. It is done in a very helpful way. What we are trying to do is empower the consumer. If they feel comfortable – and it's a big if – if they feel comfortable to raise the issue with the provider we will provide them with every assistance to do that. We have scripts, we can talk them through the way in which they would like to do that. But if there is any diffidence or any reluctance or if it's just an uninteresting thought for them, then we're there assisting with their complaint.

DR McEVOY: If they're minded to do that and they go away and do that with or without your assistance, is that complaint, as it were, regarded as a complaint for the purposes of your record-keeping and your processes or is that regarded as something else?

MS ANDERSON: We log those – the person rings, we ask them the question. They say "No, I hadn't thought of that, I will go and do that". And we say, "See how you go. If it doesn't turn out well, come back and we're happy to take it further." That call is logged as an inquiry.

DR McEVOY: Yes, I see. So let's suppose that for whatever reason they decide not to go away and speak to the provider themselves, or indeed they do decide to go away and speak to the provider but it doesn't work out and so they come back to you, what happens then?

MS ANDERSON: Okay. We look to the complexity of the complaint. We log a series of issues. So in the analysis of what the complainant is saying, the complaints officers identify how many issues and what the nature of the issues are and that's a very important part of the process because as you can imagine, when we take the complainant's concern to the provider, we need to itemise with some specificity what it is that they have a concern about, what they would like to see resolved. So that's

the logging process and there's a record of that which is obviously kept by the complaints officer. If it seems fairly straightforward and that's a judgment that the complaints officer will make, then we look to resolve it fairly straightforwardly, either in the moment if it's something that we believe we can address without even talking with the provider and that would be a proportion but probably not a high proportion.

More likely we would take the issue to the provider, say, "Right, we have your issues listed, is this – let me read them back to you, does this sound right?" Yes. Yes. We will take that to the provider and ask them to respond. We do that, we set some timeframes and we keep in touch with the complainant over the course of how long it takes to provide the information to the provider and to elicit from them a response to the issues. In the early resolution phase which is this box on the left, the vast majority of complaints are managed through a once out, one back process. Take the issue to the provider, they provide a response. Typically they fix the problem. They provide a response to us at the same time as they are fixing the problem. We go back to the complainant, say, "This is what the provider said, we understand it fixed the problem. Is that your perception? Are you comfortable?" and typically that then moves down to complaints resolved.

There is also the opportunity for a longer journey. And that is where there are a greater number of issues or some of the issues are particularly complex. There may be a change in the status of the care recipient for example. There may have been a complication in their care which then introduced new expectations which may have been less well met than they would have liked and so on. It just starts to take on a complexity. Sometimes we have to go and seek clinical advice on some of the matters. That can add complexity to the resolution. It may be we have to go back several times to the provider if their first response doesn't fully satisfy us that they have grappled with each of the issues raised. That's a longer timeframe.

Again we keep in touch with the complainant. They are always aware where we're up to, whether we're awaiting information, whether we're processing something, whether we're about to come back to them, whether we need more information from them to clarify some certain point. And by and large that – by those two means we resolve the vast majority of complaints. There is also the possibility of an ongoing difference of opinion between the complainant and the provider. Either about the definition of the problem, or about the way in which the problem or the complaint needs to be resolved. And where that difference persists we do have options of going to conciliation or mediation. Not often used but they are absolutely available to us on an as needs basis.

There are, as the very bottom suggests, there are some where for a range of reasons a decision is made about no further action which might be that the complainant discontinues the effort for their own personal reasons or the circumstances are so changed as to make the complaint null and void as it were, or it's overtaken by some other – some other action which renders the complaint resolution process irrelevant

to what's happening now. It's resolved and there is agreement between the provider and the complainant as to the manner in which it resolved.

The third one is where I'm satisfied that the provider has addressed the complaint. The complainant may not be fully satisfied but I have looked at all the evidence, looked at the efforts and the outcomes of the provider's action and believe that a reasonable effort has been made and that there will be no further benefit to be served in progressing it further. And then finally where we – and a very small number of instances where a provider is slow to move or reluctant to move to address a complaint, we do have available a referral to the department currently who can consider the matter and can take compliance action.

DR McEVOY: Well, every complaint is different, of course, but allowing for that, can you give some sort of approximation of the timing that's involved in dealing with complaints in the various categories that you've identified?

MS ANDERSON: I'm going to answer your question differently. The complaints commissioner had key performance indicators and targets which we have taken forward into the commission. And they are timeframes. There is a proportion of complaints to be addressed in 30 days, 60 days and 90 days and the targets are respectively, 70 per cent in 30 days, 80 per cent in 60 days and 90 per cent in 90 days. Now, the complaints commissioner managed to hit those targets or exceed them in all but her final month. In December of 2018 she achieved 69 per cent against a 70 per cent target, 30 days. In the first month of the operation of the commission we, too, have fallen slightly short of that first 30 day target and the reasons largely are volume. The commencement of the commission, the media coverage of that, heightened awareness, we believe, and we have seen a very strong surge in the number of complaints received which, of course, is putting a little bit our learned friend pressure on my complaints officers.

DR McEVOY: But in broad terms you would expect to get through about 90 per cent of your - - -

MS ANDERSON: In 90 days.

DR McEVOY: - - - complaints within 90 days.

MS ANDERSON: That's correct.

DR McEVOY: Yes. And in terms of the increase in volume, it's your evidence, is it, that you think that's likely to be because of the increased publicity over the last couple of months, in particular the announcement of the Royal Commission, the starting of the Royal Commission, etcetera?

MS ANDERSON: If you look at the variables in play that seems like the most logical solution, yes.

DR McEVOY: Yes. We heard evidence last week, I'm not sure if you're aware of this, but evidence of Mr Paul Versteege of the Combined Pensioners and Superannuants Association. He was inclined to think that the increase in volume of complaints might not be a reflection of anything more than a fact that the facility for making complaints was better than it had been and that previously complaints were not dealt with in perhaps quite the same way as they are now. How would you respond to that?

MS ANDERSON: I will take the compliment but I'm not sure I have the evidence for it. As I said in my earlier response, the complaints commissioner placed a very high store on performance and I have continued to look very closely at the way in which we manage complaints to ensure that we're always doing our very best. We're scrutinising our own performance. I'm not aware of any significant adjustment in settings between the previous agency and my own, certainly not in the early reaches of the commission's work.

DR McEVOY: Have you done any analysis to work out whether, in fact, there might have been or might still be underreporting of complaints?

MS ANDERSON: The short answer is no. I'm not aware of whether others have undertaken that work. I think it would be difficult to do but not impossible.

DR McEVOY: Well, just going back to your own evidence about that, I think – correct me if I'm wrong – but I think what you put to me 20 minutes or so ago in relation to your own complaint process was that if somebody does ring and make what might be regarded by rule 11 of the rules as a complaint, you would effectively triage the complaint. You would ask them whether they had raised it with the provider and encourage them to raise it with the provider if they're prepared to do so and talk to them about how they might raise it with the provider. And I think what you conceded to me was that if that was raised with the provider and it was resolved to the satisfaction of the complainant, then that would not be recorded by the commission as a complaint. That was the substance, I think, of what you said, wasn't it?

MS ANDERSON: Yes, that's correct, Counsel. May I?

DR McEVOY: Of course, yes.

MS ANDERSON: The role of the commission is not to go looking for complaints but to resolve – to assist individuals to resolve issues they may have with the care provider. So we don't go looking for a tally count on complaints. What we look for is a good outcome, the best outcome for the care recipient and if we achieve the best outcome by assisting them to take the matter back to the care provider, that's a tick.

DR McEVOY: Yes. You would be familiar though with rule number 14 of the rules which permits the commissioner to decide to take no further action in relation to an issue raised in a complaint if the commissioner is satisfied that the matter is

frivolous or vexatious or any one of a number of other matters. I suppose it might be said that, in fact, every time someone rings one of your lines, assuming they're not ringing to complain about a telephone or something like that that's outside scope, they are, in fact, making a complaint, whether or not it's appropriately triaged in an effective way; what would you say to that?

MS ANDERSON: Yes, that's correct.

DR McEVOY: What – what are you doing, if anything, to ensure that what might be referred to as the most vulnerable people are able to complain? So I have in mind people who may perhaps lack family support, people who may be suffering from dementia, people who may even not have access to a private telephone that they can utilise to make a complaint. Has that been the subject of your attention?

MS ANDERSON: Well, it's certainly something about which I'm aware and we continue to look at avenues for ensuring people are – have knowledge of the 1800 number and have the capacity to use it. We are fairly reliant on the consumer advocacy groups and the consumer representative bodies to assist us in identifying individuals who may themselves be poorly placed to take advantage of the service we offer. I believe that there's further work we should do there.

DR McEVOY: Can I turn, perhaps, slightly away from complaints simpliciter, as it were, and look at complaints in the context of complaints and regulatory action. The – your Act, of course, charges you with a complaints function – you know, I think section 18 – separately to the regulatory function in section 19. Do you have any concerns about whether the complaints function needs to be more closely connected to the regulatory function rather than perhaps being somewhat separate?

MS ANDERSON: I'm not sure I would characterise it as a concern. It's a determination. I see the two necessarily having points of connection and one of the benefits of bringing the two together in the commission is to fully harness the information which is available from both of those sources to sharpen our regulatory gaze. So if I can illustrate the point, in undertaking our quality assessment and monitoring role, ready access to timely information about active or recent complaints in relation to a provider is another information input to assist us in planning the visit and what we might ask about when they get to the aged care home.

Similarly, the findings of – from quality assessment and monitoring are vital inputs to a complaints officer as they consider a complaint in relation to a provider and if, in any of that interaction, there's an observation of trends then that is additional information which is now available to the regulator in relation to provider performance and whether we might intensify our frequency of contact with some providers if they're starting to develop a high risk profile.

DR McEVOY: Well, just on the subject of visits, I was going to ask you about visits. Am I right in thinking that the practice is to give providers an unannounced visit 90 days before their accreditation expires?

MS ANDERSON: I'm not sure that – if I can say categories yes or no counsel, I'm sorry.

DR McEVOY: Well, what has been put by COTA in evidence that was given to the Commission last week and perhaps, Operator, you could bring up COT.1111.1111.0002 at page 0009. I will wait until that comes onto your screen, Commissioner. I think that may be the next page. Yes, so Commissioner, if you could read at the bottom at point 5.

MS ANDERSON: Yes. The – Counsel, if I may, the – I should know and do not, the 90 day window, is it three months or is it longer timeframe. There is absolutely a period before re-accreditation is due when we are going to visit but do not announce when we will visit.

DR McEVOY: So it's not announced to the provider but it might be expected by the provider that it would be in a certain period prior to the expiration of their accreditation, whether it's 90 days or 120 days or whatever it is.

MS ANDERSON: Yes.

DR McEVOY: Is that the position?

MS ANDERSON: That's certainly correct, yes.

DR McEVOY: So is it correct to say that a visit that precedes within that sort of a structure is truly unannounced, would you say?

MS ANDERSON: I suppose it's semantic. They – they would expect it in – within that period. They are probably on heightened alert. They don't know when it's going to happen. They don't know what time it's going to start and they – they are less well prepared than if we designated a day and a time.

DR McEVOY: Well, when you say they don't know when it's going to occur, it only occurs during business hours, doesn't it?

MS ANDERSON: We have just embarked on a program of extending our out of hours visits. We have always – I beg your pardon, the quality agency which preceded the commission always did a proportion of out of hours visits and we are now working up a – a program to extend that.

DR McEVOY: So what does that mean? Does that mean that sometimes a visit might be late at night or on the weekend or - - -

MS ANDERSON: Exactly. That it would commence in an out of hours period and possibly say 5 o'clock in the morning rather than 8 or 9, or it may commence after hours of an evening or, indeed, on a weekend.

DR McEVOY: So how far are you with that? Is that now a regular part of your unannounced visit procedures?

MS ANDERSON: No. As I said, Counsel, we're working it up. We expect that the implementation would proceed over the next two months.

DR McEVOY: I'm sorry, I didn't realise that you had said that. Yes, I see. Over the next couple of months you're moving towards that, yes, I see. One of the – in terms of the reporting of complaints, particularly in connection with home care, the number one subject of complaint, if you like, is the issue of fees and the charging of fees. Is this – is this something that you're paying particular attention to?

MS ANDERSON: Absolutely. This was noticed under the previous complaints commissioner and, indeed, I understand they did a piece of analysis on it because they saw it as being such a striking trend and liaised with the department in relation to what they were observing in order that the department as the policy holder could factor that into the work that they were doing in relation to home care policy.

DR McEVOY: Can I take you, Commissioner, to your 13th exhibit which is CTH.0001.4000.2192. It may be convenient, Commissioner, it will come up on the screen but unless your eyesight is rather better than mine it might be convenient if we hand to you a paper - - -

MS ANDERSON: It's all right, Counsel.

DR McEVOY: You have it.

MS ANDERSON: Thank you.

DR McEVOY: Thank you. Can I – I'm dealing now with the subject of the reporting of assessment contact and if I can draw your attention, Commissioner, to tables 3, 4 and 5, which are concerned with assessment contacts. Can I ask whether the reference to contact in those tables includes contact by telephone?

MS ANDERSON: No. My understanding is that we are talking about visits here.

DR McEVOY: They're references to visits. Can you have – can you have or do you have an unannounced assessment contact ever by telephone or would that only ever be by visit?

MS ANDERSON: We wouldn't call it an unannounced assessment contact if it were a phone contact. They're – just recently there was an occasion where we had cause to contact a provider who was in a very remote area and we were not in a position to get to them quickly and we needed certain information. And under the powers available to me we were able to talk to that provider over the phone. But we didn't log it as an assessment contact per se. It's a particular language which is related to visits that assessors make to providers – services.

DR McEVOY: Just leaving that for a moment, you might be aware that on the first day of the Commission, the Commission heard evidence from Barbara Spriggs who – whose view was that there should be an 1800 number advertised in nursing homes on the walls in the public areas, that people could call if they had some concern in relation to quality or safety of care. Are you able to say whether that is something that is in train or about which you have any view?

MS ANDERSON: A couple of different questions there. One is the degree to which the complaint service is known about.

DR McEVOY: Yes.

MS ANDERSON: And then capacity to access it on a 24/7 basis. In relation to the former, I've mentioned the work we do with the advocacy agencies and the representative bodies to ensure that they are advertising the existence of the complaints service and encouraging people to use it. In terms of access we have a voicemail service after business hours. And I'm not averse to contemplating a 24/7 access to a person but I would wonder why it would be necessary. It strikes me that if someone were so driven to contact a complaints line at midnight or 1 o'clock, then it may not be a complaints line they need. They might need 000.

DR McEVOY: Insofar as you've mentioned the way you try to utilise support mechanisms to ensure that people can complain, but just going back to Ms Spriggs' recommendation or desire, is this complaints number widely advertised in residential facilities?

MS ANDERSON: Yes, it is. There is a requirement in the current standards and in the new standards for providers to make available to residents information about complaints management opportunities.

DR McEVOY: Can I take you to consumer experience reports which I know you mentioned in one of your answers to one of my earlier questions. They are to be expanded to deal with home care, I think is the position. What do you say that "risk" means in the home care context?

MS ANDERSON: It's not so differently constructed from risk for care recipients generally except that home – domestic environments are necessarily less regulated. They are home – people's homes so the sort of expectations you would have in relation to the safety of the built environment, for example, are not as easily applied. Just as one instance, somebody who's a bit unsteady on their feet or may have difficulties with balance or mobility may need grab rails in the bathroom. Now, if they've not had grab rails installed and they teeter and fall in the bathroom, then clearly that is an ungoverned risk, that's a safety risk which hasn't been satisfactorily addressed. But talking specifically about care in the home, it's – home care would be delivered meals or personal care grooming, so a showering service, getting – assisting someone to get up in the mornings, access breakfast and so on. The risks are relatively lower from a clinical care perspective, although there are some home

care packages which are at the higher level and have a component of clinical care in them.

DR McEVOY: But are we talking – do you conceive risk in the context of home care as only being clinical risk - - -

MS ANDERSON: No.

DR McEVOY: - - - or does it extend, for example, to other things, which might be regarded as risks, so something like overcharging, for example?

MS ANDERSON: Well, my mind wouldn't go there immediately. That is – that is a risk. Other risks have to do with less visibility. Home care recipients are a very dispersed population by definition. They receive care where they live which is essentially anywhere in Australia. So because it's not congregate care it's much more difficult to observe the care being delivered and I think there may be risks attached to that, that a provider going into a home is – is less visible in the care that's provided and we are probably more reliant on the care recipient and their family to bring to attention instances of poor care or underservicing. The financial risks are present. There's no doubt about that. And with the packaging arrangements there is scope for misinterpretation, both by the consumer and the provider of care.

DR McEVOY: So where you say – and I think this is in about paragraph 82 of your statement – that you're exploring initiatives or opportunities to publish more information on the performance of home services and trend data identifying areas of risk in home service, that should be regarded as being directed to clinical risk in relation to care in the home?

MS ANDERSON: Not exclusively clinical risk but certainly taking that into account. As we see more and more people exercising the choice to stay at home and be supported to do that safely and with a reasonable quality of life, the risks that we see in the home environment start to approach some of the risks for caring for people in nursing homes.

DR McEVOY: Well, just on that, and on home care, can I take you to the question of oversight in relation to quality of care provided in the home and ask you what the nature of that oversight is like at present?

MS ANDERSON: This is where we need to do the work and I believe that my statement in 82 is heading in this direction. We are aware that the way in which we regulate home care provision is not as strong, either as it is for residential care or that it needs to be. And it's an important piece of work. It's work which the department has been undertaking for a while and we have been contributing to that. I need to accelerate that work because at the moment I'm not convinced that our regulatory gaze in home care is as strong as it needs to be.

DR McEVOY: Does that mean that the regulatory regime that you have under your Act may not, in your view, be adequate to deal with that risk?

MS ANDERSON: No, I didn't say that, Counsel.

DR McEVOY: No, I accept that you didn't.

MS ANDERSON: Yes.

DR McEVOY: I'm asking you that as an independent question.

MS ANDERSON: My view is no, it is adequate. But I believe it comes – it places more onus on the care recipient that may not be in all instances a reasonable level of onus. So we, the regulator, need to work harder to ensure that we are assisting in managing those risks.

DR McEVOY: Well, what does that mean in a practical sense? What initiatives do you have in mind?

MS ANDERSON: It's too early to say. It is very much a piece of work on the priority list. It's not one that I have been able to directly attend to so far.

DR McEVOY: The commission doesn't have a professional discipline function in relation to personal care attendants, does it?

MS ANDERSON: No.

DR McEVOY: Should it, in your view?

MS ANDERSON: The use of the word "professional" in that context is a little problematic because the personal care attendants aren't a profession in the way that you would normally understand that word.

DR McEVOY: Perhaps it's easiest to ignore that word.

MS ANDERSON: Okay.

DR McEVOY: And just think of it in terms of a disciplinary function.

MS ANDERSON: We don't have a disciplinary function in relation to clinical professionals either. Our job is where we find or have concerns about professional conduct, we refer the individual to AHPRA.

DR McEVOY: AHPRA.

MS ANDERSON: And there is also the capacity, at least in some jurisdictions, to refer the occupation, the personal care workers to regulatory bodies in States and

Territories. My view on whether that is adequate goes to the expectations I have of providers. As far as I'm concerned as regulator, it is absolutely legitimate for me to expect that every single provider will step up and take responsibility for the people providing care in that home. If it's a member of staff, as indeed personal care workers are, then they are front and centre. They are responsible for recruitment, for induction, for training, for supervision and for continuing professional development. If they fall short on any of those measures then the chances are we will find them out against the standards which pertain to human resources management.

DR McEVOY: Of course, it is the case, as you say, that AHPRA exists to deal with the professional care providers. The difficulty though in relation to personal care attendants is that they don't fall under the AHPRA umbrella and so in a sense they're outside that system. And what I think I understand your answer to me is on that question, is well, look, ultimately that's something that I look to the providers to deal with and if there are problems that the providers are not dealing with, well, then that's something that comes out in the accreditation. That's the position you adopt?

MS ANDERSON: That's correct. It's an unmet standard or outcome and it's therefore an outcome that they have to make good. We put them on a timetable for improvement. We identify that as an area where they need to do further work and we satisfy ourselves through assessment contacts that they have actually made those improvements and have returned to compliance.

DR McEVOY: Can I take you to the issue of the serious incident response scheme. For the purposes of that scheme, what is a serious incident?

MS ANDERSON: My understanding is that the definition is still being worked on, but I will give you my sense of what that looks like. And I'm informed in this view by exposure to adverse event reporting in health services which has been in place for over a decade. It is something which is taken almost for granted as part of the systemic reporting that pertains to health care organisations and this is something which is very similar in aged care. Essentially, it is a process which requires providers to identify where an adverse event has occurred which has placed a care recipient at risk of harm. Now, that will need to be defined and there are undoubtedly going to be debates about what's in and what's out.

But if I can give you an example from the health domain, there are a category of events called never events and as the name suggests they should never happen. They simply should not occur. There is no risk to govern; they simply must not happen. There undoubtedly would be never events in aged care. And then there's a group beyond that which are avoidable events. And I would expect that serious incidents are a combination of never events and serious avoidable events which will be identified by the provider and then subject to local investigation, local remedy and then reporting externally to the regulator.

DR McEVOY: Can I take you back to exhibit 13, Ms Anderson, which I think you have in front of you, and in particular to table 1. If you have a look at table 1, you

will see that there are some blanks in 2014/15 and 2015/16 in relation to the number of serious risk decisions resulting. Are you able to say anything about what that means? Does that mean that there were no serious risk decisions in those years?

MS ANDERSON: I'm sorry, Counsel, I don't know. I'm happy to find out.

DR McEVOY: Yes. And – but then what happens, of course, if you look further along is that in 2017/2018 we go from virtually none to nine and then in the last six months of last year we go to 16. Now, I accept, of course, that this was prior to you coming into the job but what do you make of that change?

MS ANDERSON: My understanding is that among other things, there was actually a change of approach. Somewhere along that line – and I can provide you with advice as to when the change occurred, the – there was a shift in definition which created at least part of that increase. Before the change, the – the sense was serious risk was identified through the number of not mets. So if there were a large number of outcomes which were not met, then that would trip across the line and become a serious risk. There was a reconsideration of that and a more careful consideration particularly of the nature of the indicator and what it should say to the regulator about the nursing home. And what changed was a consideration of impact on the resident. So we moved from a count of not mets, or the quality agency at the time moved from a count of not met to a likelihood or actual impact on a resident. And if a single not met had the potential or had, in fact, actually had a very adverse impact on a resident, then that constituted a serious risk.

DR McEVOY: And might it be that that would explain why there was a significant jump in 2017/2018 in the number of times the new expected outcomes were not met?

MS ANDERSON: That's my understanding.

DR McEVOY: Let me invite you to have a look at table number 2 which is concerned with review audits. In 2017/2018, 85.7 per cent of all not met decisions in review audits resulted in a serious risk decision. That's rather high, wouldn't you agree?

MS ANDERSON: You would expect that to be high, Counsel. A review audit is undertaken where we have concerns about a provider. If I can just be clear, a site audit is what we undertake for accreditation and re-accreditation. Where a matter has come to attention, where we've received a referral from the complaints group or from the Department of Health or from some external party which gives cause for concern, we would probably undertake an assessment contact, so a day's visit to have a look. And if we continue to be concerned about what we were looking at we would stand up a review audit. So the fact that we're looking at 85.7 per cent of all not mets resulting in a serious risk decision is unsurprising.

DR McEVOY: Give me some examples of a serious risk decision; would that include, for example, an assault by a staff member on a resident?

MS ANDERSON: It could. It – I mean, these are examples of what could be there. It wouldn't necessarily – medication management would be another one where a single or several instances of mismanagement clearly constitutes a serious risk to aged care recipients. There are a range of different outcomes where a not met could have or have actually had impact on – adverse impact on a resident.

DR McEVOY: Well, in terms of incidents of that kind, whether they're assaults or other instances of adverse impact, is the only reporting procedure in place or that's contemplated a report to the commission?

MS ANDERSON: You may need to explain that question, I'm sorry.

DR McEVOY: Well, for example, if there were to be an assault would that be something that you would contemplate would also be reported to the police?

MS ANDERSON: It must be, under the rules.

DR McEVOY: And that would be appropriate as far as you're concerned. I ask that in circumstances where Mr Versteege, who I took you to earlier, reported a quite horrific abuse, indeed, that 1.7 per cent of aged care residents could expect to be assaulted by a member of staff. What do you say to that?

MS ANDERSON: I'm not aware of the information on which he's basing that claim. If it's true then it's too high. It should be zero.

DR McEVOY: What about the reporting of what one might term lower level abuse? For example, the ignoring of call bells, things of that kind, leaving – leaving food – leaving a person in residential aged care with their food and not assisting them to eat it so that the food goes cold and they ultimately don't eat it. What sort of reporting mechanisms exist for that sort of problem?

MS ANDERSON: Well, we would ascertain that in our assessment contacts and then in a review audit if we stood that up subsequently, through the consumer experience reports, through observations, through interviews and through documentation.

DR McEVOY: Commissioner, I'm very conscious of the time and we have one more witness to go this afternoon. It may be that we either need to return to you on some subsequent occasion or perhaps issue you with some further questions, but Commissioners, if it's convenient, it may be preferable for me to leave Ms Anderson for the moment and, subject to any questions you have.

COMMISSIONER TRACEY: Well, I don't want to inhibit you from completing further questioning if you wish to do that.

DR McEVOY: I think in the circumstances I've probably taken this as far as it's convenient to do this afternoon, Commissioner.

COMMISSIONER TRACEY: Well, Ms Anderson, I do have a few questions arising out of your evidence. Did I understand you to say that some of the auditors or inspectors, or whatever the correct title is, who assess nursing homes against the criteria are in some instances not full time Commonwealth employees, but who work part-time for the Commonwealth and part-time as consultants to providers?

MS ANDERSON: That's correct, Commissioner. May I extend that answer? Because I – I understand the implication of that and, in fact, we look very closely at the potential and manage the risks of conflict of interest very, very tightly. All of our quality assessors are required on entry to declare interests and before each visit, they must re-declare interests. We police this very strongly. They are also obliged to adhere to a code of conduct which has been expressly developed for them and, again, it sets a very high bar for the standard of performance that we're looking for from them.

COMMISSIONER TRACEY: There is, as you will readily accept, I imagine, an immediate risk of their findings being subject to complaints about conflict of interest, if only because they're assessing one provider and they're working in another capacity for other providers who have commercial interests that don't coincide with the establishment being assessed.

MS ANDERSON: Is that a question? They come back from the visits with a set of findings. The decision is made separate from them. The decision is made by a decision-maker who is, in fact, a superior. So there's a further layer of assessment and analysis and interrogation which occurs which is separate from the assessors. So to the extent that there are risks still attached to an individual undertaking an assessment who may have employment elsewhere, then there's a further guard against the perception or actuality of a conflict occurring.

COMMISSIONER TRACEY: Looking more broadly at these assessments, how many people constitute a team for the purpose of conducting them?

MS ANDERSON: Typically two, sometimes three, rarely one.

COMMISSIONER TRACEY: And do any of them have medical or nursing qualifications?

MS ANDERSON: Some do. They're not recruited specifically for their qualifications but we do have a number of nurses on staff.

COMMISSIONER TRACEY: You would be aware that the Commission is dealing with a number of complaints about the over-medication of patients, physical restraint and things of that kind. Would any of these assessment teams have somebody in it who you could be assured could pick up a patient's chart at the end of the bed and make an assessment as to whether that patient was being overmedicated or not?

MS ANDERSON: Where there is a nurse in the team, then they have that – that competence and that skill set, but equally there is available now within the commission – or soon to be, we have an interim chief clinical adviser but also a full clinical unit, staffed by clinical professionals who can offer that advice. They are available by phone. They are also available for face-to-face consultation by other staff. So my view is the important issue is timely access to clinical advice. The quality assessors do not have to have that within themselves and, indeed, some of my best quality assessors come from other regulatory areas which don't have anything to do even with human services but they have a very strong understanding of the job of an assessor in a regulatory environment. And they have a very acute understanding of when they need to seek independent clinical advice on something they have observed.

COMMISSIONER TRACEY: Do the assessors have the authority and capacity to call a qualified medical assessor to an establishment where there is a suspicion of over-medication?

MS ANDERSON: I don't know for sure. I don't think there's any prohibition.

COMMISSIONER TRACEY: To your knowledge has it ever happened?

MS ANDERSON: Not in the last six weeks.

COMMISSIONER TRACEY: No.

MS ANDERSON: I don't know what happened prior.

COMMISSIONER TRACEY: Yes. Well, it's something that perhaps bears some thought about, given the evidence that has already come out and there's more to come. Could I take you to another couple of matters. The first arises out of paragraph 42 of your witness statement where you refer to the rules under which – where quality reviews are undertaken. The reviewers prepare interim and final reports. What I wanted to ask you was whether those reports are published and, if so, where?

MS ANDERSON: So this is in relation to home services. I'm not sure, Commissioner.

COMMISSIONER TRACEY: Well, I wonder if you - - -

MS ANDERSON: I would be happy to find out.

COMMISSIONER TRACEY: - - - could in due course make inquiries and let us know.

MS ANDERSON: Of course. Of course. If I may, we publish a range of final reports. My hesitation is whether we publish reports in relation to home service reviews. I'm happy to provide that information.

COMMISSIONER TRACEY: And a similar question arises out of paragraph 49 where you say specifically there that the commission has a policy of publishing its serious risk decisions. Can I ask you again where those decisions are published?

MS ANDERSON: Wherever in my witness statement I refer to publication, it would be on our website.

COMMISSIONER TRACEY: And is what is published simply the finding that a serious risk has been identified, or does the report contain detailed reasons for that conclusion?

MS ANDERSON: Again, Commissioner, I would be pleased to get back with advice to you on that.

COMMISSIONER TRACEY: Thank you. Well, that has been most helpful. Is there anything arising?

DR McEVOY: Nothing from me, Commissioner.

MR FREE: Commissioner Tracey - - -

COMMISSIONER TRACEY: Yes, Mr Free.

MR FREE: - - - I was primary going to rise to ask to be excused. But can I just give you one reference and it goes to your question in relation to conflict of interest. I just want to draw the Commissioner's attention to the fact that that topic is specifically dealt with in rule 71 of the commission's rules.

COMMISSIONER TRACEY: Yes, I'm indebted to you for that reference. Thank you.

MR FREE: Otherwise, if we might seek to be excused, Commissioner.

COMMISSIONER TRACEY: Ms Anderson, thank you very much for your evidence. Again, I don't expect that you will have taken down a list of the things that you've undertaken to provide by way of additional information, but the Commission's solicitors will, I'm sure, provide you with a list in due course.

MS ANDERSON: Thank you, Commissioner.

COMMISSIONER TRACEY: Thank you very much.

<THE WITNESS WITHDREW [3.42 pm]

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner.

COMMISSIONER TRACEY: You're on the home stretch.

MR GRAY: Commissioner, I call Dr Harry Nespolon, the President of the Royal Australian College of General Practitioners.

<HARRY MICHAEL NESPOLON, AFFIRMED [3.43 pm]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Operator, please bring up WIT.0016.0001.0001. Dr Nespolon, there have been some details redacted, but do you recognise this to be a statement you've made for the Royal Commission?

DR NESPOLON: Yes, it is.

MR GRAY: Do you wish to make an amendments to either the covering statement or the submission which forms part of the statement?

DR NESPOLON: No.

MR GRAY: To the best of your knowledge and belief, are the contents of the statement and submission true and correct?

DR NESPOLON: Yes.

MR GRAY: I tender that document compendiously including the submission that's attached to it.

COMMISSIONER TRACEY: Yes. The witness statement of Dr Harry Nespolon dated 25 January 2019 will be exhibit 1-40.

EXHIBIT #1-40 WITNESS STATEMENT OF DR HARRY NESPOLON DATED 25/01/2019 INCLUDING ATTACHMENT (WIT.0016.0001.0001)

MR GRAY: Dr Nespolon, what's your full name?

DR NESPOLON: Harry Michael Nespolon.

MR GRAY: You are the President of the RACGP.

DR NESPOLON: I am the President of the Royal Australian College of General Practitioners.

MR GRAY: And the college has 39,000 or so general practitioner members; is that right?

DR NESPOLON: Yes, 39,000 GPs and those working towards becoming specialist general practitioners.

MR GRAY: And what proportion of the general practitioner population in Australia does that represent?

DR NESPOLON: There's about 50,000 GPs in Australia, so whatever that is, 40,000 divided by 50,000.

MR GRAY: At paragraph 7 of your statement you refer to the Royal Australian College of General Practitioners' mission, including some of the functions it performs such as providing ongoing professional development activities, developing resources and guidelines, helping GPs with issues that is affect their practice, developing standards of general practices used to ensure high quality health care. In respect of aged care, is it the case that the college has produced a book known as the silver book and it's – it goes through various editions.

DR NESPOLON: Yes.

MR GRAY: I would like to bring up RCD.9999.0001.0001. And is that the current edition, the fourth edition?

DR NESPOLON: That is the current edition. I understand there will be a new edition this year.

MR GRAY: I tender that document.

COMMISSIONER TRACEY: Yes. The fourth edition of the publication of the Royal Australian College of General Practitioners entitled Medical Care of Older Persons in Residential Aged Care Facilities will be exhibit 1-41.

EXHIBIT #1-41 FOURTH EDITION OF THE PUBLICATION OF THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS ENTITLED MEDICAL CARE OF OLDER PERSONS IN RESIDENTIAL AGED CARE FACILITIES (RCD.9999.0001.0001)

MR GRAY: Dr Nespolon, I want to ask you about the practices of GPs as they're known to you either from data that might be available to you or anecdotally if not, concerning in particular their patients who are over 65 and are receiving aged care services, be that in a residential care setting or at home. Firstly, does the college collect data on the extent of visiting by GPs to patients in those categories?

DR NESPOLON: Other than the publicly available data that Medicare provides, we don't collect separate data.

MR GRAY: Anecdotally, are you able to speak to what you perceive to be any trends with regard to visiting. Let's take visiting patients who may be over 65 and in receipt of aged care services at home?

DR NESPOLON: I – my – I'm not sure that we've got absolute data but my feeling is that certainly those patients are taken care of and continue to be taken care of by GPs. Certainly the number of home visits that GPs are doing has decreased over time but that there is still a large number of GPs who provide those services.

MR GRAY: And in respect of the patients of GPs who have moved into a residential care setting, what are your impressions, if you don't have any data in relation to it?

DR NESPOLON: From my understanding – and it's certainly more just impressions – is that there is a progressive decrease in the number of GPs who are willing to work or go and see patient in nursing homes. The stated figure is about 30 per cent of GPs currently. I'm not sure where that figure comes from but that's the one that's often repeated.

MR GRAY: And does that accord with your general experience in meeting many of your members, that it's roughly 30 per cent of GPs who are continuing to visit - - -

DR NESPOLON: Yes.

MR GRAY: - - - residential care facilities.

DR NESPOLON: Yes. And what we're finding is that there are less GPs seeing individual patients in aged care facilities and there is certainly growth in the number of general practitioners who are in a sense assigned to a aged care facility and are taking care of all of the patients within that aged care facility.

MR GRAY: I will ask you about that in just a moment but I just want to ask you about the question of what is it, in your experience – and you can draw on information that you've received from your members – concerning the move by a person into a residential aged care setting. You've expressed some – I understand you expressed some points about that move and the pressures that come to bear at that time.

DR NESPOLON: Sorry, are we talking about the patient or the doctor?

MR GRAY: The patient, the doctor and any affected family.

DR NESPOLON: Yes. Well, I guess if I can pick on the doctors first, doctor – general practitioners offer lifelong care to patients and many of these patients who do go into nursing homes have often been taken care of by their GP for anything up to 40 or 50 years, and that those GPs know those patients, know their family, often know their children and even sometimes their grandchildren and have a fantastic relationship with those patients, a very trusting relationship. When a patient moves into a nursing home, if they're not given the choice, they will often have to see a different GP at a very traumatic time in their lives. I don't think I've ever met a patient that sort of gladly looked forward to going into a residential aged care facility or their relatives, but it is often necessary.

Families often find these times really difficult. There's not only the emotional and sort of personal issues but there are the financial issues which are incredibly complex and often difficult to negotiate. So for patients, families and doctors it is an emotionally traumatic time or it can quite an emotionally traumatic time.

MR GRAY: What about the topic of planning for an event of this kind, particularly if, say, the GP diagnoses a condition that seems to be progressive and it might lead to the need to enter residential aged care?

DR NESPOLON: This is one of the really difficult areas of general practice. You will see a patient or a couple where one of the members of the – of the couple are clearly becoming more and more demented and becoming more and more frail and often you do have the very long conversation about the necessity to plan for moving into, potentially, an aged care facility. I say – I would say in general that most people, they don't quite ignore you but they don't really want to do it. It's not a pleasant thing to look forward to. And often what happens is that there is an acute event that occurs. So either the partner falls over and breaks a hip or has a stroke or has some other event that necessitates their movement into a nursing home and that can be a very difficult time. It's difficult to find a place – a place or a suitable place, and also as I say, the finances and dealing with the – the bureaucracy around going into a nursing home just adds to that trauma. And patients – and so as I say, I've done this counselling many times and it is really hard to get people to do something that they really don't want to do and it is completely understandable.

MR GRAY: Is it your opinion then that people should be encouraged to give forethought and planning to this topic so that it doesn't have to be a decision that's made in a rush during a crisis?

DR NESPOLON: Absolutely. And that's – I think what I'm trying to say is that as GPs we try to prepare our patients for difficult parts of their lives and this is perhaps one of the most difficult parts of life.

MR GRAY: You refer in the submission, in particular at page 5, to various barriers to the provision of access to GPs patients who are in residential care, and I want to ask you about those barriers but I also want to ask you more generally, based on your experience and the information you've received as president of the college from members, what seemed to be the pressures on GPs that might be contributing to this trend that you've referred to in decreasing visits to residential aged care facilities? Is it a combination of things? Is it just those barriers or are there other things in play?

DR NESPOLON: I was going to beg the Commission's indulgence, if I could read a blog which is titled from one of our members or one of the GPs why this doctor no longer attends to patients in residential care facilities. It's about five minutes and I understand that time is precious but I think it really does illustrate a lot of the issues that we will come across this afternoon, I presume. So bear with me:

Week one, Monday. Request prescription from the chemist, time taken 10 minutes after work. Income for doing this, nothing. Tuesday, drive to the facility for the regular four weekly review, 15 minute drive there in my own car. No payment for this. 10 minute tracking down – 10 minutes tracking down staff and files, no payment for this. 10 minutes tracking down one of the patients. At the hairdresser despite the doctor's visit being booked four weeks ago, no payment for this. 50 minutes spent with three patients, 3 x standard consults, $53 for each patient from Medicare. 20 minutes advising the RACF staff what needs to be done, no payment for this. 15 minute drive back to my rooms, no payment for this. 30 minutes doing notes, scripts and other paperwork, no payment for this.

Wednesday, received notice from the hospital that one of my patients has been sent to the hospital overnight with shortness of breath. My instructions to call me were ignored. The patient was end stage chronic lung disease and had severe anxiety disorder to the point where she had not left her room in years. She is in palliative stage of her life. 45 minutes spent on the phone trying to explain the background issues to the very smart doctors in the hospital and being ignored. No payment for this. 20 minutes more time spent explaining the issues to the anxious relatives, no payment for this.

Thursday, received script from pharmacy for medication that they had issued without a valid script and now urgently want me to write a backdated script. 10 minutes spent lunchtime doing not backdated scripts. Unpaid work.

Friday, 3 pm call. Patient has been sent home and is in a mess. I need to come and see her as soon as possible. Drive to the RACF after work, unpaid time. Arrive at the RACF after 6 pm and the doors are locked. It takes 20 minutes to get someone to open the doors as the severely understaffed team is busy elsewhere. No nurses onsite after hours and carers have no clue on where the paperwork and notes are. See the patient for 60 minutes. $150 from Medicare for this. Fix the kinked oxygen tube, help to make a cuppa, find the missing glasses and TV remote. That's the easy stuff. Hard stuff is restarting the

sedatives that the hospital doctors stopped. Horrible medication that is dangerous for breathing –

that's referring to the sedatives, which is correct.

That she has been on this medication for 40 years and absolutely addicted to and cessation is causing her intense distress. What other option do I have to source the medication somewhere and restart her on the pills. There are no staff members or relatives to sit there and hold her hand while she is having a huge panic attack and the only other choice is to send her back to hospital, something which she made me promise not to do. Further hour of unpaid work.

Sunday, drive 25 minutes from home to check her. Unpaid time. Spent 15 minutes checking her. Medicare pays $85. Sunday ditto.

So, and there is another week which I won't bore you with, but what it shows is a whole range of issues which the unremunerated aspect of the work of general – of seeing patients in a nursing home. So there is a lot of non-face-to-face work that is involved which there is no rebate for. What you don't see is the time out of practice. A lot of these consultations are done out of hours because it's the only way it makes any economic sense because if you leave your practice during the day you're not seeing patients that you would normally see. I worked out that if the – if this doctor had stayed in their practice and not gone and seen the patient, if this was done during working hours, the doctor would have lost about $260 in consultation time.

It also underlines the poor staff handover, instructions not to send people to hospital or instructions to call the doctor are often ignored. And I should have added earlier on, this is quite a common story. This is nothing special. It's not – you know, this is not a story that's – or a situation that's, you know, unique in any way. I've certainly experienced it many times myself and I wouldn't be surprised if a lot of my colleagues have experienced similar episodes, a minimum at least once or twice a year. The – then there's the issue of staff stability and quality. The – especially if it's after-hours, it's likely to be agency nursing which are not there for the long run. And the GP becomes the default for all the inefficiencies of the system, whatever needs to be done, the GP is meant to do it and they really can't just say, "Well, I'm not going to do it" because the patient needs that care.

And I can certainly attest to the issues that related to, you know, silly things like just being able to get into the – get into a RACF. It can be very difficult depending how big it is and what time of the day it is. In my part of the world where I live in Sydney on the Lower North Shore, trying to find a park in front of a nursing home can be really difficult. It just adds even more time and more frustration. What this case doesn't illustrate is the lack of physical infrastructure which is often found within a nursing home to assist the GP in providing better care for their patients. And so – and this is all sort of underlined by general practices sort of de-funding over the last five years. It makes the time spent out of your practice dealing with nursing home visits so much more relatively expensive than they have been in the past. So I think

it's a very good story which really brings to life a lot of the issue that is general practitioners face when dealing with nursing homes and why a lot of GPs are deciding not to continue doing nursing homes.

And I just want to add a little bit of a human element to this. As one of my colleagues says who stopped going to nursing homes, "I felt that I had abandoned my patients". You generally feel that. I mean, it's not just about the money. It's about that relationship which may have been going on for many decades and now is lost because of the economics of the situation. Having said that, look, patient do also move to different suburbs where it's just logistically impossible to see them. But what our college is saying is that the opportunity should be there for both that patient and that doctor to continue that relationship all the way through to their final resting place.

MR GRAY: Dr Nespolon, I just want to ask you about what seems to be a dilemma posed by the account you've just read from the blog and the explanation you've given the Commissioners on the one hand, compared with a point you made in passing a short time ago about residential aged care facilities moving to a model of having one GP who services, if I can use that expression - - -

DR NESPOLON: Yes.

MR GRAY: - - - or cares for all of the people in that facility. There seems to be a dilemma there because you just referred to the importance of continuity of care.

DR NESPOLON: Yes. Look – and this is – this is a dilemma and – look, what happens is that it is much more efficient for models of care by GPs to do a whole nursing home because it makes it worthwhile, for want of a better way to describe it. But having said that, I would – the dilemma is – and I can talk about my own experience which is any of my elderly patients who want – who do end up in a nursing home, I want to take care of them and I will take care of them if they want me to. It's not my decision; it's their decision. But the problem is as the funding drops or as the relative funding drops it means that people need to use different models of providing that care and one of the efficient ways of doing that is to see more patients in a single visit, for want of a better word. It's not necessarily a bad thing. It does lead to some specialisation of care of elderly patients but as we would – the college would still say that we should still be encouraging GPs to take care of their patient all the way through their lives.

MR GRAY: Dr Nespolon, I want to draw out some of the strands of the account you gave. You spoke about the remuneration aspect in the sense of opportunity cost and of not being remunerated for a number of activities but what is the remuneration that is available? How does that work, for example, by reference to medical or Medicare Benefits Schedule?

DR NESPOLON: Well, currently there is no payment or no flag fall payment and there is a thing called coning of – for Medicare. So what that means is the more patients you see, the less you get for them, for each individual patient.

MR GRAY: There's a law of diminishing returns, is there?

DR NESPOLON: Correct.

MR GRAY: Is that going to change?

DR NESPOLON: It is going to change. The government introduced with its last MYEFO a flag fall and the – although it's not detailed yet, there will be a per patient consultation rather than having a coning which helps but I think it works out to about six or seven dollars extra per patient.

MR GRAY: And so for a visit, an average visit to – for a standard consultation.

DR NESPOLON: A standard consultation is about $37.60 as a consultation. This is what we're not sure about, whether it's going to be the home visit out of surgery type remuneration, or whether it's going to be just straight consult as if they were visiting you in your – in your practice.

MR GRAY: And there will be an item for the trip, will there? Is that what you mean by flag fall?

DR NESPOLON: That's correct, so there will be a flag fall plus.

MR GRAY: However many consultations that occur during that trip to the facility.

DR NESPOLON: Yes. that's correct.

MR GRAY: Thank you. And will it be in the order of, say, about $100 if you're visiting one patient?

DR NESPOLON: It will be – yes, but, as I said, it depends a lot on whether it's that out-of-practice fee which will be about $100. But if it as a non-out-of-practice fee it will be about $80. So that will be the visit.

MR GRAY: All right. Now, a number of the things you mentioned in the course of reading out the account related to having to do administrative or other hands-on tasks that are not providing medical services. Why are GPs doing that? Who should be doing it, in your opinion?

DR NESPOLON: Well, that's a very good question. The – Medicare is based on face-to-face consults. I will just give a little tiny bit of background. So unless the person is actually sitting in front of you, you're not able to generate a rebate. For all it's worth, this is something the college has been pushing very had with the current

government and any future governments that there should be remuneration for face-to-face work, which is estimated to be about 30 per cent of most general practitioners' time. Look, you can – there is an argument that says that perhaps GPs shouldn't be having to do a lot of this administrative paperwork and that's a very good argument, and so there is a – raises the question about whether places like residential aged care facilities should have people – they've got a variety of names, but patient concierges or people who actually do the hard administrative work.

What this account doesn't take into account – sorry, I used the word twice – is, for example, the patient needs an X-ray. It's really difficult to organise for a patient to get an X-ray outside of – outside of a nursing home. Not only do you have to organise a time for the actual X-ray to be done but then you often have to organise a family member to come in and take the parent to have their X-ray or get some patient transport, and in most – well, certainly I can say from my experience that can be quite a difficult thing. And so there are these things which take incredible – they really do take a lot of time which general practitioners are not remunerated for and makes nursing home work much less desirable.

MR GRAY: Another strand I want to take from the account and ask you to comment on was the question of poor handovers and miss-transmission of information or failure to transmit clinical care information in respect of hospital transfers or transfers between RACSs and hospitals and you had some specific examples in the account you read out. I want to ask specifically about the palliative care or end of life matter as a separate question - - -

DR NESPOLON: Sure.

MR GRAY: - - - but just at a general level in terms of clinical care information handover, what's going wrong there? What can be done to fix it?

DR NESPOLON: Well, the big problem is – there's a number of issues that is get raised. If you've got a difficult patient at night and you're quite severely understaffed, it's very hard for a – if you've got very few staff members for one person to actually take care of that patient. Just as a – you might have 20 people – I'm not sure what the ratios are – and you've got one nurse taking care – or one carer taking care of one patient. It's often much easier to send them to hospital. It means you can take care of everyone else. Lots of my colleagues, they all don't want to be woken up at 2 o'clock in the morning but I personally will always leave instructions to say do not transfer patient without calling me. Often patients don't need to go to hospital. In fact, it's the last place they should be. But, again, if they're a new staff member or a temporary staff member, they may not know that. That may not come across.

And often patients – I've had the opposite experience where I've been able to take patients off almost all their medications. They go off to hospital, they come back and they're a;; back on them. And often – and, again, it's part of the problem with information transfer and the ability – and the importance of having a regular carer

and that's part of having that GP who knows the patient well, like in this case here, it's not – they're not following the guidelines perfectly but they actually are treating the patient very well.

MR GRAY: What's the solution with respect to at least the information transfer element in what you just described?

DR NESPOLON: Look, I think it's as simple as making sure that information appears at the front of the notes, actually. I mean, we do put – have messages like do not transfer, do not resuscitate. There's a – all that information does appear at the front of a – should be appearing at the front of notes as a minimum. But clinical handover is a very important issue. It's something that – there's certainly a lot of – a lot of time is being spent on it and it really is important for keeping patients who really should not be in hospital, being sent to hospital.

MR GRAY: On the medication management side of it which you touched upon - - -

DR NESPOLON: Yes.

MR GRAY: - - - just then because you said in hospital, one of your patients ended up getting put back on a whole lot of medications and in the blog you read out there's an example of - - -

DR NESPOLON: The other way.

MR GRAY: - - - the patient who had been returned to residential care in a state where she had been given, presumably, an inappropriate mixture of medications or an inappropriate medication in respect of – I think you said a respiratory issue.

DR NESPOLON: I think what has happened here is this patient was probably on a benzodiazepine. And it's absolutely true, as the blog says – as the writer of the blog says, the benzodiazepines are not really recommended in patients with obstructive airways disease. The young registrar said yes, that's what we're going to do, we're just going to take her off, that's the right thing to do, without realising that this patient, the reality is, has been on a medication for a very long time and withdrawing her is actually more dangerous than leaving her on it.

MR GRAY: So is there some sort of information platform that the Commission should consider recommending for a uniform introduction that might assist?

DR NESPOLON: Look, it's – I mean, we have the My Health Record which the Commonwealth has spent a lot of money on. I've certainly made comments to suggest that patients like this would actually benefit from something like a My Health Record. It still requires the infrastructure within a nursing home to put that information into the My Health Record so that if there's no IT infrastructure within that practice it requires the doctor to go back to their home practice, which is a common problem, so there are often two sets of notes – notes in the nursing home,

notes that the doctor writes up, so they're writing things up twice – and it also requires the doctor to put that information into the – into the cloud, so to speak, into My Health Record. There are a lot of proprietary software packages which nursing homes can use nowadays and they are generally very well received by members and they should be able to print out a medication record that you can hand to the patient if they were to have to go into hospital. So there are a variety of ways that you could potentially do it. From a recommendation, I would suggest that most if not all RACFs should have, as a minimum, an electronic medication management system.

MR GRAY: Thank you. I want you to now return to the topic of – I think you referred to it as palliative care that was being provided to one of your patients.

DR NESPOLON: Yes.

MR GRAY: And to expand more generally on the topic of end of life care, what are your views about the adequacy with which RACFs or RACSs are currently able to cater for end of life care?

DR NESPOLON: Certainly the discussions I've had preparing for this is that most of my colleagues who are working in – in residential aged care facilities believe that palliative care or end of life care should occur in the nursing home. It's often desired by the relatives because it's something where the patients have been, it's their "home", and that nursing homes – if I can, sorry, use the old term, are – should be in – should be resourced to allow patients to die and to have good deaths, to use the terminology, in their nursing home. Palliative care services are often very good at dealing with patients in their own homes and for dealing with often cancer-type pains. Within nursing homes, not all patients are dying from cancer. They're dying from chronic illnesses, things like heart failure, strokes, lung disease. It's a different – it is a different sort of death, and nursing homes, in my view, should be adequately resourced to be able to allow people to die, and as my colleagues have said to me, it's often where most non-cancer deaths are occurring nowadays.

MR GRAY: Is there a gap in the equipment at nursing homes, in the skills mix? Is there some issue you perceive there? You seem for saying that should be the aspiration but I'm not sure whether you're saying that it actually is the actuality now.

DR NESPOLON: Look, I was chatting to one of my colleagues this morning and often using a pump to pump things like morphine into patients subcutaneously, that sort of – I would see it as sort of as an absolute minimum sort of piece of equipment. That's worth about $10,000. So that's quite a significant investment by a nursing home in a particular – just in one piece of equipment. It can be done manually. You don't have to have the machine, the machine makes it easier, but it does require someone to be coming and seeing the patient regularly and once again you run into this problem, the number of staff members within the nursing home. If you've got – I don't know what the number is, two or three people on, if you've got one of those people just dealing with one patient it means there is a whole lot of other patients who aren't being seen.

MR GRAY: I want to ask you about chemical restraints and about some medication management issues – I need to do it reasonably rapidly – what's chemical restraints?

DR NESPOLON: Well, chemical restraints in sort of simple terms is using medication to stop particular behaviours, usually of a patient. It's not necessarily done for their immediate benefit, I guess would be the way to describe it. Often it's not – often the patient is not in a position to consent or not consent to it. And that – and all those issues make it a difficult issue to deal with by the relatives and by the patients and even by doctors.

MR GRAY: What are your views about the role of GPs in that respect, if they happen to be the medical practitioner who's doing the prescribing of the relevant agent?

DR NESPOLON: Yes, look, it's something that – if we can go one step back, what are the sorts of patients that you would think about using chemical restraints in? I think if you look at the data, most people with dementia will have a number of behavioural issues or are likely to have behavioural issues. It has been quoted as high as 90 per cent, so if you've got a patient who's violent, hitting out at the staff, patients who are screaming in the middle of the night, you know, I would ask you how you would feel if you were in a nursing home and there's one of your co-residents spends most of the night screaming, or if you're a staff member and you've got a patient that's hitting you. Now these are very real issues and so what do you do about it. There are – the guidelines clearly state – and most GPs would love to follow this, which is to – they should use nonchemical methods. Sometimes it can be as simple as just sitting with a patient. There is a step before that, to make sure that the patient doesn't have an intervening medical problem. That's a general practitioner issue.

But however, if at the end of the day it is decided that hopefully with the assistance of the relatives of the patient – and I might add that for the relatives of these patients it's incredibly distressful to see your relative in that sort of state – that you do use medication. But the point is that it doesn't work for everyone, and that it's something that should be monitored, introduced at low levels and ultimately if it doesn't work it should be stopped, so it needs to be reviewed. One of the problems that you do tend to find is that once a person is put on a medication, they tend to stay on it forever and that's not good practice. And dare I say, stuff like the medication management software will often say this patient has been on drug X for six weeks, should they still be on it.

And when it comes to regulation, if I can continue on, I think regulation is not the right answer. It doesn't – it doesn't take into account the thousands of different situations and contexts that people find themselves in. There are so many factors that are involved in this. And sometimes you've just got to trust the medical staff and the nursing staff to do the right thing and in general they will. That picture of the man – I think that was in the paper a little while ago – that was a terrible thing and I don't pretend that it isn't. But I would suggest that most of my colleagues are doing the

best for their patients. They're trying to decrease the amount of medication, they're trying to keep them as comfortable as they possibly can and that can be really difficult at times.

MR GRAY: Associate Professor Strivens, a geriatrician, gave evidence to the Commission last week on this general topic. He referred to a figure of 80 per cent in a dementia context of patients being prescribed psychotropics. Commissioners, the source of that information is a foreign study, it's not an Australian study. Nevertheless, in the Australian context, do you have any knowledge, Dr Nespolon, about what the rate of prescription is? And the next point is Associate Professor Strivens went on to say in terms of efficacy it's really only efficacious to prescribe in about 10 to 20 per cent of patients. Do you have any comment?

DR NESPOLON: First of all, patients with dementia or patients in a nursing home have about a 50 per cent quota – rate of depression. Dementia patients often do have psychotic symptoms rather than depressive symptoms, so the reason why patients might be on psychoactive medication is not about chemical restraint; it's actually about dealing with their symptoms. My feedback is that it's probably somewhere between about 10 to 15 per cent of residents have some degree of chemical restraint, if I can use that term, but again it's about making sure that it works. And, you know, it doesn't matter what medication you use, they don't all work and so the most important thing is to review patients and to make sure that what you're trying to achieve is being achieved and if it's not, then do something else to stop the medication.

MR GRAY: Thank you. I want to ask a more general question. I know that we're running up against a deadline and I will be quick. In terms of general medication management, could I ask you, Operator, to bring up RCD.9999.0016.0001. And there's two items in the Medicare Benefits Schedule described in this document. If we go to the second of them, one of them is called – one of these items which is item 903 is called residential medication management review, it's on the second page of this document, please, Operator. Or RMMR for short. And is that an item generally available once in any 12 month period - - -

DR NESPOLON: That's correct.

MR GRAY: - - - for a comprehensive medication review in combination with a pharmacist?

DR NESPOLON: That's correct.

MR GRAY: And I will now ask for RCD – another document, RCD.9999.0007.0120 to be brought up. These are Medicare statistics in relation to financial year 2017/18 in respect of take-up of item 903 and that item is in a residential care context. It's only available in a residential care context; that's right, isn't it, Dr Nespolon?

DR NESPOLON: That's correct.

MR GRAY: And the take-up of this item is 68,189 people. If we assume that the total population of people in residential aged care is about 240,000 people, it seems to be only a little over a quarter that are actually having a RMMR in this financial year. Does that surprise you? Is that of concern? Should it be better? Should the figures be higher?

DR NESPOLON: I make one preliminary comment which is RMMRs are very valuable – can be very valuable process for patients to review their medication. A lot of RMMRs are about interactions, should the patient be on the medication. If this is sort of if you're leading to, you know, should this be about chemical restraints, it shouldn't be. This is not going to make a decision about whether a patient should be on a particular psychotropic or not. As I've tried to say it's about something that should be happening almost weekly, reviewing the patient, seeing whether or not they're benefiting from it, whether they're having lots of side effects. An RMMR is not designed to do that.

MR GRAY: Thank you. In terms of general medication management though, is it – would it be better if there was a higher take-up of this item?

DR NESPOLON: Again, there's also an assumption that all people in residential care have a multitude of medications. They don't. And so for patients who are on many medications these are, as I say, invaluable but for a lot of patients who are on a small number of medications, as I say, once patients do get into a residential care, it's an opportunity to de-prescribe, to try to get them off a whole lot of medications that are not necessarily going to benefit them in the long run. That's reality. And so hopefully we're finding that we're getting patients on less and less medications as they get into residential care, rather than more.

MR GRAY: Thank you, doctor. Commissioners, I tender as one exhibit RCD.9999.0016.0001 and RCD.9999.0007.0128, documents relating to MBS item 903.

COMMISSIONER TRACEY: Well, I will entitle the conjoined exhibit the Department of Health's document on medication management reviews and that will become exhibit 1-42.

EXHIBIT #1-42 DEPARTMENT OF HEALTH'S DOCUMENT ON MEDICATION MANAGEMENT REVIEWS (RCD.9999.0016.0001 and RCD.9999.0007.0128)

MR GRAY: Finally, Dr Nespolon – thank you, Commissioner. Finally, Dr Nespolon, I will merely ask you to identify an exhibit concerning the role suggested by the College for GPs in the context of recognition of reporting of abuse or signs of

violence in the context of residential aged care. It's the case, isn't it, that the college produces a manual on that topic?

DR NESPOLON: Yes. The white book.

MR GRAY: On the topic of abuse and violence, more generally.

DR NESPOLON: That's correct.

MR GRAY: And do you refer to that manual as the white book?

DR NESPOLON: We do.

MR GRAY: Operator, please bring up RCD.9999.0006.0001. Is that the current edition of the white book.

DR NESPOLON: That is the current edition of the white book.

MR GRAY: I tender that document.

COMMISSIONER TRACEY: Yes. The Royal Australian College of General Practitioners' publication entitled Abuse and Violence, the fourth edition, will be exhibit 1-43.

EXHIBIT #1-43 ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS' PUBLICATION ENTITLED ABUSE AND VIOLENCE, FOURTH EDITION (RCD.9999.0006.0001)

MR GRAY: Thank you, Commissioner.

COMMISSIONER TRACEY: Thank you. Dr Nespolon, we've just been looking at the issue of periodic reviews of medication which involves a pharmacist and medical practitioner and presumably a representative of the nursing home where the patient resides. We've also been given evidence last week about the need in respect of every patient in care to have a management plan relating to their health to which there's at least a registered nurse, a general practitioner, perhaps a geriatrician in some cases, all involved. And that there be regular reviews of the operation of that plan and tweaking it as required to deal with the patient. Now, I have a feeling, with your immediate reaction, and the earlier evidence where you recounted the experiences of your colleague over a week coming and going in relation to patients in a nursing home, never a mention of a meeting, a collaboration, an assessment, joint decision-making. It all seemed to fall on the GP. Is that the real world?

DR NESPOLON: That generally is the real world. I think if I can expand a little bit on your comments, Commissioner. One of the strong bits of feedback that I've had

from my colleagues who do a lot of work in aged care facilities is an intake assessment is probably the most valuable part of their work. So getting, when a resident does come into a residential aged care facility, sit down with the resident and the family, and the doctor, and so everyone's expectations can be clearly outlined from day zero. And so in a sense it's a little bit of sort of what you're describing but it takes in a holistic approach; it looks at the whole patient and their whole family and their whole context. And the feedback I get from that is that it really helps everyone understand what a nursing home can offer patients – a residential aged care facility can offer patient. It cuts down significant numbers of complaints because people's expectations are aligned and it does allow – it does allow everyone to – to really understand what is a really difficult situation.

And so there is also a suggestion that it's often worth going back and reviewing that a month or two months later to see whether the expectations have been met, but I would suggest that it's not just about the health care of the patient. It's also about their whole bio-social situation. When it comes to medication or medical reviews, look, I do smile a little bit when I hear you say a geriatrician. It's quite difficult to get geriatricians to go to aged care facilities and I think even the College of Geriatricians would say that they have – the distribution of geriatric – or geriatricians is patchy at best, but I'm sure they can give their own evidence.

COMMISSIONER TRACEY: When was the last time, to your knowledge, one of your patients in a nursing home had access to a geriatrician, at your reference?

DR NESPOLON: I must admit I've never referred a patient to a geriatrician within a nursing home and I used to do quite a lot of nursing home care. I didn't ever run across a geriatrician in a nursing home.

COMMISSIONER BRIGGS: If I could pick up on the evidence you've given, and I think the questions that the Commissioner has given, in the blog from the GP, what – one of the things that was evident in that was that the GP was getting no support from anybody, really, not the nursing home management or the residential facility management, not the nursing staff, not the personal care workers, and it would be useful for the Commission if we could understand what you expect, apart from a consultation room. Do you expect that the nurse is – where there is nursing staff, that they're the people who would provide that main connecting point? Or are you equally satisfied with the management so long as there's a good process and good IT or personal care workers?

DR NESPOLON: When I first used to go visiting nursing homes you would always have a nurse standing by your side and there was no problems with communication. You could directly talk to the patient, the nurse could see the patient's reaction and you would prescribe or change and it would happen. Not that I do a lot of work now but I've certainly walked into a nursing home, seen a patient, written in the notes and walked out and not seen a single staff member, and that's not an unusual experience. With respect to what support do we need, if I look at my – my colleagues sort of, you

know, how can we make nursing homes better, it is about that support about, so that the doctor isn't doing everything.

And it is a – it is a virtuous circle if there is that support you will find that there are more GPs doing nursing home work, and dare I say it, I would like to hope that the – that the care that the patient gets is much better and actually the experience of the staff within a nursing home is actually better. Rather than sort of running from one patient to the next, they're actually providing care for that patient and that's a difficult thing. It's a change in culture and I've certainly noticed over my time – as I said I don't do as much as I used to do – but that sort of staff member being there to help, it has sort of gone.

COMMISSIONER BRIGGS: So is it a change in culture or is it a change in management, leadership or regulation? What's going on?

DR NESPOLON: Look, we've certainly called for better trained and more staff and I understand that that's an easy thing for us to call for, but if you really are caring – you want to care about patients, there's always going to be a patient that needs that extra care which means that there will be others that miss out. So if you're starting off at a very low level, it means there are a lot of patients who are missing out on that additional care and so, as I've said, we've always called on better trained, better numbers within nursing homes.

MR GRAY: Nothing arising.

COMMISSIONER TRACEY: Anything arising out of that, Mr Gray?

MR GRAY: No, thank you, Commissioner.

COMMISSIONER TRACEY: Dr Nespolon, your evidence has been very revealing about what it's like on the ground out there and we're indebted to you for giving us those insights. Thank you.

DR NESPOLON: Thank you. And I really do – it's part of my aim was to try and give you a feeling for what it's really like there. It's great being in here but, you know, nursing homes come in different qualities and there are some really fantastic nursing homes out there. I think that sometimes it gets lost in these sorts of Commissions. There are dedicated people who really want to make a real difference for people in the latter parts of their lives. And often it's more – it's not just about the building, it's about the people. And if you can allow the people to do what they want to do, which is to help older people get through that last part of their life then everyone's going to benefit.

COMMISSIONER TRACEY: The Commission will adjourn until 10 am tomorrow morning.

MATTER ADJOURNED at 4.35 pm UNTIL TUESDAY, 19 FEBRUARY 2019

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