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TRANSCRIPT OF PROCEEDINGS

O/N H-1030602

**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**

BROOME

9.30 AM, TUESDAY, 18 JUNE 2019

Continued from 17.6.19

DAY 24

MR P. BOLSTER, counsel assisting, appears with MS E. BERGIN and MS E. HILL

COMMISSIONER TRACEY: Please open the Commission. Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioners, the first witness for today is Mr Martin John Lavery, whom I call.

5

<MARTIN JOHN LAVERTY, SWORN

[9.31 am]

10 <EXAMINATION BY MR BOLSTER

MR BOLSTER: Document number WIT.0157.0001.0002 could be brought up, please. Thank you. Mr Lavery, is this your statement?

15

DR LAVERTY: It is.

MR BOLSTER: Do you wish to make any amendments to that statement?

20 DR LAVERTY: I don't.

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

25 DR LAVERTY: They are.

MR BOLSTER: Mr Lavery, you are the chief executive officer of the Royal Flying Doctor Service of Australia, correct.

30 DR LAVERTY: I am.

MR BOLSTER: Could you briefly indicate to the Commission the structure of the service. It's not just one organisation, is it, it's a number of organisations.

35 DR LAVERTY: That's right. The Royal Flying Doctor Service initiated 91 years ago is today a federation of seven companies, each of them charities registered with the Australian Charities and Not-for-profits Commission and a number of subsidiaries controlled by those seven main companies. Six of the seven provide services across remote Australia and the seventh, of which I'm the chief executive, is
40 the national coordinating body of those seven – of those six.

MR BOLSTER: You're authorised to speak on those six for the purposes of the Royal Commission?

45 DR LAVERTY: I am.

MR BOLSTER: And you yourself are familiar with the role of the Royal Flying Doctor Service across each of those entities in delivering care in rural, regional and remote Australia; correct.

5 DR LAVERTY: I am.

MR BOLSTER: Now, obviously the Royal Flying Doctor Service is not an aged care provider, but I would like to ask you about your perspective on the importance of primary health care, in particular primary health care as delivered by your service,
10 and how that impacts upon the delivery of aged care services in the Commonwealth.

DR LAVERTY: Well, it's very important for us to acknowledge upfront, we are not an approved aged care provider. Our role is as an emergency health care and a primary health care provider principally in remote and very remote Australia.
15 Primary care and aged care are interdependent, they are reliant on each other. And there's two main interdependencies. The first is the primary care, that is, access to doctors, to nurses, to allied health professionals, to dentists, to geriatricians, and primary care plays an essential role in keeping older Australians, and indeed all Australians, well and healthy, and the longer you are able to maintain your health
20 through access to adequate primary care the longer you are likely to avoid the necessity of access to the formal aged care setting.

The second interdependency is that once an older Australian enters an aged care environment, be it residential or community care, access to ongoing primary care is
25 essential to that citizen receiving appropriate care. Simple access to doctors is perhaps the easiest to observe, but it goes a step further. Access to geriatricians, to dentists, to mental health professionals, to palliative care specialists. This is the interdependency between primary care and aged care, and my evidence to this Commission is that in remote Australia primary care is failing older Australians and
30 let me outline the evidence that I'm able to make that claim. First, people in remote Australia are accessing the medical benefits schedule or Medicare at one-fifth the rate of people who live in metropolitan areas.

There are half the number of doctors working in remote Australia than they are in city areas and very similarly, when you look at all of the allied health professions, you see roughly between half to one-third the availability of various allied health professions – physiotherapy, pharmacy, occupational therapy – in remote Australia. And the consequence bears out in the acuity of those older Australians living in remoter areas. And if I can take you through potentially avoidable hospital
40 admissions to help prove my point.

MR BOLSTER: All right. I just want to pause there for a moment. I note your – the microphone is breaking up slightly. Is that something we need to attend to?

45 DR LAVERTY: Thanks very much.

MR BOLSTER: All right. The question occurs to me from your statement arising out of your introductory remarks and that is the geriatrician service that you operate in Victoria, geriatric access. How does that work in terms of – is that a geriatrician in an aeroplane being driven – being flown to people. How does the RFDS facilitate geriatric services in a remote area?

DR LAVERTY: Well, the first is the importance of the geriatrician to the older citizen. The role of the geriatrician is to conduct the assessment, to ensure that they receive the right care plan, and the right access to care services that's appropriate in their circumstances. We know that in many parts of remote Australia there is insufficient access to geriatrician services. In response, as a pilot program, in Victoria we have organised telehealth access to a geriatrician based in Melbourne to be able to serve populations across Victoria who would otherwise, (a), have to travel a great distance to be able to access that specialist care, or (b), would more likely miss out. And the point to your question, do we fly in geriatricians, well, no. It's more effective to be able to organise a clinician within a community to be with the patient, to telehealth in to the geriatrician in the city for that initial assessment and ongoing care to be made available.

If I might expand further on a similar access to dental care and, indeed, to palliative care, our evidence to this Commission is that in remote areas there is insufficient access to dental care but in particular within residential aged care services there is very often an inadequate access to oral health care. We have started at a very small volume of activity providing visiting dentists to aged care services in the State of Victoria with the intention of seeing if that is an appropriate role for the RFDS to expand into the years ahead.

MR BOLSTER: Practically, how does that work?

DR LAVERTY: Our dentists employed by the RFDS who have traditionally had the role of flying into remote communities to conduct visiting dental clinics are now adding in visits to residential aged care services, on a roster, by invitation of the accredited aged care provider. And what our experience is, is that when we are visiting these services, acknowledged at very small numbers of visits and very small numbers of patient seen to date, is that, first, there is an absence of awareness among the care staff to the importance of oral health. Anecdotally, we are being told that there isn't the time within the workload of some care staff to be able to brush teeth, to support brushing teeth for residents, that when our dentists are able to train the care staff on how best to provide oral care to residents of residential aged care services, on a return visit our dentists will observe that there has been an improvement in the oral health of those residents.

MR BOLSTER: And how does the dentist travel around?

DR LAVERTY: By road.

MR BOLSTER: By road. Can you give us an example of the sorts of centres where that service operates?

5 DR LAVERTY: Across the Mallee in Victoria but by air we are now visiting parts of western Queensland, the lower part of the Northern Territory, country South Australia. Dental care is part of the service outreach of the Royal Flying Doctor Service. What's new is the call for us to be providing that in residential aged care settings in response to the absence of dentists in country areas in particular, but also because of what we are seeing as the poor oral health of residents of aged care services.

10 MR BOLSTER: In the more remote areas, how does the service deliver these dental programs?

15 DR LAVERTY: Where distance makes sense for us to fly our health care teams which will very often comprise a doctor, a nurse, a dentist, a mental health professional, on a scheduled roster will visit communities to provide general health care services to people of all ages. Specifically to your question, providing that care to older Australians who may or may not be in residential services. Where it makes sense to drive, we do so by road. Think of the flying doctors as mobile provision of primary health care service.

20 MR BOLSTER: Yes.

25 DR LAVERTY: By road, by air and by telehealth.

MR BOLSTER: And can you give us an example of the sorts of towns where that program operates?

30 DR LAVERTY: If I can speak to Kingoonya in country South Australia and I've spoken to people that live in Kingoonya aware that today I was going to speak to their beautiful and much loved town.

MR BOLSTER: How many people?

35 DR LAVERTY: Population of 13, a wider population in Kingoonya of about 200 within an immediate radius of two hours driving time. It's the illustration of a very small community. The main street of Kingoonya is about half a dozen houses, an airstrip and a clinic built by the community that the flying doctors visits on a scheduled basis usually every fortnight. When we arrive in that town by air, we provide access to GP services, to nursing services, to dental services, but very particularly, we also provide care to some residents in that community who, in a more formal sense, would be enrolled in a community aged care service. The absence of a community aged care service in that area has called on the flying doctors to provide the types of nursing supports that would otherwise be available through a community aged care package if it were available in that very small town.

MR BOLSTER: What's the nearest centre to Kingoonya?

DR LAVERTY: Perhaps in a practical sense it would be Ceduna which is at the very least three to 400 kilometres away, and your question speaks to the decision that many older Australians and their family members have to make. The first is that where there is the absence of community or residential care services, it very often becomes necessary for the older person to leave their town, to leave community and move into a centre to access a community or a residential aged care service. The other factor is the burden that's placed on the family members, or the community members to provide that informal care. Now, to some extent, that informal care is an asset that we should cherish, it's something that we should promote, but we hear from the care providers, the informal care providers and family members that that burden falls on them somewhat unfairly and that very often it impacts their own lives in addition to those that they are caring for.

MR BOLSTER: How many people in Kingoonya might otherwise, if it was available to them, access some form of aged care whether it's CHSP home care, even residential care?

DR LAVERTY: The age profile of that particular community, and indeed the age profile of many of the communities we are serving is that people very pleasingly are living longer and able to stay in community or in their home town longer than may otherwise be possible, but in the absence of service it means that there are a number of people missing out. In Kingoonya there is perhaps a very small number of people out of that population of 13 that would otherwise be accessing a formal aged care service if it were available. But it's not, and it's not for a set of reasons, and they are that in a very, very small community like that, it's not likely to be efficient for a new aged care provider to establish that outreach. So it makes sense, where there are existing service providers, for them to extend that care, and that's the role the RFDS has taken on.

MR BOLSTER: How many Kingoonyas are there out there that you look after?

DR LAVERTY: As many as between 180 to 220, perhaps not all of that very small size. More likely that a typical community we visit would be between 200 to 500 people, but there are between 220 communities that we visit on a scheduled basis for fly-in fly-out health care provision that are of that small nature, where Medicare is not viable to operate in those towns. The RFDS service footprint is where Medicare, because of small populations, does not work. And the Commonwealth, in the absence of Medicare being viable, calls on the RFDS to deliver Medicare-like services into those communities because of market failure.

MR BOLSTER: Let's explore the broader Australia-wide footprint of the RFDS, and you have in front of you a document called a service planning operation tool.

DR LAVERTY: Yes.

MR BOLSTER: Could the document at tab 77 be brought up. I think the Commissioners have been provided with a copy.

COMMISSIONER TRACEY: Yes, we do.

5

MR BOLSTER: Did you explain, Mr Lavery, what this document seeks to do.

DR LAVERTY: We have taken the most recent census data, the 2016 census data. We've overlaid it with information contained in the national health directory. We've then added Aboriginal medical service provided to us by NACCHO as to where every health service operated by an Aboriginal medical service is operated in remote Australia. We've then further overlaid our own Royal Flying Doctor Service locations. So within our service planning operational tool we are able to look at any part of remote Australia and identify what population lives near to or distant from known health care services delivered by the Commonwealth, the State, Aboriginal medical services or ourselves. It then allows us to identify how well or how insufficient are specific populations served - - -

MR BOLSTER: All right.

20

DR LAVERTY: - - - in access to primary health care.

MR BOLSTER: Let's go to page 5 of that document and perhaps you can walk us through the colour-coded information that we have there. Let's start, shall we, with the grey circles of varying sizes. What does the grey signify?

25

DR LAVERTY: A grey dot is distance and size of population from a primary care service. So on page 5 in particular a grey dot indicates that a community is a minimum of 300 minutes drive from a primary care service. The larger the dot, the larger the population, and you can see some concentration in the top of the Northern Territory.

30

MR BOLSTER: Yes, if you could explain that, please, what's going on there?

DR LAVERTY: Well, we see that in the very large zone from Darwin down to Katherine and then across to Gove Nhulunbuy an insufficiency of primary care services. The flying doctors provides primary care services up until about Katherine and from that point up a combination of the Northern Territory Government provide, and the Commonwealth provides access to primary care services in that zone. We're seeing there's an insufficient access there indicated by the large grey dots because of that reliance or the expectation of access to services in Darwin, in Katherine and then across in Nhulunbuy. I should indicate that those services available in Darwin, Katherine and, indeed, in Nhulunbuy are exceptionally good. The evidence that our spatial mapping details is that the great distance that needs to be travelled, or the necessity of ad hoc fly-in visiting clinics organised from Darwin becomes essential.

45

In most other parts of Australia, you can see a combination of the flying doctors and Aboriginal medical services is able to provide at least access to a primary care service but you need to understand this data carefully. Where the RFDS provides a location, it might visit it once every two weeks, it might visit it once a month. It's not to suggest that it's 24 hour care. So missing from this data is an interpretation as to what's reasonable, what do we agree is reasonable access to care, to primary care in remote Australia to support older Australians.

MR BOLSTER: But let's just explore the other colour-coded indicators on the map. So the green populations, say, for example, Alice Springs right in the middle, that indicates that there's obviously close proximity to a GP, and if you look at the Kimberley region, it's fairly well covered both by access to a GP and the blue diamond dots. What do they represent?

DR LAVERTY: Blue diamond dots are RFDS service centres where we are visiting on occasion, not there 24 hours a day but visiting on occasion. But can I offer a warning about how to interpret this data, and I will speak to the Kimberley in particular. On national average, the preventable hospital admission rate for non-Aboriginal people is 27 per thousand head of population. So let me explain that. There's a set of conditions that the World Health Organisation understands are avoidable from hospital. You can prevent, through access to strong primary care, a person being admitted to hospital. An illustration of that is asthma, pneumonia, or cavities, the need for access to dental health. These are avoidable reasons that many people are admitted to hospital.

Now, across the nation, the national average for non-Aboriginal people is 27 per thousand people. In the Kimberley, the rate for avoidable hospital admissions for Aboriginal people is 75, almost three times the national average.

MR BOLSTER: That's across all ages?

DR LAVERTY: Across all ages.

MR BOLSTER: What do the stats show for people over 65?

DR LAVERTY: We have a higher prevalence for avoidable hospital admissions for people aged over 65 that I'm not able to specify but would be happy to follow-up and provide that data to the Commission. If I could make some further observations; across Western Australia it increases that the avoidable hospital admission rate for Aboriginal people in WA is 93 people per thousand, and in the Northern Territory it increases to 117 per thousand people. It is almost, in the Northern Territory, four times the national average of avoidable hospital admissions for first Australians. Why am I raising this and what's the link? Where you have a well-functioning primary care system you have low rates of avoidable hospital admissions. Where you see avoidable hospital admissions increase, you have evidence of the failure of your primary care system. The relevance for this Commission is that where your primary care is failing, you are going to have greater call on aged care services for

older Australians and when they enter their acuity will be higher such that they will require a higher level of support. Again, to the interdependence between primary care and the aged care system.

5 MR BOLSTER: Now, in paragraph 13 of your statement, you refer to the fact that between 2014 and 2017 there were 23,377 air retrievals for patients over 65 carried out by your organisations. What are we talking about with an air retrieval? How do you define an air retrieval?

10 DR LAVERTY: A retrieval is a combination of two possibilities. The first is that the citizen is in an emergency circumstance that requires them to be flown by ambulance to hospital for admission. The second is that they may already be in a form of health care, a small country hospital. They might be under the supervision of nursing care and they need to be flown in a scheduled manner to a larger tertiary
15 hospital to access care. What we know from that sample of retrieving 23,000 people over that three year period aged more than 65 is that they were flown, first, because of cardiovascular disease, heart attack. The second reason for them being transferred was injuries, and with a predominance of falls in older people, and the third highest reason for them being retrieved were illnesses of the digestive system.

20 Now, again, if we think about cardiovascular disease, injuries through falls and digestive illnesses in particular, most of these are preventable, most of them are treatable. A stronger primary care presence would possibly avoid the need for the evacuation. But in the absence of health services, because of small populations, a
25 clinical decision is made that the best care available is to transfer that patient to a larger hospital in the city.

MR BOLSTER: If you want – if we could, please, go through the rest of the spot document, if you could go over to page 7 and you will see there a slightly different
30 map where the area that was in grey in the earlier map is now substantially in green. What's the difference between these two maps?

DR LAVERTY: There is an absence of a standard of care that we see as acceptable in remote Australia, that is, government, communities, ourselves as the flying
35 doctors, do not have an agreed standard as to what is acceptable as reasonable access to care. So we've assumed it is reasonable for a person in remote Australia to live within driving distance of a primary care service. So we've set a filter at three hours drive and said how many populations live more than three hours drive and what is the size of those populations from access to a primary care service. It's our attempt
40 to try and articulate what's reasonable.

MR BOLSTER: Now - - -

DR LAVERTY: Once again the warning, access to a primary care service means
45 that it may be a visiting service once every two weeks. It's not necessarily an in situ 24 hour care service.

MR BOLSTER: Right. I'm just looking at the comparison there between – because we will be dealing with this issue later today – the APY Lands in South Australia. Are you familiar with that part of the country?

5 DR LAVERTY: Certainly not as well as one of my colleagues who will speak later today, but we certainly serve that region.

MR BOLSTER: The grey area on page 7 in the APY Lands, what do you put that down to? What's the primary health care that's missing there? Particularly for older
10 age people.

DR LAVERTY: This is the absence of GP services. So GP services that are not either in situ or are not scheduled to visit on a regular basis - - -

15 MR BOLSTER: Right.

DR LAVERTY: - - - requiring the citizen to drive more than three hours to access that service.

20 MR BOLSTER: Then on page 8, you have an example of a primary care service at a place called Glendambo in South Australia.

DR LAVERTY: So this is indicating the size of the population that lives within a two hour drive of access to a visiting clinic, and we're able to say that 88 per cent of
25 the population of 5600 people lives within a two hour drive of a visiting facility. So again, not 24 hour care, but rather, a service that is available on occasion within a two hour drive.

MR BOLSTER: And if there's no aged care services in that footprint, then your
30 organisation presumably provides some sort of care that's equivalent to it?

DR LAVERTY: Yes. Allow me to address the nuance. We're not a registered provider. We don't receive community aged care packages and we certainly aren't involved in provision of residential aged care. Instead, through our agreement with
35 the Commonwealth to provide Medicare-like care in areas where Medicare does not operate, we will provide the best alternate care that is available to citizens in that area, through our visiting nursing service, supported by 24 hour telehealth.

MR BOLSTER: Are you able to speak to the type of care that we're talking about
40 there that – if it was to be delivered by someone else, someone who was an aged care provider would be classed as aged care but when you deliver it, it's an aspect of Medicare?

DR LAVERTY: That's right. It perhaps starts with the role of the doctor, of
45 making the assessment of the patient, of ensuring the medication arrangements which then might lead on to the role of nursing care. The nurse will attend to wound care, to overseeing the medication management after prescription, through to the various

allied health services. So we do have a small number of dietitians, access to mental health professionals, and the broad range of allied health professionals to provide that care to older citizens when a formal aged care package is not available, in addition to those other supports addressed earlier such as access to geriatricians where available,
5 access to dental care where available, and also to palliative care. And if I might expand upon palliative care for just one moment.

There is insufficient palliative care services across remote Australia. That will come as no surprise. There are pockets of success and if I can speak to Broken Hill;
10 Broken Hill has the good fortune of having a palliative care physician that operates out of the Base Hospital in Broken Hill. Again, through mostly informal arrangements with the RFDS a palliative care outreach service is available from Broken Hill across the surrounding regions of about 800 to 1000 square kilometre radius that will provide initial assessment by a palliative care physician if necessary.
15 The palliative care physician will fly out with the flying doctors to meet the patient and to provide that ongoing care both through visits, over the phone or telehealth.

Again, this illustration shows that where there is the existing infrastructure of the flying doctors and, if I may, where there is the existing infrastructure of Aboriginal
20 medical services, by overlaying access to specialist services such as palliative care to geriatrics, it is possible to use outreach to get care into areas where it otherwise isn't available and citizens miss out.

MR BOLSTER: Do you keep statistics on the extent to which the sort of care we've
25 been talking about in the very remote areas, the fly-in places, do you keep statistics about the extent to which that really ought to be classified as aged care?

DR LAVERTY: We do. We certainly have patient records for every person seen or
30 cared for by the flying doctors that we would be able to interrogate and to ask what type of primary care services are being delivered that are aged care-like, nursing in particular.

MR BOLSTER: Substitutes for aged care.

35 DR LAVERTY: Thank you.

MR BOLSTER: Effectively.

DR LAVERTY: We would be in a position – and I would be happy if this would
40 support the work of the Commission – to provide an assessment of that data to ask what is substitute care that the flying doctors is providing. The warning I would make is that we see very small populations, very small numbers of people given that the population of remote Australia is just a nudge under half a million people. So it's not going to be in massive volumes, but the flipside is that the expense of providing
45 formal aged care services into those areas can be avoided by greater utilisation and strengthening of this substitute care as an option that the Commission might consider for its own recommendations.

MR BOLSTER: All right. Was there anything else that you wanted to raise about the service planning operational tool at this stage?

5 DR LAVERTY: What it tells us is that the access to primary care services in Australia is not as organised as Medicare is in areas where Medicare works. But to some extent Medicare is one of this nation's greatest assets, but it does not serve the health interests of remote Australians and because of the interdependence of primary care access with aged care, we are letting older Australians down by a failing primary care system in remote Australia. For too long, we've said small populations, a shortage of medical workforce is the reason why we have inadequate access in remote Australia. I reject both of those reasons. Until we articulate an expectation as to what is a reasonable standard of access to primary care, in both volume of access but also the quality of access, is it insufficient to just have access to GPs without palliative care, without geriatrics, without dental care in remote Australia?
10 And the Commission has an opportunity to articulate a reasonable standard. What is a reasonable standard of primary care necessary for an older Australian in a residential service, in a community service, or still living independently in their own home. And once a reasonable standard is articulated, it then requires resourcing to be able to deliver that service access across Australia. And with the existing infrastructure of the flying doctors and Aboriginal medical services there is the capacity to deliver against a reasonable standard of access of care to primary care services in the bush.
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MR BOLSTER: Mr Laverty, one question I want to ask you about: what happens after you've had a retrieval? The patient, say, from the APY Lands is taken to Alice Springs, they're treated, they recover. How do they get back to country or their property or their town? Does the - is that something that the RFDS covers?
25

DR LAVERTY: I'm disappointed with the answer that I have to give to that question, and unfortunately once retrieved, once admitted to hospital, the patient or the citizen very often, if they have recovered, has to make their own way home, that it's not the role, not resourced by the flying doctors in all circumstances, to return the patient home. So that the patient very often bears the cost. The family bears the burden. And the dislocation of the remote citizen when taken to a city hospital should not be underestimated, that without their family, without the familiarity of where they live, they're then, if they have recovered and are able to travel, take on that expense and that effort in getting themselves back to their place of residence.
30
35

MR BOLSTER: Do you find that in the case, focusing on the aged - - -
40

DR LAVERTY: Yes.

MR BOLSTER: - - - where there's a critical incident that happens, perhaps in the APY Lands, someone has to go to Alice Springs or even to Adelaide, that the result is that they effectively have to be permanently cared for in residential aged care in either of those places?
45

DR LAVERTY: In preparing to appear before this Commission, I held a discussion with our – a selection of our medical officers, our nurses and our social workers and I asked this very question because we don't have data to answer that question. Once the patient leaves our care, we don't necessarily track them. It's beyond our
5 responsibility. But the feedback I got from our clinicians is that they know, once an older citizen is moved, particularly if their frailty is such that you can predict they're not likely to return home, it means not only have they moved into perhaps a long-term stay in an acute hospital in the city, the necessity to then find a residential aged care bed in the city, but they're dislocated from their family in community. And that
10 dislocation doesn't necessarily have any bridge to be able to support it or assist it, and the burden on the informal care when that occurs, compounds onto the rest of the family or the rest of the social network that has been left in the original town.

MR BOLSTER: And I take it, given your earlier evidence about unnecessary admissions, presumably that means unnecessary retrievals and transfers if the
15 primary care had been adequate.

DR LAVERTY: If you will forgive me, the word I prefer is "avoidable".

20 MR BOLSTER: Avoidable.

DR LAVERTY: The retrieval or the hospital admission is avoidable if there were sufficient care in the community in the first place, and regrettably the national statistics on avoidable hospital admissions prove this out and they say primary care
25 in the Northern Territory has failed. Primary care in remote parts of Western Australia is failing. And the interdependency with aged care in the interests of this Commission warrant that the Commission look at the reasons why primary care is failing. And make recommendations for its improvement.

30 MR BOLSTER: All right. Next question: your personal view please, not caring another hat that I know you have, what can aged care learn from the NDIS?

DR LAVERTY: Much, and thank you for the opportunity. The – perhaps
35 opportunity of the National Disability Insurance Scheme is self-directed care, reasonable and necessary choice and control. They are the objects of the National Disability Insurance Act, reasonable and necessary care that a citizen has choice and control over. In reality, aged care doesn't yet reflect choice or control. A citizen, particularly in remote areas, would likely choose to stay in community, on country or within their own home for as long as possible. That choice is very often taken away
40 because of the absence of adequate care services. That principle of choice and control needs expansion into the way in which our aged care system can work in remote Australia, but in sufficient services denying choice and control for citizens at present.

45 MR BOLSTER: I don't know whether you heard the evidence yesterday - - -?---I did.

MR BOLSTER: - - - from Professor Flicker and some statistical evidence about the number of Indigenous men or Aboriginal men in their 40s and 50s who present early with cognitive decline because of head trauma. Professor Flicker gave evidence about the incidence of that and how it's seemingly readily apparent in the number of people using residential care. To what extent is that population being addressed by the NDIS?

DR LAVERTY: I suggest that the early phase of the NDIS in remote areas means that it's in its infancy, that the NDIS is not yet fully deployed across all parts of remote Australia and it's taking a learn and build approach to informing how service provider markets can be grown to meet demand. I will make a very similar point to that in relation to the NDIS as I will to my argument about how to expand primary care. Aboriginal communities must set their expectations and be respected in the decisions about the types of services and the types of service providers that they would want on their country, and that must be the first and foremost guide.

The second is that it makes sense for existing service providers, the majority, overwhelming majority of which are community controlled, to be bolstered to expand their care services for existing infrastructure to be grown, rather than new overlaid upon it. And I think that is a guiding principle, is informing the NDIS and indeed it's informing the way in which I think any effective primary care service is going to succeed within remote community where community controlled organisations need to be given the opportunity to plan and determine what services they want within their territories.

MR BOLSTER: Well, let's use the APY Lands as an example, because we will hear from Mr Aitken shortly about that. There's an established provider providing significant home care, CHSP resources, develop trusted relationships with the local communities. There's governance, etcetera, as we will be hearing shortly. Has the NDIS established itself in that area? Does it have a need to go there? And how should it do it when it gets there?

DR LAVERTY: Well, perhaps those authorised to speak on behalf of the NDIS are better to speak to the detail of the extent of its deployment, but I am aware that the NDIS has commenced the provision of packages within the APY Lands as it has within other Aboriginal communities. And the very important connection between the provision of service packages and ensuring that there is adequate service providers, that nexus must be made. And within the APY Lands I'm aware of existing, long established community controlled service providers. I encourage them and know that the agency has been working with them to expand their services because it's existing community controlled organisations across the country that are going to be better positioned than any others within Aboriginal communities to best deliver the opportunity of the NDIS.

MR BOLSTER: We give every witness an opportunity to talk about what they want to see changed. Is there anything else that you wanted to say that the Commission should focus upon in this area?

DR LAVERTY: There is. In thinking about how I might take the evidence that I've given to this Commission, which simply put is that primary care service is failing in parts of remote Australia, I've thought to how might the Commission turn its mind to improving primary care services, given the interdependencies with a sufficient aged
5 care system. The first is that the Commission should assess the service gaps that exist in relation to primary care across remote Australia, and we've provided and we've discussed today, perhaps tip of the iceberg, some data on where there is insufficient primary care in country areas, and I'm very happy to provide further data to help the Commission identify those areas where primary care is insufficient.

10 Second, it should then determine what's a reasonable standard of access to primary care in country areas, just as I know it will be considering what's a reasonable standard of quality of access to aged care across remote areas. It should then, in thinking about what's a reasonable standard, contemplate how can, given previous
15 challenge, we expand access to primary care services into remote areas so that dentistry, geriatrics, palliative care and medical care is available in the volume and the quality that is needed in remote areas, and my evidence is that mobile care delivery, outreach care, using the existing infrastructure of Aboriginal medical services and the Royal Flying Doctor Service is a method of building on something
20 that's proven to work, but is today not sufficiently resourced to reach what we would think is a reasonable standard of care.

We also think that the role of informal care, that provided by families, that provided by members of community, needs to be thought through, particularly as it relates to
25 Aboriginal and Torres Strait Islander communities. If we didn't have informal care, if there wasn't community bonds in many country towns the nation would be worse for it. And I think there is an opportunity to look at the adequacy of the financial and the other supports that we give to informal carers and addressing very practical things such as when a person is retrieved from a remote area into a city and that
30 dislocation occurs between family and person in care, how might we bridge those areas?

I think these few areas that I suggest of mapping the service gaps, of determining what's a reasonable standard of access to care, of using existing infrastructure to
35 expand primary care and considering the role of the informal carer in this circumstance would all improve care for the aged and strengthen Australia's aged care system.

MR BOLSTER: Thank you, Mr Laverty. Commissioners, I tender the service
40 planning operational tool which has been added to tab 77 of the tender bundle.

COMMISSIONER TRACEY: Well, I think we will just add it to the tender bundle without marking it separately.

45 MR BOLSTER: Thank you.

COMMISSIONER TRACEY: Because the tender bundle is already in.

MR BOLSTER: Thank you, Commissioner. Yes. And those are my questions.

COMMISSIONER TRACEY: Yes. Thank you. Dr Laverty, thank you very much for such detailed evidence. As you know, we're presently engaged in hearings
5 directed to assisting us to know how medical services are provided in rural and remote Australia, and the Flying Doctor Service has for – I see on the material – now 90 years provided such services, and they've become more and more essential as medicine has become more sophisticated and people have ventured more and more into remote areas. And the community is all the better off for the services that your
10 organisation provides and we thank you very much for the insights you've given us into the way in which services are provided and how they might be improved. Thank you very much for coming.

DR LAVERTY: A pleasure, Commissioner.
15

MR BOLSTER: Commissioner, I tender Mr Laverty's statement as well.

COMMISSIONER TRACEY: Yes. The statement of Dr Martin Laverty dated 22
20 May 2019 will be exhibit 4-7.

**EXHIBIT #4-7 STATEMENT OF DR MARTIN LAVERTY DATED
22/05/2019 (WIT.0157.0001.0002)**

25 <THE WITNESS WITHDREW [10.21 am]

MR BOLSTER: Thank you, Mr Laverty. I call now Mr Graham Aitken,
30 Commissioners.

COMMISSIONER TRACEY: Please make yourself comfortable there, Mr Aitken.

35 <GRAHAM AITKEN, SWORN [10.22 am]

<EXAMINATION BY MR BOLSTER

40 MR BOLSTER: Mr Aitken, before we go further, I understand you wish to make a statement to the Commission?

45 MR AITKEN: Yes. Thank you very much. I would just like to acknowledge the traditional owners of the land that we meet on today. I believe a warm welcome was provided yesterday. I would also like to acknowledge all the Elders which we provide aged care services to across South Australia. I would also like to

acknowledge one particular elder whose funeral is happening this week in the APY Lands, a very respected elder who was instrumental in us establishing our services on the APY Lands and my thoughts are with his family, our staff and the APY Lands communities this week. Thank you.

5

COMMISSIONER TRACEY: The Commission is indebted to you for advising us of those events, and extends its condolences to members of the community who no doubt are feeling deeply the loss of a respected elder.

10 MR AITKEN: Thank you. Is that okay?

MR BOLSTER: Yes. That's the microphone. If we could please bring up document number WIT.1134.0001.0001. You will see on the screen there, Mr Aitken, there's a copy of your statement, but you've got a printed copy in front of you as well?

15

MR AITKEN: Yes.

MR BOLSTER: All right. Do you wish to make any amendments to that statement?

20

MR AITKEN: No, thank you.

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

25

MR AITKEN: Yes.

MR BOLSTER: Commissioners, I tender Mr Aitken's statement.

30

COMMISSIONER TRACEY: Yes, the witness statement of Graham John Aitken dated 3 June 2019 will be exhibit 4-8.

35 **EXHIBIT #4-8 WITNESS STATEMENT OF GRAHAM JOHN AITKEN
DATED 03/06/2019 (WIT.1134.0001.0001)**

MR BOLSTER: Mr Aitken, you're an Anangu man; do I have that correct, that pronunciation?

40

MR AITKEN: Yes, Pitjantjatjara Yankunytjatjara is the APY land and my family are Yankunytjatjara people.

45 MR BOLSTER: You are the CEO of Aboriginal Services Care?

MR AITKEN: Yes.

MR BOLSTER: You've held that position for eight years.

MR AITKEN: Correct.

5 MR BOLSTER: Previously to that you've had an experience in delivering programs to Aboriginal people in South Australia through the South Australian State Government; correct.

10 MR AITKEN: Through the State Government, the Office of the Ageing where we administered the HACC program, and I was responsible for the HACC funding administration outcomes for approximately seven years, and prior to that I worked for ATSIC for about eight years.

15 MR BOLSTER: I wanted to start off with a difficult question for us non-Indigenous people. What does the word "elder" mean in an Aboriginal culture?

20 MR AITKEN: It's also difficult for me. There are learned people that would give a definition and researched what Elders are. For us it's about respect. It's not necessarily about age. And we have the great privilege of delivering supports and services to a number of Elders across South Australia. It's very hard to define what an elder is.

MR BOLSTER: Use of the terms "uncle" and "aunty" in Aboriginal culture?

25 MR AITKEN: Very common.

MR BOLSTER: And what should we take from that when we hear it used to describe a person?

30 MR AITKEN: Is that there's the sign of respect there, acknowledgement of them as an Aboriginal person and of their cultural identity.

MR BOLSTER: I just wanted to talk then about ACS and the organisation. It's a corporation with a very large footprint over South Australia; correct.

35

MR AITKEN: Yes.

MR BOLSTER: Can you - - -

40 MR AITKEN: We are an incorporated association under South Australian legislation, we've been incorporated since 1995. We started off as a small HACC program and the Aboriginal Elders Village in Adelaide at Davoren Park, which the Commissioners came to a couple of months ago, and I really thank the Commissioners for doing that. Since then we've expanded our footprint across the
45 APY Lands which we will talk about today in terms of remote service delivery. Also Marree is a small remote community in the north-east of South Australia and the

community of Coober Pedy where we also support the Commonwealth Home Support Program for the Elders in that community.

5 MR BOLSTER: Now, ACS is obviously a not-for-profit organisation.

MR AITKEN: Yes.

MR BOLSTER: What's its role, what's its mission, what does it stand for?

10 MR AITKEN: We have an Aboriginal board, although we do second non-Aboriginal people for their expertise. Our vision is to support the – is to support the growth of progressive and prosperous Aboriginal communities that are based on a foundation of respect, accountability and self-determination.

15 MR BOLSTER: And you say in your statement that you currently provide care for 592 Elders throughout South Australia.

MR AITKEN: Yes.

20 MR BOLSTER: About 60 per cent of those are in Adelaide.

MR AITKEN: Correct, yes.

25 MR BOLSTER: And about 40 per cent are elsewhere in the locations you've mentioned.

MR AITKEN: That's right. And that number fluctuates basically on a daily basis.

30 MR BOLSTER: Yes.

MR AITKEN: With movement of Elders and, unfortunately, Elders passing away.

MR BOLSTER: If we could please bring up RCD.9999.0086.0001.

35 MR AITKEN: Good.

MR BOLSTER: I take it you're pretty familiar with the locations on that map.

40 MR AITKEN: Yes.

MR BOLSTER: That's a broad depiction of the APY Lands just south of the border with the Northern Territory.

45 MR AITKEN: Correct, yes.

MR BOLSTER: And the principal centres that we deal with when we talk about the APY Lands, could you walk us through where they are and the size of the population.

5 MR AITKEN: Okay. So from the – from the south-east part, as you enter the APY
Lands, from the Stuart highway from Coober Pedy is Indulkana, and this is the first
community you come to. I'm not exactly sure of the population numbers between
one and 200 people. That's the community which my mother was born in and
consequently I have lots of relations there which we are now providing aged care
10 supports to. The second community there which we look after is Mimili. It's a little
bit smaller than Indulkana, and then we go to on to Kaltjiti. Kaltjiti is also known as
Fregon as you can see on that map. That's also a similar size to Mimili.

Then we go up to Amata which is one of the larger communities on the APY Lands,
15 and it's closer to the NT border. From there we go right across towards the WA
border to the communities of Pipalyatjara right next to the WA border, and also 10
kilometres from Pipalyatjara is the small community of Kalka which we support
from Pipalyatjara.

20 MR BOLSTER: How long is the drive from Indulkana to Pipalyatjara?

MR AITKEN: About six hours. It depends on the road conditions at the time of the
year. It also depends on how fast you drive.

25 MR BOLSTER: All right. And the wet season in that part of the world, is it
significant?

MR AITKEN: Yes. We were up there three weeks ago and there was already
significant water on some of the roads. We were lucky enough not to get bogged in
30 our four-car group, but we heard that there are a number of other vehicles that were
bogged.

MR BOLSTER: The roads, once you leave Indulkana and head west, are any of
them bitumen roads?

35

MR AITKEN: From the Stuart Highway to Indulkana, that is bituminised or has
some type of all year road surfacing, but the rest is all dirt. In communities there is
some bitumen and that's to reduce dust, etcetera.

40 MR BOLSTER: Yes. And the wet season runs from – from when?

MR AITKEN: Yes, that's a good question. I don't really pay much attention to
that, all I know is when it rains it rains. I suggest that a lot of the rain comes down
from the north-west, so from this area, associated with some tropical storms, etcetera.
45 So whenever it rains up this way, generally it rains in the APY Lands a bit later.

MR BOLSTER: Now, you – your statement refers to four home care packages and 213 CHSP packages - - -

MR AITKEN: Yes.

5

MR BOLSTER: - - - in the APY Lands. From where do you deliver those services?

MR AITKEN: In each of our communities we have a community centre and it's from there where we provide all of our aged care services as the base. In those centres we have kitchens which provide one of the main service types, which is meals and which we provide a breakfast service and a lunch service.

10

MR BOLSTER: Do the people you care for, do they come into the service in the morning?

15

MR AITKEN: A lot of the time, yes. For the breakfast. Basically after breakfast then people will move back into community, some will go to the art centres and once we've prepared the lunchtime meals we will take the meals to the Elders, no matter where they might be.

20

MR BOLSTER: And dinner?

MR AITKEN: No dinner.

MR BOLSTER: The facilities themselves, how would you describe them?

25

MR AITKEN: They range from fairly newish, when I say newish, 10 years or so, and some which are very, very old and in need of significant repair. So the Mimili centre and the Amata centre are quite newish.

30

MR BOLSTER: Am I right in thinking that the model of delivery involves effectively the care being delivered at the centre, as opposed to the home of the recipient?

MR AITKEN: It's definitely a combination of both. For meals, for instance, there's a lot of meals happening in our centres. Sometimes the lunchtime meal is delivered to the elder at their home. In terms of linen and blanket washing, our staff pick it up from the Elders, will bring it back to our centre to wash and then take that back to the Elders.

40

MR BOLSTER: Is there a practice of cleaning and making repairs to the homes of the recipients of care?

MR AITKEN: We have domestic assistance as such, although it's – can be a very – can be challenging to deliver that because a lot of the homes are overcrowded, and, you know, our – our care and support is for the elder, not necessarily the whole family.

45

MR BOLSTER: Yes. Are the people that you engage to deliver the care face to face, what sort of people are they? Where do they come from?

5 MR AITKEN: The majority are all local staff, Aboriginal staff. When we won the tender to deliver the services on the APY Lands three years ago, we spent about three months working and visiting and talking to a whole range of people from the current staff that were already operating up there, talking to community, talking to the Elders, talking to the other service providers, talking to the local community councils and talking to the APY executive about what we were hoping to achieve on the APY
10 Lands. One of the strong messages from the APY executive was that we really need to see Aboriginal employment and certainly that's what we've taken to heart and we're very proud of our Aboriginal employment numbers on the APY Lands and our workforce, which would be over – well over 90 per cent of local Aboriginal staff.

15 MR BOLSTER: Let's talk about, let's take an example, Mimili, the facility there. Do you have someone based in Mimili to do the work?

MR AITKEN: We have four or five staff based there full time, sorry, who live in community full time but who work for us. They are all local Aboriginal people and
20 that as well as Fregon are two of our communities which are 100 per cent local Aboriginal staff.

MR BOLSTER: All right. And what is the need to have someone who is not local? Why do you need someone from outside?
25

MR AITKEN: When we took over the program there was a – the coordinator position in each of the communities, so the coordinator's position is the manager of the centres and out of the five communities they're all, except Mimili, were non-Aboriginal staff. As part of our desires to train and develop and employ local
30 Aboriginal people, we now have a situation where we've decreased that number to two. Where we have non-Aboriginal people working with us on the lands, they have been working in community for many years. They know community and are respected. They also understand that our desire is to employ as many local Aboriginal people in a range of different roles within our – our service. One of the –
35 sorry.

MR BOLSTER: Sorry.

MR AITKEN: One of the things about employing people from outside community
40 is that we need to fund their housing, which is a cost.

MR BOLSTER: Other providers, are there any other providers in the lands?

MR AITKEN: Not in terms of aged care, no.
45

MR BOLSTER: You heard we were discussing the NDIS. Is the NDIS there at the moment?

MR AITKEN: Not to my knowledge, no. I have been speaking to the NDIA for nearly two years now about the APY Lands. In terms of, you know, basic disability service provision, we already provide meals to people with disabilities. Some of the – the basic assisted daily living-type services, we can provide that to people with
5 disabilities. I'm just not convinced that the NDIS and the individualised funding model, whilst I totally believe in, you know, choice and control of individualised budgets, from an operational point of view and a financial point of view, I don't quite see that it will be financially viable for us to step into that space just yet.

10 MR BOLSTER: If it was a form of block funding though, would that be different?

MR AITKEN: It would certainly achieve us start-up and once the numbers were built up then we would have the economies of scale to continue to expand the NDIS.

15 MR BOLSTER: Would you – with your experience of the community, would the community regard it as desirable for there to be coordination between the two types of service delivery?

MR AITKEN: Without a doubt. We – when we provide meals to people with
20 disabilities we also provide meals to the Elders and when we take that to the home we are seeing the same people, providing the same service.

MR BOLSTER: These people with a disability, they presumably are receiving some
25 sort of CHSP program?

MR AITKEN: We – on the APY Lands at the moment the State Government still
30 have a presence in terms of disability service provision, so they are picking up that for the time being. But clearly there is a – a time where they will exit from the APY Lands and there will be a need for an alternative service provision to happen.

MR BOLSTER: Right. Primary care there, we've heard there's an Aboriginal
35 medical service.

MR AITKEN: Yes.

MR BOLSTER: Where is that located?

MR AITKEN: Nganampa Health. We work very closely with Nganampa Health.
40 They have a head office in Alice Springs. They also have clinics across the APY Lands. We share that responsibility of looking after older people in community on the APY Lands.

MR BOLSTER: Do you have any experience of RFDS interaction in the lands?

45 MR AITKEN: Yes, definitely. Quite often we will hear that one of our Elders has been flown out.

MR BOLSTER: So people who would be receiving aged care receive primary health care in that way?

MR AITKEN: Yes.

5

MR BOLSTER: Okay and - - -

MR AITKEN: One of the things I would sort of just make clear is that ACS is the aged care, we're Aboriginal aged care; we're not Aboriginal health.

10

MR BOLSTER: Yes.

MR AITKEN: And fully understand and it's so important for Aboriginal aged care and Aboriginal health to work closely together to achieve the best possible outcomes for older people anywhere in South Australia, especially the APY Lands.

15

MR BOLSTER: And how have you done that with the local Aboriginal health?

MR AITKEN: We work with the staff that are in charge of the community programs, on the APY Lands, from – and also in communities as well, you know, we work closely with the clinics.

20

MR BOLSTER: I want to turn to the big question, trust.

25

MR AITKEN: Yes.

MR BOLSTER: And you deal with this at some length in your statement, and I won't get you to read that out. But what's the most important thing in developing trust from the community in the APY Lands?

30

MR AITKEN: So it goes back to the time where we were transitioning in and the fact that we were respectful in our conversations with community about what we're wanting to achieve in terms of aged care service delivery. Talking to as many different people as possible, and certainly the Elders has really helped us not only establish our service provision but also enabled the – the Elders to really understand what it is that we were trying to achieve and by dealing with the Elders in a respectful way, asking them how they wanted us to do business, we've been able to get to a place now and we're still developing and improving all the time.

35

This is our third year, but people in the APY Lands have seen so many different governments in – at various times from state governments to Commonwealth Governments, many bureaucrats, many programs, they come and go. One of our values is sustainability. When we talk to the Elders on the APY Lands we say that we're working with them and we're here for the long term. We are very honest in our communication with them and likewise, they are very honest with us around their expectations about us as a service provider on their country.

40

45

MR BOLSTER: You've mentioned local employment as being something that they want. What are the other things that are important to them?

5 MR AITKEN: They were very pleased that we were not government. I don't want to disparage government but community have seen, as I said, so many different governments impact their lifestyle, their wellbeing, and it's still probably be fair to say today that over many, many years there have been a number of different programs and money spent on the APY Lands and I would suggest that a number of people would still say that things haven't really improved that much for people on
10 the APY Lands. There's a long way to go.

MR BOLSTER: All right. Cultural safety, you mention that in some detail in your statement, but what's the most important thing for the Commission to understand about cultural safety from your perspective delivering care in that part of the world?
15

MR AITKEN: In our eyes, the – there's been lots of research and papers written about cultural safety. In our eyes, the judge of what culturally safe is the individual. We will speak to the elder about what they need for us to be culturally safe, appropriate, or – or whatever. It's an individual conversation and it's a respect that
20 we treat everyone as an individual and with dignity and to us it's what cultural safety is all about.

MR BOLSTER: You say in your statement that the Elders come to you through their community.
25

MR AITKEN: Yes.

MR BOLSTER: What does that mean?

30 MR AITKEN: It's sort of something that's happened for many, many years, going back to HACC days. HACC was a program that run for over 25 years. It was a program that was established in South Australia right across South Australia so that in every community there was a basic HACC service available for Elders. They knew that they could walk up to the HACC service and ask to be supported. It still happens today. But back in the HACC days, we were able to do an assessment, we were able to put them on our books, do up a care plan, provide them with services.
35 Today, we need to, when an elder comes to us, go through My Aged Care so that they are registered on the national system, so that an assessment happens, a regional assessment for instance, so that they can then start getting services.

40 MR BOLSTER: Well, let's talk about registration and assessment, because I understand it's something you want to - - -

45 MR AITKEN: Yes.

MR BOLSTER: - - - address in some detail. What are the problems associated with getting Elders registered?

MR AITKEN: So we can go through – this is broadly speaking for South Australia. We can go through a process of assisting Elders through the My Aged Care journey. We can assist them with their regional assessment service by way of supporting them with the conversation and sometimes acting as their representative. On the APY
5 Lands we come up with a work-around where the regional assessment is the NPY Women’s Council, and they work closely with us with our Elders and they will come into the APY Lands to meet an elder in our community to get them into the system and to also, as the original assessment service, do the assessment.

10 MR BOLSTER: And assessment for which programs are we talking about?

MR AITKEN: So that is just for the starting point, that’s the CHSP.

MR BOLSTER: Yes.
15

MR AITKEN: In most cases, after the regional assessment service has happened, it’s quite evident the Elders needs are greater than CHSP. So working with NPY Women’s Council, Nganampa Health to get a medical summary and ourselves, we will get an ACAT completed.

20 MR BOLSTER: How do you get an ACAT completed in the APY Lands?

MR AITKEN: So the ACAT in South Australia is run through the SA Government. The nearest ACAT we have to the APY Lands is operated out of Port Augusta. It’s
25 very rarely that a face to face will occur so it’s important for – for the three organisations to work together to enable the ACAT process to occur. And that’s done by telephone or tele link or - - -

30 MR BOLSTER: Is the disparity between CHSP and home care packages the result of difficulties with getting assessment?

MR AITKEN: It’s one of the – one of the reasons, definitely.

MR BOLSTER: And how difficult is it to get the assessment?
35

MR AITKEN: Quite challenging, although we are working with the ACATs in Adelaide. That’s the managerial part of it and the assessors work out of Port Augusta. To work out a way that we can move forward to enable these ACATs to occur a bit quicker and a bit more comprehensively so that the ACATs have enough
40 information to enable them to make an informed decision.

MR BOLSTER: We’ve heard lots of evidence about waiting times between ACAT assessment and assignment of a package. Is that an issue that faces your clients?

45 MR AITKEN: Yes. Like everyone, yes, definitely. The wait list is quite long.

MR BOLSTER: It’s the same wait list in the APY Lands.

MR AITKEN: My understanding is yes, even if someone is assessed at level 4 and high priority, the wait – the wait time is still considerable.

MR BOLSTER: You have a second waiting time though to get the assessment.

5

MR AITKEN: Yes.

MR BOLSTER: How long is that?

10 MR AITKEN: We, in terms of the ACAT, we mentioned that we had four home care packages operating. That took a considerable amount of time and effort from our staff on the ground and once again, this – all this work was unfunded.

15 MR BOLSTER: So the work on the ground that's unfunded is the registration process.

MR AITKEN: Yes.

MR BOLSTER: Getting them through the women's council.

20

MR AITKEN: Yes.

MR BOLSTER: Talking to My Aged Care.

25 MR AITKEN: Yes.

MR BOLSTER: How difficult is that when the person, I'm presuming, would have a language barrier or wouldn't have any idea about how to log on to My Aged Care.

30 MR AITKEN: Correct. Extremely, and this is why – why we need to assist Elders through that whole process - - -

MR BOLSTER: Yes.

35 MR AITKEN: - - - to navigate the aged care service system.

MR BOLSTER: How do you do that? Just practically, how does that happen?

40 MR AITKEN: So an elder would sit with our staff, and because our staff are local they – there is no language issues. There are some – some technical issues in terms of the aged care service system and navigating, but we support our staff to do that. And this is why it can sometimes take so long. There is also the conversation between the elder and a – an assessment. The RAS assessment with NPY is not too bad for the Elders, but an ACAT assessment where an elder is talking about some of
45 their very personal issues to a stranger, basically, is a very daunting thing for an elder to go through.

MR BOLSTER: That presumably takes place on the phone; it's not face to face.

MR AITKEN: Correct.

5 MR BOLSTER: It's not something that a – perhaps a doctor in the local Aboriginal health clinic could better perform?

MR AITKEN: We definitely work with Nganampa Health on that, so that between the three organisations we can get to a place where the ACAT occurs, and we
10 certainly need the Nganampa Health medical summary to assist with the ACAT process.

MR BOLSTER: Just pausing there, to compare with say, NATSIFlex assessment

15

MR AITKEN: Yes.

MR BOLSTER: - - - for residential aged care, it's much more – much easier to get through, isn't it.

20

MR AITKEN: I saw yesterday in your comments, you've mentioned that we do NATSIFlex on the APY Lands. That's not quite right. It's just the Adelaide Elders Village where we do NATSIFlex. One of the things that we do ourselves is we do want to see – we do want to see that the ACAT is, said that residential aged care is
25 needed, because we need to understand the needs of the elder and any behavioural issues they may have so that we can be comfortable with the fact that we can accept this elder into our service and know that we have the capacity to care for them.

MR BOLSTER: Right. You mention that there's a reluctance on the part of Elders
30 to leave the lands for medical treatment.

MR AITKEN: Okay.

MR BOLSTER: Where does that come from?
35

MR AITKEN: I would suggest and say the historical thing. Like Dr Lavery said, sometimes when the worst scenario happens and Elders have to be taken out of community, sometimes it can be very hard for them to get back to community. Sometimes they do not come back to community which is obviously not a good
40 outcome, which is why in our efforts in the aged care space, our providers try and keep Elders in communities and in their own homes.

MR BOLSTER: Would there be a number of people you care for who have never left the APY Lands?

45

MR AITKEN: Yes.

MR BOLSTER: What percentage?

MR AITKEN: I wouldn't have those details.

5 MR BOLSTER: A significant number?

MR AITKEN: Yes, especially the older people.

10 MR BOLSTER: Well, let's turn, shall we, to the facility in Adelaide, the Aboriginal Elders Village.

MR AITKEN: Yes.

15 MR BOLSTER: And it's a NATSIFlex-funded site. What is the attraction of NATSIFlex for your organisation?

MR AITKEN: This is an historical thing, it happened back in 1995. And it's something we have not changed as yet. My understanding is that NATSIFlex was the priority areas for NATSIFlex is the regional and remote areas. Our service in
20 Adelaide is 33 beds; it's one of the larger ones. You know, for our – our residents that come into the facility there is no upfront fees. Our assessment and admission process is all about the elder and their care needs. It is block funded, as I've seen some literature through the Royal Commission, low care and high care. Whilst we have some low care funding, we – all of our Elders are high care, some two assist,
25 some three assist. One of the things that benefits us is that as Elders pass, the vacancy issue is not – doesn't impact our income, so vacancies is a – a thing that helps us with our finances.

30 MR BOLSTER: There's 20 residents in 33 beds, or at least at the time of your statement.

MR AITKEN: Yes.

35 MR BOLSTER: Is the facility ever full?

MR AITKEN: No. No. We probably operate at around 70 to 80 per cent.

MR BOLSTER: And - - -

40 MR AITKEN: As the higher level. When Elders pass away, which has happened in the last 12 months, our numbers do drop.

MR BOLSTER: You heard evidence – you may have heard evidence yesterday about people having to acquit unused money at the end of the cycle or at the end of
45 the year.

MR AITKEN: Yes.

MR BOLSTER: Do you have to do that because you're only 70 or 80 per cent full?

MR AITKEN: No. No, unfortunately we struggle to balance our Elders village funding.

5

MR BOLSTER: Where does the problem arise, Mr Aitken?

MR AITKEN: Just increasing costs. Our facility is very old. There's a significant amount of money expended on repairs and maintenance. We have had significant water issues, and our regime to try and keep our facility clear of Legionella is quite costly.

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MR BOLSTER: Have you been successful in obtaining capital grants to support the NATSIFlex funding?

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MR AITKEN: In the past, definitely, and that has been very, very helpful. There is a current grant operating at the moment, is open, but the priority areas for those are the MMM7s and 6s, so we may or may not be successful in that.

MR BOLSTER: Yes. So the current application, what are you seeking money for?

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MR AITKEN: For the water system, to convert our water – warm water system to a hot water system.

MR BOLSTER: Right. And how long have you had to put up with that situation?

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MR AITKEN: To be – to be fair to the department, when we first started having some of these significant issues, four or five years ago, the department stepped in and provided some significant funding to address some of these issues. We have continued to monitor and try to keep our – our systems clear of Legionella which we have been successful for the last 18 months or so but it is a costly event.

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MR BOLSTER: There was some evidence yesterday about the seasonal attraction of temporary residential care during the wet season in the north, and in the area around Docker River; is that a feature of your facility?

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MR AITKEN: Not necessarily, no.

MR BOLSTER: Right.

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MR AITKEN: Although we do have Elders from all over South Australia and interstate, and including the APY Lands.

MR BOLSTER: The ones that you have from the APY Lands, are they there because of a critical health issue that's necessitated the move?

45

MR AITKEN: Yes. Generally it's dialysis.

MR BOLSTER: Is there dialysis in the APY Lands?

MR AITKEN: Not at this stage, but I believe Purple House will be starting dialysis in Pukatja very soon.

5

MR BOLSTER: If there was dialysis in Pukatja would the residents who were in Adelaide be able to stay in country?

MR AITKEN: Possibly, although, having a couple of dialysis chairs in Pukatja, it would be interesting to see how far people on the APY Lands would travel to get that dialysis.

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MR BOLSTER: Pukatja is?

MR AITKEN: Middle, high right.

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MR BOLSTER: Right. Close to the border above Amata.

MR AITKEN: That's right. So to get there from Indulkana is two or three hours, further across from Pipalyatjara, so it's fantastic that we have those dialysis chairs there, but it would be interesting to see how well it's utilised. I would suggest that it's utilised very, very well but will it meet all the needs on the lands.

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MR BOLSTER: I wanted to turn to the issue of workforce now and talking about your workforce in both the APY Lands and in Adelaide. And starting perhaps again with the APY Lands. The building of local capacity in your employees, was that something driven by the community or was that something you were – you had to do yourselves?

25

MR AITKEN: No. It's – the employment outcome is what community were after. Getting them into the services is one thing; training and developing them is another.

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MR BOLSTER: How do you do that?

MR AITKEN: So we work closely with the CDP provider on the APY Lands which is RASAC, Regional Anangu Services Aboriginal Corporation. Their role is to try and get local people job ready. If people are job ready we will employ them.

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MR BOLSTER: And “job ready” what does that mean, that doesn't mean a certificate III or a certificate IV.

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MR AITKEN: No.

MR BOLSTER: What's job ready for - - -

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MR AITKEN: For us it means a police certificate. It means having the understanding that, you know, the Elders in each of the communities need a reliable

and consistent workforce, and once they come into our service then it's up to us to then provide the additional training to enable them to do their job in a way that meets the needs of not only the Elders but us as an organisation and obviously the – the standards.

5

MR BOLSTER: Workers that come in, are they split, male/female, fifty-fifty?

MR AITKEN: No, mainly female. We probably have probably only three males that work across our – all of our communities.

10

MR BOLSTER: Are there any cultural issues in the APY Lands that make it better for women to deliver the care or are there any demands that they do it?

MR AITKEN: Once again, this comes back to the individual and the individual family. From a cultural perspective, like to this week, a lot of communities will be closed. From the fact that we employ local people, they are related to the Elders in their community. Sometimes that's a positive thing, sometimes it's not so we have to just be mindful of that. Certainly, our workers tell us whether it's okay for them to go to a house or to – to visit an elder in one of our communities. And we take that on board and make sure that that works out positively for both the elder and our staff member.

20

MR BOLSTER: I presume that's a large part of the training that you provide them after they're certified job ready.

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MR AITKEN: Yes, but also from our Elders themselves, they will provide us with that – that significant cultural understanding around some of these – these cultural issues.

MR BOLSTER: What qualifications do your staff end up having by the time they're work ready?

30

MR AITKEN: Certificate III.

MR BOLSTER: Certificate III.

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MR AITKEN: Yes.

MR BOLSTER: Where do they get the Certificate III training?

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MR AITKEN: So in the APY Lands and each of the communities there is a TAFE, and TAFE – we work closely with the TAFE. In fact, we did training in the TAFE centre in Umuwa about three weeks ago. So Umuwa is just down from – or across from Pukatja. But that's actually an administration centre on the APY Lands; it's not only Aboriginal community as such. It's where a significant number of contractors, police, etcetera, operate out of. They also have a TAFE training centre there which we went to approximately three weeks ago and had staff from our

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Adelaide office come up to – to Umuwa to meet with our – with their colleagues to talk about some of the issues around HR, budgets, data, and standards, etcetera.

5 MR BOLSTER: Retention? Do you keep staff?

MR AITKEN: Yes, we do. We do have to be flexible because quite often our staff will need to take off for various reasons, and as we say to our staff, we can – you can definitely leave, but we always need one or two staff in community every day to look after the Elders, to prepare the meals. Between our – our staff, they make that arrangement and when they come back, the job is always still there for them.

10 MR BOLSTER: And why do they need to take off? What's the - - -

MR AITKEN: It can be for family reasons, it can be for cultural reasons, such as men's business or women's business. It can also be for sorry business.

15 MR BOLSTER: I take it it's an important part of delivering trust to the community that you honour those traditions; is that right?

20 MR AITKEN: Without a doubt, and that's part of being culturally safe.

MR BOLSTER: And if you didn't do that, what would be the reaction of the community and the Elders you care for?

25 MR AITKEN: They would be very disappointed. They would voice their disappointment to us, and in particular to me, around not allowing their staff to do what they need to do.

30 MR BOLSTER: Right. How often do you need to get outside workers to fill gaps?

MR AITKEN: Very rarely. One of the things that we do have is a relationship and partnership with community stores in each of our communities. If for any reason our centres can't open, either for staff absenteeism, which doesn't necessarily happen, but sometimes our centres don't open because of community issues, where it's our staff member will say, we need to close the centre today because of, maybe some type of community disruption or like – like what happened this week, a funeral. We have a relationship with the local store whereby they will provide a meal to our Elders and we just give them a list of the Elders who – who need that meal and they will come in to get that meal.

40 MR BOLSTER: The staffing in Adelaide; how different is it?

MR AITKEN: There's obviously a greater pool of people to employ when you go through a recruitment and selection process.

45 MR BOLSTER: Yes.

MR AITKEN: We recently advertised for a coordinator's position. We had a significant number of applications. Unfortunately, not – not any that were Aboriginal even though some had experience of working in Aboriginal communities. The – so probably some of the main things that I really look at is the – when we
5 bring people into our office in Adelaide, sometimes they don't understand a lot of the – the deep knowledge and understanding required in terms of Aboriginal culture and the needs of the Elders in the remote communities, that is fairly high from day one. So a lot of the – the Adelaide staff, they learn from our Aboriginal staff in Adelaide, they also learn from the Elders themselves.

10 MR BOLSTER: Do you have staff come down from the APY to work in Adelaide?

MR AITKEN: Not so much permanently but in the next week or so we will have – we do have exchanges, people coming up and back. It's important for our Adelaide
15 staff to understand what happens on the APY Lands, to – to go into our centres, do work and see what our staff are doing. Quite often they will talk to them throughout the week. So it's very good for them to put a name to a face. With our Adelaide staff.

20 MR BOLSTER: Just in terms of getting a sense of what happens in the APY Lands and vice versa, the – and you've heard the evidence of the other providers at Thursday Island, Docker River.

MR AITKEN: Yes.
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MR BOLSTER: Juniper, Southern Cross. Is there some form of organisation where you're able to share your experiences and learn off each other and different perspectives?

30 MR AITKEN: Without a doubt. I think one of our strengths is that we don't work in isolation. We don't work in a silo. In the APY Lands for instance there's as I mentioned, a whole range of different other service providers that we work with closely. In Adelaide, the same is true. In terms of other Aboriginal organisations, in
35 South Australia, for instance, there is some of the smaller ones that are exiting aged care because of a whole range of different issues, but certainly compliance is an issue, financial viability. So whilst we've helped them in the past, it now seems that as they're exiting, we're stepping into that space which is the reason why we are becoming a state-wide service.

40 MR BOLSTER: Compliance, you talk about that, what's the most difficult thing for your organisation when it comes to compliance?

MR AITKEN: I guess it's fair to say that last year we had some noncompliance in
45 Adelaide. We rectified that in two and a half months. It's – unfortunately it can be very easy for individual staff members to – to not follow a process and procedures, to not do what's required in terms of supporting Elders, and that's where noncompliance comes into it. I've mentioned in our statement, at the present time all

of our programs across South Australia are 100 per cent compliant. That takes a lot of work. It takes buy-in from our staff. We also have a risk and compliance team and a manager who's responsible for that who works with all of our programs to ensure that we are compliant.

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I suggest that no aged care provider wants to provide substandard service and, you know, sometimes things happen. The important thing is how we as an organisation, for instance last year, is how we deal with it. That's the strength of our organisation that we were able to turn that around in a very short period of time.

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MR BOLSTER: Financial viability. Your organisation is principally reliant on NATSIFlex funding.

MR AITKEN: Not necessarily.

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MR BOLSTER: Well - - -

MR AITKEN: Yes.

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MR BOLSTER: What other funding does it rely on?

MR AITKEN: So we get CHSP funding. We get funding through the home care packages and NATSIFlex. On the APY lands, we also get funding for meals for disabilities. We also have a trachoma elimination program on the APY Lands, across three of our communities, so Indulkana, Mimili and Fregon. So we have – when we took over the APY Lands three years ago it was just base CHSP. Since then we've added additional CHSP services. We've added the meals for disability, we've added the trachoma.

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MR BOLSTER: Can you tell us briefly about the trachoma?

MR AITKEN: Trachoma still impacts Aboriginal people in some remote communities and we get funding through the State Government for those three communities I just mentioned. Our part of the trachoma elimination is, in terms of the World Health Organisation, there's a safe strategy: surgical, antibiotic, facial hygiene and environment. So we do the last two. So the facial hygiene, so the message about washing your hands, washing your face. And the environment part is all about the house. You know, our staff are trained to do bathroom assessments, to tick off, is this working, is that working, and, you know, if people don't have access to running water, they can't wash their hands, they can't wash their clothes. They can't do all the things necessary to stop the – the germs that cause trachoma and other diseases to spread.

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MR BOLSTER: Are there too many programs for you to have to manage, to deal out all the care that you deal out?

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MR AITKEN: No. No. We say no, because this all adds to our vision about progressive and prosperous Aboriginal communities. It also adds to our financial viability on the APY Lands for us to operate. It also provides us with an opportunity to provide a whole range of different skills for our workers on the APY Lands so they can be trained in CHSP, they can be trained in HCP, they can be trained in the trachoma elimination.

MR BOLSTER: Would it be easier if you had a more flexible central system of funding for all these programs?

MR AITKEN: From a – from an acquittal process – I use the word “acquittal”, but clearly there’s financial acquittals, there’s also outcome reporting, possibly, but the system we have at the moment, that’s what it looks like, and rather than not do it, I would prefer to do it and then go through the administration process to acquit the various grants that we have even though it means going to different funding bodies to acquit different funds.

MR BOLSTER: I wanted to ask you some questions about police checks. What’s the problem with having to get police checks?

MR AITKEN: Names is an issue. People don’t necessarily have birth certificates. People have different names. Then once people do get a police check finally through, there may be things on there which an individual may be, you know, a bit embarrassed by. But that really only comes to – to myself and my HR manager. So as we say to staff, don’t worry about that, don’t be embarrassed by it. If there’s things on there, we do have the authority or delegation to be able to – to look at things and put in place mitigation processes. If they’re serious, generally they’re not serious so - - -

MR BOLSTER: Where does that authority come from?

MR AITKEN: From me. From our board to me.

MR BOLSTER: And - - -

MR AITKEN: And it’s compliant with the department’s rules on police checks.

MR BOLSTER: And you mention a risk mitigation process.

MR AITKEN: Yes.

MR BOLSTER: Can you just briefly explain how that operates?

MR AITKEN: We haven’t had to use a whole lot of those but if there’s – if then – if there’s something on there, the police check, which we think, you know, may – we may have to put in place something to prevent any risk, we will do that, but as I say, whilst that’s there, we haven’t had to use it a whole lot.

MR BOLSTER: Have you had a problem with employing someone - - -

MR AITKEN: No.

5 MR BOLSTER: - - - with a problem record?

MR AITKEN: No. No, even if – unless there’s something very serious on there, then we will turn people away, but it hasn’t happened very often.

10 MR BOLSTER: I want to ask you some questions about the healing foundation.

MR AITKEN: Yes.

15 MR BOLSTER: But before I do that, I would like to finish up with the aged care, home care, community care. What would you change, Mr Aitken, if you could? What would be the priorities for you for this Royal Commission to recommend to the government?

20 MR AITKEN: I think the starting point of aged care is My Aged Care. That in itself is a challenge for everyone, let alone Aboriginal people, let alone Aboriginal people in remote communities where computers and telephones are not necessarily available. Once the people get into the My Aged Care space, then there is the assessment process where the department are looking at the assessment process at the moment in terms of the regional assessment service and the ACAT and perhaps are
25 looking at an alternative to those two. That is important when, back in 2015, I believe, when the tender was put out for regional assessment services, we applied in our own right to be a regional assessment service for Aboriginal people across South Australia, but it wasn’t the model which the department were looking at.

30 We also tried to join a couple of consortiums, but unfortunately those consortiums didn’t get up either. So the issue there is around the cultural appropriateness of the assessment service. I acknowledge the NPY Women’s Council is a regional assessment service and they do a good job. I’m not sure how widespread that is around the rest of the country. I certainly know from Adelaide’s point of view it can
35 be a challenge for our Elders to get through that process. So the assessment process is very important as is the first step My Aged Care. In terms of CHSP and home care packages, I’m aware that the department are looking at what that might look like, whether there’s a possibility to join the two. Our funding for CHSP was going to go out to 2020. It’s now going out to 2022 to enable further information, and I guess
40 some of this information from the Royal Commission to input into whether CHSP and HCP should be provided. Certainly, the notion of consumer-directed care is always important.

45 Coming back to, you know, your point about what would I like to see, after the assessment process and – and an ACAT being occurred, I would like to see quicker outcomes for Elders to achieve and receive the appropriate package which they’re assigned. Quite often once we get an elder into the system, get them ACAT’ed, they

are approved to level 4. They may be assigned a level 2. So we continue to monitor that level 2 until such time as it's level 4. So more funding, I guess that's always going to be a challenge, but, you know, people in high priority really should be just that, high priority.

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MR BOLSTER: Thank you. You co-authored a media release with Ian Hamm and Ros Malay - - -

MR AITKEN: Yes.

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MR BOLSTER: - - - under the heading The Healing Foundation and the Aboriginal and Torres Strait Islander Ageing Adviser Group Joint Statement earlier this month.

MR AITKEN: Yes.

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MR BOLSTER: I wonder if you could speak briefly to what the group is seeking to do in connection with this Royal Commission and the issues that you believe the Commission needs to confront?

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MR AITKEN: Okay. I might start with the Australian Association of Gerontology. They are a significant organisation with the ethos of connecting research practice and policy. And the reason I joined them a number of years ago was because I truly believe that to change policy you need to have the research, you need to have the benefit of practice which is service delivery to inform the policy. So we've done our - a number of reports with the AAG. And this conversation with the Healing Foundation happened just before Christmas at an AAG conference in Melbourne and, you know, we touched base with the Healing Foundation and their desire to meet with us to put the issues of the Stolen Generation survivors at the forefront.

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So we held a forum in Melbourne a few weeks ago with the Healing Foundation, the AAG and the Aboriginal advisory group. It was attended by some of the Stolen Generations. I called them their reference group which is made up of Stolen Generations survivors, people from the department, and at that forum, I talked about aged care and what aged care currently looks like. From the Healing Foundation and in particular from the reference group of the Healing Foundation, it was - they presented a significant picture of disadvantage for members and survivors of the Stolen Generation in terms of what they're experiencing today, even after so - so many years have passed, including data from the Australian Institute of Health and Welfare, that talks about the survivors having significantly more impact in terms of health and welfare outcomes, even compared with contemporary Aboriginal and Torres Strait Islander people.

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It talked about the trauma suffered by members of the Stolen Generation, being forcibly removed from their homes, being isolated from family and in particular from culture, and it's a significant issue that is still impacting members of the Stolen Generation or survivors of the Stolen Generation, and then there's also the issue of

being institutionalised and some of the abuse that some of these people endured growing up as young people.

MR BOLSTER: Do you have any of that generation in your care at the moment?

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MR AITKEN: Yes, definitely. A lot of them are very old, but yes, we definitely do have them.

MR BOLSTER: What needs to happen as more and more of them come into care?

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MR AITKEN: Yes. It is – the reason it is being talked about now is because it hasn't really been identified or talked about in the past, around do we need to do more with those survivors of the Stolen Generation. I would suggest yes, but what does it look like. So our intention is to work with the Healing Foundation, with the reference group members from both the Healing Foundation and AAG, to talk about going forward, what do we need to do to provide better services and supports to these people or this cohort of people who are even more disadvantaged than their contemporaries in the Aboriginal community.

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MR BOLSTER: And you're planning to put together a submission in this regard?

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MR AITKEN: Yes. Definitely.

MR BOLSTER: Was there anything else that you wanted to raise at this stage?

25

MR AITKEN: Yes, if I could. So today we talked about our organisation. Now, our organisation is Aboriginal aged care. We're not Aboriginal health. There is a difference. Fully recognise and understand that the – it's so important for Aboriginal health and Aboriginal aged care to work together to achieve the best possible outcomes for Elders in our community. Now, if you look at the closing the gap targets, you know, a lot of that is met by and the responsibility of the health sector. Aboriginal aged care is there, in my eyes as a, almost like a preventative measure. We see our Elders on a daily basis, if not every week. We monitor their wellbeing, how they're going, their ups and downs and so many of our Elders can – their wellbeing and their health conditions can change drastically in a very short period of time.

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Because of that – that contact that we have, because of the way that our service is delivered, we believe that we contribute significantly to the outcomes of closing the gap. The difference that we make to the lives of our Elders is significant. We – we fully understand that we're not health, but we play an important role. In terms of the quality standards, the new ones coming out, we – you know, we fully embrace implementing those. We would suggest that the – the new standards are more closely aligned to Aboriginal business and Aboriginal aged care because we've always had a focus on the Elders and their wellbeing, and treating everyone with – as an individual and with respect.

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I saw in the transcript yesterday, where the Commissioner talked about registration of carers. I fully support that and suggest that that can probably go even further to all people working in aged care. And the Commissioner mentioned about those instances of people going from one place to another and I think the registration, just like nursing, I think is appropriate. One of the things that is tying us up at the moment in Adelaide is the Elders village, our residential facility, is anonymous complaints. We fully understand and know that complaints systems are – can be positive. Sometimes when the complaints are anonymous and vexatious, they are a detraction from our business and the support that we provide to our residents. The big issue there is that if the – the agency comes in and investigates a complaint, finds there's nothing there, it's resolved, because it's anonymous, they have nowhere to go to say to the complainant, it's been resolved. So we are seeing the same complaints happening once or twice, if not three times.

15 The last comment I make is around the aged care reforms. I think we all understand aged care reform has been happening for many, many years, probably around 10 if not more. One of the things we've tried to do is to ensure that through these aged care reforms that none of our Elders are disadvantaged in terms of the service delivery. This not only applies to our Elders within ACS but also the Elders right across South Australia. We've had many conversations with Aboriginal community controlled health organisations and communities around what the aged care reforms look like, what it means for individuals and how they can get into the system. Once again, it comes back to getting into the system and being assisted.

25 But it's important for us that throughout these reforms, and they will continue to happen through till 2022, that we as an organisation have the expertise to manage that reform, that change, manage the new standards, and continue to deliver high quality services to our Elders.

30 MR BOLSTER: Thank you, Mr Aitken. Nothing further, Commissioner.

COMMISSIONER TRACEY: Mr Aitken, we had some time the map of the APY Lands on the screen. One can't but be impressed by the enormity of the territory that's covered. Do you have people who have been assessed as eligible for packages for home care in that massive area that you simply can't reach or they can't reach you?

MR AITKEN: No. Generally our home care packages, because we have that continuum of aged care from CHSP to home care packages to residential, we are able to channel people or transition people from CHSP onto home care packages. So they are already known to us. Yes, they may move about but we generally are able to find them.

COMMISSIONER TRACEY: And is part of your funding providing you with capital, for example, to buy buses or cars so that you can pick up the elderly people and bring them into your centres?

MR AITKEN: Yes, in each of our centres we have small mules; they're little buggies that we utilise. We were gifted those from the previous provider which is the State Government. They are all needing attention if not replacement. We will have to fund that one of two ways: either through our operational budget or apply
5 for one-off funding. In terms of our other infrastructure, we were – we applied for infrastructure upgrade funds for our APY Land centres through the Department of Health. We were successful in a grant of \$500,000 to do that. So we – at the moment we are engaging with community around what that upgrade might look like in each of our five centres. Unfortunately it doesn't cover buses or vehicles.

10 COMMISSIONER TRACEY: And what's going to happen when you've got dialysis facilities in the lands about getting the elderly people who need that service to the centre?

15 MR AITKEN: Transport and transport disadvantage is a big problem for the Aboriginal community. It would be very interesting to see, you know, whether or not the health sector, our dialysis provider or the aged care sector would have to pick that up. Either way, I'm sure between the three of us we will ensure that Elders get the appropriate dialysis that they need. The same is true in Adelaide. Elders who are
20 on our home care in Adelaide, either CHSP or home care packages who require dialysis, we ensure the Elders still get to a dialysis even if the health sector don't pick it up.

COMMISSIONER TRACEY: And on another matter altogether, I couldn't but be
25 impressed on my visit to the residential facility in Adelaide about the work that was being done by volunteers. There was a - - -

MR AITKEN: Yes.

30 COMMISSIONER TRACEY: - - - country and western singer there. There was the lady reading to one of the residents. There was the gentleman assisting another resident with the form guide for the day.

MR AITKEN: Yes.

35 COMMISSIONER TRACEY: Where do you recruit these people and how important are they to the operation of a residential care centre?

MR AITKEN: We're very lucky with our current residential services manager,
40 Warren, who you met. He came to us with a whole range of networks, including the current volunteer connection and they have done wonders for us. We don't necessarily pay them, but we certainly make sure that they're not out of pocket to attend our village and they attend our village a minimum of twice a week. And one of the things that we want to ensure is that, you know, we give Elders a reason for
45 getting out of bed. We can provide them with the clinical care, the food and the nutrition, but we need to also get them active and involved in certain – in various activities.

Thank you.

COMMISSIONER BRIGGS: Mr Aitken, thank you very much for coming here today, and I would like to echo Commissioner Tracey's words earlier on about the
5 sorry business in your local community and say to you we really do appreciate you coming. I wanted to pick up the issue about the workforce, and you've made great efforts with the support of the APYs TAFE to recruit an Aboriginal workforce, and we heard yesterday, I'm not sure whether you did – about the problems the Uniting Church has in the Docker River community and how they fly in and fly out staff in
10 order to maintain their services. What are the factors that absolutely enable you to employ Aboriginal people in your services? Is it the close connection with community? Is it the availability of the TAFE? Or what?

MR AITKEN: All of them. Including the connection with the job provider up
15 there, CDP, which is the RASAC organisation. Between the three of us our role is to try and get people into employment. I would also add that at this point in time our workforce is relatively young in terms of their skills and their development. So we are still only providing basic services. As we continue to develop our workforce, we will be able to provide higher levels and more complex aged care services. For the
20 time being, the health sector pick up some of that – that need.

But over time, I would expect that through our development of our own staff, that we will be able to provide a wider range of services and I think I spoke to Paul about this, the range of services we provide in Adelaide as opposed to what we're able to
25 provide on the APY Lands is significantly different. Our vision is to – so is to the elders no matter where they are in our organisation, they are able to access the same types and range of services that meets their needs, and that would only happen through the development of our workforce.

30 COMMISSIONER BRIGGS: How does the connection with the TAFE work in practice?

MR AITKEN: Just in the last couple of weeks, they've held food safety training. They've done that after hours, after our staff have done all their food delivery and
35 other aged care services. So that will happen in community in their centre. And that goes to – that bounces from community to community to community where this training is provided. And that's just one example of the training which is provided by TAFE.

40 COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising from that?

MR BOLSTER: The media release, Commissioners, has been added as tab 74 to the
45 tender bundle.

COMMISSIONER TRACEY: Thank you for that. Mr Aitken, thank you very much again for coming and giving evidence, particularly at the difficult time that is confronting you and other members of your community. We're very grateful. Thank you.

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<THE WITNESS WITHDREW [11.38 am]

10 COMMISSIONER TRACEY: The Commission will adjourn until 12 midday.

ADJOURNED [11.39 am]

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RESUMED [12.02 pm]

20 COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: Commissioners, I call Ruth Anne Crawford. Ms Crawford, please take a seat while the associate swears you in.

25 **<RUTH ANNE CRAWFORD, SWORN** [12.02 pm]

<EXAMINATION BY MS BERGIN

30

MS BERGIN: What is your full name, please?

MS CRAWFORD: Ruth Anne Crawford.

35 MS BERGIN: And what is your current role?

MS CRAWFORD: I'm the manager of Kimberley Aged and Community Services.

40 MS BERGIN: Thank you, Ms Crawford. Have you prepared a statement for the Royal Commission?

MS CRAWFORD: I have.

45 MS BERGIN: And is there a copy there in front of you?

MS BERGIN: Yes.

MS BERGIN: Operator, could you please bring up document number WIT.185.0001.0001. Do you ever any amendments to your statement, Ms Crawford?

5 MS CRAWFORD: No.

MS BERGIN: Is it true and correct to the best of your knowledge and belief?

MS CRAWFORD: Yes.

10

MS BERGIN: Commissioners, I tender the statement of Ruth Crawford.

COMMISSIONER TRACEY: Yes, the statement of Ruth Anne Crawford dated 23 May 2019 will be exhibit 4-9.

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EXHIBIT #4-9 STATEMENT OF RUTH ANNE CRAWFORD DATED 23/05/2019 (WIT.185.0001.0001)

20

MS BERGIN: Ms Crawford, you mention that you're the manager of the Western Australian Country Health Service in your statement. Could you tell - - -

MS CRAWFORD: I'm not the manager of the WA Country Health Service, sorry. The Kimberley Aged and Community Services which is part of the WA Country Health Service.

25

MS BERGIN: Yes. Could you tell us a bit more about your role, please.

MS CRAWFORD: Okay. So in my current role, I've been in that role since 2013. I manage the aged care services for the remote Aboriginal communities of the Kimberley which includes Commonwealth Home Support Program and home care packages and the WA HACC under 50 transition to NDIS people. I also manage the aged care assessment team for the region and the Commonwealth Respite and Carelink Centre for the Kimberley and various other smaller respite programs as well as the older person's initiative which is based at Broome Hospital, stroke liaison, and the visiting geriatrician and services for the region.

35

MS BERGIN: Thank you, Ms Crawford. What is the role of the Kimberley Aged and Community Services?

40

MS CRAWFORD: Okay. So we provide – we work in partnership with remote Aboriginal communities to provide the aged care services for the Aboriginal people who live in remote communities. And we also provide home care package support to clients who live in the small towns of Derby, Fitzroy Crossing and Halls Creek because there are no other providers, and we do that in conjunction with the town community care services.

45

MS BERGIN: Does KACS also provide respite services for the Kimberley?

MS CRAWFORD: We provide – we are the Commonwealth Respite and Carelink Centre which means that we organise respite for clients throughout the Kimberley, remote communities and towns, and we provide mental health support for clients with mental health conditions for residential respite or other types of respite, as well as we have one position that does Kimberley direct flexible respite, so out in the communities. And then we have flexible respite which is part of the Commonwealth Home Support Program and we have three positions for that that provides respite on a daily basis in the communities.

MS BERGIN: Does KACS also provide ACAT assessments?

MS CRAWFORD: Yes. And we do that throughout the Kimberley. Our current funding for ACAT is only for 1.6 FTE and because of the geographic size of the Kimberley, it's bigger than Victoria, it would be very difficult for 1.6 staff to cover the whole of the region. So we have funding through the home care packages and CHSP that we use to employ clinicians. And so all our clinicians have a dual role of doing either ACAT assessments or doing the support for the home care package clients, so they will do the reviews of the care plans and also just follow-up with our remote care workers if there's any issues with the clients if, say, they've developed continence issues, then our continence nurse specialist would go. So when our clinician is in a community they will do whatever clinical work is required, so that would include the continence assessment, the ACAT assessment or the follow-up with the home care package client.

MS BERGIN: Continuing on with the extensive role of KACS and services in the community, I understand KACS provides a stroke liaison program and is that correct?

MS CRAWFORD: That's a one day a week program through the State Government. It operates from Broome Hospital but it's for anyone in the Kimberley that's admitted to hospital having had a stroke and it works to assist in the process of people that are transferred to Perth or the people that remain in the Kimberley because they've passed the opportunity – the window of opportunity for the acute treatment of stroke. The Kimberley doesn't have subacute care for rehabilitation at this time.

MS BERGIN: Does KACS also consult with a visiting geriatrician?

MS CRAWFORD: Yes. We have funding for roughly three to four visits a year from a visiting geriatrician who comes from Royal Perth Hospital, and a similar number of visits from a psychogeriatrician. And when the geriatrician is coming, the clinicians will see the clients first, do all the baseline assessments, including the KICA tool which was mentioned yesterday by Dr Flicker, or another form of mini mental examination depending on the culture of the client and the education of the client. And they will have all that prepared. They will work with the GPs or the

small hospitals to insure the clients have the screening blood tests done before the geriatrician comes to exclude that they might have a delirium from another cause, not a cognitive impairment, so that will all be done and then the geriatrician will come and see the client predominantly face to face but sometimes we use video
5 conferencing if – if it’s an urgent matter or if we can’t get the geriatrician to where the client is.

MS BERGIN: So before I ask you to explain how KACS sits as part of the State-based WACHS service, are there any other services that KACS provides which you
10 wanted to mention to the Commissioners before we move on?

MS CRAWFORD: I think I’ve mentioned them all.

MS BERGIN: The services are extensive.
15

MS CRAWFORD: Yes. We have 14 different funding buckets which is challenging at times because some of them are very small. Like our dementia education training funding bucket is only 33,000 a year, so some of them are very, very small but we just put them all together to provide services to clients.
20

MS BERGIN: Now, turning to the role of the Western Australian Country Health Service, could you describe that to the Commissioners.

MS CRAWFORD: The WA Country Health Service provides the care for all of the
25 residents in country WA, government hospital system, mental health, population health and public health, and some aged care. In some other parts of WA, aged care is linked to multipurpose centres as well as CHSP services. There are no multipurpose centres in the Kimberley.

MS BERGIN: So is KACS the Kimberley-based office of the Western Australian Country Health Service?
30

MS CRAWFORD: Yes, for aged care.

MS BERGIN: Now, could you tell the Commissioners a bit about the people that KACS provides the range of aged care services to.
35

MS CRAWFORD: So our services for remote Aboriginal people are usually always Aboriginal people. We have had over time about two non-Aboriginal people who
40 live in remote communities but they’re predominantly Aboriginal people. We have many clients who came out of the bush as – in their – when they were young, when they were children. We have many that have experienced the trauma of being part of the Stolen Generation, either directly themselves or their siblings or their children or their cousins and other family members, and that has had significant impacts on
45 people. We have clients that were in Canberra at the camp site to get the vote in – for Aboriginal people, and they were there in the late sixties until the vote came through for Aboriginal people.

We have clients who were affected by the Noonkanbah walk-off which was in – I think the seventies/sixties, where people prior to that had only been paid with flour and meat from the stations, and at Noonkanbah they tried to bring in getting wages. And so the stations had turned the people off of the stations because they didn't have
5 the money to pay them. So that had impacted on people's homelessness, becoming more displaced, similar to the Stolen Generation issues. We have many clients whose English is only their third or fourth language, and they may not be at all literate in English and they may not actually speak any English. We have clients who are really, really famous artists. One of our client painted the roof of the Louvre
10 in France with her barramundi scales which you might have seen previously on the news. So we have a whole range of clients, yes.

MS BERGIN: And where are your clients located?

15 MS CRAWFORD: The ones we provide the most services for are in the remote Aboriginal communities of the Kimberley, starting with Bidyadanga which is 190 kilometres south from here. Going up the peninsula about 240 kilometres, there's three communities up there. Then moving up to Looma which is three and a half
20 hours away, Noonkanbah which is four, four and a half hours away and includes a 70 kilometre dirt road. Wonkajunka, which is the other side of Fitzroy Crossing and has about 50 ks of dirt road which can be really difficult in the wet season, out to the Kajunka region, which is Balgo, Billiluna and Mulan which is a little bit south of Halls Creek, and that's 240 to 290 kilometres of dirt which is frequently impassable
25 in the wet season.

And we go all the way up to Kalumburu which is north from Kununurra which is a one hour flight or a two day drive and the road to Kalumburu is only open usually from late May to October where it closes because of the wet season. So our clients are very, very spread out and mostly in pockets of very small numbers from one to
30 10 to, there's a couple of communities that have 20.

MS BERGIN: So given that very diverse spread of clients within the Kimberley, could you explain to the Commissioners, firstly, where are KACS staff located and how many staff do you have?
35

MS CRAWFORD: So we have 31 staff in total, and we are located, 20 of us in Broome and 10 in Kununurra, roughly that, and we just have recruited one who is based in Derby.

40 MS BERGIN: Does that include a clinical team?

MS CRAWFORD: That includes clinicians, remote care workers, respite workers and administration.

45 MS BERGIN: Where is the clinical team based?

MS CRAWFORD: The clinical team is mostly based in Broome, one in Derby and one in Kununurra.

MS BERGIN: How does KACS work with remote Aboriginal communities?

5

MS CRAWFORD: We work in partnership with the 12 of the bigger Aboriginal corporations across the community to provide services for 13 Aboriginal communities, and in that partnership – do you want me to explain that?

10 MS BERGIN: Yes, please.

MS CRAWFORD: In that partnership, like you heard yesterday from the people in Bidyadanga, the communities themselves employ the workers. There are six coordinators across those organisations, and the workers and coordinators in the remote communities do the day-to-day care. They do the showers, meals, provide some day centre. They will do transport inside the communities and sometimes to the towns, depending on the availability of transport. They do all those kind of services. The KACS role in that partnership is to provide the communities with the funding for workers and for the buildings because care in most instances occurs in the centre. It doesn't occur generally in homes, and I can talk about that a bit more later because that's quite complex.

The KACS remote care coordinators, of which we've got six, have a cluster of communities each that they're responsible for, and they go into those communities at least monthly. They provide support to the community care coordinator and staff in the communities to ensure the services can keep running. They make sure there's no equipment needs, there's no education. They do the education of the remote workers, the basic orientation education. They also do all the case management for the home care package clients and they do that face to face each month, yes.

30

MS BERGIN: So the remote care coordinators who have this broad range of tasks in delivering aged care services, do they – how do they work with Aboriginal communities?

MS CRAWFORD: Okay. So they all, when they commence work with KACS as part of the WACHS orientation we have cultural orientation. We also pay for and support our staff in work time to go to the cultural orientation that a lot of the communities have now. Madeleine yesterday mentioned the one that she has set up in Bidyadanga so our staff that regularly go to Bidyadanga attend that training. There's similar courses in Kalumburu and Warman and Balgo, and our staff would go to those. We also ensure that our staff have some sort of update of cultural awareness or training every year. We link a lot of things to NAIDOC Week and to Sorry Day so that staff become aware of those things. So that when the staff are going to communities, they're very aware of the cultural needs of the clients, the historical factors that impact on the clients, and they – they know that a major part of their role is to treat the Aboriginal people they see with respect.

45

And that includes the workers in the remote communities, the carers, the clients and anybody else that they deal with in the remote communities. Most communities have protocols for visiting where you have to get permission in advance and our staff have to adhere to any such protocols. If there's a funeral or a sorry business, or men's
5 business or women's business, it might mean that staff can't go to communities and that's part of the protocol of communicating with the communities before they go. So they could have it all lined up to go, book the flight say to Kalumburu and then on the day they're going, they can't go, and that's just part of what happens and what we just deal with, so we don't – we just know that that's normal, if you like. I can't
10 explain it any other way - - -

MS BERGIN: You mention in your statement the role of community care coordinator.

15 MS CRAWFORD: Yes.

MS BERGIN: Could you tell the Commissioners a bit about how they work with the remote care coordinators who are the staff of KACS.

20 MS CRAWFORD: Yes. So the KACS remote community care workers go, like I said, to the communities each month. They work closely with the community-based coordinators to follow-up any client issues, to follow up any issues those community coordinators are having with getting their services to run. They work with the community coordinators and hold regular planning days with all the communities
25 where the community people, any community people at all attend, other health service providers attend, and their – those happen annually and then about every two to three months, depending on the community, they will hold a community care meeting with the community to follow-up on issues from those annual meetings, and also just to get feedback from the community on any aspects of the aged care that's
30 happening. They have quite a diverse role.

MS BERGIN: Thank you, Ms Crawford. We've heard about the importance of trust in working with Aboriginal communities.

35 MS CRAWFORD: Yes.

MS BERGIN: Is that the underlying foundation for the partnership model?

40 MS CRAWFORD: Very, very much so because if you don't have the trust of the communities and – the communities, (a), won't let you visit; they won't listen to you when you go, and they – they don't want to work together with you. So having trust of people in the communities is really important. And we're very fortunate in KACS. We have – out of our 31 staff we've got nine that have been there for 10 years or longer. The longest serving person has been there 17 years. I've been there
45 14 years. So another third of our staff have been there for more than five years. And then we have a group of shorter staff. We have about five of us that have worked for KACS more than once, we've come and gone. So it means that over time the

communities have really got to know the KACS staff. They know that we're reliable. We go in regardless.

5 If we can't get there because the road's closed, we will charter flights to get in. We will talk to people on the phone when we can. We talk to the clinics; we work closely with the clinics. We work closely with the shops because if a community is cut off because of flooding we might have to organise meals through the local shops. They have a shop; there's only ever one shop in a community, the community store. So because our staff work so closely with the communities and they – they know that one of – besides respecting the people they see, they also have to be reliable and follow through and do what they say they're going to do. You know, they don't just turn up and go, "Yes, yes, I will do that" and then not do it. The team leaders very much follow through to make sure things are actually happening the way they're supposed to.

15 MS BERGIN: Ms Crawford, given that framework with the remote care coordinators being employed by KACS, working with the community care coordinator who's employed by the local Aboriginal corporation - - -

20 MS CRAWFORD: Yes.

MS BERGIN: - - - how are, for example, home care package services delivered to the end client?

25 MS CRAWFORD: Okay. So the KACS staff do all the clinical part of the home care packages. The clinicians within KACS are also allocated a geographic area and they work closely with the remote care coordinators, so they will do any clinical assessments that's required for falls or if the person has got continence issues or if they're deteriorating or if they're cognitively not as good as they were, then they will be involved in that. The remote care coordinators see those home care package clients monthly to monitor them and make sure everything is going well. They also do a lot of case management. Case management is probably the biggest service we do all together. Case management includes assisting people to navigate the housing services to, say, get a repair to their bathroom. It might include going to Centrelink and helping the person going through the Centrelink processes if there has been a problem with their payments.

40 It can be helping them to navigate the health system with the clinics, it can be assisting if families are getting very stressed. So we will get the respite people involved. It can – it's just so varied. Then the remote workers do the day-to-day shower or hygiene or whatever the person needs. That is very much a development thing. So some communities, where the staff have been there for quite a while and have had lots of education and training, can assist somebody with a shower. Another community that might have a very high turnover of workers, we would have to get a staff member, either our – usually our clinicians but sometimes the remote care workers to work with those staff and teach them how to do a shower and actually train them from the start.

So in that instance there might be a gap until that service can then be developed to be restarted. The date – if the person has, say, a wound or needs assistance on a daily basis, that can't be done by our staff because of the geography so that is done with the remote Aboriginal clinics – the clinics in the remote Aboriginal communities, I
5 should say, because that clinic service is there for all residents within the communities anyway.

MS BERGIN: Thank you, Ms Crawford. So you mentioned the importance of
10 clinics.

MS CRAWFORD: Yes.

MS BERGIN: Could you explain to the Commissioners what services are delivered
15 in the clinic in these remote locations.

MS CRAWFORD: A clinic in a remote community is predominantly nursing –
nursing – remote area nurses. They will have visiting medical services once or twice
a week. Some areas it's only maybe once a fortnight depending on the clinic and
20 how many people live in the community. The very large communities like Balgo
have a doctor who's there all the time. And they deal with everything from birth to
death, every health issue that the person might have and might need goes through the
clinic.

MS BERGIN: Are there also centres where services are provided in remote
25 locations?

MS CRAWFORD: That's for the aged care services which are distinct from the
clinics and always separate. They're buildings that the communities have provided
30 where the aged care services occur. Most commonly in Aboriginal communities,
services don't occur in the homes. There's a lot of overcrowding and because of the
overcrowding, bathrooms, showers may not work very well, and there may not be
much privacy. There may not be space so the older person might be in a bedroom
with four or five others or sleeping in a lounge room. So there may not be space for
35 the things they need like a wheelchair or a commode. The – sorry, I just lost track of
what I was going to say. So the – most of the care, like I said, occurs in the centre.

Also within the communities because the care is being done by local Aboriginal
people, there's sometimes cultural issues with workers not going into a house. Or if
40 they're from the wrong, different family group or the wrong male/female
relationship, they can't necessarily deal with that person so they won't go into the
house and do individual care. Clients also don't want other people from the
community coming into their house because they don't want them to see how they
live because they're scared people will gossip. Even though workers are taught it has
45 to be confidential, the clients themselves are scared that people will gossip about
their house so they don't like people going into their house.

We do occasionally get single bedrooms, so a person is in a bedroom and high care needs. We will get the bedroom cleaned. They won't do the rest of the house because often when there's so many people living in the house the argument is, well, those other people should be doing that, which I can understand their point. So we
5 focus on the most essential care in making sure that gets done somehow, yes.

MS BERGIN: So we're talking here about services provided under both Commonwealth home support and home care packages?

10 MS CRAWFORD: Yes, the main difference between the two is that the home care packages clients get the additional case management. Usually, they're needing that additional services to navigate all the other different things that have to be done, whereas the Commonwealth Home Support Program people are still able to be more independent in that regard and not needing as much.

15 MS BERGIN: How many home care package and Commonwealth home support clients does KACS have at the moment, approximately?

20 MS CRAWFORD: Roughly at the moment we've got about 140 Commonwealth home support program clients, and we've got about 76 home care package clients and we have roughly 30, WA HACC under 50 clients that are in the grandfather phase.

25 MS BERGIN: And in addition to those three categories of funding does KACS also have clients transitioning to the NDIS?

30 MS CRAWFORD: Well, those WA under 50 people are the ones that are waiting to transfer to NDIS. They're the last ones to be transferred and some of those will possibly never be transferred because they've never had formal assessments or diagnosis of what their disability might be, particularly if they've possibly had something like FASD, foetal alcohol syndrome. That might never have been diagnosed in those people that are now in their 40s because it wasn't known about previously.

35 MS BERGIN: Does that also extend into the age bracket of 50 and above?

MS CRAWFORD: Yes, but most people once they're over 50 start to also have aged care conditions.

40 MS BERGIN: Yes. Okay. So WACHS is often described, as one of my witnesses yesterday described in his statement, that WACHS is a provider of last resort. What does that mean?

45 MS CRAWFORD: It means when there's no other NGO or private organisation and there's a need for services then WACHS provides those services.

MS BERGIN: Do you think that's a fair description of the role that KACS also plays in the Kimberley?

5 MS CRAWFORD: Yes. There are no other service providers currently in remote Aboriginal communities. In the towns, the small towns of the Kimberley, Fitzroy, Halls Creek and Derby, the people who provide the Commonwealth Home Support Program there don't want to do the home care packages because of the administration and compliance requirements.

10 MS BERGIN: You've mentioned the administration and compliance requirements a couple of times, both in the context of home care packages but also there must be compliance requirements or there are compliance requirements that come along with administering CHSP, HCP, NDIS; you mentioned 14 buckets of funding.

15 MS CRAWFORD: Yes.

MS BERGIN: Could you talk to the Commissioners about the effect of receiving multiple sources of funding on your administration?

20 MS CRAWFORD: It's really big. So every program has its own requirements for financial reporting every year. Some of them twice a year. They all have their own requirements for data reporting. That has got a little bit more streamlined since the data exchange system came into being but some of them still require a more manual system. All of them have different requirements for reporting on the program itself
25 and the outcomes of the program, and most of them are now covered under the aged care standards so that does make it easier from a quality perspective, yes.

MS BERGIN: So if KACS wasn't doing the reporting for the remote care coordination - - -

30 MS CRAWFORD: Yes.

MS BERGIN: - - - who would do it; could the Aboriginal corporation do that reporting themselves or would it affect the service delivery?

35 MS CRAWFORD: It would affect the service delivery, in my opinion. Previously Warmun community had 11 home care packages that they administered themselves, but last year in April they handed those packages over to us because with the new requirements for reporting under the consumer-directed care model and the aged care
40 quality – there was nothing wrong with the services they were delivering from day to day, but the high level of requirements in terms of the policies, and the reporting and the compliance was too much for the CEO who also has to deal with making sure the water is running, the electricity is working, the snakes haven't taken over, that there's a fire plan in place, that there's a flood plan in place and all the myriad of
45 other things that the CEOs in the communities have to do, she just couldn't comply, so in conjunction with the Commonwealth they – and the Aboriginal Elders in the community, they approached us to take over their home care packages.

MS BERGIN: So in administering those 14 packages of funding, could you give an estimate of how many people or how many hours, staff hours are involved in the administration requirements?

5 MS CRAWFORD: Okay. So we have four – four and a half administration staff who do the data collection and do our cars and do all the stuff that is required for KACS. Since the home care package individualised budgets came into being, we – we always had consumer-directed care. That was not an issue for us because we’ve always sat down with our clients, worked out what it is they wanted, how they
10 wanted it, where they wanted it, but with the individualised program budgets, we’ve actually increased our staff by two that just do administration and we also now employ a consultant accountant that we didn’t previously need because things weren’t so complicated, just to make sure that we are meeting all the requirements and able to put out all the statements every month to the clients with the budgets.

15 MS BERGIN: So you’re talking about an increase in staff just in relation to home care package administration or do these staff have other functions?

MS CRAWFORD: No, that was the overall increase we had to do just because of
20 the home care package changes when it went to individualised plan budgets.

MS BERGIN: Is the total staff count now three and a half including the new staff members?

25 MS CRAWFORD: No, no, it’s four and a half manager myself.

MS BERGIN: Am I correct to summarise that as being four and a half staff out of 31.5 staff full-time equivalent just doing administration?

30 MS CRAWFORD: Yes.

MS BERGIN: You’ve talked a bit about this already, but I’m interested in better understanding how service delivery works between KACS and the community partner.
35

MS CRAWFORD: Okay. So like I said about the role of the remote care coordinator, they also do the training for the remote Aboriginal workers. We have developed – our training coordinator developed a basic six modules of orientation training. Includes what is aged care, hand washing, occupational safety and health,
40 basic food safety. I’ve forgotten the names of the other two. And so that gets delivered by our staff and then once the remote workers have done those we link them into the Kimberley TAFE and they do their certificate IIIs in aged care and some of them now are doing their certificate IVs. We have national job creation package funding which is funding for 27 part-time units of employment, Aboriginal
45 specific employment. One of those units is within KACS for the administration of the program.

The other 26 units goes to the remote Aboriginal communities and then we fund six coordinators on top of that from the other funding. And those 32 workers, 13 of them have finished the certificate III. And of those 32 workers, three are non-Aboriginal and that's because of the choice of the community to employ those non-Aboriginal people as coordinators. The three other coordinators are all Aboriginal and all our national job creation package workers are Aboriginal. They're required to be. We work very closely with the communities to ensure those workers have their police clearances because that's a requirement under the Aged Care Act.

10 That can be problematic because the community often see it as our fault if they can't employ someone that they want to because they've perhaps not got a very good police record. It's also very difficult to get the police clearance record, sometimes because people don't have the required identifications and it can be very difficult for them to get all the bits that they need to be able to go for their police clearance. The workers in the remote communities, we have some that have been there up to 10 years or more, and we have some that are just there for a matter of weeks. They do the job, they don't like it, they move on, do something else. So in some areas there's lots of turnover, in other areas there's not so much. It's always good when there's not so much turnover, but, you know, it just very much depends.

20 Things external to aged care also impact on the aged care services. So if the chairperson, Aboriginal chairperson in a community changes, that might alter who and how aged care services happen. If the CEO of a community changes, that always has an impact because the CEO does a lot of the administration within the communities, so that will impact then on the – the services. Things like if the community is cut off with floods, so two years ago Noonkanbah community was cut off for over three months with floods. It got so bad, the floods, you couldn't even land a helicopter to evacuate somebody medically. And so quite obviously at that time the aged care services couldn't run. So we were doing a lot of support on the phone to individual families when they had phones, which not everybody does.

30 And after the floods, the community was in quite a disarray for some time. So we actually sent in our employed workers on a second weekly basis to do the basic services within the community for about three months until the – the community was able to get back on its feet and start operating services again.

MS BERGIN: So circling back to recruitment and training for a moment.

40 MS CRAWFORD: Yes.

MS BERGIN: You mentioned the significance of police checks, how much of an obstacle is the requirement for a police check in the recruitment?

45 MS CRAWFORD: Getting the required identification documents can be really onerous for some people, because they just don't have a birth certificate, they don't have a passport. They may not have anything other than their key card for the bank. They may or may not have a Centrelink card. But their names might have changed,

their name and date of birth on their Centrelink card can be different to what's on their Medicare record and that's a big problem. So there's all sorts of reasons why it's difficult for people to get their identification to get the police clearance checks. Then sometimes when people are maybe younger they might have been in trouble for
5 some sort, and even though it might be many years later, they might have had jail time or something like that which means that they're automatically disqualified from working in the community, even though, you know, they might have been quite clear of any of that for many years.

10 MS BERGIN: So then it sounds like KACS is quite strict about compliance with all the requirements under the Act.

MS CRAWFORD: Well, we're required to be so we have to be, yes.

15 MS BERGIN: All right. Thank you.

MS CRAWFORD: And we make sure that we check every worker's police clearance.

20 MS BERGIN: Now, on training it sounds like the training is significant. You mentioned induction training, cultural awareness training, six modules of training delivered to the remote community care partners.

MS CRAWFORD: Yes.

25

MS BERGIN: How much of an obstacle is retention of staff?

MS CRAWFORD: In KACS or in the remote community?

30 MS BERGIN: In both if you wouldn't mind.

MS CRAWFORD: In both. In KACS what we are having difficulty with now is recruitment because a lot of our contracts with the Commonwealth for a number of years now have been one year rolling contracts, especially respite contracts and that
35 programs are all ending in November. We also have change with the CHSP coming in. Initially, it was only going to be for two years, and now it has just been extended to 2022. All of that, and the individualised nature of the home care package budgets means that within WACHS we're only allowed to employ people for the term that we have funding. So we currently have 19 people that are on rolling contracts
40 because it's been a number of years now that all of this has been happening with the short-term Commonwealth contracts and that's quite significant.

We're lucky that a lot of them have chosen to stay but trying to recruit clinicians in particular or a senior staff to be team leaders when you're telling them they're going
45 to have a six month contract because we don't know what's happening with our funding, it's really difficult.

MS BERGIN: So would you agree that the uncertainty associated with security of tenure is a problem?

5 MS CRAWFORD: Yes, yes. And one of our nursing positions was vacant for 10 months last year and we advertised three times before we finally got somebody, yes.

MS BERGIN: Thank you, Ms Crawford. Now, turning to sort of, I would like to ask you to address the Commissioners on some practical challenges of delivering services in the remote communities. So let's take the example of a typical day for a community care worker, being one of the KACS staff based in, say, Kununurra who is in a case management role with someone in Balgo. What does that look like?

MS CRAWFORD: Usually they will leave on a Monday, sometime between 6 and 7 am. They will drive to Halls Creek. They'll usually see the home care package clients in Halls Creek. Then the next day they'll drive to Balgo and they'll stay in accommodation in Balgo until either the Thursday or the Friday. While they're there, they will go to the community care centre, meet with the workers, talk to them, find out how things are going. They will go to the clinic, follow-up with clinic or the clients, especially any that have medical issues. They will go to the store and see if the store has got any feedback. They will meet with the chief executive of the community and the chairperson of the community and see if they've got any issues regarding the aged care.

Then they'll meet with the individual home care package clients, and every three months they meet with the Commonwealth home support program clients because they need less follow-up so they will meet with them roughly about every three months and just make sure they're going okay on the amount of services they're getting and the amount of services, check if they need assistance and support with referral to My Aged Care if the Commonwealth Home Support Program is not really meeting their needs and they're needing a higher level of service, and then they will sit with them and phone My Aged Care or do the online applications for My Aged Care with the person. And it just varies so much, but that would be a typical week.

Then at the end of all that – and then in the afternoons most communities have a siesta in the Kimberley in the afternoon so that's when the staff will do their notes, any writing up they might have to do. They might go out and see people after the siesta time. It depends; some clients don't like to see government or health workers after the siesta time because that's their time so they like that to themselves. That's often when our staff are following up with the clinic and the store and those type of people. They will have seen the clients in the morning. And then on Thursday they will drive back to Halls Creek or they might go to Billiluna or Mulan and then drive to Halls Creek, and Friday they drive up to Kununurra. Halls Creek to Kununurra is about a four and a half hour drive on the tar, but Balgo to Halls Creek can be between three hours, four hours or more if it's wet.

45

MS BERGIN: So how many hours – if you could estimate, how many hours driving would that worker do – or how many kilometres would they cover in the round trip, visiting the three communities and returning to Kununurra; a lot?

5 MS CRAWFORD: Yes, a lot.

MS BERGIN: And when they return in three months time - - -

MS CRAWFORD: They return in a month.

10

MS BERGIN: In a month. Would it ordinarily be the same worker visiting again?

MS CRAWFORD: Yes. We try very much to keep our remote care support workers and the clinicians that are linked to the group of communities the same people all the time. If they have to change for some reason because somebody is leaving, somebody else in the team will go out and have orientation so that they get to know the people in the community and everything else so that if there is a gap between the person who is leaving and the new one coming then we have another staff member who's familiar with everybody who can then take the new person out and orientate them. The clinicians, like I said, we've been lucky, many of our clinicians have been with us a long time so they will also provide support to that and be the backup.

MS BERGIN: You mentioned getting to know clients, is that – does the repeat visits from the same care worker and the same clinician help build up trust in the community?

MS CRAWFORD: Yes. Before 2008/9, we used to run on program models. So I went as the continence nurse, one of my colleagues went as the HACC coordinator, somebody else went as the, it was CACP, it's now home care packages coordinator. Somebody else went as the respite person, and then the remote worker for that community would go on a different day of the week. And we would all go different times, different days, we wouldn't necessarily travel together. Then we changed our model to the team model that we now have so we have the three teams and each team has a team leader and in that team are remote care support workers.

Clinicians have their own team but they are linked to the remote team and then we have respite workers also attached to that team. And that way the communities that that team is responsible for gets to know the team, so that if one person is on holiday there's something else from the team they know. And the team leaders have always been to all of those communities in that area; they've also met most of the clients and they will to up if somebody else isn't there also. Yes.

MS BERGIN: You mentioned that the community care worker is involved in cultural awareness training of the remote care coordinator, if I'm not mistaken. How important is that training program?

MS CRAWFORD: Okay. The community care workers in the communities don't do the training of the KACS staff as such, but the community itself might have a cultural training program. So like Bidyadanga has its own cultural awareness training day that our staff that go there regularly attend. But the workers in the remote communities do help our staff to advise us if something is not appropriate for us to see a person at a certain time for some reason culturally or if there's – there's something else going on in the community, they will advise us and say, no, you know, this isn't a good time because it's cultural, this is happening, and our staff know that they have to listen to that.

10 MS BERGIN: So when you mention that had there might be cultural business happening, what's your experience of an example of what that might look like?

MS CRAWFORD: Okay. So I was previously the continence nurse for the remote communities and myself and a work colleague, we went to Balgo one time from Broome, so we drove. It was about a 10 hour drive because you go up to Halls Creek which is 780 kilometres and then you do the 280 or whatever it is in. And we got to Balgo, we were there on the very first day. I had clients to see for ACAT assessments and continence assessments and my client – my colleague was there to organise some training with the remote workers and when – as soon as we got there, we weren't there even I don't think half an hour and men's business started.

And when that happens, all the women – we were outside the store, all the women immediately went into the store and then we were told by the woman in the community that we had to go to our accommodation and stay there. We had to stay there until the Friday before we were allowed to leave. So two weeks later we went back to Balgo again to do the work we hadn't been able to do the first time around and we no sooner got there when an elder in the community died and it was the same again. We had to go and stay in our accommodation and stay there for the week because we weren't allowed to leave and go back out. So, and those things happen fairly regularly, you know, and neither of them were predictable. You know, nobody could tell us exactly when cultural business was going to happen, so we couldn't cancel our trip before we went and certainly couldn't know that the person was going to pass away.

35 MS BERGIN: Yes. Well, thank you for sharing that story with us. Does KACS use interpreters in these care worker roles?

MS CRAWFORD: Yes, we use interpreters for any ACAT assessments, for any cognitive assessments. We – it was previously the Kimberley interpreting service; it's now the WA interpreting service, and we use interpreters when they're needed to explain a home care package to clients. And the issue with interpreters, not with the interpreters as such, with the process, is that if a home care package client needs an interpreter to explain their package to them, the Aboriginal interpreting service is \$88 for half an hour. Now, we pick up the interpreters usually from the nearest town, take them with us, they do the assessments, they might have to wait somewhere while we're seeing other people and then we drive them back home.

So it might be a very full eight hour day that we have to pay for that interpreter for. If a person is of a culturally and linguistically diverse background, they can have that interpreting service for free as part their home care package provision through the Commonwealth. Aboriginal people can't have those interpreters for free, so the
5 money has to come out of either the package or most commonly we take it out of our administration money because it's very, very difficult if you've got to charge one client for two or three hours at \$88 for half an hour; they don't have much money left.

10 MS BERGIN: So is the concern that taking money for interpreters out of the client's home care package may affect the delivery of - - -

MS CRAWFORD: Well, it reduces what's available from services, yes.

15 MS BERGIN: Just continuing on the topic of cultural safety; how many of your RCCs are Aboriginal?

MS CRAWFORD: Currently two of them out of six.

20 MS BERGIN: And do they assist other staff to sort of learn about culture?

MS CRAWFORD: Yes, they would tell us if we're doing something wrong.

25 MS BERGIN: Okay. How important is that relationship between the remote care coordinator and the community care coordinator who's the staff of KACS?

MS CRAWFORD: It's very important. It's very important that they have to respect the community workers and our staff from when they start are taught, you know, that it's not an easy process to provide services in remote communities. So they do have
30 a lot of respect for their co-workers in remote communities.

MS BERGIN: And in terms of the clinical team, how often do the psychogeriatrician and the visiting geriatrician, how often do they visit a remote
35 community?

MS CRAWFORD: Roughly three to four times a year. They visit the Kimberley three to four times a year. We group clients by where we've had the most referrals so they might spend a day in Broome. Then if we've got clients to be seen, say, in the Fitzroy Valley, we would fly, most commonly, to make the best use of the
40 geriatrician's time, fly them to Fitzroy, drive out to wherever the clients are and then fly them back. And similarly in the East Kimberley if we have - once we have a cluster of referrals there, then we would get the geriatrician to fly into Kununurra and we would either drive or fly them, depending on where it is, out to see the clients. If it's possible, some clients do come in from the remote communities to the towns to
45 see the geriatrician but for many that's very difficult.

MS BERGIN: So how do you find the availability of geriatricians to respond to referrals?

5 MS CRAWFORD: We've always had a very good working relationship with the Royal Perth geriatrician unit and because they're the ones that service this region, and if we have a client who has an urgent need for an assessment and can't wait until the three or four visits a year that we would have, they will do the assessment by video conference or sometimes organise an extra visit just, say, for a quick one day visit or a two day visit, rather than coming for three days or four days at a time.

10 MS BERGIN: Commissioners, I'm not quite halfway through my examination of Ms Crawford. Would that be a convenient time?

15 COMMISSIONER TRACEY: Yes. Certainly. How long do you think you've got to go?

MS BERGIN: I think at least another 45 minutes.

20 COMMISSIONER TRACEY: I see. Well, it's not just a few minutes.

MS BERGIN: It's not just a few minutes, Commissioner.

COMMISSIONER TRACEY: That would allow you to finish.

25 MS BERGIN: Thank you.

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

30 **ADJOURNED** **[12.55 pm]**

35 **RESUMED** **[2.02 pm]**

COMMISSIONER TRACEY: Yes, Ms Bergin.

40 MS BERGIN: Thank you, Commissioners. Ms Crawford, we heard evidence yesterday about the demand for respite care from a carer based in Bidyadanga.

MS CRAWFORD: Yes.

45 MS BERGIN: I think you were here for that evidence.

MS CRAWFORD: Yes.

MS BERGIN: What challenges – or how available is respite care in the Kimberley?

MS CRAWFORD: It depends on the organisation running the respite. The residential aged care respite, I'm talking about. For example, Juniper, who run the facilities in Derby, Fitzroy, Kununurra and Wyndham, and the People's Church who own the one in Halls Creek, are very flexible and understand that for many Aboriginal people they don't book respite six months in advance because they don't know what's going to happen six months in advance that they might need a break from. They might need the support if there's a funeral they have to go to that's far away, or they might need the support because they have to go and do some cultural business to do the with the community, the carer might have to. So they might need the respite at fairly short notice.

The other thing is that many of our clients, like I said before, are from – experienced difficulties due to the Stolen Generation. So when we know in the future they might need residential care as a permanent thing, we start getting them to go for respite for maybe one night or two nights and then maybe for a slightly longer time and slowly build that up over time so that when it comes the time of them needing permanent residential care they've become accustomed to it they know what to expect and it's not so scary because for Aboriginal people – and I think anybody – residential care is seen as the place to go to die, so they don't want to go.

So the organisations I just mentioned are very good at being flexible and working around that. With the Broome respite provider, they changed their policy earlier in this year and they now will only take clients for a two week stint, so they must go in for a whole two weeks, not just a day or two and they need to all be high care. So that's impacted on the type of people who can stay there and the people that will go because often people don't want to go for a whole two weeks. They just want to go for a short break and, like I said, they can't book it in advance. So I do understand; I've worked in residential care. It's very difficult when you've got people coming and going all the time, so I do understand the organisation's needs for such policies but it's difficult for the clients and the carers.

MS BERGIN: So which provider is that?

MS CRAWFORD: It's Southern Cross here in Broome.

MS BERGIN: In Broome.

MS CRAWFORD: Yes.

MS BERGIN: You've talked a bit about the administrative burden created by the move to individualised home care packages.

MS CRAWFORD: Yes.

MS BERGIN: What other effects has the move to consumer-directed care has on the way KACS operates its services?

MS CRAWFORD: Yes. So prior to the individualised budgets, a client who needed
5 the care got the care when they needed it. So if they needed really high care then they would get whatever it was they needed to be able to support them to stay at home, as much as could possibly be provided where they lived. Now, if they've reached the limit of their budget, then that's the limit that they can have. Whereas we have other people who might have 15 or more thousand dollars sitting in their
10 budgets unspent and unlikely to spend and since consumer-directed care came in, a bit over three years ago now from memory, we have KACS which only has, you know, the maximum we've had is 90 home care packages and currently we're sitting around 76.

15 Over that time we have \$380,000 of unspent client funds that we can't touch, whereas we've got clients that we're saying, sorry, no, you can't go to the day centre every single day for six hours because you just don't have the money in your package even though the carers really need that level of support because the person
20 might have advanced dementia or might have a lot of physical needs and they're also dealing – because quite commonly the person who's the carer for the old person is also the carer for the grandchildren and other people in the community. So they often have a very high carer burden.

MS BERGIN: So what's your view about weighing up the differences, the
25 advantages and the disadvantages between block funding and individualised client budget?

MS CRAWFORD: In my opinion, I would much rather have block funding because
30 then we could put the money to where it was needed at the time it was needed, and it meant that people weren't being told, no, you can't have things. So in my opinion, I would much rather have block funding. It's also greater security for employment of both our staff and then the funding that we give through contracts to the remote communities because we know what – how much money we're getting, we know how much, how we can work around that much money but now, like I said, we were
35 up to 90 packages at one point, then in the month of April this year we went from 86 to 75 in three weeks because people passed away or went into permanent care and that has a huge impact then on our budget in a short timeframe.

40 Working up here, it's not the kind of work environment where you can pull in casual workers. You know, you've got to have permanent staff so you've got to staff for the median amount of clients you think you're going to have. But when there's sudden big changes like that, and with no idea how long you will be waiting to get more packages because of the national wait list being so long, it's very difficult to manage, especially when you've got small numbers of packages. Even – sorry.
45 Because I was going to say, even though we are part of the WA Country Health Service which is a much larger organisation, because our funding into KACS is all

tied to different programs we have to manage those programs within the budgets that we're provided through the Commonwealth. We don't get extra State money.

5 MS BERGIN: Sure. I understand from your statement that from time to time air travel is necessary to provide home care package – services under a home care package to a client.

MS CRAWFORD: Yes.

10 MS BERGIN: What does the move to individualised budgets mean for that need?

MS CRAWFORD: That has been really difficult and up until now we've averaged the cost of all our travel across all of our clients. But starting on 1 July, the budgets have to be changed so that there's not going to be the administration component of the budget which is where we previously sat our travel costs. Now, it all has to be attributed back to the client individualised care, individual care cost. And we've been trying to work that out so it could be done fairly and to this point we haven't – with the assistance of the accountant we haven't been able to. He's done different models and we've looked at the best practice education that was provided by ACSA and we haven't been able to come up with anything that doesn't then severely disadvantage a great number of our clients, especially ones that live in the most remote spots.

MS BERGIN: Could you give me an example of a location that you might need to fly a, for example, clinician to and what that would cost?

MS CRAWFORD: Kalumburu. They've just recently started a regular air service and if we can get a seat on that, that's about 200 and something dollars each way. If we can't and we have to charter a flight it's \$3000 each way. The same going to Balgo; in the wet season if the road gets closed which it sometimes is for many weeks on end. It wasn't this year, thank goodness, but most years it was closed for three, four weeks at a time. That's another \$3000 each way.

MS BERGIN: How often does KACS use telehealth as an alternative or an additional means of client contact?

MS CRAWFORD: We use telehealth for clinician assessments for ACAT when it's not possible to travel or when it's an urgent ACAT required. So the person urgently has to go into residential care for some reason, then we will use video conferencing, telehealth for that. And if it's an urgent geriatrician appointment that is between when the geriatrician is going to visit then we will use telehealth for that. Otherwise, as far as is practical we try and visit people face to face because you get, in my opinion as a clinician, you get a lot more information from the person, and when you've got an interpreter, the client – the client may or may not have cognitive impairment. They already have a distrust of white government systems anyway, trying to talk to them through the medium of a TV screen can be quite difficult to get a comprehensive picture.

MS BERGIN: What are the obstacles of using telehealth with an interpreter?

MS CRAWFORD: It just adds one more layer of complexity because the
5 Aboriginal interpreting service, the interpreters are trained and they have their
qualification but often if you're doing clinical assessments you have to explain the
concepts that you want first to the interpreter to make sure they understand what
you're going to take about so they are then prepared to do the interpreting. So that
can, like I said, add another layer of complexity, yes.

10 MS BERGIN: Thank you, Ms Crawford. Now, you mentioned My Aged Care and
the role of the remote care coordinators in liaising with My Aged Care on behalf of
clients.

MS CRAWFORD: Yes.

15

MS BERGIN: I'm interested in understanding what your experience has been of
using My Aged Care on behalf of Aboriginal and Torres Strait Islander people.

MS CRAWFORD: Dreadful. It's a very difficult system to use. It relies on people
20 having the telephone, internet, being at a fixed address and speaking English, and
being cognitively intact and not being too frail to not have the energy to deal with the
system. So if a referral is made to My Aged Care, then the My Aged Care people
will try to contact the client, if it's not made by a clinician. They will try to contact
the client by telephone. On the My Aged Care system when you're doing referrals,
25 they have a tick box that you can say the person speaks Aboriginal language but
there's no space to specify which Aboriginal language and they don't use
interpreters, not even Creole interpreters when they telephone back to clients.

30 So they will often get people who don't understand what they're talking about, or
who, you know, just don't understand English well enough to be able to respond.
That is, if the person has a phone, and many times our clients have pre-purchased
mobile phones that they use till the end of the credit on the phone and then they will
get a new prepaid phone with a different phone number. So the phone number that
might have been on their contact details on their referral may not be the same one as
35 they've got in a month's time. Like I said, many of our clients don't speak English
and if they do speak some English they may not be very literate in English. The
letters that come from My Aged Care can be quite difficult to really understand what
they are asking and what they want from the person, and the mail delivery in remote
communities is sometimes, well, it's always a little bit difficult.

40

In most communities there's a pigeon box system that the mail goes into, and if it's
not collected by the residents of the community within a certain timeframe it all
comes out and goes into a cardboard box and there it sits until somebody rifles
through the box and finds their mail, if they know they're going to get it. So all of
45 those things make it more difficult. Also, we've had experience with some clients
who move from community to community because we've a number of people who
do that. Then, of course, because they're not at the address that it says on the referral

form, no, no, no, you can't do that to My Aged Care. And if they send you a letter and you've actually moved on to your other community that you also live in for part of the year, well, then you never get that letter so you never know what's happened.

5 The ACAT in the Kimberley tick for everybody unless somebody says they don't want them to, that the ACAT is contacted when a home care package is allocated so that the ACAT can then assist the person regardless of where they live in the Kimberley or their culture to access that ACAT package. Because older people, if they live alone, they may not have family supports, they might just be too frail even
10 if they do speak English and have a phone, they might just be too frail to actually deal with the process.

MS BERGIN: How accessible is the My Aged Care internet platform for your clients?

15

MS CRAWFORD: Not terribly. The shire of Halls Creek did a survey last year, and they found that 80 per cent of the residents in the Shire of Halls Creek, which includes Balgo, Billiluna, Mulan and the Halls Creek town, a small town, 80 per cent of the residents had no access at all to the internet. And that's fairly typical of the
20 remote communities. And three of our remote communities only got mobile phone access last year in July. That was – they were the last three, and there is still patches of areas of the Kimberley with no mobile phone access and therefore no internet.

MS BERGIN: Could you describe – I want to move to the topic of grants which you also deal with in your statement.

25

MS CRAWFORD: Yes.

MS BERGIN: How important is it to be – firstly, is KACS an approved provider?

30

MS CRAWFORD: KACS, as part of WACHS, are approved providers for Commonwealth aged care provision, yes.

MS BERGIN: And are the Aboriginal corporations approved providers?

35

MS CRAWFORD: No, because we hold the approved provider status because we do the reporting to the government, the data, the financial reporting, the quality, all of that stuff because that would be too onerous for many of the communities, so with
40 – sorry, what did you ask me?

40

MS BERGIN: I was just asking you about the model.

MS CRAWFORD: Yes.

45 MS BERGIN: The approved provider status, and I then wanted to ask you about what the difference, where KACS is the approved provider and the Aboriginal corporation is not, what does that mean for grant applications?

MS CRAWFORD: Okay. Prior – previously when we had the WA HACC system as our main source of funding for the clients in the remote communities, if the remote community service – and it’s the community’s building, it’s not a KACS building, it’s a community’s building – if it needed an upgrade, if it needed the kitchen modified or the bathroom upgraded or something done to its roof or something done because it had asbestos, we would apply – or a vehicle for the community to provide services with, we would apply to WA HACC, and through their processes we would most commonly get the grants and we could then put the improvements into the communities in conjunction with the community.

10 Last year, because of the change to the Commonwealth Home Support Programme, we had to apply to the rural and remote aged care grants for money for three of the communities for upgrades, and when we did that we were unsuccessful. Because we are part of the WA Country Health System, we were seen as government so we weren’t eligible for the grants. The communities weren’t eligible for the grants because they’re not actually the approved provider and that means there’s no currently formal way of getting support for those communities if there’s anything they need at all to do their services.

20 MS BERGIN: Now, you mentioned earlier that KACS uses the KICA tool developed by a number of people, including Professor Flicker who we heard from yesterday.

MS CRAWFORD: Yes.

25 MS BERGIN: Operator, could you please bring up tab 73 in the general tender bundle. Is this a example of the KICA tool?

MS CRAWFORD: Yes.

30 MS BERGIN: I will just ask you, operator, to scroll through it so that Ms Crawford can identify the pages within it.

MS CRAWFORD: Yes, that’s correct.

35 MS BERGIN: Commissioners, I tender the KICA tool.

COMMISSIONER TRACEY: This is part of the tender bundle, I think, which is already in evidence.

40 MS BERGIN: I think that this document wasn’t in yesterday’s general tender bundle. We’ve added it. Okay. Very good. And similarly I wanted to take you to tab 79.

45 MS CRAWFORD: Yes.

MS BERGIN: Could you describe to the Commissioners the role of the mini mental test and how it's used together with other tools to diagnose conditions in Aboriginal and Torres Strait Islander people.

5 MS CRAWFORD: This – the Mini-Mental State Examination has been a tool that has been used for a very long time, at least 40 years that I can remember, by doctors, geriatricians, for assessing the cognitive status of the people they see. Some of the questions in this tool weren't suitable for Aboriginal people because they
10 presupposed that somebody had education and schooling, things like question 4 that says spell the word "world" backwards, and there's another question about counting in sevens. And things like the day of the year, and people will know maybe that it's the wet or dry season but they might not know that it's, you know, June the 18th, for example, because they don't need to know unless they're going somewhere or got an appointment.

15 So this test never had very good results with the Aboriginal people in the Kimberley and that's why in about 2003 or 4, Dina LoGiudice, who's a geriatrician, from Melbourne started her first project at looking at the prevalence of dementia in the Kimberley and then went on to develop the KICA tool with Kate Smith who's now a
20 professor at UWA.

MS BERGIN: Yes. In assessing whether a client is eligible for a home care package, the Commonwealth have a number of criteria that are included in the assessment.

25 MS CRAWFORD: Yes.

MS BERGIN: Which of these tools are valid under the Commonwealth's criteria?

30 MS CRAWFORD: The KICA is, the PAS score which is a psychological assessment score is used and the RUDAS – I can't remember what the letters stand for, but the RUDAS is used for people from non-English speaking backgrounds, usually European-type languages, and those three tests are used to determine if somebody is eligible for the dementia supplement. The MMSE score that's on the
35 screen is not one of the validated tests that the Commonwealth accept.

MS BERGIN: Okay. Thank you, Ms Crawford. You mentioned earlier in your evidence the approach that KACS takes to police checks.

40 MS CRAWFORD: Yes.

MS BERGIN: Yesterday we heard from – today, this morning, I think you were present for his evidence, Mr Aitken gave evidence about the approach that the – they take in the Elders village to assessing police checks. Would that approach be
45 available at KACS?

MS CRAWFORD: I'm not quite sure. We – we provide the funding for the police check. We take the people to the police station. We assist them with getting Medicare cards or Centrelink information cards or a Medicare card so that they've got some form of identity. We assist them with getting somebody in the community
5 can write a letter to say that this person is known to them and that they are Aboriginal and what their name is. So we will assist them with all of those steps and quite frequently also take them to the police station if they haven't been able to do it in the community without us.

10 MS BERGIN: And once the results come back, Mr Aitken gave evidence about the
- - -

MS CRAWFORD: So the results – because the people are employed by remote Aboriginal communities the results go to the chief executive officer of the
15 community. If that person has concerns about what's in the results they contact me.

MS BERGIN: Okay.

MS CRAWFORD: And they will usually send it, a copy to me and say well, what
20 do I think and I will go no, that's really outside the guidelines, we can't employ that person or, no, that one is okay because they haven't done jail time for whatever it is.

MS BERGIN: Thank you, Ms Crawford. We heard this morning evidence from Mr Laverty from the Royal Flying Doctor Service and he talked about – he gave
25 evidence that the RFDS isn't able to give assistance for people returning to country
- - -

MS CRAWFORD: Yes.

30 MS BERGIN: - - - after they've received medical attention that was required. Do you have experience with the return of people home to country in that way?

MS CRAWFORD: Yes. Yes, we do. It can be very difficult. It is covered under the patient's assistant travel scheme in terms of air fares and bus fares, and if the
35 person needs accommodation on the way or something like that. But if somebody has had to go to Perth or Darwin or even to Broome if they're from, say, Balgo, it is a very long journey to then go home because they either have to fly to Broome and go on the bus, and unless they're being transferred to another hospital within the Kimberley where perhaps their family might visit, once they go on the bus somebody
40 from the community has to come out and meet them on the highway where the bus stops, and in some instances that can be really far, like Balgo, 280 kilometres, Noonkanbah is about 70 kilometres from the highway. So it all has to be lined up that the person will meet them, and this can pose a lot of difficulties for people travelling.

45 MS BERGIN: Now, what is the – talking big picture now, by way of conclusion – what is the end term goal for KACS in the Kimberley?

MS CRAWFORD: What we've always worked towards is that the client – the communities, I should say – are developed to eventually become able to be self-sufficient in managing their own services. So we work very much on a community development model. We develop the community to employ the staff, to develop the services, to run the services and to get to be as independent in doing all of that as is possible. To date, the communities have not been directly involved in doing, involved in the quality assessment process, other than by contacting and talking to quality assessors when they come.

But we are just about to start involving the coordinators from the remote communities to be involved in training on the new quality standards with us, with our workers, so that they all learn it together.

MS BERGIN: Then in terms of your wish list – sorry.

COMMISSIONER BRIGGS: Could I just ask, does that then mean that they would have to become approved providers?

MS CRAWFORD: Our eventual aim is that the bigger communities would become approved providers in their own right, yes. I think it's still quite a bit off for most of the communities. Some communities now, compared to when I started at KACS in 2002, are – provide very reliable services. It used to be they might do them one day a week and then people wouldn't be there. But now communities provide the services reliably every day of the week, and they come back after the Christmas break because that used to be another issue. People would go on their Christmas break and then not come back for a couple of months. But this year, last year, all the communities came back within the timeframe of the holiday that they decided they were going to have which ranged from two to four weeks depending on the community, which the long-term people like myself at KACS were really pleased about. We felt like it was a major achievement.

COMMISSIONER BRIGGS: That's good. Thank you for that. I'm struggling a little bit to hear. Is it possible to just move the machine a bit closer to your mouth?

MS CRAWFORD: Do you want me to pull it? Sorry, how is that?

COMMISSIONER BRIGGS: Much better.

MS CRAWFORD: Sorry.

MS BERGIN: Thank you, Ms Crawford. By way of conclusion, we ask all of our witnesses for their wish list. Are there a few things you would like to leave with the Royal Commissioners to consider for the way forward?

MS CRAWFORD: Yes. My things are probably very similar to what Mr Aitken said this morning. The number one thing is the My Aged Care system; it really needs to be fixed – sorry – from all sorts of perspectives. The second thing for me

would be that block funding is restored, so that we have certainty and we know where we are in terms of what we can plan. I would like the grant system fixed so that just because providers like ourselves who happen to sit under the State Government can actually qualify for the grants for the communities we deal with.

5 The hardship application process, which I haven't actually mentioned in this, people on home care packages are supposed to pay \$10.77 a day out of their own personal money towards their packages.

10 Most of our clients might pay somewhere between one and \$5 or nothing at all. And there is a hardship process that they can apply for. It is so onerous, people have to have bank statements and they have to have all sorts of statements about assets and all sorts of things, which is really difficult when you're an Aboriginal person and your only income in the whole world is the aged pension and you have no money. So we've tried multiple times to get that through on a satisfactory basis for clients
15 and we've been successful once and the person got \$2 a day benefit which, by the time we added up all the hours it took to get to that point, it had actually cost money to get the \$2 a day for the person so we've not done it again.

20 And the other thing that I think would be really good to see is long-term contracts with the Commonwealth, you know, at least five years, 10 would be better but at least five years so that we stop this rolling one year contract and stop the uncertainty of not knowing what's going to happen in the future. That would be the major things I would see as making a difference.

25 MS BERGIN: Thank you, Ms Crawford. Commissioners, that concludes my examination.

30 COMMISSIONER TRACEY: Thank you, Ms Bergin. Only one question because you've covered so much ground. But you have explained the problems that your staff confront when they try to assist an elderly person to apply for a Commonwealth benefit. I just want to go back behind that and ask you, how you become aware that there are people out there that might be entitled to benefits and are not getting them?

35 MS CRAWFORD: Because we visit the communities every month and we visit our home care package clients monthly we get to know them and as part of their care planning process we sit down and go through the care plan with them. We explain what their budget can purchase and not purchase and we explain to them that they are allowed to contribute extra money, and we ask them if they are able to do that. And the ones who say they're really just not able to because things are very expensive in
40 remote communities, then they are the ones that are eligible to have the hardship application for the additional funding through the Commonwealth. And we have tried to assist about 15 of our clients, and like I said, we've been successful so far with just one. And the time it took, it's really not viable to do.

45 COMMISSIONER TRACEY: But even a more antecedent question: is it possible there are people out in remote communities who meet the criteria for particular Commonwealth benefits, a package, for example - - -

MS CRAWFORD: Okay.

COMMISSIONER TRACEY: - - - but you don't know about it?

5 MS CRAWFORD: There – it's a possibility, but I think it's unlikely. Because we
work so closely with the community care centres, we meet with the CEOs, we talk to
the clinics, we talk to the remote area nurses in the places where there's just the
remote area nurse, we talk to the shopkeepers. If there's anybody that they have
concerns about, they say to us, that old person down there, or that disabled person
10 down there, they need some help. We don't now deal with disabled people as such
but if we were to come across a person like that, we would then tell - - -

COMMISSIONER TRACEY: So it's a process of informal referrals.

15 MS CRAWFORD: Yes.

COMMISSIONER TRACEY: Yes, I understand.

MS CRAWFORD: And we're very well known in the community so people see us
20 coming and they go we need to tell you about so-and-so. Yes.

COMMISSIONER TRACEY: Well, thank you very much for such detailed account
of how health services are provided to the elderly in the Kimberley. It has been a
real education to us to learn how it's done, because it's quite unique in the evidence
25 that we've heard and we're very grateful to you for sharing your knowledge and
expertise with us. Thank you very much.

MS CRAWFORD: Thank you.

30

<THE WITNESS WITHDREW

[2.33 pm]

MS BERGIN: Thank you, Commissioners. I've just been asked to indicate that the
35 Mini-Mental State Examination is tab 79 and it has been added to the general tender
bundle. Mr Bolster will take the next witness.

COMMISSIONER TRACEY: Thank you, Ms Bergin. Yes, Mr Bolster.

40 MR BOLSTER: Thank you, Commissioner. We move to a small panel of provider
witnesses and I call Ms Rejane Antoinette Le Grange and Ms Belinda Jane
Robinson.

45 <BELINDA JANE ROBINSON, AFFIRMED

[2.33 pm]

<EXAMINATION BY MR BOLSTER

5

MR BOLSTER: Dealing firstly with Ms Robinson, Commissioners, and Ms Robinson is sitting on the left. Can we please bring up document WIT.0211.0001.0001. Ms Robinson, is that your statement that you see on the screen?

10

MS ROBINSON: Yes, it is.

MR BOLSTER: And you've got a copy of it in front of you?

15

MS ROBINSON: I have, yes.

MR BOLSTER: Excellent. Do you wish to make any amendments to the statement?

20

MS ROBINSON: No, I don't.

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

25

MS ROBINSON: Yes, they are.

MR BOLSTER: And Ms Le Grange, is that the proper pronunciation, you have your statement in front of you?

30

MS LE GRANGE: Yes.

MR BOLSTER: That's document ID WIT.0212.0001.0002. Do you wish to make any amendments to that statement?

35

MS LE GRANGE: No.

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

40

MS LE GRANGE: Yes.

MR BOLSTER: I will deal, firstly, then with you, Ms Robinson. You are currently the – you're a registered nurse?

45

MS ROBINSON: Yes, I am.

MR BOLSTER: And you run two facilities in Derby.

MS ROBINSON: I do.

MR BOLSTER: Tell us about them.

t

5 MS ROBINSON: Okay, so I've got the two facilities; there's Numbala Nunga which is a more traditional-style facility. We've got 26 beds, fairly high acuity in that facility. And then Ngamang Bawoona is more low-level care. We have 17 beds, and both facilities are mainly Aboriginal. I think we have one non-Aboriginal person across both facilities.

10

MR BOLSTER: And the facilities are in the Juniper group?

MS ROBINSON: They are.

15 MR BOLSTER: We will have from the chief executive or one of the executives of that group later so I won't talk about the group itself but you previously worked in a Juniper facility at Fitzroy Crossing.

MS ROBINSON: I did, yes. Fitzroy Crossing.

20

MR BOLSTER: Was that an ACFI or a NATSIFlex facility?

MS ROBINSON: A NATSIFlex.

25 MR BOLSTER: And what's the name of that facility?

MS ROBINSON: Guwardi Ngadu.

MR BOLSTER: How long were you there for?

30

MS ROBINSON: About 16 months.

MR BOLSTER: All right. And what was your role there?

35 MS ROBINSON: I started there as care coordinator and then became the manager.

MR BOLSTER: What's the difference, from a practical perspective, running an ACFI facility in Derby to a NATSIFlex facility in Fitzroy Crossing?

40 MS ROBINSON: To try and cater to the cultural needs of the residents is very difficult under ACFI. It's very clinical care based. Whereas obviously flexible care, we're allowed to be a bit more open with our cultural – attending to the cultural needs, taken on country and doing all the things that they really want to do, but with the boundaries of ACFI that's obviously harder to achieve.

45

MR BOLSTER: That suggests a different model of care.

MS ROBINSON: Definitely. It's definitely the – flexi is more resident-focused and we're able to provide what they want.

5 MR BOLSTER: Give us an example of the difference that someone at Derby might experience compared to someone at Fitzroy Crossing.

10 MS ROBINSON: I do try and achieve as much as I can at Derby. To do that it usually means that I may have to take the residents out in my own time because we may not have the staff to be able to do it. But, for example, the – a lot of the residents, Fitzroy and Derby, they like to chew their tobacco and they like a certain ash and you have to go out and source the correct tree. You get the bark, then you have to bring it back, it has to be burnt and sieved. So it's fairly time-consuming. There's no way I can claim for that in ACFI, but it's still something that's required.

15 MR BOLSTER: Ms Le Grange, let's talk about your facility. You're an ACFI-funded facility - - -

MS LE GRANGE: Yes.

20 MR BOLSTER: - - - here in Broome.

MS LE GRANGE: Yes.

25 MR BOLSTER: How many beds?

MS LE GRANGE: There are currently 42 people living there.

30 MR BOLSTER: What is the population from an Aboriginal and Torres Strait Islander perspective?

MS LE GRANGE: So yesterday the population was 60 per cent of the people living there are Aboriginal, yes.

35 MR BOLSTER: And is it full?

MS LE GRANGE: No, it's not.

MR BOLSTER: How many vacancies do you have?

40 MS LE GRANGE: Well, we have closed down one wing with 14 beds where we've got only three people living there, reasonably independent in that specific side of the building.

45 MR BOLSTER: You've closed the wing down.

MS LE GRANGE: Yes, we don't have enough people to open that – residents to open to fill those beds.

MR BOLSTER: Right. Okay. Now, you operate under the non-profit organisation Southern Cross Care.

MS LE GRANGE: That's correct.

5

MR BOLSTER: Can you tell us a bit about Southern Cross Care.

MS LE GRANGE: Southern Cross Care is a not-for-profit organisation. We have several facilities in the metropole, I think about seven, and we have a facility, two
10 facilities in Kalgoorlie and one in Broome.

MR BOLSTER: Right.

MS LE GRANGE: And then several home care packages in Perth as well as in
15 Broome and also in the south-west.

MR BOLSTER: You have been here in Broome since March of this year.

MS LE GRANGE: That's correct.

20

MR BOLSTER: And how long have you been appointed to be the acting business manager of the facility?

MS LE GRANGE: For three months.

25

MR BOLSTER: For three months. And was one of the reasons that you were brought up to Broome to attend to matters that were of concern to the management at Southern Cross?

MS LE GRANGE: That's correct.

30

MR BOLSTER: And what were they?

MS LE GRANGE: They related to behavioural management of people with
35 complex needs living with dementia and some issues around restraint at that stage.

MR BOLSTER: Right. And your experience previously, is it had a focus on remote aged care?

MS LE GRANGE: My previous experience in terms of management of facilities
40 has always been in urban. I have supported the Broome and the Kalgoorlie facilities as the dementia service manager which is my position in Southern Cross Care.

MR BOLSTER: Yes. All right. Could I ask you, Ms Le Grange, have you, until
45 you've taken up this role, had experience in delivering care to indigenous Aboriginal and Torres Strait Islander people?

MS LE GRANGE: No.

MR BOLSTER: And what steps did Southern Cross take to educate you about the sorts of issues that you would face up here in Broome with that cohort?

5

MS LE GRANGE: Very soon after my arrival, a meeting with the Yawuru people was organised, and so that was some exposures in terms of the needs of the local people. And the rest was a training package that's available in – online on – providing care and support to people with – of Aboriginal background.

10

MR BOLSTER: When you spoke to the Yawuru people, did you speak to the local Elders in Broome?

MS LE GRANGE: I spoke to a lady called Minnie. I'm not exactly sure what her surname is, but she's the CEO of the specific group.

15

MR BOLSTER: Did she indicate what the local Aboriginal communities' expectation was or what their desires were about how the facility should respond to their cultural needs?

20

MS LE GRANGE: That wasn't specifically the topic of the day. It was far more about how we could connect and make sure that we direct future care along their needs. So it wasn't already giving direction. It was about developing opportunity to receive more direction.

25

MR BOLSTER: Right. And where are you at in that, in terms of that process?

MS LE GRANGE: So we've had two meetings and we've established that all our staff are attending a four hour care at their facility – at their centre. The second group is doing their training tomorrow and I have attended the first training session, and we were about seven to nine people, I can't remember exactly, that attended that training.

30

MR BOLSTER: Could I turn to you, Ms Robinson, and basically approach the same topic with you. Let's talk about Fitzroy Crossing first; was the local Aboriginal community involved with you in the way in which you would manage that facility?

35

MS ROBINSON: Because I was very new to the field, I was hospital-based, once I got to Fitzroy Crossing, I liaised with a lot of the local services, I formed a – a really strong relationship with the HACC service providers who are basically next door to our facility, and from that, I was able to, if there was anything in – in regards to culture that I was unsure about, I would go and talk to them. I also had a resident that would actually advise me on what I should be doing. So I sort of used as many – many different networking facilities as I could - - -

40

MR BOLSTER: What were the most important things that you learnt as a manager, presumably in a very unfamiliar situation in your time at Fitzroy Crossing?

45

MS ROBINSON: I think that the most – probably the most helpful was news travels really, really quickly round these small communities. And the residents had already got wind that somebody had passed, and I didn't know what to do. So I immediately spoke to my colleague from HACC and she gave me an explanation and from that, I was able to – once the process of the news being shared, we then offered to transport them down for sorry time, the family were all congregating.

MR BOLSTER: Yes.

10 MS ROBINSON: Drop them all off and agreed to pick them up when they were ready, and just supported them as best we could.

MR BOLSTER: Was there a handover to you from your predecessor or from someone at Juniper about these issues or were you left to learn it on the job?

15 MS ROBINSON: The previous manager left at short notice, so I hadn't been there long myself, so it was very much a learning curve.

MR BOLSTER: And for you, Ms Le Grange?

20 MS LE GRANGE: It was the same. I came down to Broome to assist because of the issues around behavioural concerns of how we support people with dementia, realised that there was a little bit more clinical development that has to happen, and I was back for the second day when the manager resigned and I had to step – or I was asked to step into that role.

MR BOLSTER: Right. Ms Robinson, what's the most important thing you need to do to deliver culturally safe care?

30 MS ROBINSON: I think initially you've just got to show – show your respect, but gain their trust. Because when you're coming from an external area they don't know you, they don't know anything about you, and it takes time and it was aware of how much a new staff member, once they got used to us, if a new staff member came in, they would choose me to do care over this person because they were familiar with me.

MR BOLSTER: Can you give us examples of the things that you did at both Fitzroy Crossing and at Derby, to attempt to do that?

40 MS ROBINSON: As for – other than my job as manager and care coordinator, I also used to work in the kitchen. I was the cook once. I used to – I still do, actually, work on the floor as a carer, as a nurse, kitchen hand, cleaner.

MR BOLSTER: Were you the senior clinical person at Fitzroy Crossing?

45 MS ROBINSON: Yes.

MR BOLSTER: And you're the senior clinical person at - - -

MS ROBINSON: I have a care coordinator at Derby which is excellent.

5 MR BOLSTER: Does that person have more experience than you?

MS ROBINSON: She's a nurse practitioner so obviously we've got, yes, some really good to have.

10 MR BOLSTER: Right. And Ms Le Grange you don't have a clinical nursing background, you're in - - -

MS LE GRANGE: I'm an occupational therapist.

15 MR BOLSTER: Yes. Your care, the person who's responsible for delivering care at your facility, how long have they been at Broome?

MS LE GRANGE: So she's at Broome, a lady from Broome, we've recruited her and her first day at work was 1 May and she is a lady that was trained as a clinical nurse at the Broome Hospital and she's an Aboriginal lady.

20 MR BOLSTER: Right. Okay. Good. Okay. Could I get an idea now, please, of the staff profiles of both organisations. Ms Robinson, at Derby, how many nurses do you have on staff?

25 MS ROBINSON: I have five registered nurses and I have two of my multi-skilled carers that have actually completed their enrolled nursing, so I actually dual role them as needed to cover shifts if people are sick or that sort of thing.

30 MR BOLSTER: How many of those are indigenous?

MS ROBINSON: We have no indigenous nursing staff.

35 MR BOLSTER: Right. Is that something that you're trying to change?

MS ROBINSON: Ideally, it would be wonderful but very often our applications – we might get 25 people apply and maybe 23 of those will be looking for sponsorship and for their visas.

40 MR BOLSTER: So if 25 are looking for sponsorship, so they're people who are here on a type of visa that requires them to work in a rural or remote area; correct?

MS ROBINSON: That's right, yes.

45 MR BOLSTER: And from what countries do they generally come from?

MS ROBINSON: We have India, various parts of Asia, parts of Africa.

MR BOLSTER: Right. So of the, I think it's seven nursing staff, how many of them are non-Australian?

5 MS ROBINSON: They're all – no. No. I have two, the enrolled nurses are Australian.

MR BOLSTER: Yes.

10 MS ROBINSON: And the – but all my nursing staff, registered nurses, they're all from other countries.

MR BOLSTER: From other countries, okay. And what about your carers?

15 MS ROBINSON: Again, very mixed. I have – across the whole facility I have nine Aboriginal or Torres Strait Islanders but they tend to be in the roles, and actually through choice in some circumstances, housekeeping, kitchen hand. I have two that I'm hoping to – to get to work on the floor but they need the confidence, they haven't got the confidence, so I'm working with them with that.

20 MR BOLSTER: Are you engaged with the local indigenous organisations?

MS ROBINSON: Yes, I - - -

25 MR BOLSTER: In trying to get indigenous staff - - -

MS ROBINSON: Yes.

MR BOLSTER: - - - as carers?

30 MS ROBINSON: Absolutely, I'm working with Willingarri who – we liaise if there's a position available. I let them know and what the criteria is and they look out for prospective employees for me, and also now, instead of just advertising online on the internet, I've started putting notices up on the local notices boards at the supermarket, at the post office, that type of thing.

35

MR BOLSTER: Are you familiar with the organisation Anja.

MS ROBINSON: Anja, no.

40 MR BOLSTER: Okay. Now Ms Le Grange, your staffing profile?

45 MS LE GRANGE: So we have one clinical nurse that's Aboriginal. Six registered nurses, none of them are Aboriginal. Two of them are Australian. We have one Aboriginal enrolled nurse and one Australian enrolled nurse. And we are in the process of recruiting another registered nurse who is sponsored and from Africa.

MR BOLSTER: Right.

MS LE GRANGE: She's worked in Alice Springs for some time.

MR BOLSTER: What needs to change for you to get more indigenous staff?

5 MS LE GRANGE: I think one thing is the development of the people that live in
Broome, so that's one of our goals with the Yawuru people is to draw people in that
they have in programs with in terms of joblessness and looking at how we can
expose them to work environments, work ethics and giving them opportunity to
connect with local people. So not only do we help them develop people that I need
10 but we have the opportunity to expose our residents to younger people from their
own culture or from Aboriginal culture.

MR BOLSTER: Ms Robinson.

15 MS ROBINSON: As I said, we're trying to advertise locally within the town. I –
we also get a lot of people actually just walk in looking for opportunities and I
always have a little chat with them, see what sort of thing they're looking for, what
they would like to do. We can offer the training and support so that they don't have
to have an aged care certificate. But then I would encourage them to attend TAFE to
20 actually gain that, because obviously down the track that will benefit them also.

MR BOLSTER: When you do employ Aboriginal people, is it difficult retaining
them?

25 MS ROBINSON: I have my gardener is – he has been with the company a while.
He's excellent. I've got another lady that turns up religiously. I've got one or two
that don't always turn up but they are now calling me and letting me know if
something – if they have to go out of town, if they have to go back to their
community. So we sort of work on the fact that they let me know, I can adjust the
30 roster to suit and when they're back in town they let me know they're back and then I
can re-roster.

MR BOLSTER: Does Juniper have a policy about responding to customary
obligations of staff?

35

MS ROBINSON: We have policies and procedures in place in regards to workforce
and at the moment we're sort of working on a plan so that we can address all these
issues.

40 MR BOLSTER: Were you able to hear Mr Aitken's evidence this morning?

MS ROBINSON: Yes.

MR BOLSTER: About the way they deal with that.

45

MS ROBINSON: Yes.

MR BOLSTER: Is your approach similar to that or different to that?

MS ROBINSON: I think my – personally, I’m – I’m happy to give – give anyone a go really if they – if they really want to work and they want to learn, give them the opportunity, lots of encouragement, positive feedback. It’s all - - -

MR BOLSTER: When they come to you and say, look, I have to go back to Alice Springs, there’s sorry business and I will be away for a month.

MS ROBINSON: As long as I know about that I can plan round it. It’s not always easy, it can be challenging but it’s when I don’t know, if somebody just doesn’t turn up for work and they’re gone for a month it can be difficult to work with that. But as long as I know when they’re going, if they give me a call and say “I have to go”, thank you for letting me know, let me know when you’re back in town and I do the best I can to work with that.

MR BOLSTER: Ms Le Grange, is that an issue that’s arisen in your experience in Broome?

MS LE GRANGE: Yes, we have had people not being able to work for some time and it creates great difficulty because when you employ people you have an obligation to give them shifts and if you employ them just in case somebody else is not going to arrive at work there’s a commitment that you can’t fulfil. So we often find that we suddenly sitting with the situation where we can’t fill a shift at all, after having called every person, even asking the nurses if they would be happy to step in. What I find difficult is going back the next day and staff that are very loyal to the facility, hearing that there was an open shift that couldn’t be filled and they apologise. And I feel it’s not correct that they have to apologise for having a life outside work. But that’s how close the community is and that’s the sense of responsibility the regular staff have to the facility.

MR BOLSTER: All right. Okay. Thank you. I would like to ask you, now, Ms Le Grange, some questions about the disclosure by your employer of some matters concerning a facility in the – about a year before you came to Broome. If we could bring up, please, tab 76 of the tender bundle. While that’s happening, Commissioners, can I tender the statements of Ms Robinson and Ms Le Grange - - -

COMMISSIONER TRACEY: Yes. The statement of Belinda Jane Robinson dated 6 June 2019 will be exhibit 4-10.

EXHIBIT #4-10 STATEMENT OF BELINDA JANE ROBINSON DATED 06/06/2019 (WIT.0211.0001.0001)

COMMISSIONER TRACEY: And the statement of Rejane Antoinette Le Grange dated 6 June 2019 will be exhibit 4-11.

**EXHIBIT #4-11 STATEMENT OF REJANE ANTOINETTE LE GRANGE
DATED 06/06/2019 (WIT.0212.0001.0002)**

5 MR BOLSTER: Now, tab 76, you should see that in front of you on the screen. I take it since that conference last week that you've been shown this document.

MS LE GRANGE: Yes.

10 MR BOLSTER: And if we could go, please, to the entry number 6 on page 3600. Can we have that page? You see there –

COMMISSIONER TRACEY: We're not there yet, Mr Bolster.

15 MR BOLSTER: Hopefully, it will be there in a minute. 3600. It's the fifth page of the document. So it's SUB.0001.0012.3600.

COMMISSIONER TRACEY: I think we've gone past it.

20 MR BOLSTER: Just go back one more page, point 6, box number 6 on the left. See there the date, 7 May 2018. That would seem to be an error from documents you've subsequently seen and the incident occurred in January of last year when you were in Perth - - -

25 MS LE GRANGE: Yes.

MR BOLSTER: - - - and you had nothing to do with this. I appreciate the difficulty that you're in. But you see that the description of this incident that was disclosed to the Commission in accordance with the request that the Commission made of every
30 provider of any significant size in the country:

Family found maggots in wound of respite client, wound cleaned, bandage type changed.

35 Was that entirely accurate?

MS LE GRANGE: No, not to what we found in the end.

MR BOLSTER: Yes.

40

MS LE GRANGE: It seems like there's a bit of a misunderstanding exactly what the situation was.

MR BOLSTER: Yes.

45

MS LE GRANGE: Yes.

MR BOLSTER: So the incident in question occurred in January last year and there was a complaint, an oral complaint about maggots in the mouth of a palliative care client.

5 MS LE GRANGE: That's correct.

MR BOLSTER: And if we could please call up tab 80 and tab 81, which is – tab 80 is SCW.0001.0001.0014. If we could just go to the document on the left, please, not the document on the right for now. If we could focus in on the first substantive
10 paragraph on the page and you've reviewed these papers, I take it?

MS LE GRANGE: Yes, I've seen it, yes.

MR BOLSTER: Were you unaware of the circumstances of this event prior to last –
15 sometime last week?

MS LE GRANGE: Yes, I wasn't aware.

MR BOLSTER: And this wasn't an example of one of the clinical issues that you
20 were asked to come up and deal with?

MS LE GRANGE: No.

MR BOLSTER: Since being made aware of the circumstances of this event, what
25 have you as the residential manager come to do at Germanus Kent?

MS LE GRANGE: So I have visited the facility before this event and again after, not knowing what has happened and noticed that there were flyscreens hanging on cables. So that was already in place when I arrived. What I've done after I have
30 become aware of this, was considering the fact that wound care management does not happen in communal spaces where all the flyscreens are, so I've installed IV drips that you can increase in height and attach a flyscreen to that, so the nurse can use that as she move through to do wound dressing and ensuring that when she does wound dressing or care or maybe putting somebody outside to sit outside, sometimes
35 that could be a action for person in end of life care, being pushed in the bed outside if that's what they wish to do or would enjoy, that at least we could cover the person and the person caring for them with a flyscreen.

MR BOLSTER: That first paragraph doesn't really indicate the gravity of the
40 situation. Is it fair to say this, that during the course of one evening, in the wet season when flies would have been a considerable problem up here, have obviously laid eggs in the mouth of the patient or the resident and that with the incubation time of flies being a number of hours, there was a – there was an incubation and there were maggots in the – in the gums of the resident.

45

MS LE GRANGE: That's correct. I don't know if it happened at night-time but I do know that there's an incubation period of about eight hours. I know that the

resident had poor ability to chew so there was food pooling and moisture pooling in her mouth.

MR BOLSTER: Yes.

5

MS LE GRANGE: Which would have created an ideal environment.

MR BOLSTER: Yes. And the issue was – there was a complaint, an anonymous complaint to the Aged Care Complaints Commissioner. Have you reviewed the circumstances of the resolution of that complaint by the commissioner?

10

MS LE GRANGE: Yes, I have.

MR BOLSTER: And you will see, if we could bring up, please, the next document, which is SCW.0001.0001.0020, and if we could go, please, to page 20. So it's two pages after that page. If you see the paragraph with – I think there are nine dot points in the second half of the page, are there still registered nurses being flown up to Broome to work on short-term placements to increase the skilled staff coverage?

15

MS LE GRANGE: Yes, on a regular basis.

20

MR BOLSTER: So how many nurses do you have on at any one time in the facility?

MS LE GRANGE: One at all times plus during office hours a clinical nurse if everybody is well.

25

MR BOLSTER: Are you actively recruiting skilled staff and made a policy change to only recruit those with certificate III in aged care?

30

MS LE GRANGE: We are. I have not been involved with recruitment but I've reviewed our rate of people with certificate III and it's currently something like 29 per cent of our care staff.

MR BOLSTER: And when you arrived, was the facility providing education on oral care in accordance with the third dot point there?

35

MS LE GRANGE: Yes, we are.

MR BOLSTER: And the dementia support team, is that a dementia support team within Southern Cross? Or is - - -

40

MS LE GRANGE: Yes, that's the support team I'm the manager of in my usual job.

MR BOLSTER: Right. And the specific education was being provided.

45

MS LE GRANGE: Yes, it's in the form of a short YouTube video clip and it specifically addresses how to help a person brush their teeth when they are not keen to have a foreign object being placed in their mouth.

5 MR BOLSTER: Yes. Were you in charge of the dementia support team before you came up here?

MS LE GRANGE: Yes.

10 MR BOLSTER: And were you delivering that education before you came up here?

MS LE GRANGE: We don't deliver it on a face-to-face basis. We deliver it through YouTube. It's a very simple YouTube that teaches very basic skills but very useful skills.

15

MR BOLSTER: Am I right in thinking that whilst you were in Perth, before you were appointed here, you were delivering that specific education in ignorance of this action plan?

20 MS LE GRANGE: We were delivering it to everybody because it is a general problem for people with dementia to accept oral care.

MR BOLSTER: All right. What about the documentation issue raised in the fifth dot point?

25

MS LE GRANGE: So we are having ongoing documentation education for staff on documentation. So we, for instance, two weeks ago had our head of learning and development who's a registered nurse up at our facility and she did various toolboxes, which included documentation, administration of medication, so that is ongoing process, as well as with myself being there, it was one of my goals to encourage better documentation.

30

MR BOLSTER: Have you ever come across an incident such as this in your experience?

35

MS LE GRANGE: No.

MR BOLSTER: What about you, Ms Robinson, have you ever seen this sort of thing?

40

MS ROBINSON: No.

MR BOLSTER: Is the new soft – has the new software system been implemented throughout the organisation?

45

MS LE GRANGE: No, it's implemented in one of our facilities. It seems to be taking time to actually get it to integrate it into our systems.

MR BOLSTER: When was it implemented in Perth?

MS LE GRANGE: In, I think, around July last year.

5 MR BOLSTER: Right. Have you since been made aware of these commitments, to use a neutral term, have you made any inquiries of Southern Cross about that?

MS LE GRANGE: About the implementation of - - -

10 MR BOLSTER: Yes.

MS LE GRANGE: No, I haven't. I'm aware of it being rolled out and I'm kind of aware of some difficulties, so that's why I haven't inquired any further. I just made an assumption, I suppose.

15

MR BOLSTER: Yes. There's a reference there to a newly appointed clinical nurse manager. Has that clinical nurse manager – is that clinical nurse manager still with the facility?

20 MS LE GRANGE: Yes. No, not in this report. She's still working as a nurse at our facility, yes, but not in the clinical – not in the role as clinical nurse.

MR BOLSTER: And are you familiar with the resident in Bargana, I assume that's one of the wards, is it?

25

MS LE GRANGE: It's one of the houses.

MR BOLSTER: Are you familiar with who that resident is?

30 MS LE GRANGE: No.

MR BOLSTER: Are you aware of whether staff have explained to that resident why the doors need to be closed?

35 MS LE GRANGE: There are several residents that enter and exit the building on an ongoing basis, and it's encouraged. So I am not aware.

MR BOLSTER: Yes. All right. Thank you. Commissioners, the Southern Cross response and the Aged Care Complaints Commissioner findings are at tabs 80 and
40 81. They're in – so they're now in evidence. The disclosure of Southern Cross is at tab 76. I would like to move on now to some other matters, if I may. A question of food. And both of you run organisations where there are significant Aboriginal populations. To what extent do you provide a diet that corresponds with the particular wants, customs, preferences of Aboriginal people?

45

MS ROBINSON: So we provide – kangaroo is on the menu regularly but we also cook, in the traditional way, utilising our gardener who's an expert in that field. So

he will actually cook the kangaroo in the traditional way with the guidance of the cook, so then the temperatures can be monitored so we can be assured we're still following all the guidelines, then obviously it's dished up. The activities officer will get all the residents to make their own damper which is baked in a traditional oven
5 and then they all have that with their kangaroo tail.

MR BOLSTER: So that will be traditional food. How many times a week does that happen?

10 MS ROBINSON: It probably happens, it's probably once a fortnight they do it in the traditional way. But it's on the menu more often than that.

MR BOLSTER: Do the residents take a role in the preparation of that food?

15 MS ROBINSON: The fire pit is done in, in Ngamang so down there they've very often sat around the fire for yarnning anyway so they're all a part of that process.

MR BOLSTER: Can we just stop and talk about the fire pit. It's a feature in the Aboriginal nursing homes or residential aged care facilities that I've seen. Can you
20 describe the fire pit place? How does it work? What's the importance of it?

MS ROBINSON: Well, Ngamang is basically an external facility, so all the rooms are on the outside with verandahs and in the middle is a garden area with big boab trees, it's beautiful. And then the fire pit is set under there and then all the residents
25 sit round yarnning while the fire is burning. They do that – I'm very lucky, I have a gentleman who worked down in Ngamang for 16 years. He has just decided to retire but he has actually come back as a volunteer, and he comes in every morning, lights the fire for them and sets them all up round the fire pit in the morning where they all sit with their jackets on and a cup of tea.

30 MR BOLSTER: Do you have a similar facility, Ms Le Grange?

MS LE GRANGE: We do have a fire pit. Since I've been there we've had one fire pit experience, Friday a fortnight ago, which was received very well. It was when it
35 was a little bit cooler here in Broome. It's something that I would hope that we could run on a fortnightly basis. We've had once before when I was there kangaroo tail but it was just cooked by the kitchen, by our chef. We have the breakfast club which mean that people come in from the community and sit outside on the verandah where they are served a cooked breakfast as their choice. But there's certainly a lot
40 of potential and exciting opportunities to develop this area in care.

MR BOLSTER: Good.

MS LE GRANGE: I have run, while I was there, a resident family meeting as well
45 as a survey to find out what people were thinking of the food, and there was some criticism, but I was very impressed with how our chef managed that and we've had quite a few compliments since then.

MR BOLSTER: Given the location of Broome's connection with the sea, do I take it the residents have expressed an interest in fish as a – as a meal?

5 MS LE GRANGE: Yes, but fish is very common in aged care every Friday, it's always fish wherever you are, whichever country you go to.

MR BOLSTER: What's the – what desire have they expressed in relation to the local fish that they're perhaps accustomed to?

10 MS LE GRANGE: That has not been specifically voiced in any of the feedbacks, yet.

MR BOLSTER: Right. Now, I wanted to ask you about your – the day centre that's attached to the residential. It's Bran Nue Dae, what is it?
15

MS LE GRANGE: So Bran Nue Dae is what we call our community services, so it could include people going to the community on a daily basis to provide all kinds of services at home. It also includes a Meals on Wheels service that comes from our kitchen. It includes people being collected early in the morning and going –
20 attending the breakfast club, so about five to six people do that on a daily basis and then about six to 11 people attend Bran Nue Dae on a daily basis. Bran Nue Dae is a day centre thing, so some people merge from the breakfast club into the day centre where they watch movies, sing songs, play games, go to church, do craft activities, play bingo. This is also a part where the community integrate with the care home
25 because they share bingo and church services, so people move between the different services but it's based in this day centre.

MR BOLSTER: From your observation, are there relationships between the residents and the people that come in during the day?
30

MS LE GRANGE: Certainly trying to develop it. I think historically it was a little bit more of a divide but we have integrated these activities and it's very well accepted that people from all the areas in care attend.

35 MR BOLSTER: And from where do you draw your residents? Do they come from Bidyadanga, do they come from up north?

MS LE GRANGE: So I've made a list of where we draw our residents from and we have 17 different cultural groups that our residents come from. 16 per cent call them
40 Broome people, then Bidyadanga is 14 per cent, Halls Creek, Beagle Bay, Wyndham, One Arm Point, I won't be able to say all of these names.

MR BOLSTER: No.

45 MS LE GRANGE: So it reduces to a one per cent, one person from Port Hedland, Kalgoorlie, Geraldton, Fitzroy, Billiluna, yes so there's a lot of places.

MR BOLSTER: Ms Robinson, your experience?

MS ROBINSON: Again, the same.

5 MR BOLSTER: The same.

MS ROBINSON: We've got residents from Wangkatjunga which is about 130 kilometres past Fitzroy Crossing. We've got residents from Fitzroy Crossing, Noonkanbah, Looma, One Arm Point, I've got one from One Arm Point. So quite
10 scattered as well as the local community.

MR BOLSTER: Language: how many of your residents struggle with English?

MS ROBINSON: There's quite a few that struggle, especially if they've got
15 cognitive decline, it's not unusual for any – anybody with English as their second language to go back to their original language. So - - -

MR BOLSTER: How do you deal with that from a clinical perspective?

20 MS ROBINSON: It can be challenging. We have, because we do have some Aboriginal staff, we can – we often use those to interpret for us if we need. We can get an interpreting service in, and we have a resident who's also very good at doing that for us, obviously depending on what it's in regard to.

25 MR BOLSTER: Ms Le Grange, is that - - -

MS LE GRANGE: So we have – I think our population is a little bit different because so many of them come from Broome, so we have 10 people out of the 25
30 Aboriginal people living there at the moment that have grown up and can speak another language, except for English, but of that 10 one – well, one person can't speak English at all and the other person has learned English as a second language. The other 10 have learned both English and indigenous language at the same time.

MR BOLSTER: All right. And what do you do to communicate with the person
35 who just doesn't speak English? How do you do that?

MS LE GRANGE: We have organised a translator for the specific gentleman because we had a gerontologist that came up to do assessments of many of our clients after the visit before last week by the aged care accreditation team. And so
40 we got a person in from the Aboriginal indigenous WA interpreting services, and in that case, the interpreter's opinion was that the person's dementia was so advanced that it didn't make much of a difference at this stage which language we used.

MR BOLSTER: Right. Who bears the cost of getting interpreters in if you need
45 them?

MS LE GRANGE: The facility does.

MR BOLSTER: I wanted to change topic. When you have a difficult resident, someone suffering from dementia, exhibiting behavioural symptoms associated with dementia, how do you deal with that?

5 MS ROBINSON: I think especially when they're challenging behaviours, it can be, perhaps if they're anxious and showing signs of aggression, then – and it goes for anybody, reassurance, support, being aware of your own safety as well as the safety of the resident, but regardless of what – what language you speak, if you hold somebody's hand and they can understand – anyone would understand that that's a
10 gesture of kindness and caring.

MR BOLSTER: Ms Le Grange, it's your expertise, isn't it?

MS LE GRANGE: Yes, that's my area, I can talk for too long about it.
15

MR BOLSTER: How do you deal with it, how have you had to deal with it in Broome from the Aboriginal perspective?

MS LE GRANGE: Well, understanding a cultural perspective is absolutely crucial.
20 So versing yourself around the person's back ground, where they come from, where they grew up and what the values would have been living with is absolutely important. There's a stage of dementia where those things does not matter so much anymore because the person responds purely to the way you communicate with your body, and language becomes irrelevant. It's really important to teach staff how to
25 approach a person, not to invoke a fight or flight because what we see as complex behaviour is purely a fight or flight reaction, of a misunderstanding of intention and over – over challenging the person in terms of the speed we use. So if we do that, and I agree with your comment, the appropriate physical contact, often once accepted, a hand grip would make holding the person's hand, can make a really big
30 difference.

MR BOLSTER: Commissioners, I note the time. Perhaps - - -

COMMISSIONER TRACEY: We will take a short break.
35

MR BOLSTER: Thank you.

COMMISSIONER TRACEY: Please adjourn the Commission.

40 **ADJOURNED** [3.23 pm]

RESUMED [3.30 pm]
45

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Ms Le Grange, we were talking about the responses to troublesome dementia behaviours, had you finished what you wanted to say there?

5 MS LE GRANGE: I wanted to say that if it relates to complex behaviour and dementia that there's a lot that we can do that could deescalate or prevent these incidences from occurring. It's a lack of understanding what is triggering it that could be causing complex behaviour.

10 MR BOLSTER: All right.

MS LE GRANGE: And it's cross-cultural, it's not specific.

15 MR BOLSTER: I'm just wondering whether in the case of Aboriginal people, who express themselves in that way, whether they get the opportunity to visit their country very often in your facilities. Ms Robinson, how often do you take them out to country?

20 MS ROBINSON: As often as we possibly can. We recently took them to Birdwood Station which a lot of them actually grew up on stations or worked on the stations so they went out there for a day trip. We organise bus trips. Some of them are just happy to stay on the bus, just to go out and see their country. So drive up to the jetty, drive back. We do morning teas down at the jetty. We're in the process of organising some fishing trips. That's slightly more complex but - - -

25 MR BOLSTER: What about getting back to their country?

30 MS LE GRANGE: I have one gentleman who hadn't been back on country for two years. Financially, he couldn't afford to go, so I liaised with the - he's also on dialysis which complicates, so I liaised with the renal dialysis unit and we organised for him to go back to Fitzroy and I took him myself and brought him back after his visit.

35 MR BOLSTER: Just on that dialysis point, how many of your residents are in Derby because they have to be on dialysis?

MS ROBINSON: I've got three dialysis residents.

MR BOLSTER: If they didn't need dialysis, would they be in the facility?

40 MS ROBINSON: They would probably need to be in a facility but perhaps, as I say, one of the residents is originally from Fitzroy Crossing and because they've only got small bed space there for dialysis, he needs to be in Derby.

45 MR BOLSTER: Ms Le Grange, getting your residents back to their country, is that possible? Is it done?

MS LE GRANGE: Again more just outings, there are weekly outings to Cable Beach or Town Beach or – we’ve recently had residents going on, we have occupational therapy students – final year students there, and they got the residents out to the beach but – and they go on weekly shopping trips but the people with
5 advanced dementia are basically, their country is going out in the garden and observing the bush.

MR BOLSTER: I wanted to ask you some questions about ACFI funding because I will be talking from Mr Preece about it from the Juniper perspective. Has there been
10 any consideration to a switch from ACFI funding to NATSIFlex funding for your facility?

MS LE GRANGE: I have. I can’t answer that.

15 MR BOLSTER: Are you familiar with the way ACFI funding operates?

MS LE GRANGE: I have a basic understanding of ACFI funding.

MR BOLSTER: So are you responsible for admissions at the facility?
20

MS LE GRANGE: Yes, we are.

MR BOLSTER: And does ACFI play a role in deciding who you admit as a resident at the facility.
25

MS LE GRANGE: Yes, it does.

MR BOLSTER: What role does it play?

30 MS LE GRANGE: Well, there’s a minimum income that we need to keep our facility viable and that minimum ACFI income might be too high for some of our people that would like to stay there.

MR BOLSTER: So what level of ACFI assessment is too low for your facility?
35

MS LE GRANGE: So a person that is under hundred – comes up under hundred dollars we usually – we don’t take in our facility. \$100 a day.

MR BOLSTER: All right. And what level of ACFI funding is that? What
40 characterisation? Or are you - - -

MS LE GRANGE: I would guess, I can’t say.

MR BOLSTER: \$100 a day.
45

MS LE GRANGE: Yes.

MR BOLSTER: Okay. All right. Are there many people that you have to turn away like that?

5 MS LE GRANGE: I have one specific client at the moment who is there for respite and that would like to stay as a permanent resident but we can't accept her because her ACFI turns out to be \$68 a day and there's no way that we can provide the care that is part of the care home at that – at that income.

10 MR BOLSTER: Is she from Broome?

MS LE GRANGE: She's from Broome.

15 MR BOLSTER: And if she can't get a place at Germanus Kent, where can she go for residential care.

MS LE GRANGE: The only thing she can access is at home care and that's not suitable for her at this stage.

20 MR BOLSTER: Ms Robinson, if someone like that knocks on your door?

MS ROBINSON: We will take them.

MR BOLSTER: You will take them.

25 MS ROBINSON: Our service is mission-based so Juniper provides quite a large subsidy to support all of the Kimberley facilities so that we can actually provide a service.

30 MR BOLSTER: All of your facilities as I think Mr Preece will tell us, all run at a loss.

MS ROBINSON: Yes.

35 MR BOLSTER: And they're all subsidised by facilities in Perth.

MS ROBINSON: That's correct.

40 MR BOLSTER: Ms Le Grange, is there any – any ability to be more accommodating on that from the Southern Cross facilities in – in Perth.

MS LE GRANGE: I can't make a comment on that. I don't make decisions like that.

45 MR BOLSTER: Who makes those decisions? I assume it's a policy that you are bound by, not a decision that you make yourself.

MS LE GRANGE: I'm following our organisational approach.

MR BOLSTER: And that approach comes from whom?

MS LE GRANGE: That comes – I – from finance department, from our management. It's – it's different in the city, but yes, so it's lower in the rural area.

5

MR BOLSTER: It's lower in the rural area than the city. So if this lady came to one of your Perth facilities would she get a place?

MS LE GRANGE: No.

10

MR BOLSTER: What's the minimum ACFI assessment or ACAT assessment that you need to look after someone?

MS LE GRANGE: I believe that some of our facilities also \$100 but it's around \$130 a day.

15

MR BOLSTER: All right. There's some statistics that we discussed earlier this week about the need for residential care on the part of Aboriginal and Torres Strait Islander people as arising when they're much younger in life than the rest of the population. Is that brought out in the cohorts that you care for?

20

MS ROBINSON: My youngest resident is 36.

MR BOLSTER: 36.

25

MS ROBINSON: Yes.

MR BOLSTER: Ms Le Grange?

MS LE GRANGE: I believe we have two residents that are in their 40s, because they are also there for dialysis.

30

MR BOLSTER: Do they have cognitive difficulties, each of them?

MS LE GRANGE: To some degree because of foetal alcohol syndrome.

35

MR BOLSTER: Ms Robinson?

MS ROBINSON: To some degree.

40

MR BOLSTER: Is the NDIS the preferred destination for those people or are you comfortable with them in residential aged care?

MS ROBINSON: It's not ideal, but there is nowhere else so the – the younger residents I have would not be able to live in the community. They need to be somewhere and there is nowhere.

45

MR BOLSTER: How many people do you have under 50?

MS ROBINSON: Probably – I know there's about 12 under 65 and probably six or seven – I've got a few that are around the 50, 52 mark.

5

MR BOLSTER: Yes.

MS ROBINSON: So there's probably about seven up to 52 years of age.

10 MR BOLSTER: And you, Ms Le Grange?

MS LE GRANGE: I have to deduct this from a request from the NDIS to put in information about six clients that would qualify for NDIS. So yes, I will assume there are six people that are a bit younger.

15

MR BOLSTER: And your organisations, how have they come to terms with dealing with people so young in what is notionally, or at least termed, aged care.

MS ROBINSON: As I said, it's the same in Fitzroy Crossing as well, we've got some young people there, but if there is nowhere else then they need to be cared for. Somebody has to do it. Ideally it would be great if there were group homes through NDIS funding that they could actually live as a group rather than have young people in an aged care facility so what we try to do is get them out as much as we can into the community so they're not spending all day every day in that environment.

25

MR BOLSTER: Are the people we've been talking about all Aboriginal?

MS ROBINSON: Yes.

30 MR BOLSTER: Do you have any non-Aboriginal people under 65 in any of your facilities?

MS ROBINSON: I've only got one non-Indigenous person and he's over 65.

35 MR BOLSTER: Over 65. Right. Commissioners, that's the end of my examination.

COMMISSIONER TRACEY: Thank you very much for coming and explaining to us exactly how things work up here in the Kimberley compared with other parts of the country. It's obviously a very unique system and one in which you have to take account of variables that you would never encounter in the city and we in evidence thus far have not heard about. So thank you very much for your insights and your assistance.

45 MS ROBINSON: Thank you.

MS LE GRANGE: Thank you.

<THE WITNESSES WITHDREW

[3.41 pm]

5 COMMISSIONER TRACEY: Thank you, Commissioners. The next witness is Dr Michael Steven Preece.

<MICHAEL STEVEN PREECE, SWORN

[3.42 pm]

10

<EXAMINATION BY MR BOLSTER

15 MR BOLSTER: If we could please bring up document number WIT.0256.0001.0001. You will see that on the screen in front of you, Dr Preece, there's a copy of your statement.

DR PREECE: That's mine.

20 MR BOLSTER: You have a copy of your - - -

DR PREECE: That is mine, thank you.

25 MR BOLSTER: Do you wish to make any amendments to that statement?

DR PREECE: No, I don't.

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

DR PREECE: They are.

MR BOLSTER: I tender Dr Preece's statement.

35 COMMISSIONER TRACEY: Yes, the witness statement of Dr Michael Steven Preece dated 13 June 2019 will be exhibit 4-12.

40 **EXHIBIT #4-12 WITNESS STATEMENT OF DR MICHAEL STEVEN PREECE DATED 13/06/2019 (WIT.0256.0001.0001)**

MR BOLSTER: Dr Preece, you are the CEO.

45 DR PREECE: Executive director.

MR BOLSTER: Executive director of operations.

DR PREECE: I'm sure Chris won't like to hear that, but yes, executive director of operations.

MR BOLSTER: Of Juniper.

5

DR PREECE: Correct.

MR BOLSTER: What is Juniper?

10 DR PREECE: Juniper is a part of the Uniting Church under the WA synod of the Uniting Church. We operate further from Wyndham to Albany, a vast area which is further than Perth to Melbourne. We have a total of 27 facilities in that space of aged care, residential aged care facilities numbering close to 1400 beds. We have home care packages, CHSP, day therapy and then close to 1000 independent living units
15 spread over a number of villages.

MR BOLSTER: What's the history of the Uniting Church in delivering aged care in remote - - -

20 DR PREECE: Remote. Our role started in 2014 when we took over a few of those facilities we have in the Kimberley from Frontier Services.

MR BOLSTER: You may have heard the evidence of the Queensland Uniting witnesses. They took over facilities in the Northern Territory from Frontier. What
25 was the problem with Frontier at that time that led all these services to be transferred back to the churches?

DR PREECE: My understanding was that the – the environment had become too difficult. It had become quite complex to operate aged care facilities, residential
30 particularly, and the Frontier Services really took the stance that they needed to step out of that role because of the complexity and needed to hand it over to someone such as Juniper who had the capacity, the governance, the management, the structure policies, procedures in order to take that role on.

35 MR BOLSTER: What was the Uniting Church's role in establishing those facilities before Frontier Services took over?

DR PREECE: That's not something that I'm aware of, sorry.

40 MR BOLSTER: So when you took over, are we talking about Gerdewoonem in Kununurra?

DR PREECE: Gerdewoonem is a brand new facility. It only opened in June 2018 but in Kununurra Juniper took on the home care and CHSP services.

45

MR BOLSTER: What's the population of Kununurra, roughly?

DR PREECE: 25,000.

MR BOLSTER: Was there an aged care – a residential aged care facility there?

5 DR PREECE: No.

MR BOLSTER: What was the nearest facility?

10 DR PREECE: Wyndham, a small facility in Wyndham, nine bed, which we operate as well.

MR BOLSTER: That's Marlgu Village.

15 DR PREECE: Marlgu Village and then the next closest to that would be Halls Creek which is operated by the People's Church.

MR BOLSTER: Guwardi Ngadu in Fitzroy Crossing; that's your NATSIFlex facility.

20 DR PREECE: That's correct, that's a 24 bed facility, yes.

MR BOLSTER: And then you have the Wyndham nine bed.

25 DR PREECE: It's a nine bed residential aged care facility as well as CHSP operating.

MR BOLSTER: Then two facilities in Derby.

30 DR PREECE: In Derby, correct.

MR BOLSTER: That Ms Robinson manages for you.

DR PREECE: Yes.

35 MR BOLSTER: They are ACFI.

DR PREECE: ACFI, yes.

40 MR BOLSTER: What's the – what's the difference from a practical perspective for your organisation - - -

DR PREECE: Yes.

45 MR BOLSTER: - - - of ACFI and NATSIFlex funding?

DR PREECE: I would like to say in the first instance that ACFI is – the ACFI process is complex even in the – in the city. And at least there we have the access to

specialties, specialty people that can assist us to assess the residents and be able to claim for the care that we provide. Even in that environment we struggle, but we do okay and we're able to have a small surplus at the end of each year. Up here, you cannot, you do not have the specialty that people, the trained staff to do those
5 assessments so their ACFI scores are very low. As a result of that, the revenue is very low.

The flipside to that is your NATSIFlex is block funded and you – you meet the need of any individual that walks through the door, whereas ACFI, there is a need to try
10 and get as much revenue as possible. So it's difficult up here particularly.

MR BOLSTER: But you don't turn people away.

DR PREECE: No, we do not.
15

MR BOLSTER: And is there – has that been a decision that has been taken at a board or an organisation-wide level?

DR PREECE: That decision is one that we live every day. That is part of our
20 mission, and the simple version of that mission is that we're there for people who need us.

MR BOLSTER: Has that decision been under pressure?

25 DR PREECE: Absolutely not at the slightest.

MR BOLSTER: All right. Now, you criticise NATSIFlex in terms of its – the narrowness of its scope. Am I right in thinking that.

30 DR PREECE: NATSIFlex – NATSIFlex by the virtue of that it exists is recognition that there's a problem. So my – my – if I have a critique of NATSIFlex, is that it is – it hasn't – it doesn't truly reflect the cost of care in this remoteness. So it, by virtue of its existence it says there's a need and we need to fund it differently, but it does not – it cannot truly – it does not truly reflect the cost of care, and if you reflect on
35 each of our – our facilities up here, they've all got different needs. You take it to Docker River that we heard yesterday and that is the extreme and those situations that were talked about this morning, extreme situations. So where NATSIFlex falls down is it does not reflect a cost of care.

40 MR BOLSTER: All right. What does it need to do, or – I withdraw that. How do you believe that the cost of care should be reflected in a funding instrument such as NATSIFlex?

45 DR PREECE: Well, you could still apply the region, so some kind of – it would be too difficult and I would imagine it would become cumbersome to go into a certain facility and assess it under any – some criteria. So you could still say that very, very remote areas, that need to bring staff in, that are cut off for months of the year, the

cost of food is – our cost of food is a third higher, in some places it's double – double, etcetera, etcetera. So you could categorise it, but what is actually needed is a study done to understand the true cost of employing somebody and retaining them. And then the cost of returning people to country. You can't put a person on a bus
5 and send them off to country for a week, you've got to send a staff with them. They're in a care facility for a reason so that comes at a cost and it's a must. It's a not negotiable.

MR BOLSTER: What do you – you heard the evidence from Docker River.
10

DR PREECE: Yes.

MR BOLSTER: That's it's \$380 per bed per day.

15 DR PREECE: Yes.

MR BOLSTER: What is it in Kununurra?

DR PREECE: In Kununurra, the Gerdewoonem facility today would be close to
20 probably \$305 a day.

MR BOLSTER: In Fitzroy Crossing?

DR PREECE: Fitzroy Crossing is – I'm trying to think, the cost of care is higher so
25 it would be about 320.

MR BOLSTER: In Marlgu?

DR PREECE: Marlgu is slightly less; and the staffing there is – it's only a nine bed
30 facility, the staffing is shorter so it would be probably closer to 280.

MR BOLSTER: And the Derby facility?

DR PREECE: Derby facilities would be very close to 300, because Derby is not too
35 bad because it's up the road from Broome so a bit closer to 300 a day.

MR BOLSTER: And - - -

DR PREECE: That's the real cost, that's everything put together.
40

MR BOLSTER: Everything put together. What's the – obviously staff is the biggest.

DR PREECE: Yes, it's interesting though, the staffing rate – the cost of staffing in
45 Fitzroy – sorry, in Derby, for instance, is 74 per cent of the cost is in staffing.

MR BOLSTER: Yes.

DR PREECE: But at Guwardi which is NATSIFlex-funded it's only 62 per cent, because of higher revenue.

MR BOLSTER: Is that because you have more Aboriginal staff there?

5

DR PREECE: No, it's got nothing to do with that; it's the level of revenue.

MR BOLSTER: Right.

10 DR PREECE: Yes, it's the revenue that you get.

MR BOLSTER: The evidence of Mr Aitken this morning is to the effect that the Aboriginal staff that he employs in remote locations are cheaper to employ than bringing up someone from Adelaide.

15

DR PREECE: Not only cheaper, they're better.

MR BOLSTER: And - - -

20 DR PREECE: Yes, and that is because they live in the area, you don't have to provide housing and – but in another sense, the cost of – the cost of those staff can be equal or higher because you're actually providing a lot of training, and a lot of support in order for them to be successful. You never want to take on an indigenous staff member and it fail.

25

MR BOLSTER: What is – what is your goal in terms of employing Aboriginal staff?

30 DR PREECE: We have – we're in the process of – we just – sorry, I will start again, if I may, Commissioners. We undertook a major review of the Kimberley services utilising the services of a consultant group, the Nous Group earlier this year. That has been completed and presented to the board and within that we now have developed strategies, major strategic plan and transition plan which includes 30 per cent minimum staffing of Aboriginal staff.

35

MR BOLSTER: And where are you at now?

DR PREECE: We – we would be lucky to say 10 per cent today.

40 MR BOLSTER: Yes.

DR PREECE: Yes.

45 MR BOLSTER: Have you identified what you need to do to make that number change?

DR PREECE: Certainly. The first thing to do, well, it's multi-factual, in fact. You can't just go out – you can't just think that you can go out and employ people off the street. You actually have to have a strategy for it to be successful. So the first part is a workforce strategy that we are currently working with and our executive leads that
5 process. From that, we – we respond to that, we're already setting up relationships with training groups which is the university here in Broome, the TAFEs, the East and West Kimberley TAFEs and developing pathways. So I want to reiterate that. You don't want to be going into this and fail. You want to give certainty to communities, certainty to young people that if they go into this, there's employment. There's
10 guaranteed employment. You – you don't want to be getting their hopes up and then nothing.

MR BOLSTER: The perspective of Mr Aitken, sorry to keep going back to that, because it seems to be a useful paradigm - - -
15

DR PREECE: It is.

MR BOLSTER: - - - in which to compare things. The community expressed a desire for local staff.
20

DR PREECE: Yes.

MR BOLSTER: I'm assuming the communities tell you that.

25 DR PREECE: They do. They do, yes.

MR BOLSTER: What do you tell them?

DR PREECE: To date, all we – all we've been able to do is explain to them it's
30 difficult to get local staff and, in fact, many of our elders in our facilities and their families understand that because they know that the – the young people don't want to necessarily work in aged care because it's not seen as – they're not having that conversation that it's an important part of persons giving back to the community as well as employment as well as doing well for their elders. So they actually
35 understand that it's difficult.

MR BOLSTER: What about formal engagement in cooperation with the local indigenous community.

40 DR PREECE: Yes, sure.

MR BOLSTER: How can you work that into your model of care and your business structure?

45 DR PREECE: One of the other, well, I would say the major aspect to our transition/action plan is that we have a strong desire and outcome to hand our facilities over to communities. Now, that will take five, 10, 15, 20 years but that is a

strong desire. So within that context, we have to have solid relationships, trusting relationships, long-term relationships, to make that happen.

5 MR BOLSTER: What about consultative committees with the locals? What about board - - -

DR PREECE: Yes.

10 MR BOLSTER: - - - participation - - -

DR PREECE: Yes.

MR BOLSTER: - - - inside your organisation?

15 DR PREECE: We're about to – we're in the process of employing a mission executive at the moment and that – that will be within their role. Mission in this context isn't religious but as in our role in – in the provision of care, plus we will – I've got the approval to employ Aboriginal liaison in Perth and in the Kimberley. So we're taking the step of embedding our self within those communities through
20 people of action rather than trying to control it.

MR BOLSTER: Where will that person be based?

25 DR PREECE: The – both Perth and up here and wherever they live up here.

MR BOLSTER: Yes. All right. Commissioners, that's my examination.

30 COMMISSIONER TRACEY: Dr Preece, thank you very much for your evidence. The way of catering for great need in this and other areas depends on organisations like yours being prepared to go the extra mile. And you obviously do that and not only that, but you've got a vision for the future which would take you a lot further. And we're very grateful to you for coming and telling us about it.

35 DR PREECE: Thank you.

COMMISSIONER TRACEY: Thank you very much.

DR PREECE: Thank you.

40 <THE WITNESS WITHDREW [3.58 pm]

45 COMMISSIONER TRACEY: Any other matters, Mr Bolster?

MR BOLSTER: That's all for today. Thank you, Commissioners.

COMMISSIONER TRACEY: 9.30.

MR BOLSTER: Thank you.

- 5 COMMISSIONER TRACEY: Yes, the Commission will adjourn till 9.30 tomorrow morning.

MATTER ADJOURNED at 3.58 pm UNTIL WEDNESDAY, 19 JUNE 2019

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