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TRANSCRIPT OF PROCEEDINGS

O/N H-985232

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

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

ADELAIDE

10.06 AM, TUESDAY, 19 FEBRUARY 2019

Continued from 18.2.19

DAY 6

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

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

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COMMISSIONER TRACEY: Please open the Commission. Yes, Dr McEvoy.

DR McEVOY: Commissioner, can I just raise one matter relating to exhibits from yesterday. I think the Commissioners may have in front of them an amended table of exhibits.

COMMISSIONER TRACEY: Yes.

DR McEVOY: You will see, Commissioner, that exhibit 1-31 which is the document Caring for Older Australia, Productivity Commission Inquiry report number 53 of 28 June, that was correctly allocated the number 31. However, when we went to the next exhibit, Caring for Older Australia, Productivity Commission Inquiry report 53 volume 1, that was also given the exhibit number 1-31 but, in fact, should have been given the exhibit number 1-32, as I understand it. Once that is corrected that will have the consequence that what was exhibit 1-32 will become 1.33, namely volume 2 of that report. What was 1-33 will become 1-34, namely, the Aged Care Financing Authority sixth report of July 2018. What was 1-34 will become 1-35, namely, the Legislated Review on Aged Care 2017. What was 1-35 becomes 1-36, the Resource Utilisation and Classification Study of 19 November 2018 and what was 1-36 becomes 1-37, namely, the Report on the Operation of the Aged Care Act 1997. Thereafter, Commissioners, the exhibit numbering is correct. So it's just those amendments that need to be - - -

COMMISSIONER TRACEY: Yes. So we've presently got 43 exhibits and the first one this morning will be 1-44.

DR McEVOY: I think that's right, Commissioner, yes.

COMMISSIONER TRACEY: Yes. Thank you.

DR McEVOY: If the Commissioner please.

MR BOLSTER: Commissioners, I call Ms Maree McCabe.

COMMISSIONER TRACEY: Yes. Thank you, Mr Bolster.

<MAREE McCABE, AFFIRMED [10.09 am]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Thank you, Ms McCabe. Could we bring up document number WIT.0005.0001.0001, please. Now, Ms McCabe, is that the statement that you have provided to the Commission?

MS McCABE: It is, Counsel.

MR BOLSTER: And do you wish to make any amendments to the statement?

5 MS McCABE: No, thank you.

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

10 MS McCABE: They are.

MR BOLSTER: So I tender, Commissioners, Ms McCabe's statement, document number WIT.0005.0001.0001 and the identified annexures.

15 COMMISSIONER TRACEY: I'm sorry, and the?

MR BOLSTER: And the identified annexures.

COMMISSIONER TRACEY: The witness statement of Maree McCabe dated 31
20 January 2019 and the exhibits thereto will be exhibit 1-44.

EXHIBIT #1-44 WITNESS STATEMENT OF MAREE MCCABE DATED 31/02/2019 AND THE EXHIBITS THERETO (WIT.0005.0001.0001)

25

MR BOLSTER: Thank you, Commissioners.

The organisation of which you are the CEO, Dementia Australia, what is its principal
30 function?

MS McCABE: The role of Dementia Australia is to advocate on behalf of people living with dementia, their families and carers. We also provide services, programs, education for people living with dementia, family carers and the health care
35 community.

MR BOLSTER: And one of the most important programs is your dementia help line; is that correct?

40 MS McCABE: Indeed, that's one of the services, yes.

MR BOLSTER: The number for that 1800 100500.

MS McCABE: Yes.

45

MR BOLSTER: And the chair of the organisation is Mr Graeme Samuel.

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MS McCABE: Correct.

MR BOLSTER: Previously it was Ita Buttrose.

5 MS McCABE: That's right.

MR BOLSTER: Is it fair to say that Dementia Australia is the leading consumer voice for people with dementia - - -

10 MS McCABE: Absolutely.

MR BOLSTER: - - - across Australia whether they're in aged care or not?

MS McCABE: Yes.

15

MR BOLSTER: Thank you. The name Dementia Australia, you were previously known as Alzheimer's Australia, and the change occurred a few years ago. What is the significance of the name change?

20 MS McCABE: The significance of the name change – in Australia there are 436,000 Australians living with dementia – and the significance of the name change was related to about 60 per cent will have Alzheimer's disease. There are about 100 different types of dementia and what we didn't realise was that the name Alzheimer's Australia was actually a barrier to access, and people with other forms of dementia
25 thought that we only supported people living with Alzheimer's disease, as did some health professionals, which wasn't the case. We actually are there to support people of all ages living with all forms of dementia.

MR BOLSTER: I just want to raise with you very briefly. There's a companion
30 organisation called Dementia Australia Research Foundation, of which you're on the board.

MS McCABE: Yes.

35 MR BOLSTER: And it funds dementia research across a number of fields; is that correct?

MS McCABE: Correct.

40 MR BOLSTER: Just for the benefit of the Commission, there are five basic research areas, dealing with the causes of dementia.

MS McCABE: Yes.

45 MR BOLSTER: Diagnosis, how to diagnose it.

MS McCABE: Yes.

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MR BOLSTER: Care research, treatments and cure, and finally, risk reduction. Now, we – time doesn't permit us to go through the status of the research, but I want to go back to Dementia Australia itself, and you mentioned the figure of 436,000 Australians with dementia.

MS McCABE: Yes.

MR BOLSTER: I just wanted to just probe that figure. Where does that figure come from?

MS McCABE: So that figure comes from the economic modelling and data that we had done and it is based on the DYNOPTA study, so the Dynamic Optimisation of Ageing study. And that's nine longitudinal studies of ageing across nine years.

MR BOLSTER: Who carries out that research?

MS McCABE: Professor Kaarin Anstey.

MR BOLSTER: Okay. That's really only an estimate, isn't it?

MS McCABE: It is an estimate and our concern is that it's actually an underestimate.

MR BOLSTER: Is there anywhere where you can go and find out definitively how many people have been diagnosed with dementia in all its forms in Australia?

MS McCABE: Unfortunately not, no.

MR BOLSTER: Would data about that issue assist government, research and organisations like yourself?

MS McCABE: Absolutely.

MR BOLSTER: And why is there no data along those lines?

MS McCABE: It's a very complex issue and part of the issue is around diagnosis so getting a diagnosis for something over the age of 65 can take up to 3.1 years. For somebody under the age of 65 in their 50s, their 40s and their 30s it can take seven years to get a diagnosis of younger onset dementia and often dementia is not diagnosed so there are – although 50 per cent of people in residential care have a diagnosis of dementia, many more have dementia and many more will develop it throughout the course of their stay in aged care.

MR BOLSTER: All right.

MS McCABE: And GPs often will tell us that they don't give patients a diagnosis of dementia because there's no effective treatment.

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MR BOLSTER: All right. We will come back to the diagnosis issue generally, but the health care online record that we all have a choice to sign up to - - -

MS McCABE: Yes.

5

MR BOLSTER: - - - will that assist in the identification of those who have dementia and those who don't?

MS McCABE: Not necessarily. So for people who have dementia they may not

10 actually identify as somebody living with dementia and that's also a significant issue.

MR BOLSTER: All right. And we will come to the issue of stigma shortly, but does stigma have anything to do with people identifying with dementia?

15 MS McCABE: Absolutely.

MR BOLSTER: All right. Thank you. Now, just before we move on to diagnosis, talking about residential aged care now, and the difference that needs to be taken into account between a resident with dementia and someone without dementia.

20

MS McCABE: Yes.

MR BOLSTER: Would you please explain just briefly what the differences are.

25 MS McCABE: Many people living – dementia is a disease of the brain and it's progressive, and there are about 100 different types, and depending on the type of dementia that the person has will depend on the symptoms that they display. So, for example, somebody with dementia with Lewy bodies might be having hallucinations; they may have the visual hallucinations and delusions. Whereas a resident – a

30 typical resident in residential care without dementia wouldn't be experiencing that. Many people living with dementia also have perceptual disturbances, so they may misinterpret what they see in the environment. And a good example would be carpet that's highly patterned, for example. So for you or I we would look at the carpet, we would see the pattern. For somebody with dementia what they might see is bugs

35 crawling all over the carpet and that explains a number of the challenges that people have regarding the environment.

And they may not be able to sufficiently understand; they may lose the capacity to understand requests that are made of them. If they've got Alzheimer's disease, the

40 characteristic feature there is memory loss and particularly short-term memory loss so somebody, you know, a staff member will come in, they will introduce themselves and they will care for that person for the day. The very next day the same staff member may come in and the person living with dementia won't recall who they are. And so they may misinterpret them. They may think that they're somebody else, a

45 family member. They may think they're somebody that they've been afraid of in the past. So their experience of the world is very different from the experience of somebody who doesn't have dementia. They also may have mobility issues, they

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may have compromised immunity and they will have lost the ability to do things that they could previously do. And that might be – particularly somebody from a culturally and linguistically diverse background who may have spoken very – spoken English very well but they revert to their language of origin and they can no longer
5 understand English.

MR BOLSTER: All right. Some people with dementia who are diagnosed early still have their strength, still have their mobility.

10 MS McCABE: Yes.

MR BOLSTER: What challenges does that involve for the provision of care?

MS McCABE: That can often create significant challenges. And if I can give you
15 an example of one instance where there was a 45-year-old woman, she was admitted to residential care. She had a diagnosis of frontotemporal dementia. She had previously been a midwife. She was also a very fit and active lady, had two children, a 12 year old and a 10 year old and she was – she was physically active and there were times of the day that she would get particularly agitated and would be
20 aggressive to other residents. She was in an area that was, you know, in an area – a dementia-specific area and she was aggressive to elderly residents who were frail, and that compromised their health and safety. It was a real concern for staff and it was a very difficult situation for the team to support her.

25 MR BOLSTER: Is there – is there a range of services for the person in that age group, say up to from, say, 45 to 55, who has dementia and who has those challenges, is there a range of services available for them in residential care?

MS McCABE: No, Counsel, there is not.

30

MR BOLSTER: All right. I want to turn to stigma.

MS McCABE: Sorry, may I just expand on that? So what ended up happening with this particular resident was she was moved to a psychogeriatric facility which was
35 the only area where her care could be managed. And that tends to be the referral process for people who are – where their dementia causes those sorts of responses.

MR BOLSTER: Someone with that sort of diagnosis, presumably otherwise their health is fine, they could live for a very long time.

40

MS McCABE: Absolutely.

MR BOLSTER: At the other end in the residential aged care facility where the average age of entry is in the early 80s, 81, 82, the prognosis is generally much
45 shorter.

MS McCABE: Yes.

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MR BOLSTER: Thank you. I want to turn to stigma. What is the stigma about dementia and Alzheimer's disease? How do you describe it? You come across it fairly regularly?

MS McCABE: Yes. So what our consumers and advocates share with us is that when they get a diagnosis of dementia that it is the most profoundly isolating diagnosis, and that people that would once be close friends or family are often very confronted by the diagnosis. They don't know what to do to support their loved one living with dementia. Family and friends fall away, that they're not included in social functions anymore, that when they go to see their doctor potentially with their carer or loved one, that the person – the doctor speaks to the carer, not to the person living with dementia. So there are some very clear examples of discrimination, and people often relate to people living with dementia like they have lost all capacity, which is absolutely not the case.

MR BOLSTER: Could we bring up, please, document DEH.0001.0001.16 on page 3, please. Do you recognise that document?

MS McCABE: Yes.

MR BOLSTER: Perhaps we could just go quickly back to page 1 just to make sure, Ms McCabe. So that's a report that you put out on dementia and the impact of stigma in 2017.

MS McCABE: Yes.

MR BOLSTER: I just want to take you to the results of the survey which appear on page 3 and there's a graph there at the foot of page 3. I think we're on the wrong document there. That should be 0017, page 3. It should be 0016, page 3. Sorry. See the graph at the foot of the page, perceived reasons for negative community attitudes?

MS McCABE: Yes.

MR BOLSTER: When I read there, I was taken by the figure, 60 per cent of people – this was in a nation-wide survey of 1500 people – weren't sure how to talk to someone with dementia. And 50 per cent didn't know much about dementia. How do – how do you talk to someone with dementia? How should you talk to someone?

MS McCABE: Well, the same as we would speak to each other and I think one of the things is it's about being respectful in our communication and taking into account that we may need to take more time. We may need to explain things more clearly, but engaging the person living with dementia is absolutely essential to their wellbeing, and it's also their right. And if we look at the Convention on the Rights of Persons with a Disability, people have the right to be engaged, to be informed and to seek consent for their treatment and their care.

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MR BOLSTER: All right. If we could then move on to 0017, please, and page 4 - - -

COMMISSIONER TRACEY: Are these both part of the same document?

5

MR BOLSTER: No, they're separate documents but they're in evidence.

On page 4, the heading Conclusions, at the foot of the page, the results of that survey show there was a lack of understanding of the disease, but only 50 per cent of the
10 public wanted to know more about how they could help. Why should people want to know how they can help?

MS McCABE: At the moment, there are 438 – 36,000 Australians living with dementia. By 2056 there will be 1.1 million Australians living with dementia. There
15 won't be anybody that is not impacted in some way, and the more that we educate people about dementia, the more we raise the profile about dementia, the better equipped the community will be to support people. This is the chronic condition of the 21st century and it's also a social issue, and one that we need to get very interested in because we will know somebody, it will be a loved one. One in three of
20 us in this room will develop dementia at some point and we need to know how to best support people living with it.

MR BOLSTER: What is the most important thing for the public to understand? Does it revolve around early diagnosis? Does it revolve around just knowing how to
25 talk to someone? What is it?

MS McCABE: Counsel, it's a few things. It's understanding that it is a disease of the brain and that it does – it's progressive in nature. Many people don't understand that dementia is the second leading cause of death in Australia and the leading cause
30 of death of women and there are many myths that surround dementia, one being that it's only a condition of old age. Now, it's more common as we age but one in 13 Australians living with dementia are in their 50s, their 40s and their 30s.

MR BOLSTER: I want to move on to the issue of diagnosis.

35

COMMISSIONER TRACEY: Do you want to tender those documents?

MR BOLSTER: They're in evidence already, Commissioner.

40 COMMISSIONER TRACEY: Are they?

MR BOLSTER: They are part of the identified annexures.

COMMISSIONER TRACEY: Yes.

45

MR BOLSTER: The diagnosis – and you've indicated what a traumatic position that might be for someone, how does that typically occur?

MS McCABE: It typically occurs, people will usually go to their GP and that will be the first point of contact. They will go – and it may be a family member that raises the issue where they've noticed changes in their loved one, and it may be changes in mood, changes in personality, changes in memory and behaviour or their ability to function. They will go to a GP and the challenge for GPs is that many of the presenting symptoms are also characteristic of other conditions. So if it's a change in the person's mood, perhaps they have become more apathetic, then it's quite valid for a GP to look first at the person being depressed. So it's not always that they will go to thinking about dementia as a diagnosis for the presenting symptoms.

MR BOLSTER: In your paper that has just been tendered, you refer to the dementia-specific tools and training that is available to GPs in Australia. Could you please elaborate on that? How adequate is it? What needs to change?

MS McCABE: Counsel, can I ask what number you're looking at, please?

MR BOLSTER: Let me just find it. You dealt with that at 21.1 on page 3.

MS McCABE: Thank you. So one of the challenges for GPs is that there's actually – GPs see many, many people and depending on the type of practice that they have they may only see a couple of people a month with dementia. So it's not front of mind necessarily. Their practice may be more geared to families and younger children. If it's geared to older people they're more likely to have a greater level of awareness about dementia and to be able to distinguish the presenting symptoms from other conditions that they may consider. But certainly I think that there needs to be a lot more training for general practitioners around how dementia presents, the ability to diagnose and then the referral and that's a real breakdown at the moment, is that there is often not a referral post-diagnosis to ensure the person gets the support they need.

MR BOLSTER: Okay. Are there places where people can be referred to get that support?

MS McCABE: Absolutely. And Dementia Australia is one of those places and we may refer to some of our own programs or we may actually refer out to other organisations depending on the goals of the person with dementia.

MR BOLSTER: All right. You mentioned earlier a reluctance to diagnose. Could you talk briefly about that?

MS McCABE: Many of the GPs that we've spoken with – and we've talked to a number of GPs about how we can better support them in supporting their patients living with dementia – and often they retort with that giving a diagnosis is not helpful for the person. There's no treatment where they can say, right – there's no cure for dementia at the moment, and they say that there's often no effective treatment for dementia. So it's better not to tell the person that they have dementia. And that

they've got – and often what they would say is, look, you've just got a few memory issues, it's normal as we get older and they normalise it when the person themselves often knows that there's something wrong and many people say it's actually a relief to get a diagnosis because they've been struggling with some of the challenges,
5 they've noticed changes and they don't know why.

MR BOLSTER: If there was a diagnosis in that situation, how much could the lot of that particular patient be improved?

10 MS McCABE: Significantly. And there is a lot that we can – like all conditions, the earlier the diagnosis the better the outcomes – and there is a lot that we can do to support people. There are lifestyle changes that we can support people with. There's a lot of research that exercise is great for reducing our risk of getting dementia but also delaying the exacerbation of symptoms. Making sure that people look after their
15 vascular health if they have dementia is really important. Their blood pressure, their cholesterol, encouraging them to stop smoking if they smoke. There is a lot that we can do. We can connect them with social networks and resources, provide education for them about the challenges that they experience to ensure that they then can take control of the illness and what's happening to them and are better equipped to deal
20 with those challenges and we provide strategies for that.

MR BOLSTER: Now, I want to take you to a document that Dementia Australia published in 2017. It's document DEH.0001.0001.0005. That is a submission that Dementia Australia made about the redesign of dementia consumer supports. That's
25 the topic we're on now, isn't it? How you assist the person entering the system after a diagnosis, and there were four key points. If we could go, please, to page 5, I just wanted to ask you to speak briefly to them. On page – yes, on page 5, and none of this will come as a great surprise from the discussion we've just had.

30 MS McCABE: Yes.

MR BOLSTER: But point 1 you see there information and awareness, and I think we've dealt with that. Was there anything you wanted to add to that point?

35 MS McCABE: The one thing that I do want to add is that even people living with dementia may have a limited understanding and they may also be concerned about the myths about dementia that all of a sudden they can't do anything, and often the information that's given to people at the point of diagnosis is go and get your affairs in order. Now, that's not conducive to supporting people to continue to engage in the
40 workforce, in the things that are meaningful and important to them and there are ways that we can support people to do that. So that's a really important part of the information that's given to people at the point of diagnosis.

MR BOLSTER: The second point there, again, we've touched upon that, timely
45 diagnosis but the last sentence there in that paragraph:

Linkages to primary health network, GPs and specialists.

Where does that fall down at the moment?

MS McCABE: There is a breakdown in ongoing referrals so often people will get a diagnosis and they're told get your affairs in order and there's no referral pathway.
5 If we had a diagnosis of another chronic condition, for example, whether it be diabetes or we get a diagnosis of cancer, there's actually a referral pathway. There's a team of people that is available to you. You're told, right, this is what we need to manage. We need to manage your blood sugar level. We need to do regular vascular health checks, we need to ensure that you are seeing a particular allied health
10 specialist on these occasions, but it doesn't happen with dementia and it's something that would make a significant difference for people if it did.

MR BOLSTER: The third point we haven't touched upon yet and that's diversity issues with dementia. What's your evidence to the Commission about what needs to
15 be done for people in minorities that are referred to there?

MS McCABE: Counsel, this is a very significant issue and, in fact, it often thwarts the experience of people moving into care where as a minority group they won't identify as part of that minority group. And for somebody living with dementia it's
20 actually more complex and if I can give an example of a gentleman. He was married for a number of years, had children, he later on left his marriage and then entered a same sex relationship. He was in that same sex relationship for 35 years. He then developed dementia. He was admitted into residential care. He forgot his same sex partner and could only remember his wife and children. And for his partner, who
25 had also been a significant part of his care over a number of years as his dementia developed, that was absolutely heartbreaking and for his wife, who had been out of their marriage for a number of years, it was heartbreaking for her too.

And so it's a significant issue. People need – we need to equip people to better able
30 to be dealing with this. And staff want to – they want to support people where they're from minority groups. They just don't know how and the system fails us in terms of doing that.

MR BOLSTER: Yes. Do people miss out from residential aged care because of this
35 issue?

MS McCABE: Often they do, yes.

MR BOLSTER: What happens to them?

40

MS McCABE: Well, they then are in situations that are – that compromise their safety in the home or the community and they're unfortunately neglected and they're isolated and we see, you know, we talk about the instances that we see but there's a whole issue around social isolation, neglect and the inability to receive the care and
45 services that people need.

MR BOLSTER: Is there a specific advocacy group for – group or groups?.

MS McCABE: Yes there are.

MR BOLSTER: For these minority groups?

5 MS McCABE: Yes.

MR BOLSTER: Right. Thank you. And I think the Commission will be looking at this issue later in the course of its hearings. Finally, point 4, I think we've dealt with; that's access to ongoing care and support. Was there anything else there that you
10 wanted to add?

MS McCABE: Counsel, I would actually like to emphasise the importance of supporting carers and many carers of people living with dementia, and if we look in the older age group, you may actually have two people with dementia in the
15 relationship so there may be a 93-year-old man caring for his 86-year-old wife, both of which have dementia, and that is not an ideal situation. And not only do they have dementia but many people living with dementia also have other complex health conditions. They may have diabetes, they may have heart disease, arthritis, you know, there are many conditions of ageing that are – that restrict people's mobility
20 and their capacity and ability to care for themselves, let alone to care for others. And supporting carers is absolutely essential to good care outcomes for the person living with dementia and also for their carer.

If therefore – if they have a younger carer it may be that that person has been –
25 they've needed to give up their employment to ensure the care of their loved one at home. There are financial constraints that are then imposed. It affects the person's career and their ability to go back to the workforce in the future. They also are subject to social isolation, to discrimination and to not getting the support that they need, such as respite, for example, and for them to have time to care for themselves.
30 The research shows that carers for people living with dementia, they have worse health and wellbeing outcomes than carers who care for people with other conditions.

MR BOLSTER: At paragraph 34.2, you deal with these issues and one of the points that you make is the need for respite care. Just for people that don't know what
35 respite care is, what is it?

MS McCABE: Respite can occur in a number of different ways so there may be a day program that people will go to. It may be overnight respite in a residential aged care home or it could be where the person gets respite, somebody comes into their
40 home and that's called a flexible respite option.

MR BOLSTER: So we're talking about someone who's perhaps on a home care package, a level 3 or level 4 you would think, not 1 or 2, and is there enough funding for respite care under those packages?

45

MS McCABE: I would need to look at the details around funding, Counsel, and I will do that. But the issue is really – it's about whether it's appropriate to the person's needs.

5 MR BOLSTER: Yes.

MS McCABE: And that is sometimes what is very challenging and for people living with dementia and particularly as their dementia advances it can be very difficult for them and cause quite a lot of distress to have people other than those
10 with whom they're very familiar caring for them.

MR BOLSTER: Abuse is a point that you raise in that paragraph as well. And you make the point that often the abuse from a loved one is because of their own frustration about their inability to care.
15
MS McCABE: Look, and that can certainly be the case and I think that the issue of abuse is a very complex one, and abuse is a social issue and – as well, and we don't know what goes on in a relationship, and it can be that the carer themselves are being abused by their loved one and that there are times when in frustration they, too, may
20 retaliate, and I think it's really important that we provide sufficient support for people so that it minimises the risk of that occurring.

MR BOLSTER: Well, what support are you talking about? What's needed there? Is it out there? Is it available for people?
25
MS McCABE: For carers, they really need the opportunity for counselling themselves to deal with their own grief about what's happening with their loved one. They need it to be able to provide strategies for how to best to support their loved one living with dementia and particularly if their loved one living with dementia has
30 challenging responses to their, you know, to their intervention. They're trying to care for them and to provide support and the person may be aggressive and that's very difficult for them in a relationship to understand that it's actually not personal, that this is part of the disease process and the person doesn't have a choice about the way that they're responding in that moment. So education, support, counselling and
35 respite, they need time out for them to care for themselves.

MR BOLSTER: Are you aware of whether providers under the level 3 and level 4 home care packages go that extra step to help the carer at home?

40 MS McCABE: I would have to check the package – the details of the package, Counsel.

MR BOLSTER: All right. Thank you. We're talking about someone who actually has a carer. Can we talk now about the unfortunate people who don't, people who
45 are alone in the world.

MS McCABE: Yes.

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MR BOLSTER: What is there for them?

MS McCABE: It is very difficult and it's so important to ensure that they have the support they need at home in terms of doing basic things, showering, you know, managing their environment, cleaning, doing the things, the activities that they can no longer do and unfortunately their care and wellbeing is often compromised because they have insufficient support.

MR BOLSTER: Well, that person, perhaps isolated, having few friends, where do they get picked up by the system?

MS McCABE: Well, unfortunately they may not. And there are many instances where people have fallen through the gap – through cracks in the system and they are left to fend for themselves.

MR BOLSTER: And what's out there? Is anyone doing anything about that person?

MS McCABE: Certainly the work that Dementia Australia does, we have a number of people who live alone and there are support services that we put in place. We refer and make sure that people are getting the home care support that they need and also the physical and the health care that they need as well. But if they're not part of the system and somebody doesn't flag that this is an issue they may very well not be supported.

MR BOLSTER: Yes. All right. I want to turn to the My Aged Care interface between the government and consumers and carers. You make some criticisms about that particular website and help line. What's the most problematic thing about My Aged Care from the perspective of Dementia Australia?

MS McCABE: Counsel, the consumers share with us the challenges that they have and web access can be difficult for older people and people living with dementia and sometimes the phone line, the wait times to speak to people can be too long, it can be confusing. The challenges that they also face is that it is – it's – staff unfortunately don't have a good grasp of what to do to support somebody with dementia, and there are numerous examples that people have given us and, unfortunately, My Aged Care requires to speak with the person living with dementia. So if you've got a parent or a loved one with dementia and you make the call to My Aged Care, My Aged Care will request to speak with the individual.

Now, it may be that their dementia is quite advanced and they're not able to provide the answers. They may say, look, there's nothing wrong with me, my daughter is trying to give me a hard time and put me into aged care. But in fact, the person has advanced dementia and they're a risk to themselves at home. So there have been instances where carers have rung seeking support and their loved one has – you know, their dementia is advanced and they are not safe to be left in the home on their

own and when that's explained to My Aged Care, unfortunately, they don't understand the complexities of dementia.

MR BOLSTER: All right. Is advice consistent?

5

MS McCABE: Unfortunately, it's not. So it may be quite inconsistent and depending on the level of awareness of the staff at the time it will depend on the quality of advice that people get, particularly in relation to dementia.

10 MR BOLSTER: There seem to be misconceptions amongst clients that when they go to one organisation through the My Aged Care website that they will get services from that particular organisation. Have you got any experience about that particular issue?

15 MS McCABE: There's often confusion and what – depending on, like, organisations' naming, for example, can be confusing for somebody living with dementia and they may think that they're – that organisation is well equipped to be able to provide services for people with dementia when, in fact, they're not and they don't realise that. So supporting people living with dementia particularly through the
20 My Aged Care process is essential to make sure that they get the services that are most appropriate to their needs.

MR BOLSTER: All right. Do you have examples of situations where the quality of the advice on My Aged Care has been problematic for someone with dementia?

25

MS McCABE: Absolute – I can give an example of a carer's husband is at very high risk of wandering. Now, if you and I were going out and about in the community we would be going for a walk but somebody living with dementia it's considering that they're wandering and the person is considered at high risk. He has
30 four hours of in-home respite per week on a level 2 package and awaiting a level 4. So his care needs are much greater than what he's currently being supported with. The carer rang My Aged Care to ask for the priority of a level 4 package and asked for him to be changed due to the high risk of his wandering and the fear that he would wander across a highway. My Aged Care stated they could not do this
35 because he was not at risk and he was no harm to himself or to others.

MR BOLSTER: Was that without an assessment?

MS McCABE: Pardon?

40

MR BOLSTER: Was that without an assessment?

MS McCABE: Yes.

45 MR BOLSTER: And – all right. We will talk about assessment, the assessment process itself. ACAT assessors, do they have, in the experience of Dementia

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Australia, an adequate understanding of dementia when it comes to their dealings with the people they have to make decisions about?

MS McCABE: Not always, no.

5

MR BOLSTER: What's the problem?

MS McCABE: One of the – often they're not well versed in dementia and the complexities that dementia can present and the risks that can be inherent in the safety

10 for somebody living with dementia. And I can certainly give an example in – a Tasmanian example where a woman received – she received – a person was taken on a carer role for their friend who had advanced dementia, he lives alone, requires assistance with almost all aspects of daily living. Tried to register her friend for a My Aged Care assessment and wasn't able to do that. The call centre said that the

15 person living with dementia won't be assessed as she didn't give consent. So there's an issue about actually getting an assessment and then there's an issue about the assessment process.

MR BOLSTER: All right. Let me ask you this: once you get an assessment, let's

20 look at the carer situation, the carer often will be quite elderly.

MS McCABE: Yes.

MR BOLSTER: A partner, under stress. How do they, when they're dealing with it

25 by themselves, assuming they don't have kids or they don't have someone to help them do this, how do they – how do they make mistakes when they are engaged with My Aged Care?

MS McCABE: What they often expect is that once they've registered, is that they

30 will be informed about, you know, that the services will start and one of the big breakdowns is that they actually don't and carers often don't understand the communication, the information that is delivered to them by My Aged Care. My Aged Care might send out a letter and we've had an instance where an elderly carer was unable to understand what the letter meant and what they were meant to do to

35 actually get the services started, and they went for months without those services.

MR BOLSTER: Are we talking about a situation here where there's an entitlement to the package?

40 MS McCABE: Yes.

MR BOLSTER: But it just – it's foreign to the carer to understand that they have to negotiate with a provider and work out a plan and come to an agreement about the level of care to be provided?

45

MS McCABE: Absolutely. And what happened was there was a significant delay in actually getting access to the services.

MR BOLSTER: Because – putting yourself in the position of the carer, they – when they need help they go to the doctor, the doctor tells them what to do.

MS McCABE: Yes.

MR BOLSTER: Gives them a prescription, whatever, but that's missing from the My Aged Care interface; is that right?

MS McCABE: Absolutely. Yes.

MR BOLSTER: All right. Ongoing communication, I think you've identified as a problem. How does this manifest?

MS McCABE: In relation to?

MR BOLSTER: Well, someone has been assessed, they have a package, how does it develop over time? What problems arise in communicating with their provider and back with My Aged Care itself?

MS McCABE: Look, there are issues, certainly our consumers have shared with us some of the challenges that they experience around financial transparency. They don't understand some of the fees and charges that are appearing on their bill. They don't understand why so much money is allocated in administration costs and not more money allocated to their care and to the services. They're not clear about as their condition progresses and their abilities become more challenged, that they can actually ask for another assessment and then get a higher level package. They will often be told, look, if you don't want this, you need to tell us because there's other people on the waiting list. And what they will often do is – and this is very typical of this generation, they will go, well, at least I've got a level 2 package, I'm getting some care so somebody else probably needs it more than I do and they will default the – you know, the opportunity for services to further support them so that somebody else gets that – that service.

MR BOLSTER: Is this a fair summary: that My Aged Care once it arranges contact with the provider, doesn't really follow-up to see - - -

MS McCABE: Well, my - - -

MR BOLSTER: - - - that the package is delivered and that it's operating as intended?

MS McCABE: I'm not sure, Counsel, that that's actually in the remit of My Aged Care. My understanding is My Aged Care is an assessment service.

MR BOLSTER: Right. Okay. Well, when that assessment comes up for review over time, as the patient deteriorates, how does My Aged Care deal with that process?

MS McCABE: I'm not sure. I'm not sure of the answer to that.

MR BOLSTER: All right. For example, when someone who has been on a level 2 or a level 3 is getting to the point where they need a level 4, where the carer's not coping and the person's going downhill.

MS McCABE: Yes.

MR BOLSTER: Does My Aged Care, how does My Aged Care assist in that situation?

MS McCABE: My understanding is that the process then starts again. So they've got to go back and they've got to be re-assessed for a higher level package.

MR BOLSTER: Does My Aged Care review patient assessment over time? Do they come back every six months, every 12 months, every 18 months to see how the package is going or is it really left to the service provider and the customer?

MS McCABE: I'm unsure of the answer to that, Counsel.

MR BOLSTER: Okay. All right. Was there anything else that you wanted to raise about My Aged Care?

MS McCABE: No, sir.

MR BOLSTER: I want to turn now, if I may, to the issue of current level of home care packages and how that plays out for people with dementia. How short is the program? How many packages do you think it needs to be effective?

MS McCABE: Currently there are about – there are definitely over 100,000 Australians on waiting care for a home care package.

MR BOLSTER: What levels are they at?

MS McCABE: They, well, I think they – the packages go from level 1 to 4 and the higher the level the more funding is required – the more funding is provided, and the greater the level of service.

MR BOLSTER: Is the need at the higher end or the lower end or across all levels?

MS McCABE: I think the need is certainly at the higher end and often what happens is when people are assessed they may be given a level 2 package, for example, so that they get some services, when, in fact, they actually need a level 4 package.

MR BOLSTER: Yes. All right. Well, what – how does that play out? Someone who actually needs 4, gets 2; how do they live with 2 when they really need 4?

MS McCABE: Well, their care is compromised, the support they get is inadequate and unfortunately it has a deleterious impact on their health and wellbeing and often what we see is premature entry into residential care and increased presentations to acute hospitals.

MR BOLSTER: Are you able to assist the Commission with figures as to the prevalence of that sort of situation?

MS McCABE: In – we don't have that data, Counsel, no.

MR BOLSTER: Is it a common thing that you get feedback about through your organisations that work under you?

MS McCABE: It is, yes.

MR BOLSTER: All right. And do you know where – do you know of any – I will withdraw that. I will withdraw that.

COMMISSIONER BRIGGS: While counsel is pausing, might I follow up your discussion earlier about the inability of a carer to speak to the My Aged Care phone person. Is there no facility in this arrangement for the person with dementia to say they give approval for their family to – to answer the questions for them?

MS McCABE: Commissioner, it's a real – it is a difficult issue and even when carers have had enduring power of attorney, it has been difficult for, you know, for My Aged Care to accept that, that, in fact, the carer can speak on behalf of the person living with dementia and I really think that they need to be supported with education around that area.

COMMISSIONER BRIGGS: Is it a privacy issue or is it just a rule within the system?

MS McCABE: I'm actually not sure. I don't know the answer to that.

COMMISSIONER BRIGGS: Even the banks can deal with this - - -

MS McCABE: That's right.

COMMISSIONER BRIGGS: - - - so let's hope the sector can.

MR BOLSTER: Thank you, Commissioner.

I wanted to turn to dementia-specific quality standards which is a point that you raise in your statement.

MS McCABE: Counsel, may I ask what point you're on.

MR BOLSTER: Dementia-specific quality standards, let's find that. That is at 28.7, please.

MS McCABE: Thank you.

5

MR BOLSTER: The quality framework that you refer to there seems to be a broad framework for everyone - - -

MS McCABE: Yes.

10

MR BOLSTER: - - - in the aged care sector. And your argument is that it does not deal with the particular issues that face the dementia resident/patient.

MS McCABE: Yes.

15

MR BOLSTER: I take it Dementia Australia has been advocating for a dementia-specific guideline for some time?

MS McCABE: Yes.

20

MR BOLSTER: And what is the reason that people tell you why you can't have such a guideline?

MS McCABE: Counsel, if we look at other areas, if we put our child in child care,
25 we expect that our child will be nurtured, they will be educated and their wellbeing will be taken care of and we will be informed if anything happens during that time. We expect if we go into the acute sector for an acute illness that we will come out better than we went in and that our needs and our – quality care will be provided. There will be a clinical pathway that if somebody goes in for a hip replacement, for
30 example, there is a very clear pathway of care that will be implemented to care for the person for the duration of their stay and, in fact, for, you know, for rehabilitation after they leave hospital.

When somebody goes into residential care, we should be able to expect exactly the
35 same thing. 50 per cent of people in residential care have a diagnosis of dementia, many more have it, are not diagnosed and many more will develop it. And that is the very least that people living with dementia should expect when they go into residential care. And we need to have quality care standards that are clearly articulated, that are regulated and monitored to ensure that quality care is delivered to
40 people living with dementia and to all people in residential care throughout their stay.

MR BOLSTER: All right. On that topic, I want to conclude with the issue of restraint. And I want to bring up, please, if I may a document. It is
45 DEH.0001.0001.0006. Do you have that document?

MS McCABE: I do.

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MR BOLSTER: That is a report that was prepared in 2014 on the issue of restraint and on psychotropic medication.

MS McCABE: Yes.

5

MR BOLSTER: And that was by a Professor Carmelle Peisah and Dr Skladzien.

MS McCABE: Yes.

10 MR BOLSTER: I hope I pronounced that correctly. What was the purpose of that report?

MS McCABE: So the purpose of the report was to look at the use of restraint and antipsychotic medication in people living with dementia and it was about looking at
15 – the recommendations that came out of it were around educating staff in some of the non-pharmacological methods rather than using antipsychotic medication as a first line intervention. Now, we know from the research that antipsychotic medication is not effective in 80 per cent of instances where it's used. It's only effective in 20 per cent of those cases. And we wanted to ensure that there were opportunities for staff
20 to be educated in other forms of intervention and support for people. It also recommended around the skills mix of staff, information around consumer rights and - - -

MR BOLSTER: Just pausing there.

25

MS McCABE: Yes.

MR BOLSTER: If we can just go to page 9, please. Bring up page 9. I want to go through what it did in some detail with you. I just want to ask you a bit about the
30 report first. Is this the sort of report that was actively published by Dementia Australia?

MS McCABE: Yes, sir, it was.

35 MR BOLSTER: Certainly not something you wanted to hide under a bushel, is it?

MS McCABE: Absolutely not.

MR BOLSTER: Did it go to government?

40

MS McCABE: I'm unsure. It was in 2014, Counsel. I don't actually know.

MR BOLSTER: Right. It has been on the website, I take it, and it has been there for everyone to see.

45

MS McCABE: Yes.

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MR BOLSTER: If we go, please, to page 9 and the key recommendations, and again this is only a summary of the report. Could I deal with the headline at the top of the page. You were calling on the government to develop a multifaceted strategy to reduce chemical and physical restraint as part of its action to build on the 2012
5 aged care reforms; correct?

MS McCABE: Yes.

MR BOLSTER: And let's look at the particular recommendations. So firstly, you
10 were calling for education of the aged care workforce on person-centred care. BPSD which is what?

MS McCABE: Behavioural and psychological symptoms of dementia.

15 MR BOLSTER: And non-pharmacological interventions as well as information on when and how to access specialists, such as - - -

MS McCABE: Yes, the Dementia Behaviour Management Advisory Service.

20 MR BOLSTER: Yes. You called for a review of staffing arrangements within aged care facilities to ensure that they were caring for people with BPSD and that they had sufficient staff and an appropriate skills mix to provide the level of care required. You were calling for information to be provided for consumers about their legal rights on this very issue in 2014. Support to assist physicians and facilities to ensure
25 that they were following clinical guidelines and using an evidence-based approach to prescribing psychotropic medications and which should be used as a last resort. Well, it would appear that the headlines of 2018 and early 2019 should have come as no surprise to anyone who had been following this report and the work of Dementia Australia.
30
MS McCABE: Correct. Yes.

MR BOLSTER: And I take it that this is – remains the position of Dementia Australia.
35
MS McCABE: It is, Counsel, yes.

MR BOLSTER: Has there any – has any further work been done by Dementia Australia on this – on this issue, that the Commission ought to be aware of?
40
MS McCABE: Look, I think this report accurately reflects the position of Dementia Australia.

MR BOLSTER: Yes. All right. Finally, just to cap it off, in your report – in your
45 statement at paragraph 47, you list a course of action that involves a number of dot points, and I think – I think we've been through each of them. If there's anything

that we've missed, would you like to highlight it? I think we've dealt with aged care data. We need that.

MS McCABE: Correct.

5

MR BOLSTER: You dealt with the issue of restraint. Funding to build capacity.

MS McCABE: There is actually one – in terms of building capacity around education and training, there is actually something I would like to highlight to the
10 Commission. It is about the type of education that we provide people with and of the 240,000 aged care workers in Australia, 70 per cent work as personal care workers, and their certificate III does not provide any education around dementia, not as mandatory or even optional training. And one of the key things about education is it is about developing empathy. And when I say "empathy" I don't mean that people
15 don't care. People do care. It's about the ability to stand in the world of somebody living with dementia and experiencing it through their eyes, and at Dementia Australia we develop the educational dementia immersive experience where we can simulate for people the experience of what it's like to have dementia.

20 And our theory was that if we could actually simulate that, it would change people's attitude, it would change their behaviour and it would then change the practice and care that was implemented for people living with dementia and we're seeing some significant changes in the way that people operate. And I think it's really important that we look at this as a cultural element to the change that's required around
25 mandatory training.

MR BOLSTER: Thank you. The fifth dot point calls for an exploration of what quality dementia care looks like. Does Dementia Australia have a view on what it looks like?

30

MS McCABE: There's – look, there has certainly been work that has been done and we need to get together – together with government. We're actually working with consumers at the moment and we need to be able to define this as a joint initiative to ensure that we get this right.

35

MR BOLSTER: Is there any research that the foundation is carrying out on this particular topic that the Commission ought to be aware of?

MS McCABE: Look, I can take that on notice - - -

40

MR BOLSTER: If you would.

MS McCABE: - - - and come back to you, yes.

45 MR BOLSTER: Thank you. I think we've dealt with referral pathways, early intervention. The third last dot point is about research translation and the time it takes for research to be embedded into practice. What are you talking about there?

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MS McCABE: It's actually I think one of the greatest barriers to change. We have terabytes of research that shows that there are better ways for us to do things and, in fact, antipsychotic use – the use of antipsychotic medication is a very good example. But where we are not well versed is actually getting those changes into practice and
5 if it were a simple thing to do, the industry would have done it. It's obviously far more complex than we imagine and it's something that I think needs to be facilitated to ensure that we are agile in making sure that what we deliver is evidence-based practice and good care.

10 MR BOLSTER: The last dot point on page 13 is about workforce – a workforce strategy, and I think – I think we've dealt with that. Is there anything more, though, that you wanted to say about - - -

MS McCABE: The only other thing that I would like to say about workforce,
15 Counsellor, is that we currently have a system where if aged care workers have been involved in poor quality care, there is no way of ensuring that they don't work elsewhere. And with the nurse – you know, with AHPRA, for example, if it's a registered nurse then it's noted on the nurse's registration and that's then transparent to the industry to see, that there may be restrictions on practice or that their
20 registration has been removed. We don't have that safeguard in the area of personal care workers, for example.

MR BOLSTER: Thank you. And finally, I think the last dot point in paragraph 47, community understanding and awareness and I think we've dealt with that in some
25 detail. And those are my questions. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you very much, Ms McCabe. I think we will be consulting you further in the course of at least one round table in the not too distant future. So we're very grateful for your insights into this very difficult area
30 and we will be striving to find some solutions that improve the current lot of those suffering from dementia.

MS McCABE: Thank you very much, Commissioner, and I would just like to thank you for the opportunity to participate. It really is a once in a generation opportunity
35 to make a profound difference to the care, not only of people living with dementia in aged care but for all people who access aged care. Thank you very much.

<THE WITNESS WITHDREW [11.11 am]

40

COMMISSIONER TRACEY: The Commission will adjourn until 11.30.

45 **ADJOURNED [11.11 am]**

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RESUMED **[11.32 am]**

DR McEVOY: Commissioners, I call Patricia Lee Sparrow.

5

<PATRICIA LEE SPARROW, SWORN **[11.33 am]**

10 **<EXAMINATION-IN-CHIEF BY DR McEVOY**

DR McEVOY: Operator, could you please bring up WIT.0014.0010.0001. Now, Ms Sparrow, is this your statement? Do you recognise this statement as one that you
15 prepared for the Royal Commission?

MS SPARROW: Yes, I do.

DR McEVOY: I think that's an amended statement dated 7 February; is that right?
20
MS SPARROW: Yes, that's right.

DR McEVOY: Do you wish to make any further amendments?

25 MS SPARROW: No, I do not.

DR McEVOY: Are the contents of that statement true and correct to the best of your knowledge and belief?

30 MS SPARROW: Yes, they are.

DR McEVOY: Commissioners, I would tender the statement bearing the document number that I've just read out.

35 COMMISSIONER TRACEY: What is the date of the statement?

DR McEVOY: It's 7 February 2019, Commissioner.

COMMISSIONER TRACEY: Yes. The witness statement of Patricia Lee Sparrow
40 dated 7 February 2019 will be exhibit 1-45.

EXHIBIT #1-45 WITNESS STATEMENT OF PATRICIA LEE SPARROW DATED 07/02/2019 (WIT.0014.0010.0001)

45

DR McEVOY: Ms Sparrow, could you just give the Commission your full name?

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MS SPARROW: Patricia Lee Sparrow.

DR McEVOY: And you're the chief executive officer of the Aged & Community Services Australia, also known as ACSA?

5

MS SPARROW: I am.

DR McEVOY: And how long have you been in that role?

10 MS SPARROW: I started in the role on 1 August 2016 so just a little over two years.

DR McEVOY: What were you involved in doing prior to taking up that role?

15 MS SPARROW: I have worked in various roles in aged care over a long period of time, both in state government running aged care funding programs. I've worked with Council of the Ageing representing consumers and also as an adviser to the Australian Government.

20 DR McEVOY: So what's the purpose of ACSA?

MS SPARROW: ACSA is a member organisation. We represent not for profit aged care providers and we do a number of things in that role. We do advocate collectively on behalf of not for profit aged care providers. We also deliver services
25 and support to them to help them deliver quality care services, events and education. We also have a help line for them, some ER or employee relations-type services as well as consultancy and a workforce and industry development unit.

DR McEVOY: Can you say something about the membership of ACSA?

30

MS SPARROW: Our membership is not for profit church and charitable aged care providers.

DR McEVOY: You mentioned in answer - - -

35

MS SPARROW: Sorry, I should say they also deliver residential aged care home care but also independent housing for older Australians as well.

DR McEVOY: I think you mentioned in reference to one of my earlier questions,
40 one or two of the things that you do with your members. Do you want to just enlarge a little bit on, really, the nature of your activities with your membership?

MS SPARROW: Sure. With the members we provide a lot of information to them, and we provide services and support. So as I said, we have a help line that they can
45 ring if they have a query about funding, perhaps, or regulation or something that's happening that they want to have a better understanding about, they can ring our help line, a member help line. We also provide an ER service to help organisations make

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sure that they manage their HR and ER services appropriately. We have a consultancy service which is often employed by our members if they need assistance in terms of complying with regulatory requirements and we also recently created our workforce and industry development unit because we recognise how important it's
5 going to be to actually build the right fit workforce for aged care into the future.

DR McEVOY: So I think prior to your present role you said that you had worked for the Australian Government in various roles in aged care.

10 MS SPARROW: Yes.

DR McEVOY: Can you say something about the extent to which your perspective has changed since you've moved from the government side of things, as it were, to the provider side?

15

MS SPARROW: My perspective has actually been informed by all of the roles that I've had. I think you can see from my career that I'm actually very committed to services for older Australians and to making sure that services are the best they can be. I've been really fortunate to work in a number of different capacities and one of
20 the things that that has done is given me a perspective, a quite a broad perspective and to be able to see things from different – different perspectives including government but also obviously from consumers and one of the important things that I – I did in my career, too, was to work with the National Aged Care Alliance and one of the important things around that is that has representatives of consumers, of the
25 unions, of the health professionals and of providers. And I think it's important that those of us who work in aged care understand and communicate and connect with each other so that we can work together to deliver a better quality of care.

DR McEVOY: Well, just in relation to quality of care, if you have a look at
30 paragraph 20 of your statement. Operator, you might bring that up. You say there that there's a fundamental expectation that the services provided keep people safe and are of high quality as prescribed by the aged care standards and monitored by the Aged Care Quality and Safety Commission. What does "quality" mean to you when you use that word in that paragraph of your statement?

35

MS SPARROW: I think there are the two – the two areas that you have talked about in – the questions that you asked in our witness statement around quality and safety and, really, what we're saying there is we do believe that people should expect and we expect – I expect as an individual that people will be safe and that various things
40 happen in an aged care facility to ensure that. Quality can mean different things to different people and so we do think there is also the need to look at what does quality mean to an individual person.

DR McEVOY: Well, so that's quality, and you say that it's important to look at
45 what it means to an individual person. What does it mean to you, perhaps viewed through the lens of ACSA?

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MS SPARROW: Quality does mean that as an individual that the needs that I have are acknowledged, understood and met by – met by the provider.

DR McEVOY: And safety?

5

MS SPARROW: And safety means that there are things that you assume are going to happen that will keep me safe.

DR McEVOY: Well, on the subject of quality and safety, in the next paragraph,
10 paragraph 21 of your statement, you say that you believe the majority of care provided by approved providers is of a good standard. Can I ask you what it is that makes you say that? Is that the result of particular surveys that you've conducted or where does that observation come from?

15 MS SPARROW: It comes from an extensive – extensive working in aged care, much visiting to aged care. Clearly I've seen the ways service are delivered, some personal experience of aged care as well.

DR McEVOY: But you, I think, also acknowledge in that paragraph - - -

20

MS SPARROW: Yes.

DR McEVOY: - - - that there have been shortcomings, there have been - - -

25 MS SPARROW: There has been and we do acknowledge – and it's unfortunate when that happens and we do feel for – extend our sympathies to families and to older Australians who have had a poor experience, but it is a uniquely human service and sometimes things can and do go wrong. What we try and do as aged care providers and as a peak body of aged care providers is to take an approach of
30 continuous improvement and improve things wherever we can to ensure that services are of the best quality.

DR McEVOY: Well, in that paragraph 21 you mention in particular shortcomings in the policy or legislative scheme and, of course, the delivery of services as being
35 responsible for some of these failures. I just want to unpack that a little bit with you. What are the main things you have in mind when you make that reference in that paragraph?

MS SPARROW: To the policy and legislative schemes?

40

DR McEVOY: Yes.

MS SPARROW: So I think, you know, we've probably acknowledged around some of the issues that have happened where there's a failure of care which we regret and
45 try and address. In policy and legislative I suppose I'm thinking about things like – and ACSA would look at things like in home care where there are 126,000 older people waiting or in residential care where there may be things that families or a

resident may want that can't be provided as a result of those constructs that sit around our service delivery.

DR McEVOY: So they're effectively funding constraints that you're referring to, and we certainly have heard a good deal of evidence and no doubt we will hear more about those, but are you identifying or do you seek to identify in that paragraph other shortcomings in the legislative scheme or in policy more generally in this area?

MS SPARROW: Yes, I think that what we – what we've noticed over time is there is a changing nature in the residential aged care population. When I first started working in aged care it would be true to say that people who came into residential aged care were very much more independent, drove – the carports, people would drive in and out. That is not the case now. People come in at an older age. They often come in now with much more complex health care and we heard from Dementia Australia earlier about the number of those people who have dementia. We think that with some of the those changes, perhaps to your point about the funding, that the funding hasn't kept pace and doesn't reflect the changed nature of residential aged care and one area that clearly has been discussed quite significantly of late is the access with and interface with primary health care.

DR McEVOY: So there's a couple of policy areas.

MS SPARROW: Yes.

DR McEVOY: What about the legislation?

MS SPARROW: The legislation sets how services can be delivered.

DR McEVOY: Sure.

MS SPARROW: There are separate legislative approaches to primary health care and to aged care and also around a theme that is in our submission, around dignity of risk which I'm sure we will talk about at some point, too.

DR McEVOY: Yes. But I understood you to be saying in paragraph 21 that you apprehended that there might be shortcomings in the legislative scheme, and so I suppose what I'm inviting you to do, to the extent you think there are, is to outline, perhaps in broad compass, what they might be.

MS SPARROW: I think in what I've touched on is around the legislation and regulation is around dignity of risk for older people, which I'm happy to expand on more when we come to talk about that element. But there are also issues, as I've said, around the different constructs for primary health care which perhaps impact on people's access to important GP and medical services when they're in residential aged care.

DR McEVOY: Turning then to the statement there in paragraph 21 that:

Approved providers are committed to continuous improvement in the delivery of service, particularly in relation to quality and services.

Can you perhaps provide some examples of areas that have been identified as
5 requiring improvement and the steps that your providers are taking to effect those improvements?

MS SPARROW: I can't give you specific or real instances rather that it is an approach, and that we support providers through our general work and through
10 consultancy services where there has been perhaps a shortcoming that needs to be addressed. And we also, in terms of our policy and advocacy look at those areas and what needs to change to support aged care providers to deliver quality of care.

DR McEVOY: Well, take, for example, the quality standards, do you consider that
15 – that they encourage continuous improvement?

MS SPARROW: Yes. I do consider that.

DR McEVOY: Now, of course, there have been significant recent reforms with the
20 establishment of the Aged Care Quality and Safety Commission. ACSA, I think – and this is something you deal with later in your statement – ACSA was supportive of the creation of the commission.

MS SPARROW: Yes.

25

DR McEVOY: But it did, you say, have some concerns about how clinical care could best be supported and how effective serious incident reporting could best be achieved. I wonder if you might explain what concerns you had in mind in that respect?

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MS SPARROW: Sure. With respect to clinical care we think clinical care obviously is absolutely critical in aged care. One of the debates or the considerations that we have is should aged care continue to be regulated completely separately from any other system. So one of our discussions for ACSA was there is already a clinical
35 care and a chief medical officer for health services with the Commonwealth; would it not be better that those same standards and that was delivered across aged care rather than creating a separate aged care regulation. That is a theme when you look at aged care that we often create completely separate regulation, rather than looking at regulation that already exists.

40

So on clinical care we need to look at both nursing in residential aged care but also, as we will talk about and I know there has already been discussion around the role of GPs in aged care, the role of visiting specialists coming to aged care, they all need to be regulated. And I guess our question was, was that best done through the system
45 that already exists in health or did we need to create something different. So, as I said, we're supportive of it, obviously want the best clinical care but it's a question of do we continue to silo things and put aged care somewhere over here separate or

do we actually run it through the same standards and systems that exist in the health system. That was clinical care.

The other one you mentioned was the serious incident reporting scheme. Again it's
5 really important that incidents are reported. Our concern though is to make sure that the regulation supports and protects older people and there is – there was a question in our mind about whether some of the reporting that was proposed would actually do anything to improve the service or the support for the individual or just replace – just create an additional reporting burden to an organisation that may not then come
10 in and do anything that supports the resident.

DR McEVOY: Well, just going back to what you said a minute or two ago in relation to the new commission, I think you used the word siloing the problems of aged care. Do you take the view, do you, does ACSA have the view that that is
15 perhaps what has happened with the establishment of this commission?

MS SPARROW: Not so much with the commission because there are specific things that are aged care specific that need to be looked at but in the instance of clinical care where we're talking about health services across the board, not just what
20 the nurses in aged care do, we thought that that was potential that we could not have that as a separate aged care but across and be embracing of all of the health specialists who go into and interact with the resident in residential aged care.

DR McEVOY: So how would you envisage your slightly alternative model, if you
25 like, working in contrast to what we've had now from 1 January this year?

MS SPARROW: Well, I think the – that it would – I think the main difference that we're highlighting is that it wouldn't work that differently in terms of how it works on the ground, but the important principle is that it would be fitting overall with
30 health services that all older Australians – all Australians are receiving and that older Australians have the right to receive in residential aged care. So it puts it in its place with health and clinical services that any of the population would be having, albeit in this instance delivered in residential aged care.

35 DR McEVOY: Let me just take you back to the issue of the new quality standards which, of course, take effect from 1 July this year. What do you think is required in relation to outcome measures to assess whether the standards are being met?

MS SPARROW: I'm not sure exactly what you're asking me there.

40

DR McEVOY: Well, the standards make – they have a series of principles, if you like.

MS SPARROW: Yes, they do.

45

DR McEVOY: By which providers – which providers are required to observe. But, of course, inevitably there needs to be some assessment made of whether providers

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are, in fact, observing the standards. And so, really, what I'm asking you to focus your attention on is what sort of outcome measures might be contemplated by the commission in particular to ensure that the standards are being adhered to?

MS SPARROW: And I think the assessors will go in and look at the services that are being delivered. They will take into account the safety considerations and they will, importantly, talk to the residents and the families themselves about the quality of care that's being delivered.

DR McEVOY: And you regard that as being the appropriate measure – the appropriate way to measure - - -

MS SPARROW: The new standards that are coming in on 1 July; I think the answer I've given sort of outlines in general terms. I think we will all learn more about those standards and how they can best be measured but in broad terms, yes.

DR McEVOY: I think you said earlier in response to one of my questions that ACSA supported the standards, that you support the standards. Do you have any concerns that the standards are imprecise?

MS SPARROW: We support the standards because what these new standards actually do is focuses much more on the individual and what the residents themselves are seeking. So that's an improvement, we think, because we think that's actually the focus of service delivery is what an individual needs and what they want to get out of this service. We think that the issue is around the consistency of how that is assessed across providers. We think that regulation and standards should be very outcome focused so it does make it hard to be very precise because it is going to be a little bit based on what the individual is actually looking for. The important thing will be that the commission's assessors are actually consistent in the way that they address that.

DR McEVOY: So you – your position is you don't regard them as imprecise?

MS SPARROW: I – ACSA regards them as broad statements that are focused on what individual residents need and want and we think that's an important shift.

DR McEVOY: Can I change the subject a little bit and, still on quality though but moving away from the standards, and talk to you about the use of CCTV cameras. The Commission has already heard evidence in this round of hearings about the perceived desirability of having cameras in individual – in public areas, communal areas of residential facilities but also in certain circumstances, and obviously when the resident consents, to having them in individual rooms. What's ACSAs view in relation to that? Is that the sort of measure for the protection of residents and staff that ACSA would support?

MS SPARROW: I think the key thing that you identified there is that it is around consent of the individual whose room it is. There's a patchwork of legislation and

requirements that are State-based which means it's not necessarily a simple thing to do. So for me the key thing in that question is that it is actually about consent and as we know there are CCTV in many of the public areas in aged care already. I think that it's an important principle that the individual in that room and their family,
5 particularly if the person has cognitive issues that it is supported to make that decision and providers often do actually now – not uncommon for a family to come and say to a provider that they want to put a CCTV into a room and the provider will often facilitate that. But the key thing has to always be the consent of the individual.

10 DR McEVOY: When you say a provider will often facilitate that, is that routinely the case in your experience?

MS SPARROW: I don't know that it's routinely the case but we have had instances where that has been the case where the family has said they are concerned and the
15 provider and sought the appropriate consent and put CCTV into the room. As I keep saying, the key principle in this is the consent of the individual.

DR McEVOY: And also, presumably, the preparedness of the provider to incur that expense?
20

MS SPARROW: In those instances, yes.

DR McEVOY: And is that a particular issue here, do you think?

25 MS SPARROW: The expense?

DR McEVOY: Yes.

MS SPARROW: I think, you know, you will see that providers are under financial
30 stresses and strains but I think that most providers would be more concerned with ensuring, if consent has been obtained, with ensuring that that was – that was complied with.

DR McEVOY: Do you have particular experience of this as an issue with your
35 providers or are you speaking at a level of generality here?

MS SPARROW: Well, I guess I'm doing both. I've had some specific instances where the members have talked about the issue and the difficulty and making sure there is informed consent around that and it's a provider member that I'm talking
40 about that actually worked with a family and agreed to put that in but also, obviously, speaking at a general level.

DR McEVOY: Can I move to the issue of home care which is clearly a significant one in the work of the Commission, and also you've dealt with it extensively in your
45 statement. You've mentioned – I think this is at paragraph 24 which we might bring up – that recent changes in home care packages mean that funds go directly to the consumer rather than to the provider. I want to ask you a couple of questions about

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that. In the first place, do you think that the allocation of home care packages to individuals rather than providers results in a better outcome for the individuals who are the recipients of the service?

5 MS SPARROW: Yes, we do – I do think that in terms of what happened in the past, was that the packages were allocated to providers and if a consumer or an individual needed a package and was assessed as being eligible they had to go through trying to find a provider that had a package at the level they needed. This actually allocates it to the consumer and to that extent gives them greater ability to take their package to 10 a provider of their choice.

DR McEVOY: And in a practical sense, how does that work for consumers?

MS SPARROW: And I think we've talked a little bit about some of the difficulties 15 with that. So in principle, the consumer has the package and can take it and for those where it works well through My Aged Care they identify a service and they can take their package to that service provider. We do know and heard this morning around some of the challenges with My Aged Care and we think that there does need to be more support for individuals to navigate the system and find the support that they 20 need that is going to best meet their needs.

DR McEVOY: More support in what dimension?

MS SPARROW: Really at the moment they would get information through My 25 Aged Care. They would get letters, which as Dementia Australia said this morning, sometimes they don't understand what the letter is telling them to do. The government is about to trial a navigation service that actually gives people support, someone that they can talk to so that they can understand what's in the letter and clearly the letters should be written in plain English but perhaps aren't currently, but 30 nevertheless it's support for those individuals to then find the services that they need that's not just on a website or on a phone call. And we think that's an important principle and would actually advocate. It's good that there's going to be a trial but we think from the experience and from everything that we know around the system, it should just be being progressively rolled out around the country rather than being a 35 trial.

DR McEVOY: Does ACSA play a part in assisting in this sort of endeavour?

MS SPARROW: So ACSAs role would be to advocate for making the system better 40 for older people. Individual ACSA members often will step into the breach when there isn't support for a person to explain the letter or to help them to find a service.

DR McEVOY: Well, just on the subject then of providers, I was going to ask you – I mean, you've said a number of things about how individuals are finding the 45 changes in the home care package regime – what about providers, your members, what are their views about how it's working?

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MS SPARROW: It is a challenge for providers, a changed system where the funding that was automatically allocated to them now goes to consumers, so there has been some challenges associated with that. Many of the providers we talk to are very concerned about the 126,000 people who are on the waiting list and that tends to be the focus of our – of our discussions. There are some issues that have come up around guidelines though, around what consumers can actually utilise taxpayer funding for, and there are some instances where the guidelines are perhaps not as clear as they could be, and some interesting requests that come through that need to be considered in terms of is it appropriate or not and does it best meet the individual person's need.

DR McEVOY: Can you give some examples of that?

MS SPARROW: Yes. One of the examples actually in the statement is around a thing that's not uncommon to do in a home care package is to make some adjustments to the bathroom to put grab rails in, to do that sort of things – to do those sorts of things, so we do that routinely. But one of the questions that has come up a couple of times now since consumers and their families have more say is that they didn't particularly like the grab rails that were put in. They thought that they might affect the resale of the house. I guess I understand why people might have that view but, actually, our concern as providers and the use of taxpayer funding is about making sure that what's provided is fit for purpose to support that person to live at home while they are living in that home, not the – not the after-effects.

DR McEVOY: Well, what does that say about the guidelines? Does that say the guidelines are in need some of re-working?

MS SPARROW: I think the guidelines are in need of some re-working and we need to do that carefully though because one of the important principles is that there's more choice for consumers but I think we need to also balance that with what's the right support and what's a reasonable expectation for use of taxpayer funds.

DR McEVOY: What's your view or ACSAs view about the introduction of the new packages that have recently been announced in terms of reducing or even working towards the elimination of the waiting period?

MS SPARROW: So it's good that there are new packages being introduced and I would suggest that there's a factor where new packages are introduced anyway, that they grow. What has been good about having the wait list, as disturbing as it is to see that there are 126,000 people waiting, is it's a very clear case for why additional packages are needed and the government has responded so it's terrific that there are new packages coming through. But clearly – and I think it's over the last period of time and there was a recent, 10,000 I think over the last six months or so, it has been 40,000 packages but against a waiting list of 126,000 packages, it's not enough.

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DR McEVOY: Well, what about the supply side? Is there an ability, in your view, for your members and others to, in fact, supply what's necessary to take up the demand?

5 MS SPARROW: I think that there are two things and if the funding and the packages are there then providers will work to deliver them. There are – and it does touch on the workforce challenges in making sure that we have the workers to do that and that will slow it down but to have the number of packages that are needed, providers are standing by ready to take that on.

10

DR McEVOY: I'm going to move away from home care, unless there's anything else in that – on that subject that you would want to add.

MS SPARROW: Only to say that, you know, many more people are supported to
15 live at home. So we support 1.3 million people a year. The majority of those are in home care and, in fact, the majority of those people are supported through the Commonwealth Home Support Program. We're talking here specifically about the home care package program. We do think it's important that we look at home care overall, so both what happens in the Commonwealth Home Support Program and
20 what happens in home care packages to try and make it a more seamless experience for older people as they need to come in and clearly much more needs to be done. It is where older people want to – they want to stay at home, they want to be supported at home. It's important that we get that end of the system right, that it works.

25 Many people are waiting for high level packages and we need to make sure that they're supported and we think that people are waiting for high level packages, they're waiting often for more than 12 months by which time they may have entered residential care or have been sent to hospital. So I guess I'm saying we think it's an incredibly important area for us to get right and we need to take an overall view and
30 look at home care packages and also the CHSP to make sure that older Australians can get the support they need.

DR McEVOY: When you say much more needs to be done in this space, you're talking, I think, really about funding?

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MS SPARROW: Increasing the number of packages. And you did raise the issue of the guideline and making sure that those issues are clear and educating families and consumers about what sorts of things can and can't be done under a home care package.

40

COMMISSIONER BRIGGS: Might I intervene there and just ask do you know, Ms Sparrow, what's the average lead time, once a new set of packages is announced, before they could be implemented on average? And I think this draws a little bit on counsel's comment about is the workforce available, for example.

45

MS SPARROW: Look, I would like to check the specifics of that but it's a matter of months if the workforce is available, rather than in residential aged care it can take anything up to six years for a bed to come online.

5 COMMISSIONER BRIGGS: And your experience with the providers in ACSA is if somebody is assessed as needing a level 4 package and they get a level 2, how does your organisation or that individual negotiate with the system to actually get their proper entitlement. What happens?

10 MS SPARROW: Sure. So the way – my understanding of the way the prioritisation system works is if I'm assessed as needing a level 4 but I get a level 2, I do stay on the prioritisation list as needing a level 4. That might be something to – for me to double-check. That's my understanding of how it works. So I will get the level 2 package while that's occurring and I should at some point, when a level 4 package 15 becomes available, be offered a level 4 package.

COMMISSIONER BRIGGS: And would that typically be with the same provider?

MS SPARROW: It could be because the package is now transportable so it belongs 20 to you so if you wanted to have the same provider but it would also be open to the individual if they said no, we actually want to move to a different provider.

COMMISSIONER BRIGGS: And would it always be a single provider?

25 MS SPARROW: It's a single provider in terms of how the package is held but the way that the services are delivered under the package is that it is around what the person needs. And one of the changes that came into place in 2017 was that an individual might request a service that the provider who holds the package funds doesn't deliver and the provider can bring that in from outside.

30

COMMISSIONER BRIGGS: So there's a lot of cross-purchasing. Is that one of the reasons why the administrative costs with these packages are, I gather, around 30 per cent?

35 MS SPARROW: So the administrative costs – I think one of the things around the administrative costs is I'm not sure that everybody in saying what their administrative costs are counting the same things so I think there's variation. But there are different models that call on different – you know, create different issues in terms of how administrative costs are captured. There has been work done now, 40 though, around pricing transparency which ACSA and many have been involved with to try and make it clearer to consumers about what the fees are and how they're utilised.

DR McEVOY: Well, can I just take up that last point in answer to what 45 Commissioner Briggs asked you and you mentioned pricing transparency. Is it proposed, is some sort of initiative proposed by ACSA or some of the peak provider groups to deal with that issue?

MS SPARROW: So there has been a lot of work across the board from government and from all of us as provider representatives, consumer representatives, talking about how we make it more transparent, but not just more transparent; it actually needs to be meaningful. People need to understand the information they're being
5 given so quite a lot of work has been done on if we're going to provide information, how do we explain what it is that's being charged and how do you then compare if you're looking as a consumer to compare, how do you compare and know that you're comparing apples with apples.

10 DR McEVOY: Well, just on that, is there consistency, in your experience, between providers in the way these administrative charges are made?

MS SPARROW: It's variable. And picking up on Commissioner Briggs' point, sometimes it's to do with the model of service or they've counted things differently.
15 So one of the important things about this work around transparency is that hopefully it will make it more consistent across and not subject to the way individual providers might actually be calculating or capturing data.

DR McEVOY: Perhaps I will move to the subject of residential care. I think in
20 paragraph 27 of your statement you deal with the profile of individuals entering aged care and how this is different from a decade or so ago. Can you just elaborate a bit on that.

MS SPARROW: Sure. We've seen an increased – an increase of people coming in
25 at a later stage and partly that's because home care has been effective in supporting people to stay at home. So people are coming into residential aged care at a later stage with more complex health care conditions than they perhaps used to. And there's some recent data from the Productivity Commission report on government services that goes to that point and shows across the domains in the aged care
30 funding instrument in 2008-9 it was – for those complex health care it was 12.7 per cent of the resident population that needed the highest level of complex health care and last year it was 53 per cent. So it shows that there has been a significant increase and providers anecdotally have been talking about that for some time. There's often a lag in data that shows what providers are actually experiencing on the ground.
35
DR McEVOY: As you say, I think in paragraph 28 of your statement, the Act requires that:

Residential aged care providers maintain an adequate number of appropriately
40 *skilled staff to ensure that the care needs of care recipients are met.*

Now, we will talk about staffing ratios in a moment but noting that ACSA doesn't support minimum staffing ratios, how do you say that providers are to assess the appropriate number of staff to meet this requirement?
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MS SPARROW: It's very much based on the profile of the residents that they have and the needs that residents have at any point in time. So residents' needs do change

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up and down and providers will staff according to that. It's important to note in this regard that the StewartBrown data which is perhaps one of the largest datasets we have actually shows that there has been an increasing number of hours per resident per day provided in residential aged care which also reflects the changing nature of
5 the needs of people in residential care.

DR McEVOY: Well, let's focus on the skill aspect of that. How are providers supposed to assess the skill requirements of staff to meet this requirement, bearing in mind, of course, the nature of the workforce available to them with the personal care
10 attendants? How is that to be done?

MS SPARROW: The workforce is actually much broader. I know we focus a lot on nursing and personal care, as we should, but there are a whole range of other staff in residential aged care that are also – also need to be looked at and factored into our
15 staffing models and the support that's provided. So there are – on here there's allied health staff as well, registered nurses but also there are activity officers who play an extremely important role. There are hospitality staff. There are a whole range of staff that are factored into determining what your staffing is to meet resident needs and to make sure that the quality of care is good. The organisations have different
20 models of care and sometimes that requires different staffing. So a provider would take all of those things into account in determining what staff and skills mix they need to support the residents in their care.

DR McEVOY: I suppose one question that might arise here is whether providers are
25 in a position to second-guess or to review their own processes in ensuring that the skill mix is right, ensuring that the staffing levels are adequate to meet the needs of residents. Are you aware of the extent to which that is able to happen, does happen?

MS SPARROW: Well, it happens through the regulatory system so - - -
30
DR McEVOY: It certainly happens through the regulatory system.

MS SPARROW: So the agency, as it was, and the commission as it now is, actually explicitly looks at that and determines whether or not providers are meeting.
35
DR McEVOY: Yes, and I accept that that happens in that connection but I'm really inquiring about your level of knowledge of whether there's anything organic, if you like, in providers that enable them to look at this, to reassess it, to review it themselves outside the impositions of the regulator.
40
MS SPARROW: Of course, and I think providers do do that. I'm not sure that I can give you explicit examples. It's something that I'm happy to come back to you about but I do though that providers have a range of approaches that they use to ensure that their models do meet that. There was the Workforce Strategy Taskforce that looked
45 at some of the different systems and models that are available for people to use to review their staffing models and the way they're delivering care.

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DR McEVOY: I think in about paragraph 83 of your statement you identify that the public has expressed a desire for more information about staffing and service models which the providers are using. What are the challenges and the risks associated with the metrics that attempt to compare staffing in facilities?

MS SPARROW: And I think that's what we were just talking about actually with home care as well, that to be really useful to an individual consumer looking at it, you actually need to understand more than just the flat number of staff on at any one time. So different models of care require different forms of staffing. And so if you can't explain – you need to be able to explain what your model of care is and why you're staffing it that way. Different environments and different layouts of facilities also impact on the staffing that you might need at any given point in time so being able to explain that to people is important for them to be able to compare like with like, rather than a blunt number which tells you something but not the whole story that you need to know as either an older person or as a family member about the care that's going to be provided.

DR McEVOY: And I suppose it's those issues relating to different models of care that inform the view that you hold in relation to ratios?

MS SPARROW: That's correct.

DR McEVOY: Do you want to say something – anything more about ratios?

MS SPARROW: Only that we do think that they're – that they are a blunt instrument. They don't capture those variances and differences and that needs change over time, and providers need to be able to be flexible to do that. But also that we do understand and support that if we can get that right, in terms of explaining models of care, etcetera, then we understand the desire for transparency but we don't think ratios achieves that.

DR McEVOY: Well, you say that you understand the desire for transparency. Are you saying that some form of ratios within the context - - -

MS SPARROW: Not a form – not necessarily a ratio, but information about staffing and staffing models within a residential aged care facility that will inform people about the type of care that they can expect.

DR McEVOY: So you really don't conceive of any circumstance in which it may be appropriate, having regard to the different models of care and the need to accommodate that, and to be responsive to that in the setting of minimum numbers, ratios, you don't consider that there's really any scope for that?

MS SPARROW: I think there's scope for transparency so that people understand how a service is staffed, but I don't think that a blunt instrument of a minimum number of staff actually is very informative or guarantees better quality of care.

DR McEVOY: Also, what do you say needs to be done on this subject of staffing? I hear what you say about transparency, but what do you say should be done?

MS SPARROW: In terms of – I'm not sure what you're asking me.

5

DR McEVOY: Well, appropriate numbers of staff to accommodate the resident mix.

MS SPARROW: And I think that the approach that's taken now around providers
10 working out what their staffing is based on the different model, their residents' needs is important, being transparent about that is important, having the process that we have with the commission and an independent sort of checking is important.

DR McEVOY: Let me take you then to the subject of complex needs which you
15 address in paragraphs 30 to 34 of your statement. Can I ask you to just identify the features of the system which make it difficult to provide care to those with more complex needs?

MS SPARROW: So we look at the system, particularly talking here about
20 residential aged care, in terms of the way that we're funded and our ability to make more complex health care needs is constrained by the level of funding that we have. Residential care and the services for older people tend to be planned as if it's a completely separate part of your life and that there's an expectation if you're in aged care that every single need that you have will be met by aged care and, in fact, that's
25 not the case. So we would say that an older person in residential aged care has the same right as you or I to primary health care, to hospital care, to the whole range of services that the rest of the community has because we are not funded specifically to deliver those services.

30 So we think it's important in terms of that, that GPs are able to come into residential aged care and given the shift in our client population, that complex health care is more important than ever. That also covers things like oral health, mental health, psychosocial services and palliative care.

35 DR McEVOY: Well, can I just take you up on the subject of palliative care. Can you just enlarge upon that. What's your position about how that should be dealt with?

MS SPARROW: Palliative care funding in the Aged Care Funding Instrument in
40 particular doesn't work well. And we think that much more needs to be done to support residential aged care providers and to bring in palliative care services that other people in the community receive to support people to have a good death.

DR McEVOY: That would be a very different model though, would it not?

45

MS SPARROW: In some instances, it would be a different model. And I guess in saying – with health care we're saying, you know, it shouldn't be the expectation that

– well, there's only two ways to address that. Older people in residential aged care need access to health care services. We either get them through the system that currently delivers those health care services to older people or aged care has to be funded differently to be able to deliver them.

5

DR McEVOY: And what's the position of your members in relation to palliative care?

MS SPARROW: In palliative care, we believe – and in health care generally, we
10 believe that we need additional funding and more supports from the system where those services are actually delivered for the rest of the population.

DR McEVOY: I think you mentioned a moment ago that one of the difficulties was attracting GPs to visit. What's your observation about how that aspect of the system
15 is working or not?

MS SPARROW: And I think it doesn't work well. So it's important to understand that when someone comes into residential aged care they are given, you know, rightly, the opportunity to choose their GP. So they may choose a GP that they've
20 been seeing all their life or they may choose someone else to come in, so there is a principle there where individuals are choosing their own GP. As aged care providers we can't guarantee that that GP will actually attend and we don't generally employ GPs on staff. So GPs, we – they come in to attend a particular resident. We do have difficulties with getting GPs to come into residential aged care for a whole host of
25 reasons which I'm sure they've already provided comment on. But largely they would say – the arguments that we've heard largely are around they're not funded adequately to come in to visit someone in residential aged care and clearly it's very difficult and increasingly rare that a resident can go and visit a GP in their setting.

30 DR McEVOY: One of the problems you also mentioned in paragraph 32 is the difficulty or the concerns in relation to transfers between hospitals and aged care facilities. That has certainly been a subject matter that we've had addressed to us by a number of witnesses. Does ACSA have a position about this?

35 MS SPARROW: I guess it's the same position. We think that older people, if they need hospital services, they should be able to be transferred to hospital and get the level of care that they need. There is some discussion between hospitals and residential aged care about when that happens. Aged care providers transfer people to hospital when they believe that a residents needs hospital level care. We believe
40 that hospitals should then deliver that care.

DR McEVOY: It's a little bit more complicated than that though, isn't it, because often what appears to be happening in residential facilities is that people are being transferred to hospital when there's really good – no good need for that to happen.
45 They're being transferred, we've heard evidence, very often because there's not adequate staff in place, there's not adequate delivery of care for them, and the sort of

care they need is not really hospital care, it's just greater intensity of care in the facility. What do you say to that?

MS SPARROW: So I would still say we need people to go to hospital when they
5 need hospital level care but we have been talking about the changed level of acuity and need in residential aged care, we understand that there are increasing concerns about staffing levels and we do think that we – and many members will say this – would like to have more staff available to support people in residential aged care, and that would require additional funding to be achievable.
10
DR McEVOY: Can I take you then to this question of person-centred care which you've adverted to at various times in the course of your evidence. One of the observations that you've made is that the system presently doesn't support what you call the dignity of risk. I wonder if you might explain what you mean by the dignity
15 of risk.

MS SPARROW: Sure. Dignity of risk is about allowing people to make choices, to be safe in the environment but also to make choices that reflect what they want and need to do. It may be easier to talk about it if I give some examples.
20
DR McEVOY: Yes, an example would be good.

MS SPARROW: So two examples: one example that we've used in our witness statement is actually around a person who wants to, after dinner, walk to the local
25 shop to buy an ice-cream. That's something that the person would like to do, but there is concern – regulation sets up a concern that that may not be a safe thing for the person to do. But for that person that's going to have an impact on their quality of life and it gives them dignity about them having choice. That's one example. And there are ways that we can, as providers, if the regulation supports and if the
30 community supports and understands, help that person to do that. We're not a prison, people aren't locked away. If somebody wants to be able to go for a walk to buy an ice-cream, and we can support them to do that safely, it should be done rather than just ruled out.

35 Another example – I seem to be going for food-related examples, but another one that's oft quoted in aged care is about eggs and it was particularly in New South Wales where you didn't have the right to have a soft-boiled egg. Eggs had to be boiled for something in excess of 15 minutes because there was a slight risk that you could contract listeria. Our view would be that if you are in your 80s and have made
40 decisions all of your life and perhaps fought in a world war and brought up a family and you wanted to have a soft-boiled egg you should be able to have a soft-boiled egg and that should be a choice you should be able to make. I understand the regulation – that's a State-based regulation around food – has actually changed now so that people in New South Wales can have, but it's quite a striking example which
45 people seem to understand the principle about why I might want to, as an individual, choose to have that, and should have the right rather than have that right taken away by restrictive legislation or regulation.

DR McEVOY: And is this concept of dignity of risk something which your members are saying to you is a concern for them and something that they wish to try to deal with?

5 MS SPARROW: Yes. Yes, they do. They often feel they can't do some of those things, mostly for concern about how the regulation would view that and how it would be seen. So I think it's the way the regulation is set up now is we're very risk averse. We think it's really important to get the balance right. We think there has to be safety for people but one of our jobs as providers should actually be to support
10 people to have the quality of life that they want and those small examples about choices that people can make that give, you know, quality of life and meaning to them, we should be able to support them to do.

DR McEVOY: Can I take you, perhaps, to paragraph 93 of your statement where, in
15 response to the question the Commission has posed to you about whether you're aware of any examples of good practice or innovative models for delivery of aged care services, you set out there, in the sub-paragraphs, a series of examples of good practice or innovative models for the delivery of aged care services. I wonder if you might just walk the Commission through those various examples that you've
20 provided there.

MS SPARROW: I'm happy to, and please excuse me, it's easier for me to read off the page so my head might be focused down. It's actually – there are some really fantastic things happening in aged care and some different models. We've talked
25 about the models generally so we've outlined what has been called the household model that a number of providers are now implementing which is that there are much smaller groups, generally around eight to 12 residents living in a household arrangement. They work with their staff, they have more choice over their meals, they can be involved in preparing the meals. They can be more involved in their
30 activities of daily living. Food is cooked on-site and they're part of that. So it actually is more like living in – living in a home environment which many people, it's what people kind of want so we've got the challenge of the complex health care but people still want to live in in a home-like environment. The household level does that.

35

Montessori, I think people would know Montessori more in terms of child care but there are a number of providers who are starting to use the Montessori model which really does focus on the individual and, obviously, history, experience and relationships and brings that into all of the – into all that is done. And Montessori
40 uses techniques that assists people learn procedures and routines which increase their independence. So it helps people perhaps to have more initiative around medication, using their walking frames and a whole range of other strategies.

The Eden Alternative is one that has been around for some time. It's one that came
45 out of the United States by Dr Bill Thomas and his concern has been in aged care; he talks about the three plagues of older age, being loneliness, helplessness and boredom and his model is designed to actually relieve those. It has a great emphasis

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and organisations that use the Eden Alternative have a great emphasis on providing what they call human habitats so it's around contact with animals and children, keeping people active and involved. So that's a model that's used in many.

5 In the Netherlands we've seen the Apartments For Life or Humanitas Foundation which you may have heard about. That is an apartment that you live in and as your care needs increase the services actually come to you where you live, rather than perhaps moving into a residential aged care setting. That's a model particularly in Holland and they've done a whole range of other innovative things. They have
10 students living there and great intergenerational relationships developing between younger people and older people so that's a very interesting model.

The Butterfly Household Model of Care particularly rests on the belief and support for people with dementia that feelings matter and that emotional intelligence is the
15 core competency. And so it focuses on moving some of the institutional features around staff wearing uniforms and having medicine trolleys and really rigid task-based routines. Home Share is a model more for people who are living in the community so that might be that there's an older person living in a home that's got capacity to offer accommodation to – largely it will be a student or someone like that
20 who is looking for somewhere to live, so they, in exchange for having somewhere to live agree to provide a certain amount of hours of support to that older person. That's agreed before the person moves in. But that's quite an innovative model and it helps two people. It helps the older person and also the person who has perhaps moved to a new town and needs somewhere to live as they're studying.
25

There's – the Dementia Village is the next model we talk about. This, again, has come from Europe. We're about to have the first dementia village built in Australia. It's a gated community and it is like a community that anybody would live in. The residents can then more safely move around the village. They can go to a shop and
30 have a coffee, whatever, so it's like they're living in a village rather than just in an individual setting. The last two that we talk about are a little bit different in that they are models and actions that were taken to try and improve residential aged care specifically. So the first one we talk there about – first talk about there is RedUSe which was actually around medication management, particularly antipsychotic and
35 psychotropics. It was a pilot program that was funded that was terrific in terms of taking a multidisciplinary approach which is absolutely what we need in this space. And it worked with residential aged care staff, pharmacists and GPs, which is the kind of partnership there to improve the way that was done, to provide training on the risks and benefits associated with that, and it was actually shown that there was a
40 very high degree of satisfaction with that approach.

And I think it did, it shows the partnership model, that it's all three that are involved and supported more effective interventions. Unfortunately that was a pilot program and the funding stopped for that and so it didn't sort of get right around the country
45 and we would argue that those kinds of things need to actually be in place right around the country. And the last one, similarly, was a pilot project called Teaching Nursing Homes. And that was about that often people go into aged care and don't

necessarily have the support on their placement and, again, that there's a multidisciplinary approach to supporting people in aged care. GPS don't often in their training go into a nursing home. So the idea was that we would create nursing homes, residential aged care facilities that were multidisciplinary training sites. That does two things: it improves people's skill and understanding about aged care, but also what we found out of that was people actually really liked working in aged care and were more than inclined to say after they had graduated that they wanted to move into aged care. And, obviously, it had fantastic benefits for the residents as well.

So they are some of the ones we list. I'm sure there are others but they were the ones that immediately came to our mind as being quite innovative and having a good impact on the quality of care that people are receiving.

DR McEVOY: Perhaps finally, Ms Sparrow, can I just take you to this issue of the absence, perhaps, of a culture of respect for older Australians and how that might best be fostered. What's ACSAs position in relation to that?

MS SPARROW: It's so important and it has been fantastic to see that the terms of reference for this Commission embrace that because there is no doubt that there is discrimination against older people and a prevailing society view around ageing that is in the negative. We would like to see that turned around. That's why we're supporting the Benevolent Society in New South Wales who've created an EveryAGE Counts campaign to try and actually start to talk about the prejudices that often we hold. I think you only have to look at a birthday card to see how growing older is treated. We use language around, you know, what's a wonderful story to tell about longer life and longevity, saying that, you know, we talk about it as a tsunami.

There seems to be a connection between the growing number of older people and describing it as a natural disaster, when in actual fact it speaks to incredible medical benefits and the wonderful things that older people are able to including caring for grandchildren. And people continue to contribute but we tend to focus just on the negatives. So we think campaigns like EveryAGE Counts which is why we're very proud to support that. We will work to, hopefully, educate people and remove some of the discrimination that there is around older people, which I think we see in many ways in terms of across society in all walks of life. Sorry, I should also mention there, too, that the Age Care Workforce Strategy report does also talk about the need for a social change campaign in a similar vein to address some of that and also to promote and reframe the aged care workforce. ACSA has done some work in that regard to – on the Humans of Aged Care to talk about, you know, we have over 300,000 workers in aged care. They're very dedicated and we're telling some of their stories through the Humans of Aged Care so that people understand what happens in aged care.

DR McEVOY: Commissioners, I have no further questions for Ms Sparrow.

COMMISSIONER TRACEY: Yes. I would like to ask you to resolve, if you can, a difficulty I have in understanding a lot of the evidence we've received. We've been told, for example, that the addition of funding packages, whilst welcome, is not going to make a great impact, at least for a while, because the resources aren't there to provide the services that are being funded by these packages. We're told that there are workforce problems, that there are just not enough trained people out there to provide the services that are needed for the growing population of elderly people in need of either home care or institutional care.

On the other hand, your evidence seems to be that your members are able to provide the services that are needed by a wider range of people who are presently awaiting assistance, and that tends to be backed up by the fact that some at least of your members are treating themselves as acting in a competitive environment, advertising their services on radio and television, trying to attract people to their brand, rather than somebody else's, which tends to pull in the opposite direction. They wouldn't be advertising these services if they couldn't provide them. You understand my dilemma. Can you assist me in resolving it?

MS SPARROW: I do. I will try but I'm not sure that my answer will resolve it for you because I think both of those things are true. So there is capacity. Our members do want to – and can provide additional services and that's why we do see them, you know, advertising. But it is true that we have to triple the workforce in aged care by 2050 based on the current and the anticipated growth in the number of people who are going to need services. So I think there is capacity to provide additional packages of care now but we do need to also concentrate on increasing the number of people who want to work in aged care. That's why we've also done the work in Humans of Aged Care, but also why we've increased our workforce and industry development unit to try and educate people more about all of the roles that are available in aged care so that we have got the workforce that grow.

We've done particular work in Tasmania which we're now trying to roll out around the country that focuses on going into schools and talking to younger people about working in aged care. They generally don't think about working in aged care but what we do know is the current generation – I think they're referred to as the Millennials – actually want to work in areas where they have relationships and meaningful connections and are making a social contribution. It's part of our job to make sure that aged care becomes something they can be – that they will consider, not just in terms of personal care and nursing which is incredibly important but all of the other roles that there are in aged care around hospitality and gardening and technology, that there is a whole range of things that we need to be attracting a workforce for.

So I don't think that I did help you but I think that there are – it's true that there is ability to provide additional services if the funding is made available for us to do it but we also need to be looking at how we grow the workforce and making sure that people understand that aged care is a pretty wonderful – is a pretty wonderful area to work in and you get the chance to make a difference to people's lives every day.

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COMMISSIONER TRACEY: I would also like to get you to expand a little bit about the concept of teaching nursing homes. Do I understand them to be institutions like teaching hospitals where people seeking nursing qualifications get practical experience? And is that in conjunction with academic training - - -

5

MS SPARROW: Yes.

COMMISSIONER TRACEY: - - - at a tertiary institution?

10 MS SPARROW: Yes. So they are modelled on that notion of teaching hospitals. There's a number of reports if you are interested, Commissioner, that we could perhaps provide that give you more detail about the teaching nursing homes and how they operated and what came out of that trial.

15 COMMISSIONER TRACEY: And was there an assessment done at the end of that trial that was published?

MS SPARROW: Yes, I think there was, but I need to double-check that for you but, as I said, it was - - -

20

COMMISSIONER TRACEY: Look, I would be most grateful if you wouldn't mind providing a copy of that to the solicitors to the Commission, because it does strike me as being a very useful concept given that we are going to need an expanding workforce of people with qualifications in dealing with the elderly, and this may be
25 one of the solutions. But I gather from your evidence that the trial was run but nothing has come of it.

MS SPARROW: Unfortunately, the funding that supported it stopped. I would need to check whether there's any that continued. Again, this one actually came out
30 of Tasmania as well. But we will check, Commissioner, for the reports and send some information that expands on that. And it was, unfortunately, one of the issue was pilot programs and trials is they're very good but it often ends that the funding then runs out and you lose the – you lose what it has created in the system and that is something that we're concerned about long term, that we don't lose such great
35 examples as the teaching nursing homes because you are right about that whole multidisciplinary challenge that we have that the teaching nursing homes actually did assist with.

COMMISSIONER TRACEY: And in principle, I assume that there would be a
40 significant proportion of your membership who would be willing to participate in such an arrangement, provided it was properly structured and funded.

MS SPARROW: Absolutely. The same with the RedUSe program, we had many, many members who put their hand up and wanted to be involved in that trial and
45 then because it ended weren't able to be. So, you know, in our membership we see providers striving to deliver and on the models of care we're seeing many of them look at how do they deliver better dementia care, how do they get involved and

create better spiritual services and chaplaincy services and how do they provide better dementia care. So there is a real appetite and desire amongst aged care providers, that's why they do what they do. They provide aged care services because they care about supporting older people and so yes, they want to be involved in
5 delivering good quality care but also they want to be involved in where there are any models that they can trial that will improve services, they desperately want to be involved in those things, too.

COMMISSIONER TRACEY: Thank you.
10
COMMISSIONER BRIGGS: I would like to just ask you a little bit around the funding arrangements around palliative care. Is it correct that funding is only provided for about a week for palliative care once you go through the process of applying for it?
15
MS SPARROW: I would have to check exactly the days or the weeks that it is available but it is actually only available right at the end. And providers will talk to us about it, it can be very difficult for them to show that someone is palliative. So in some instances providers have said by the time we've actually got through that
20 process and proved the person is palliative, the person has passed away. But I will check on the number of weeks or days that that funding is actually available for.

COMMISSIONER TRACEY: Anything arising, Dr McEvoy?

25 DR McEVOY: I don't have anything arising, Commissioner.

COMMISSIONER TRACEY: Thank you, Ms Sparrow, very much for your most helpful evidence and if you would be so kind as to just follow up with those additional pieces of information, they will be of great interest to us.
30
MS SPARROW: I will do that and I want to thank the Commission for the opportunity to present. We think there's nothing more important and our members think there's nothing more important than getting this right. We have a vision for aged care that we want to see everybody be able to receive the services they need as
35 and when they need them at the level that the community would expect and that's what we're working towards as providers and keen to see and work with you as the Commission to also support that and achieve that outcome.

COMMISSIONER TRACEY: Thank you.
40
MS SPARROW: Thank you.

<THE WITNESS WITHDREW [12.46 pm]
45

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

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ADJOURNED **[12.46 pm]**

RESUMED **[2.04 pm]**

5

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioners, I would call Mr Sean Thomas Rooney.

10

<SEAN THOMAS ROONEY, AFFIRMED **[2.04 pm]**

15 **<EXAMINATION-IN-CHIEF BY DR McEVOY**

DR McEVOY: Operator, could you please bring up two documents. The first is WIT.0013.0001.0001. And the – yes, the second is 0024.0001.0001 which you are
20 now displaying. Now, Mr Rooney, you will see that there are two statements there, one of 31 January 2019, the other of 12 February 2019. Are they your statements?

MR ROONEY: Yes, Counsel.

25 DR McEVOY: Do you wish to make any amendments to those statements?

MR ROONEY: No, Counsel.

DR McEVOY: I should note, Commissioners, that in relation to Mr Rooney's 12
30 February 2019 statement, there have been certain matters relating to LASAs membership and internal matters of that kind which have been redacted but I would seek to tender, together with the identified annexures, the first of those statements and then as a separate tender, the second of those statements.

35 COMMISSIONER TRACEY: Yes. Well, the first statement of Sean Thomas Rooney dated 31 January 2019 will be exhibit 1-46.

EXHIBIT #1-46 STATEMENT OF SEAN THOMAS ROONEY DATED
40 **31/01/2019 (WIT.0013.0001.0001)**

COMMISSIONER TRACEY: Now, in respect to the second one, Dr McEvoy, I see in paragraph 4 that there's the request for the information contained in certain
45 identified paragraphs and appendices not to be made available to other witnesses or the wider public.

DR McEVOY: That's so.

COMMISSIONER TRACEY: Is that the material that has been redacted in the latter part of that statement?

5

DR McEVOY: Yes, it is, Commissioner. Yes, that's right.

COMMISSIONER TRACEY: Yes. All right. Well, then the second statement of Sean Thomas Rooney dated 12 February 2019, with redactions, will be exhibit 1-47.

10

EXHIBIT #1-47 SECOND STATEMENT OF SEAN THOMAS ROONEY DATED 12/02/2019, WITH REDACTIONS (0024.0001.0001)

15

DR McEVOY: Thank you, Commissioner. I should perhaps have said to you, Mr Rooney, but I will say it now, you can confirm, I take it, that the contents of both those statements are true and correct to the best of your knowledge and belief?

20 MR ROONEY: That's correct.

DR McEVOY: Mr Rooney, what is LASA?

MR ROONEY: Counsel, Leading Age Services Australia is an industry association
25 for organisations that provide care and support, accommodation and other services for older Australians. May I say at the outset, like all Australians, I've been shocked and saddened by failures in our aged care system. These failures are unacceptable and I am sorry for the hurt that this has caused. My aspiration is to realise a better aged care system for our country and there are countless examples of passionate
30 professional individuals and organisations that do this every day. But it is clear we need to do more and LASAs role is to support our members to be high-performing, respected and sustainable as they go about their work in providing that quality care for older Australians.

35 DR McEVOY: Yes, and how do you go about supporting your members in that respect, Mr Rooney?

MR ROONEY: The activities that LASA conducts are really in two key areas. One is around representing our members and we do that in various ways at both
40 individual member level and at sector level in submissions and inquiries and other forums. We also provide a range of services and supports to our members that assist them in their operations and their performance. Would it assist, Commissioners, if I was to provide some insight into the types of organisations that are in our membership?

45

DR McEVOY: That was going to be my next question, Mr Rooney.

MR ROONEY: Sorry, Counsel.

DR McEVOY: Why don't you tell us that.

5 MR ROONEY: So our organisation and the members that we have are very, very diverse and they match the diversity of providers in the aged care industry. We have organisations that would be sole trader home care providers with just a handful of clients, right through to large-scale organisations that would provide care and accommodation for thousands of older Australians. The mix of our members provide
10 residential aged care services, home care services and also some independent living, retirement living services. They operate in every – every State and Territory, in capital cities, regional centres, rural and remote communities. The majority of our membership are small to medium-sized businesses and their ownership structures span not for profit, faith-based, privately owned for profit and also some government
15 owned and operated services.

DR McEVOY: And what role do you perform at LASA, Mr Rooney?

MR ROONEY: So I am the chief executive officer of LASA.
20

DR McEVOY: And what does that involve doing?

MR ROONEY: Well, I have overall responsibility and accountability for the operations and the performance of the organisation. I report to the board of directors
25 and I am appointed by the board of directors.

DR McEVOY: You touched a moment ago, I think, in your answer to one of my questions on the services that you offer to your members.

30 MR ROONEY: Yes, Counsel.

DR McEVOY: Do you want to just tell the Commission a little bit more about what services you offer.

35 MR ROONEY: So Commissioners, there's a range of services. They span information, so we would provide regular information to our members on key matters happening in the industry, updates on regulatory change. We would share good practice guidelines as well as provide information of currency and importance. For example, we provide our members with a daily media watch service so they are
40 abreast of key issues that are happening in the press and the industry each day. Another area of service is in advice. We conduct a national phone line and we have employed a number of principal advisers. These principal advisers are people that have vast experience in both residential care, home care and retirement villages and at any time that a member requires any information or insight with regards to an
45 operational matter, they can contact the principal adviser to get some advice around what would be an appropriate thing to do in a certain situation.

We also have an employment relations advisory service where a member could ring up and seek some insight into how to deal with a personnel matter and getting back to the point I made earlier, that the majority of our members are small to medium-size enterprises. They often don't have those types of services and supports in-house so that's why they would draw upon our resources. Beyond information and advice, we provide a number of events where we share good practice as well as deal with particular issues. For example, we're conducting a webinar shortly with regards to pricing transparency in home care packages to bring good practice to our members.

We also conduct a national conference where we bring international speakers to come and share good practice and I note some of the testimony from Ms Sparrow where she talked about some of those international examples and we've had speakers that have brought that information through our national conference. Beyond that, we also conduct training. We have a registered training organisation that provides accredited training for our members. We also provide a non-accredited training and, again, this is for areas where members would require up-to-date or upskilling with regards to skills and competencies of importance to the work that they deliver.

DR McEVOY: I don't think in there you've mentioned lobbying activity.

MR ROONEY: I beg your pardon, sorry, I was making a clear distinction between services. The representation element of the work that we do, so that is advocacy on behalf of our members on what I would term issues of importance to our members and I would argue also to older Australians. We participate in many forums where we are asked to bring forward the views and represent the views of our members. This is in the Aged Care Sector Committee, the National Aged Care Alliance, and we participate in a range of submissions or inquiries that government conducts on key issues relevant to the industry and to the aged care system.

There is also occasion where we would advocate on behalf of an individual member. We provide a service which we call the member advocate. This is a service that works as a go-between a member who is having an issue with regards to payment and the government, who is the entity that is to make that payment. At times, there are issues that arise with regards to the timely payment or disputes over what is an appropriate payment to be made. The member advocate will work with our member to understand the issue and then go and work with the relevant departments or agencies to be able to resolve that matter appropriately. So that's an individual advocacy as opposed to a membership or sector advocacy role.

DR McEVOY: Operator, could you please bring up exhibit LAS.001.0001.0001. Mr Rooney, this is an exhibit to your first statement which I think is a link to – I'm just waiting for that to come up so you can see that. Yes, so you recognise that document?

MR ROONEY: I do, Counsel.

DR McEVOY: Yes. So that's – perhaps you might tell us what that is, Mr Rooney.

MR ROONEY: So that would be a list of submissions or inquiries or forums that we have participated in over recent times. I – if I recall, I think that might be since 2016 where we have responded or participated in consultation or inquiry processes.

5 DR McEVOY: If you go to the bottom of that page you're looking at there and three up from the bottom, submission to single aged care quality framework – guidance on standards, are you able to tell me what that submission was about?

MR ROONEY: Counsel, if I recall, that was a submission – a consultation process
10 that was conducted in 2017. That was a government consultation process where they had put out to industry stakeholders the draft set of standards and guidance materials. I think it was a rationale and evidence, I think was the terms used if this is the one that I'm thinking of. And we consulted with our members and provided feedback through that consultation process.
15
DR McEVOY: Operator, could you please bring up document RCD.9999.0017.0001. Does that look like the submission that's referred to there at the bottom of the other page?

20 MR ROONEY: It does, Counsel.

DR McEVOY: Yes. And were you involved in the making of that submission?

MR ROONEY: Our organisation was involved. Obviously, in consulting with our
25 members to get their views on the consultation with regards to the draft standards. I wasn't directly involved in the production or the consultation process with our members, but I do recall being involved in the signing off of the document, yes.

DR McEVOY: Operator, I might ask you to take down the document on the left,
30 which is the exhibit from Mr Rooney's statement, but to leave up the document on the right, and could I also ask you to call up, please, RCD.9999.0018.0001. Do you recognise that document on the left of your screen, Mr Rooney?

MR ROONEY: Yes, Counsel. I believe that's the paper that I referred to as the
35 draft statements or the – yes, the draft standards that was being consulted upon.

DR McEVOY: Yes. So it would be right to say, would it, that your submission – LASAs submission on the right of the screen is a response, if you like, to the document on the left?
40
MR ROONEY: Yes, counsel.

DR McEVOY: Right. Operator, could you please go to page 18 of the single aged care quality framework, which is at 0019 of that document. I'm sorry, we're at
45 cross-purposes, Operator. I'm talking about page 18 of the single aged care quality framework, which is the document on the left. Now, Mr Rooney, can I direct your

attention to about point 6 of the page, towards the bottom of the box, paragraph 2.3, where you will see the words – and these might be brought up, Operator:

Care and services are implemented and continuously monitored and evaluated for effectiveness.

MR ROONEY: Yes, Counsel.

DR McEVOY: Do you see that?

MR ROONEY: I do.

DR McEVOY: Now, Operator, could I ask you, in relation to the document to the right of the screen, to go forward to page 11. Now, Mr Rooney, if I just take you down again to about point 6 of the page, that's that paragraph above standard 3:

Delivering personal care and/or clinical care.

You see that statement there, that sentence:

Some LASA members have suggested amending clause 2.3 to remove "continuously monitored" to replace it with "regularly monitored".

Do you see that?

MR ROONEY: I do, Counsel.

DR McEVOY: Do you want to give a bit of background to why it was thought by LASA or LASA members that that might be an appropriate amendment?

MR ROONEY: Counsel, I would suggest at the starting point here is that the new quality standards actually provide a greater provision for an outcome focus with regards to the quality that's delivered for older Australians - - -

DR McEVOY: Yes, so Mr Rooney, just going back to my question - - -

MR ROONEY: Yes.

DR McEVOY: - - - could I just ask you to explain why it was thought that that might be an appropriate amendment?

MR ROONEY: I would suggest at the time that would have been seen as regulatory – regular monitoring would be with respect to the process of reporting that information to the regulator. I guess, perhaps, at the time – and, again, I wasn't directly involved in the consultation – that "continuous monitoring" would perhaps reflect an added burden on the people providing the information. But not having been involved in that consultation, I can't be absolutely sure. I'm quite happy,

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Commissioners, to go and get that information to find out what is behind that particular statement.

DR McEVOY: Now, you would be aware, Mr Rooney, wouldn't you, that in the aged care quality standards which are coming into force on 1 July, that suggestion has, in fact, been incorporated by the government, and 2(e) refers to care and services being reviewed regularly for effectiveness. Are you familiar with that?

MR ROONEY: Yes.

DR McEVOY: Yes. I wonder whether you might agree with me, Mr Rooney, if I were to make the observation that the amendment that LASA has proposed, and which has, in fact, been taken up, has the effect of reducing the standard required because there's no requirement for continuous monitoring of the effectiveness of the services, and that the original idea of continuous monitoring has been replaced, in fact, with a rather more imprecise reference to "regularly". What would you say to that?

MR ROONEY: Counsel, I would suggest that that was not the intent of the suggested change to the – to the standards.

DR McEVOY: Yes, I wasn't asking you, Mr Rooney, about the intent. I was asking you about the effect. Would you agree that that might be said to be the effect?

MR ROONEY: It could be – it could be construed in that way. I would suggest the intent, Counsel, really was really from a practical perspective, rather than an intent to reduce the effectiveness of the standard.

DR McEVOY: So from a practical perspective, the intent was to make it a bit less precise. Would that be fair?

MR ROONEY: No, I don't believe that would be the intent. To continuously monitor something, I would interpret to be a real term ongoing monitoring of every activity that was being undertaken by a service. To regularly monitor, I would suggest, is something that would be more practical in being able to provide information with regards to performance and compliance with standards.

DR McEVOY: But don't your members continuously monitor the effectiveness of their services?

MR ROONEY: I would suggest that they do, but the issue here, as I understand it, is then how do they continuously report that to the regulator.

DR McEVOY: Well, if they do, why the need for the change?

MR ROONEY: Well, I would suggest, again, that it comes down to the practicality of being able to report continuously externally whilst managing the care of the people that they're looking after.

5 DR McEVOY: Is what you're really saying that it's a bit more practical if the standards are a bit harder to measure, they're a big vaguer. Is that the point?

MR ROONEY: No, I'm not suggesting that at all, counsel. What I'm suggesting is that in this particular instance, "continuous" versus "regular" has practical impacts
10 upon the people providing that information.

DR McEVOY: What do you think "regular" or "regularly" means?

MR ROONEY: I would suggest that in this case organisations that are providing
15 their care and services have internal mechanisms that would periodically review everything that's going on in their organisation. So they would have their own regular internal reporting mechanisms to look at all number of the facets of their operations. With regards to regular external reporting it really is at the request of, in this case would be the regular – the regulator to seek that information. If the
20 regulator wanted that on a monthly basis, then that could be provided on a monthly basis.

DR McEVOY: Operator, could you go to page 26, please, of the draft aged care quality standards consultation paper which is the document on the left,
25 9999.0018.0027. Just wait till that comes up, Mr Rooney. Yes. Now, can I direct your attention, Mr Rooney, to the document on the left, or the page on the left which, as I say, is part of the government's consultation paper in relation to aged care quality standards. And could I direct your attention in particular at about point 3 of the page under the heading Requirements, that section beginning:
30

The organisation demonstrates the following.

Do you see that?

35 MR ROONEY: Yes, Counsel.

DR McEVOY: It has now been brought up. So just reading that, 5.1:

Consumers experience, (a), a safe, clean, secure, well maintained and
40 *comfortable service environment. (b), a welcoming and culturally appropriate service environment, comfortable internal temperatures, ventilation and noise levels.*

Do you see that?
45

MR ROONEY: Yes, Counsel.

DR McEVOY: So that is what at that stage the government was providing. I want to invite you to go to page 14 of the LASA submission which you will see there on the right of the screen. And if you go down to the heading in the middle of the page, Standard 5, Service Environment, you see those words there, I will read them:

> *Under the requirements of standard 5 there is reference particularly at clause 5.1(b)-*

that's what I've just taken you to, of course –

> *to comfortable internal temperatures. This may be interpreted that all services are required to have air-conditioning. This needs to be clarified in the rationale and evidence section.*

You see that?

MR ROONEY: Yes, Counsel.

DR McEVOY: Now, Operator, if you go to the Aged Care Quality Standards 2018 which are to come into effect in July of this year, and if you go to 5.3(b) of those standards, scrolling forward a few pages. Okay. So, Mr Rooney, you see there under the heading Requirements:

> *The organisation demonstrates the following: (a), the service environment is welcoming and easy to understand and optimises each consumer's sense of belonging, independence, interaction and function; (b) the service environment is safe, clean, well maintained and comfortable and enables consumers to move freely, both indoors and outdoors; (c) furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

So it's apparent, you would agree, wouldn't you, that there is no reference there to internal temperatures and ventilation. That would be right, wouldn't it?

MR ROONEY: Yes, Counsel.

DR McEVOY: So is it the view of LASA that it's unnecessary to have heating or air-conditioning in residential aged care facilities.

MR ROONEY: No, Counsel.

DR McEVOY: So if that's the case, why was it suggested that reference to "comfortable internal temperatures" be removed and, indeed, why was there a concern that were they – were that reference not to be removed, that it might be interpreted that all services are required to have air-conditioning?

MR ROONEY: So, Counsel, I don't think that we've said we wanted anything removed. What we sought in our response in the consultation process was

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clarification, if this now required all residential aged care facilities to install air-conditioning. That was just – it was not an objection to the standard. It was basically just asking, is this the interpretation that the standard is now looking to realise?

DR McEVOY: And so do you have a view about whether all residential aged care facilities throughout Australia should have air-conditioning?

MR ROONEY: My view would be, as it says in had the standards, safe, clean, well maintained and comfortable. "Comfortable" would necessarily include appropriate heating and cooling to ensure the comfort of the residents and the staff.

DR McEVOY: So just going back to my question, it would be your view and LASAs view, would it, that all residential aged care facilities in Australia should have air-conditioning and should have heating?

MR ROONEY: Should have appropriate, you know, cooling and heating to meet the needs to provide a comfortable environment, yes.

DR McEVOY: Is it within the realm of contemplation that there might be aged care facilities in Australia that would not need to have air-conditioning?

MR ROONEY: Look, there could well be locations where that's not a requirement. But I get back to the point, the focus here is on an outcome for the older person.

DR McEVOY: Sure.

MR ROONEY: If it's a requirement to provide comfort which is both heating and cooling, then that should be provided.

DR McEVOY: Well, where might those – you said it could well be that there might not be a requirement in certain locations where air-conditioning – whereabouts might that be?

MR ROONEY: Well, I guess it depends on the climatic conditions of the location, Counsel.

DR McEVOY: No doubt, it does. And just going back to my question, where might - - -

MR ROONEY: Well, Counsel, I would suggest if you're in the tropics, perhaps heating is not appropriate.

DR McEVOY: I wasn't asking about heating, Mr Rooney, I was asking about air-conditioning.

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MR ROONEY: Well, there's many ways to cool a room. Air-conditioning is but one.

DR McEVOY: What does that mean, Mr Rooney?

5

MR ROONEY: Well, I'm suggesting that there would be locations or there would be service types and design types of buildings that can provide a comfortable cool environment. Air-conditioning is one way to realise that. LASA has not objected to air-conditioning per se, in the consultation process. All we sought was clarification
10 from the government as to whether the requirement is that all aged care facilities have air-conditioning.

DR McEVOY: You've succeeded in clarifying it out, haven't you? That's the effect.

15

MR ROONEY: Well, I don't believe that's the case. We have to provide an environment that is comfortable and meets the needs of the older person in care and also the staff. It needs to be either warmed or cooled as appropriate.

20 DR McEVOY: Was LASA lobbied by members about the suggestion that air-conditioning might be required?

MR ROONEY: I wasn't involved in the consultation process so I can't speak with authority on that. I can certainly take that on notice but I – I guess, obviously, the
25 question has been raised, so it must have been raised by a member at some point.

DR McEVOY: The effect of what has happened, Mr Rooney, in consequence of this intervention is to reduce the burden for monitoring in relation to air-conditioning, isn't it?

30

MR ROONEY: I don't believe that's the case, Counsel. That wasn't the intent of the comment that was provided in the consultation process. It is the role of the regulator to assess these standards to see whether they are delivering against each of the standards, and providers who are out there delivering that care, you know, would
35 be doing their utmost to make sure that those standards are adhered to and the comfort of people they care for is absolutely assured.

DR McEVOY: Do your members – does LASA ever advocate for changes that are in the best interests of residents at what might be thought to be the expense of
40 providers?

MR ROONEY: I would suggest that LASA has always looked to ensure that we are supporting our members to deliver the best possible care that they can, notwithstanding that there are some constraints in the system, and more often than
45 not, this is where we have issue with a number of things that are going on in the aged care system. And if you allow me to expand on that, I would suggest that we're in a situation - - -

DR McEVOY: Well, Mr Rooney, just before you do - - -

MR ROONEY: Yes.

5 DR McEVOY: - - - what I might ask you to do is just go back to my question which I will put to you again. Does LASA ever advocate for changes that are in the best interests of residents at what might be thought to be the expense of providers?

MR ROONEY: I cannot recall an occasion where we have advocated any change
10 that I would see to have been – sorry, your words were, not in the best interests of residents or at the expense of a provider?

DR McEVOY: My words were whether there's advocacy for changes that are in the best interests of residents, but at the expense of providers.

15

MR ROONEY: I cannot recall a – any occasion where that has been the case. What I would say is that where that – an issue has arisen, we would point out to government or the regulators or whoever that with that outcome would come a series of issues that would need to be resolved from a provider's perspective in order to
20 deliver that outcome.

DR McEVOY: Is there anything more you would like to say in answer to that question?

25 MR ROONEY: No, Counsel. I – as I said, that would be my – my recollection.

DR McEVOY: Well, let's move then, Mr Rooney, to some of LASAs specific policy positions. Let's start with funding and the Aged Care Funding Instrument. You're familiar with that, of course.

30

MR ROONEY: Yes, Counsel.

DR McEVOY: Can you tell the Commission how that works.

35 MR ROONEY: So in residential aged care, there are a range of fees that are provided to providers to deliver care. Hotel services, for want have a better term, and accommodation. The Aged Care Funding Instrument deals with the allocation of subsidy for care. There is a separate funding for hotel services, as it's called in the Act, and that is what's called the basic daily fee, and then beyond that there is a fee
40 for accommodation which is a combination of either a bond or a RAD, a deposit or a DAP, which is a daily fee payable for accommodation. Those three streams provide the fees, for want of a better term, for the resident. Elements of those are means tested, so in part the government will pay a subsidy. In part, the consumer, the older person, would contribute to the cost of their care.

45

There are a number – I think it's around 44 per cent of residents are currently fully supported residents, so fully funded by the government. The Aged Care Funding

Instrument is basically the tool through which an individual's need are assessed relative to the subsidies that can be applied to meeting their needs. And the funding instrument has a number of areas, activities of daily living, behaviours and complex chronic conditions, and within there, looking at the care needs of the resident, you
5 would then score what those needs are and that would then assign a subsidy against that individual relative to that set of needs.

DR McEVOY: So I think one of the things you identify in your statement, Mr Rooney, is that the indexation hasn't kept up with the increasing costs of care. How
10 has LASA identified that? Is that something that members are coming to you saying? Is that the consequence of surveys or independent research? How – what's your position in relation to that?

MR ROONEY: So just for context, if I take a big step back, I would suggest what's
15 going on in aged care is the needs of older Australians have been growing faster than the system's ability to meet those needs, and that plays out in home care waiting lists, it plays out in funding and a whole range of things. With respect to the ACFI and the issue that you're talking about, in 2016 the government made a decision to change the scoring rules in the ACFI, and to also implement a freeze on indexation. So
20 effectively what this was doing was asking providers to continue to deliver a standard of care and a range of services, but in effect paying less for those, and so there's evidence to show there is a clear disparity between the rising cost of delivering these care – these services, but a departure in the subsidy or the fees that are being provided in order to deliver that care.
25
And over the past two years, if you look at the expense sheet of a residential care facility you will see about 70 per cent of expenses relate to staff. We have seen in the past two years a three per cent and a three and a half per cent increase in staff wages from the Fair Work Commission. At that same time we've had an indexation
30 pause for one year across all fields in the ACFI and then the following year we've had some of that indexation recouped but really the indexation is well short of CPI, when it is applied, and the halting of the indexation and the changing to the ACFI score has resulted in significant financial pressure on many providers in residential care.
35
DR McEVOY: Can I ask you, Mr Rooney, whether you're aware of cases where there has been abuse of the ACFI assessment tool, so as to increase the funding to a residential aged care provider?

40 MR ROONEY: So at the time that the government chose to change the scoring to the ACFI, and to bring in this indexation pause, the rationale for that change was – I think the language was used was up-coding, optimising. I think at one point it was called – similar terms. And the view being that there was a large proportion of providers that were behaving in a way that was seeking to maximise the ACFI
45 scoring.

DR McEVOY: Including LASA members?

MR ROONEY: Well, that was the assertion by the government of the day. Our approach to that, when that was raised, was first of all we asked the government what is the evidence to suggest that this is the case. The evidence brought forward by the government was that the budget for the ACFI was blowing out. We said, well, that's okay, but the starting point is the budget enough in the first place. We argued that the issue here was perhaps more about rising acuity of residents, rather than a budgetary issue, and we had put forward an alternative option for government to consider, rather than what we saw as a very blunt instrument that would directly impact the care that was afforded to older people, given that we would be constraining the level of fees available to meet those care needs.

DR McEVOY: I'm just trying to establish in my own mind whether – or what the answer to my question is. I think your answer to my question is, well, there were some issues, the government advanced a position to LASA, you asked for evidence, but you're not altogether clear that there ever were. Is that what you're saying?

MR ROONEY: That's what I'm saying, Counsel, and if I expand on that, the alternative that LASA put to government was if the government was concerned that there was anomalous or erroneous claiming patterns in the ACFI, the government has the ability to run an algorithm across the database of the claims and if they saw areas where they felt that there was any inappropriate behaviour then they should be investigated. If there were found to be wrongdoing, then there should be some level of penalty and that that should be reported to the industry. So we had visibility. Unfortunately, the government of the day chose not to proceed with that approach.

We also heard suggested that whilst that process was going on, David Tune was to conduct his legislative review of the aged care reforms and that was the opportunity to look in detail at funding now, but also funding into the future, and we had suggested that that was the appropriate time to work with industry and consumers and others to address a sustainable funding strategy for the industry for the next few decades, rather than having to have uncertainty and instability in the funding provided that could be changed, literally overnight.

DR McEVOY: All right. So what's LASAs position on funding and how funding should work?

MR ROONEY: So, again, if I take a step back, if we're to look at how we would appropriately fund aged care in Australia, I would suggest the starting point is to determine what are the needs out there. Once we understand the needs then work out what are the services that are required to meet those needs and then from that, then determine what standard of quality and safety is required then with regards to the delivery of those services. The next point and a fundamental point which I see has been missing from the system is once we agree, this is the need, these are the services and this is the level that that service needs to be delivered, what does that cost? And as far as I'm aware, industry has been calling for what's termed a cost of care study for some time because without knowing what is the cost, we can never be confident that the subsidy that's provided is appropriate.

Now, once we have that cost we can then work out an appropriate subsidy and then importantly put in place measures that would transparently ensure that we are delivering that care to the right standard, we're adequately funded to do that and that the system can continuously improve through transparency of information that gives
5 consumers insight into what's happening but also providers so they can benchmark performance.

DR McEVOY: In paragraph 53 of your first statement, Mr Rooney, you make a reference to funding stress, and what you mention there is the fact that investment in
10 new buildings and the refurbishment of existing facilities is slowing at a time, of course, when we all know that we're going to need tens of thousands of beds over the next 10 years to meet rising demand. Do you have your own data in relation to those matters? I'm aware of the StewartBrown data.

15 MR ROONEY: So there's two data points to note in addition to the StewartBrown data. The Aged Care Financing Authority has said with regards to residential aged care – I think the latest report was we would require something like 83 and a half thousand new beds, new places to come online in residential care over the next decade. That would require an investment of around $35 million. To put this into
20 context, in the last 10 years I think we brought online about 33,000 places, so that is a significant uplift in activity and building requirement. The other data point is we conducted a survey of our members in 2018, I think it was, to get an insight into their experience of financial pressure, given that StewartBrown was reporting significant pressure. And through that, we found evidence to suggest that instability and
25 insecurity with regards to funding certainty was causing providers to put on hold plans with regards to refurbishment or construction in some cases.

DR McEVOY: Can I turn to the issue of margins, Mr Rooney. Obviously, return on capital is a matter of significance to your members. Would you agree with that?
30
MR ROONEY: Yes. Yes. But return on assets I think is perhaps a better way to describe it.

DR McEVOY: What sort of return would your private for profit members, expect?
35
MR ROONEY: To be honest, I – I don't know. I don't operate an aged care facility as a private owner, so I think a lot of factors would go into that. So there would be the cost of the capital employed. There would be a whole range of other motivations that would need to be – be understood, I think, really, at the – at the individual
40 organisation level. I would say the vast majority of our members are small to medium-size enterprises. The privately owned operators more often than not are family businesses, often handed down from generation. They are in this business because they care for the work that they do and they care for the communities that they operate in.
45
DR McEVOY: Well, I accept, of course, that you personally don't run one of these facilities but, of course, all of your members do, and you're involved extensively in

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the representation of their interests. Are you not able to give us some sort of a range, at least in relation to the private providers?

MR ROONEY: To be honest, Counsel, no, I cannot because I believe that the
5 diversity of the membership base and the different models involved – I do not. I can certainly go and survey our members. If that would be of interest to the Commission, I could go and find out with regards to membership what is the – a range. I'm happy to get that information if that's a requirement.

10 DR McEVOY: Can I turn, Mr Rooney, to the issue of nurses and personal care attendants. As far as you're concerned, what's the key feature of care in both residential facilities and in the home care setting?

MR ROONEY: Sorry, Counsel, I'm not sure I followed the key feature.

15

DR McEVOY: Well, what do you regard as being fundamental in relation to care in both those settings?

MR ROONEY: Well, in both those settings I would have thought the starting point
20 is compassion. We have a professional and passionate workforce. If you talk to providers of these services, the first thing they're looking for in their staff is the right temperament that has the compassion to care for others. And then there's adequate skills, qualifications, and then it flows from there.

25 DR McEVOY: And you would agree, I take it from that answer, that generally speaking when things have gone wrong, there has been some sort of a breakdown in that delivery of compassion, some sort of breakdown in the interface between those providing it and the people receiving it?

30 MR ROONEY: Yes, Counsel. My reflection would be at the heart of failures there would be questions of either the character of people involved. At times it could be their competency or qualification. I think beyond that, and certainly as being played out in some issues that have been brought to light, that the culture of workplaces, systems and processes can also be a contributing factor. But then beyond that there
35 are also factors outside the direct control of those factors that would impact and availability of staff in some areas would be an example of that; changes to the funding would also be an example of that.

DR McEVOY: And you would accept that there has been, over time, a decline in
40 the face-to-face contact between residents and nurses?

MR ROONEY: I don't have that information in front of me. What I will accept is that there has been a decline in the numbers of registered nurses and enrolled nurses in residential care over time. And that decline has seen at the same time an increase
45 in the number of personal care workers. That increase has also seen – and that change has also seen an increase in the direct contact hours of care provided to residents.

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DR McEVOY: Why do you think that – that there is – there has been over time the reduction in nursing care that I think you accept there has been?

MR ROONEY: I think what's behind that is the upskilling of the personal care
5 worker, the requirement for that personal care worker to do more or do tasks that might have otherwise been dealt with by others. I have struggled in the work that I do to reconcile the paradox between rising acuity, in the – in a large number of people coming into residential aged care and the – the reduction in registered nurses and enrolled nurses. I suggest that the way that – to resolve that is through the work
10 of the workforce taskforce and the workforce strategy where the approach has been to look at care being provided in a very holistic way, rather than focusing singly on clinical care, understanding this as a more broader set of outcomes, holistic care or wellbeing, that requires not just clinical care but a range of other skills mix or inputs that deal with social, emotional, spiritual and others, and what I would suggest is
15 required here in order to deliver the best care outcome for older Australians in residential care is to work up an evidence base through research to come up with a range of optimal models to meet all of those needs.

DR McEVOY: What makes you say that there has been an upskilling in personal
20 care attendants in this period?

MR ROONEY: I would suggest that in order to – in order to be able to provide that care there has been a greater requirement upon those personal care workers. We – as I said - - -

25

DR McEVOY: But that's a different point, with respect, Mr Rooney. I'm wanting you to address your claim that there has been an upskilling - - -

MR ROONEY: Yes. So I can - - -

30

DR McEVOY: - - - in personal care attendants.

MR ROONEY: Sorry, Counsel. I can say from LASAs experience in operating a registered training organisation that we have – many of our members would have
35 personal care workers that have been trained by our organisation in certificate III and certificate IV qualifications over time. That is the basis upon which I would suggest there has been an upskilling.

DR McEVOY: That's the bare minimum, isn't it, Mr Rooney?

40

MR ROONEY: That is right, but that's the personal care worker - - -

DR McEVOY: Yes.

45 MR ROONEY: Sorry, let me go back. There isn't a regulated bare minimum with regards to a qualification for a personal care worker. The workforce taskforce identified this as an issue and we have now moved to implement an Aged Care

Industry Reference Committee which will set for the first time a national standard for qualification, and I would suggest that part of that would be looking at the implementation of a bare minimum qualification to work in aged care.

5 DR McEVOY: I want to do justice to your answer, Mr Rooney, but I'm still struggling to see where the upskilling is happening.

MR ROONEY: Well, Counsel, all I can say is from my experience, in operating a registered training organisation, our members have asked us to train their personal
10 care workers in certificate III and certificate IV qualifications. To me, that is an upskilling of their workforce.

DR McEVOY: So that's the extent of it, you would say?

15 MR ROONEY: Yes, Counsel.

DR McEVOY: So does LASA run training programs for dementia care?

MR ROONEY: As part of the certificate course, the accredited training, there are
20 units for dementia care, yes, Counsel.

DR McEVOY: And is that something that is in any sense regarded as mandatory?

MR ROONEY: No, Counsel. For a personal care worker (ageing), it is a – what's
25 known as a core elective. For a personal care worker, other category, it is not. It is just an elective. We would argue, again through the IRC process, that that should be a mandatory requirement for anybody working in aged care.

DR McEVOY: Can I turn to the issue of quality and rating systems. I think at
30 paragraph 33 of your statement, your first statement, you note that there is – yes, it's the last sentence, Mr Rooney:

A lack of robust and reliable information on the performance of different aged care services.

35

What's LASA doing about that problem, if anything?

MR ROONEY: So this is obviously a fundamental issue for both consumers but I would also argue for providers. For consumers, they need to have enough
40 information to make an informed choice with regards to the people that are providing their services. It's of fundamental importance. For providers, it's equally important to have information where they can benchmark their performance against others in order to continuously improve. The work that LASA has done is participated in a range of forums seeking to realise both those outcomes and I guess my observation
45 in recent times has been the approach is really quite siloed or symptomatic, rather than coming up with a solution that actually meets the needs of the consumers and

supports continuous improvement for the providers. If I can expand on that, Counsel?

DR McEVOY: Well, what I would perhaps like you to do, Mr Rooney, if you could, is to say succinctly whether LASA is doing anything about the problem that you identify in paragraph 33, that is to say that there is:

> *A lack of robust and reliable information on the performance of different aged care services.*

I accept that it's on the agenda but can you tell me in a tangible way - - -

MR ROONEY: Yes.

DR McEVOY: - - - what's happening.

MR ROONEY: So we have been participating in forums with government with regards to pricing transparency in home care. That is a tangible example. We have participated in forums - - -

DR McEVOY: And what has come of that?

MR ROONEY: So there is now a process by which providers are required to put on the My Aged Care portal their pricings lists. There is further development to bring a greater consistency in those prices. And what we've also suggested is in that process being able to expand the interpretation of the service aligned to the price. And the point being, price point is one element but there's not – that's not the entire element of a service. There are different models that are delivering that service and so having some further explanatory information to explain, well, why one price is X and the other price is Y, there could be reasons for that, and so it's important for the consumer to be informed as to why that is the case.

DR McEVOY: So in paragraph 70 of your second statement, Mr Rooney, you say that:

> *LASA is supportive of consumers having readily accessible, appropriate and reliable information that will enable them to make informed decisions and choices with respect to service types and service providers.*

So how is this to be done, would you say?

MR ROONEY: I would suggest that what we need to do is come up with a model – a tool or a framework, I'm not sure how best you describe it, but for want of a better term, a dashboard that would provide to a consumer a set of information that would make sense to them and help them make an informed choice. For example, that could include things like information from the consumer experience reports with regards to that service. So you heard, I think, recently that those reports look at "Do

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I feel safe, do I like the food, do people care for me". Those types of things are important to a consumer. Equally, a range of appropriate clinical indicators might also be appropriate for that consumer, as would be a record of the compliance performance of the provider and also insight into the staff skills and staff mix.

All of that needs to be provided in the context of what is the model or models of care that are being provided by that service, because all of those things that I've mentioned as indicators would be – would be variable and different depending on those models of care and the types of people that they were caring for with regards to their care needs.

DR McEVOY: So would you support transparency of a kind that showed, for example, that at provider's facility A there would be no nurse on duty at night, but at provider B there would be a nurse on duty at night. That's the sort of thing you would like to see?

MR ROONEY: I would suggest that that information is of importance to a consumer and I think that information needs to be provided with the contextual information around the model of care in that facility.

DR McEVOY: So do I take it as a "yes"?

MR ROONEY: Yes, Counsel.

DR McEVOY: It would be better though in all facilities, would it not, Mr Rooney, if there was always a nurse on duty at night?

MR ROONEY: I think the level of staffing and the skills mix of staffing needs to reflect the needs of the residents. If it is shown that those needs require 24 hour clinical oversight then that would be appropriate.

DR McEVOY: In paragraph 114 of your first statement, Mr Rooney, you moot the possible deregulation of residential care. Can I ask you what you're driving at here?

MR ROONEY: As part of the Living Longer Living Better reform agenda, there is the expected outcome that at a point in time the control and choice will rest with the consumer. What that means in practice is that the current model of the government allocating bed licences to a provider and possibly even capping the number of subsidised bed licences available across the country would be deregulated. So in effect, a provider could basically build a new facility anywhere and provide their service and the quality, price, etcetera, attributes of that service would then be, you know, put to the market and the market would – would respond because the older person has the choice to choose that provider as opposed to another one. That is the intention of the reform agenda. It's outlined in the NACA blue print for reform and also the Aged Care Sector Committee's aged care roadmap.

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DR McEVOY: Can I turn, finally, Mr Rooney, to the issue of physical and chemical restraints in residential nursing care. What's LASAs position in relation to restraints?

5 MR ROONEY: So I mean restraint is a serious issue in society. Certainly in residential care it's a serious issue. We support what the ALRC has said with regards to the use of restraint is not something to be taken lightly. It needs to be a measure of last resort. There are a number of things that can be done to deescalate a situation before you would use restraint. It must be applied with consent. It is a
10 clinical decision in most cases. And it needs to be properly monitored and applied, obviously, with discretion.

DR McEVOY: Do you know whether the use of restraints amongst your members is trending up or down?

15

MR ROONEY: I do not, Counsel. It's not something that I have requested from our membership. I have just recently, in response to recent reports around the use of psychotropic medications in residential care, conducted a very snap survey of our residential care members to gain some insight into the prevalence of the use of such
20 drugs in their facilities. The headline response from that survey was that around 30 per cent of our providers, our members who responded, were using – on that day, had 30 per cent of their residents were being prescribed those medications.

DR McEVOY: 30 per cent of what you asked in relation to a particular day, did
25 you, and you found that 30 per cent - - -

MR ROONEY: If I recall, it was conducted over a few days. It was a very snap survey because I was concerned with the reports at the time that there was – seemed to be a significant prevalence of the use of those medicines and I guess I wanted
30 insight into that from within our membership base. In response to that survey, what we ended up then doing was share guidance materials back to our members with regards to appropriate use, and then the Minister, obviously, came out and made some announcements with regards to that and, again, we sought clarification and that was provided to our members.

35

DR McEVOY: But you don't know whether that was on the increase or reducing?

MR ROONEY: No, Counsel, because we had not previously requested that information from our members. I do understand that with regards to the new Quality
40 and Safety Commission that the use of restraint – pharmacological restraint will now be one of their screening questions that they will be using in their audit process.

DR McEVOY: Can I take you, finally, Mr Rooney, to paragraph 34 of your first statement where you say that:

45

Most providers make every effort to provide quality care for those living with dementia and at times presenting with severe behavioural and psychological symptoms of dementia.

5 Can I ask what's the basis for saying that, particularly if you're not aware of whether the use of physical and chemical restraints is trending up or down?

MR ROONEY: Sorry, Counsel, I've lost the thread of the question. Can you repeat that, please.

10

DR McEVOY: Certainly. So if you have a look at paragraph 34 of your statement, you will see there in the second sentence:

In residential care most providers make every effort to provide quality care for
15 *those living with dementia and at times presenting with severe behavioural and psychological symptoms.*

And then on you go. I'm wanting to know what your basis for saying that is, particularly in light of the fact that you've just said to me that you're not really sure
20 whether use of physical or chemical restraints by LASA members is trending up or trending down?

MR ROONEY: So that reflection is through consultation with our members. I think what I'm hearing is you're suggesting that there's a correlation between members
25 providing care for people with BPSD and the use of restraint. Is that what I'm inferring from the question? And that because we don't know if restraints are being – moving up or down that that is – that that somehow doesn't support that statement. I - - -

30 DR McEVOY: The essence of my question, Mr Rooney, is what your basis for saying that is. And I think what you've said to me is it's through consultation with your members that you're able to say that.

MR ROONEY: Yes, Counsel.

35

DR McEVOY: What am I to take that to mean? Simply that they're telling you that they're making every effort to provide quality care. Is that why you say what you say in paragraph 34?

40 MR ROONEY: Yes, but I think the qualifying statement there is whilst they're doing everything they can - - -

DR McEVOY: Whilst they say they're doing everything they can to you, yes.

45 MR ROONEY: Whilst they say they're doing everything they can, they report that the funding provided to support residents displaying BPSD is inadequate. That was the thrust of that statement.

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DR McEVOY: Commissioners, for present purposes, I don't have any further questions for Mr Rooney.

COMMISSIONER TRACEY: Yes. Thank you very much for your evidence, Mr Rooney. It will be brought into account in due course when we're considering what recommendations to make.

<THE WITNESS WITHDREW [3.48 pm]

DR McEVOY: Commissioner, just before we move to the next witness, could I just indicate that I did not tender two of the documents I took Mr Rooney to in the first part of his examination. The first of them I think was the single aged care quality framework document which is RCD.9999.0017.0001. So I would seek to tender that.

COMMISSIONER TRACEY: Does it bear a date?

DR McEVOY: Yes, April 2017, Commissioner.

COMMISSIONER TRACEY: And its full title?

DR McEVOY: The Single Aged Care Quality Framework, LASA submission.

COMMISSIONER TRACEY: All right. The care quality framework document dated April 2017 will be exhibit 1-48.

EXHIBIT #1-48 SINGLE AGED CARE QUALITY FRAMEWORK, LASA SUBMISSION DATED APRIL 2017 (RCD.9999.0017.0001)

DR McEVOY: And the second document, Commissioner, which I would seek to tender, is the Australian Government Department of Health single aged care quality framework draft Aged Care Quality Standards consultation paper 2017 which bears the identification number RCD.9999.0018.0001.

COMMISSIONER TRACEY: The Department of Health 2017 document, the full title of which appears in your tender statement, will be exhibit 1-49.

EXHIBIT #1-49 DEPARTMENT OF HEALTH SINGLE AGED CARE QUALITY FRAMEWORK DRAFT AGED CARE QUALITY STANDARDS CONSULTATION PAPER 2017 (RCD.9999.0018.0001)

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DR McEVOY: Thank you, Commissioner. Commissioner, I would now seek to call Mr Nicolas George Mersiades.

5 **<NICOLAS GEORGE MERSIADES, SWORN [3.16 pm]**

<EXAMINATION-IN-CHIEF BY DR McEVOY

10

DR McEVOY: Operator, could you please bring up WIT.0011.0001.0001. And then, Mr Mersiades, do you recognise that document as your statement?

MR MERSIADES: Yes, Counsel, I recognise the first page.

15

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

MR MERSIADES: No, thank you.

20 DR McEVOY: And are you able to confirm for the Commission that its contents are true and correct to the best of your knowledge and belief?

MR MERSIADES: Yes.

25 DR McEVOY: Commissioner, I would tender it the statement of Nicholas George Mersiades bearing the identification number I've listed and the identified annexures to that statement.

COMMISSIONER TRACEY: Yes, the witness statement of Nicolas George
30 Mersiades dated 31 January 2019 and the annexures thereto will be exhibit 1-50.

EXHIBIT #1-50 WITNESS STATEMENT OF NICOLAS GEORGE MERSIADES DATED 31/01/2019 AND ANNEXURES THERETO
35 **(WIT.0011.0001.0001)**

DR McEVOY: Thank you, Commissioner.

40 Mr Mersiades, could you give the Commission your full name.

MR MERSIADES: Nicholas George Mersiades.

DR McEVOY: And you are the director of aged care at Catholic Health Australia.

45

MR MERSIADES: Yes.

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DR McEVOY: And what does that role involve?

MR MERSIADES: That role involves, on behalf of our members, the monitoring and review of government aged care policies, development of policy options,
5 alternative policy options, representing our members in consultations with the government, and in consultation with other stakeholders and looking particularly at system-wide levels, not – not service delivery levels.

DR McEVOY: And in broad compass who are your members?
10

MR MERSIADES: Our members are religious orders, archdiocese, congregations and the like.

DR McEVOY: So would it be fair to say that pretty much all residential care
15 facilities provided by Catholic religious orders or diocese in Australia are members of Catholic Health Australia?

MR MERSIADES: The overwhelming majority would be.

20 DR McEVOY: And your members provide both residential and home care?

MR MERSIADES: And home support, correct.

DR McEVOY: And what's your own experience in the aged care industry?
25

MR MERSIADES: My experience is on – from – as an employee of the Commonwealth Government and in the various iterations of the Department of Health for a number of years. Then for a short term with an aged care provider and more recently with – as the aged care director of Catholic Health Australia.
30

DR McEVOY: And you're also, I think, the deputy chair of the Aged Care Financing Authority.

MR MERSIADES: Correct.
35

DR McEVOY: And what does that authority do?

MR MERSIADES: It was set up by the government in 2013, I recall, to provide an annual advice to the government on the funding and financing of aged care in
40 Australia.

DR McEVOY: Now, Mr Mersiades, in your statement at about paragraph 110 you describe the aged care system as being primarily designed around an outsourced government service model where the government regulates most aspects of the
45 system. What would you say is the principal reason for the system's current design?

MR MERSIADES: It stems from the fact that the Commonwealth Government has been the major funder of aged care for a long, long time, and it was – it was probably the way for the government to be able to control outlays as effectively as possible.

5 DR McEVOY: So one of the things that you say is a consequence of the current design of the aged care system is that there are numerous areas where consumer needs are not met and one of those is that in selecting a type of aged care service, families are constrained in their choice of service type. This is at about paragraph 53 of your statement. Can you just elaborate for the Commission on the question of
10 why that is happening?

MR MERSIADES: It is a by-product of the control measures that the government has in place for the – for the provision of services, the level of service it's prepared to fund. And it does that through provision ratios and over the years that ratio has
15 altered and also the components within it have altered. So there's – it's the government that determines the proportion of the overall rationing service that will be residential and which will be home care. And – and the widespread view and the evidence coming through more recently is that consumer preference is to age at home, rather than in a residential facility, and at the moment the provision ratio has a
20 target of 87 places per thousand people over 70 for residential care, moving to 45 for home care. At the moment home care is about 32.

DR McEVOY: So one of the things you say – I think this is 53(d) of your statement – is that the balance of care types are determined by government, not by consumer
25 preference. So - - -

MR MERSIADES: That's right.

DR McEVOY: - - - the critique, if you will, is that there's an element of – a very
30 substantial element of central control in all of this - - -

MR MERSIADES: Yes.

DR McEVOY: - - - rather than consumer driven - - -

35

MR MERSIADES: That's right.

DR McEVOY: - - - demand. And another of the points that you make is that residential aged care providers who might have a good reputation are limited in the
40 flexibility they have to expand their services because of the aged care allocation round system. Can you just explain to the Commission exactly what you mean by that?

MR MERSIADES: The aged care allocation round is something that's conducted
45 generally on an annual basis – not always – and it operates within those provision ratios and depending on the movement of population growth, there will be a number of places advertised nationally and providers have to apply for them, and they're

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assessed and if they're successful, they're granted those places in perpetuity. And it means that if a provider – a provider has to have achieved those places in order to qualify to receive government subsidies.

5 DR McEVOY: So I think the position historically is that home care packages were provided in a similar manner but as part of the 2017 reforms that's no longer the case. Does Catholic Health consider that a similar approach should be taken in relation to residential packages?

10 MR MERSIADES: Catholic Health puts a lot of emphasis on the importance of consumer choice and believes that that's where the reform should take us but we need to do it in a very careful way. You can't introduce it overnight. It has to be staged and carefully thought through.

15 DR McEVOY: So how might that be done in a way that was not unduly disruptive?

MR MERSIADES: Well, the primary way is to give people in the sector advance notice, rather than having knee jerk ad hoc policy development.

20 DR McEVOY: And do you think there is too much of that, do you?

MR MERSIADES: Historically, yes, that would be the case, but, you know, there are circumstances which – which explain why it happened that way. I mean, there are budget restraints on governments and a level of risk averseness. Reform and
25 change is always risky and sometimes it's easier to let sleeping dogs lie.

DR McEVOY: One of the issues you raise – and this is at paragraph 57 of your statement – is the issue of unmet demand in relation to the supply of aged care effectively because government policy caps or rations the services and the service
30 types. What are the major problems that that gives rise to?

MR MERSIADES: Well, the major problem it gives rise to is that it generates the waiting lists. We've always assumed there were waiting lists or queues but we didn't know – but the policy reform around home care packages, the funding following the
35 consumers for the first time made that transparent which I think took most people by surprise at the extent of it. So you're not only having waiting lists, waiting times and people missing out on care, despite their needs, but it also means that they're not having the same capacity to pick and choose their provider. You know, it has generally been the opposite. Providers have had much stronger capacity to be able to
40 pick and choose who they provided care to.

DR McEVOY: You've mentioned that there are issues with the ongoing viability of some providers, and this is particularly in connection with the financial pressures that have been evidenced since the introduction of the Aged Care Funding Instrument.
45 Can you explain what some of the issues with the ACFI are from the perspective of your members?

MR MERSIADES: The biggest problem with the ACFI is it is prone to volatility because of its subjective nature, and certain – certain aspects of it which drive that – which drive that volatility. At the moment we're going through a period where the government has sought to pull back on the rate of growth in – of – of ACFI expenditure, which means that we've gone from – from a relatively high level of government subsidy to a low level. For example, in '17/18 there was no real growth. In fact, there was no growth at all. The per residents per day figure in '17/18 was the same as in '16/17. Now – but if you're looking at – at the performance of the ACFI in that way you really need to look at it over the entirety of its existence, and in that sense, the real increase has been 57 per cent over that period, which is – which is a significant figure.

But the trouble is, it has gone from, you know, from an average of 2.1 real – 2.1 per cent real in one year up to 8 per cent in another year. I mean, that's not desirable from a government point of view or a provider point of view. Linked to that is the issue of indexation. The issue there is that I think the indexation formula is particularly harsh, and as a result it's not keeping up, it's not faithful with the – with price movements that are being incurred in comparable sectors of the economy which means that providers who administer the ACFI understandably look at ACFI as the only avenue for having an impact on their revenue, as they're looking to maximise it as much as they can. And that's why, you know, we have these – this fluctuation from year to year which is to me is an indication of a flawed system and that is precisely why the government has taken steps to develop a – to work towards a new funding model.

DR McEVOY: In paragraph 70 to 73 of your statement, just on the subject of indexation, you refer to analysis that Catholic Health has done. Are you able to explain the outcome of that analysis?

MR MERSIADES: Counsel, I'm not sure which analysis you're referring to.

DR McEVOY: So in paragraph 71, you will see there, there's a reference to – at the bottom of 70 and start of 71 there's a reference to ACFA analysis, is that an analysis which Catholic Health has also conducted?

MR MERSIADES: No. Not really. We rely on our data on the analysis that ACFA does and also the analysis that StewartBrown does.

DR McEVOY: So where you say that the ACFI funding model is difficult to administer in 74, can you just explain to the Commission what some of the problems are there?

MR MERSIADES: It is – ACFI is a very technical document. It requires people with clinical skills to do it effectively, and it means it's diverting people with skills which would be better directed towards the care of residents to doing this administrative task. And, in fact, quite often, you know, there has been basically an industry that has also developed around providing this service for aged care homes

and, of course, providers pay for that. So that whole system where – where the ACFI is administered internally but by providers is a significant cost to the sector.

DR McEVOY: So insofar as the government is currently considering alternative
5 funding models to replace the ACFI, which is I think the subject of at least paragraph 75 - - -

MR MERSIADES: Yes.

10 DR McEVOY: - - - of your statement, what would Catholic Health say, what features should Catholic Health say any alternative funding model might have?

MR MERSIADES: We would argue that the eligibility assessment and the funding assessment should be – should be done externally and independently, and we also
15 support the thrust of the Resource Utilisation and Classification Study which is moving towards creating a funding system based on the case mix system, which is used throughout public hospitals. And also we would argue that that new instrument ought to be administered by an independent statutory authority of some kind, rather than – rather than by the department or by providers themselves, and that – that
20 independent approach is one that – that CHA has advocated since the 2011 Productivity Commission review, and – and we were – we would argue that the ACFA should have been an independent pricing authority rather than just an advisory body on funding and financing.

25 DR McEVOY: Well, on the subject of financial viability, you say at paragraph 88 that:

The financial viability of the aged care sector is a precondition for addressing its future workforce requirements.

30

Now, you also identify that the caps that are placed on prices that residential providers receive to provide personal and nursing care for residents influences the standard of personal and nursing care that can be provided. Do you want to just elaborate on that issue?

35

MR MERSIADES: If we're focusing on personal and nursing care – that's the ACFI funding – the reality is that there's no calibration between that funding level and the achievement of a particular quality of care as well as not to mention quality of life. I mean, the two – they're related but they're quite different. The funding
40 that's delivered for – through the ACFI is really – see, the ACFI is a resource allocation tool. It's – the government determines a fixed amount, essentially, this is going to be the budget and what the ACFI tool does is distribute that according to the needs of individuals based on an assessment. And – and that's – that quantum that it has has really just developed over the years. It really hasn't been subject to
45 significant analysis to see how it relates to the quality of the care being provided. The assumption is that, you know, we've got a – we've got a quality agency, you

know, it's – it's delivering a reasonable level of care, most providers – most – the overwhelming majority of providers are accredited so it must be doing okay.

It's not really a sophisticated tool based on what it really costs to deliver quality of care and quality of life. But the other one that's also capped is the activities of basic – of daily living which is capped at pension levels. So for every resident anywhere in Australia will pay 85, up to 85 per cent of the pension towards their living – daily living expenses. That puts a cap on the quality of life that can be supported there. And, of course, you know, we don't have red dollars and green dollars so the care money and the pension money can move across both frontiers.

DR McEVOY: Well, on the subject of money, you've mentioned in your statement that increased care contributions by those who can afford to contribute more is a matter that you say the government should address moving forward.

MR MERSIADES: Yes.

DR McEVOY: What do you say – what does Catholic Health say might be appropriate by way of change or reform in that regard?

MR MERSIADES: What we would say – what we would say and I hope the Royal Commission will say – is that we need to have a national conversation about the quality of aged care that we expect to have in the future, and how we're going to pay for it, and – and there to be some analysis and scenario planning done which indicates options about levels of consumer contribution, because at the moment – and also we need to tease out the various streams of – of costs, be they accommodation, activities of daily living and personal care and support. They're all quite different and we take different approaches in them. But we can't talk about increased contributions from consumers who can afford it with – without giving the community and consumer something in return and that has to be greater consumer choice and control and – and the option in terms of the quality that they expect to receive.

So I'm trying to move away from an aged care system which is controlled and managed to the nth degree by the government and instead move to one where we have a genuine aged care service industry where it's the consumer that calls the shots. And as well as that, I also recognise that not every consumer and family is going to be as adept and have the functionality to be able to – to be effective in that environment and therefore we also need to have in place other appropriate consumer supports and the government is moving on – in that area but more needs to be done there before we can open the system up.

DR McEVOY: Well, let's hope that we're having as a part of this Royal Commission that conversation.

MR MERSIADES: Yes.

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DR McEVOY: What though – I mean, do you have in mind particular structures, particular ways that we might have a system whereby there is more by way of contribution by consumers for their care?

5 MR MERSIADES: Inevitably the conversation is going to have to go to the value of the land that people have got their houses on because most wealth – wealth for most people is in their home and the land that it sits on. And it would only take – we're not talking about the government still not contributing the bulk of the cost of personal care and nursing care. It's a question of increasing the contribution by those
10 – those who can, rather than taking the view that every last dollar has to be preserved for – for inheritances. In 19 – in 2014, the value of inheritances in Australia was $24 billion. If we could – if the community were able to agree that a small proportion of that could be directed towards providing better care and services for our older generation then so much the better. Now, that's a 2014 figure. If you can go to the
15 Productivity Commission and get them to do an update I think you will find it's considerably more.

DR McEVOY: And is it a position of Catholic Health, is it, that one feasible answer to this conundrum is to tap into that?

20

MR MERSIADES: Yes, and that's not just Catholic Health Australia. It was a recommendation of the legislative review which also had a number of other recommendations looking at improving or securing sustainability of aged care services. The current funding model we've got at the moment is plain and simply
25 not sustainable. And we're going to – as a result you're going to have – have a real cap and a blanket over the top of the quality of care which can be provided to older Australians.

DR McEVOY: A necessary limitation, you say, already exists and is only going to
30 become worse?

MR MERSIADES: Yes.

COMMISSIONER BRIGGS: Can I just check that. So in effect, Mr Mersiades,
35 you're suggesting that there should be a shift in the proportion of the cost of care borne from the government to the older community through their estates to support the demographic challenges we face with the sector?

MR MERSIADES: Yes. And that's specifically to do with personal care and
40 nursing care. As I said earlier, you could take a different approach to everyday living expenses and accommodation. In accommodation, for example, we have already got market-based prices and the government in supporting those of lesser means virtually matches those prices, not precisely but it's near enough.

45 COMMISSIONER BRIGGS: Thank you.

DR McEVOY: Can I just go to the issue of home care packages, which is something you have something to say about in about paragraph 168 of your statement. And you say there that the policy effect of allowing consumers to use their home care package budget flexibly is one that you regard as appropriate, but
5 you observe that it's problematic in practice for a number of reasons. So what are some of these practical problems that you are referring to?

MR MERSIADES: It's really to do with the level of unspent funds. What we're – what we're evidencing is that there is significant under-expenditure of the individual
10 budgets that the – that go with the packages. The latest figures I've seen suggest that it's around about $6000 a year. And that – which means that providers have in their custody – I think the last figure was about 350 or 400 million dollars. Now, over the next three years or so we're going to see the number of home care packages going from about 90,000 to 150,000 so unless consumer behaviour alters, the amount of
15 money which is sitting with providers doing nothing is going to be upwards of half a billion dollars. The reason that was put in there originally was to do with a bit of a contingency. But obviously something is going on and people are not wanting to use all those resources, and it could be that they never wanted the full value of the package in the first place.
20
We don't know the answer to that question because we've only – they're allocated at four levels; perhaps we should have more levels or should allow people to choose to work with a package less than the assessed level because people have got different levels of resilience, they've got different levels of informal support. So we've got all
25 this money sitting in providers, sort of laying idle. The other reasons include I think it creates – it can create a perverse incentive for that money to be used in a way which is not material to someone's real needs. And in a competitive service environment you can see where one provider will be asked to sort of say, well, I want you to do this landscaping or put in a new fridge for me and the provider said no, I
30 can't do that. And they say, well, the one down the road will do it for me, why can't you do it. So, I mean, that system is – it also has its perverse aspects. It creates a contingent liability for the Commonwealth in that if something goes wrong with its provider, someone is going to pick up the tab. It could be lost. And bear in mind some of that unspent money is also private money and there's a fourth one which
35 escapes me right at the moment.

DR McEVOY: It's there in your statement. So we're conscious of what you say in that regard. One of the things you suggest is that there might be the introduction – or one thing that might be worth considering is the introduction of debit card
40 functionality into the payment system. What's the basis of that proposal and what does that seek to address?

MR MERSIADES: It seeks to address the level of money which is sitting with the provider laying idle. And also what it does away with – this is the fourth one, I now
45 recall it. What – in being – being responsible for that unspent funds, the providers have to – have to ensure that it's properly accounted for, that it's secure, which is additional costs, so this is regulatory-related cost and, again, that is eating into – into

the moneys which could be available for direct care delivery. And so – and also for the government point of view, it reduces its costs of the interest charges on money that it has to borrow. And – and it also means that there's – the contingent liability goes away. I mean, in many respects the unspent money sitting in providers' bank accounts creates the same financial risks as an accommodation bond or a lump sum deposit.

DR McEVOY: Can I turn to the issue of access to medical and allied health providers.

MR MERSIADES: Yes.

DR McEVOY: One of the things you say – I think this is in about paragraph 115 of your statement – is that the current interface between the residential facility and the health sector isn't working in the interests of people living in residential aged care and this is – it seems to be a recurring theme in the evidence that we're hearing. Can you just indicate what are the issues that Catholic Health identifies in this regard?

MR MERSIADES: It goes back to the nature of the health system we have in this country, and that is it's a characteristic of it that it is quite fragmented – fragmented in that we have a number of funders, a number of budget holders, different accountability arrangements. That works okay if you've got one health issue, a single health issue. But for older people with complex and chronic conditions where it goes across a number of health requirements and medical interventions, it becomes a nightmare for them. And the problem we have in residential care for residents is that there's a tendency to see residential care as sort of a standalone health service in its own right when, in fact, residents should have the same access to the wider health system in the way – in the same way under Medicare that any resident of Australia has.

And for a variety of reasons, there are difficulties being experienced in different parts of the country in providing ready access to – to those wider health services for residents of aged care homes. I mean, there are examples where, through local initiatives, they have sought to minimise those – those barriers, and they're working fairly cooperatively together. But by no means is that replicated throughout the country, by no means.

DR McEVOY: Well, as you've identified, access to GPs is obviously a big issue. What does Catholic Health say can be done to rectify that particular part of the problem?

MR MERSIADES: The irony is that the residents per – the number of GP attendances per resident has actually been going up. You know, that's the paradox. But the – there is still reports of problems and I suspect that's because of regional differences. The answer seems to be around providing sufficient incentive for GPs in certain locations to actually attend. I think there's probably things that providers can also do to make it a bit easier for – for – for GPs once they visit. I mean, there's

some providers have effective surgeries where – where instead of visiting the resident in their own room they actually bring them to the surgery. Then there's questions of how good the paperwork is and how much time providers – GPs have in terms of down time in searching through someone else's records to find out what is
5 going on. I think you heard a lot of these issues from the GP spokesman yesterday. I mean, they're the sorts of things that need to be tackled. I think My Health Record, if it's taken up extensively by older people would help in that regard. So there are a number of things that can be done but there have to be the incentives in place as well.

10 DR McEVOY: Palliative and end of life care is another aspect of the difficulty of access. Does Catholic Health have particular views about how that issue is playing out and can be dealt with?

MR MERSIADES: We would – what we have found is successful is if the aged
15 care home and the palliative care services within the local health district can work together. An aged care home can't be a hospice and can't have in-house specialists, palliative care specialists such as nurse practitioners. The idea would be – would have to be that there would be a palliative care specialist from – from the local health service that in-reach into aged care homes. And in some parts of the country that
20 works very effectively. In other parts of the country, that service from the local health service is available for people living in their own homes, but tends not to be available for people living in residential facilities. So the model is there and I think I've referenced in my statement an example in the ACT where it's working very effectively and there's no reason why it can't be replicated. And in fact – and the
25 government is seeking to – is embarking on a program to try and replicate that model or variations on that model around the country. So it's not an issue that is being left to go through to the keeper. The government is starting to move.

DR McEVOY: Another of the problems in this dimension that you've identified is
30 the fact that quality of care can be compromised by poor relationships that residential aged care facilities may have with hospitals and the difficulties in establishing and maintaining collaborative relationships with hospitals. How do you see this problem impacting on quality of care for residents?

35 MR MERSIADES: Again, it gets back to the fact that an aged care home is not a standalone health facility and there has to be that interface. It's to do with the quality of the discharge information. It's the quality of the care planning that comes with – and information that comes – if a person – that resident has had to spend a bit of time in a hospital. It's more – it's mostly – then there's – I think there's also capacity for
40 – for there to be a direct communication about the circumstances and how the medication changes, to have that explained rather than the person just turning up and being left at the front door by the ambulance. In some places it works well, other places not so well. But it comes down to individuals and their diligence and their work pressures that they're under. Again, My Health Record should help in that
45 regard.

DR McEVOY: Perhaps we can move to areas of for improvement. One of those that you mention in about paragraph 20 of your statement is paying more attention to reablement.

5 MR MERSIADES: Yes.

DR McEVOY: And social and emotional supports, social engagement and inclusion.

10 MR MERSIADES: Yes.

DR McEVOY: Can you say something about what Catholic Health is doing in that department?

15 MR MERSIADES: A number of our providers are doing – are experimenting successfully with making greater use of physiotherapists, exercise physiologists and allied health generally to mobilise people, to create social engagement opportunities, low level gymnasiums, all those sorts of things. The sorts of things which when this original specified care and services were written way back when, these weren't part
20 of the lexicon. And this gets to the issue of an aged care home is just not a nursing home; it's where people live and where people can have a meaningful life and a fulfilled life. And to do that, you need social inclusion, you need social activities. If you want to run a cheap aged care home, just put people in the lounge chair and have them watching television all day. I've seen that in – I spent a lot of time in aged
25 care homes a decade or so ago. Hopefully things have moved – well, I know things have moved on from that, but it costs money to have activities going for individuals and social – social inclusion activities.

DR McEVOY: You mentioned the home independence program in Western
30 Australia as an example of the application of good reablement and wellness. What does all that involve?

MR MERSIADES: It was targeting the Commonwealth Home Support Program or the HACC program. So it was the early intervention, early – a low level intervention
35 when you first require some sort of assistance at home to be able to stay home. Traditionally once a person received a level of care, they were on it for the rest of their lives and gradually it was built on and built on and built on. What Gill Lewin found in her work under the HIP – I forget what it stands for, home improvement program, I think it was. And what she found was that even with modest
40 interventions and teaching people to adapt to their particular frailty or learning how to cook or to – to give them some physiotherapy, it can restore their capability and their quality of life, where they can carry on much longer with a better quality of life and a lower cost to the government as well.

45 I think there's enormous potential to take that a lot further with our CHSP and I know the department has started working on trying to replicate that system in

Western Australia across – across all CHP – CHSP providers. So there's a lot of work that's under way, it just takes time.

DR McEVOY: Can I turn to the issue of younger people with a disability in residential aged care. Now, this is something, of course, that the Commission will be looking at very carefully. Does Catholic Health have younger people with disabilities living in residential aged care facilities?

MR MERSIADES: Yes, there would be, yes.

DR McEVOY: And what sorts of difficulties does that cause?

MR MERSIADES: Well, it's a question of putting in younger people with an older age cohort. I mean, their social interests are completely different. And it's not an ideal environment. As – I mean, on a practical sense, the ACFI was never designed to support – to meet the costs of meeting the needs of a younger person with a disability.

DR McEVOY: So does Catholic Health have a view about how these problems – this tendency should be addressed?

MR MERSIADES: Well, it's a question of the funders of the disabilities system providing other alternatives for people. Most people with a – most younger people in an aged care home are there as an absolute last resort. There are examples where an elder parent wants to stay with a child with a disability. I've seen that and that works well. But by and large, most people with a young – young people in an aged care home are there as a last resort because there's no other alternative.

DR McEVOY: Can I just deal with some workforce issues, and in particular the issue of ratios which has been getting a good deal of attention. I think Catholic Health's position is that it doesn't support – does not support the introduction of a minimum staff ratio nurse/personal care attendant to patient. That's the position, I think?

MR MERSIADES: Yes. That's our position. Our view is that there are a number of other things, a number of other ways of addressing the pressing workforce issue, and which should be looked at.

DR McEVOY: And do you want to just walk us through those?

MR MERSIADES: Well, there are a number of aspects to it. Firstly, there needs to be a significant upskilling of our personal care workers. The latest data, even though there has been a significant upskilling that has happened with personal care workers over the last 10 years or so, we still have instances where only 66 per cent of aged care homes have more than 75 per cent of their – of their PCAs with a cert III. In other words they've got no qualifications. In 33 per cent there are no qualifications. And that really plays through on issues on their competence in terms of dealing with

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people with dementia and people with mental health issues which, as you've heard, are a growing and significant proportion of residents as well as home care recipients.

Now, there's also the difficulty – so there's upskilling that needs to take place.
5 There's the issue of under-remuneration of personal care workers. The Pollaers work has – work that was done in conjunction with the Pollaers review demonstrated that in a work value sense, the personal care workers are under-rewarded by about 15 per cent compared with comparable areas in other sectors, which makes attraction and retention difficult. It's very important that we get the most qualified and empathetic
10 people working in aged care that we can. I think the other – in terms of delivering higher quality care, we have to tackle the issue of the interface we were talking about before, with the wider health sector. This has been recognised as a problem for a long, long time and we've been through coordinated care trials, the business of general practice, Medicare local and our primary health networks, all designed to try
15 and coordinate the delivery of services from the various fragmented elements, particularly into residential care.

I think we have to tackle that aspect of it because I think that has got bigger dividends than looking at a blunt instrument like staff ratios. Now, and also there are
20 practical problems with staff ratios. For one, we are still living in a bifurcated – essentially bifurcated aged care system. It wasn't so long ago we had separate hostels and separate nursing homes. They were funded completely separately and when you had a particular care need, which when you achieved a threshold, you had to move to a nursing home. We introduced ageing in place in 1995 or 6 or
25 thereabouts. The fact is that a lot of our facilities were built as hostels. They're not amenable to nursing homes. And so we still have a lot of services out there with a preponderance of lower level staff, lower level residents.

And as a result when you look at the average per resident per day care payment it can
30 vary from $40 per day to $214, current figures, $214 a day. You multiply that through, do the maths in terms of an average 80 bed facility and there will be a huge difference in the total revenue available. Now, how do you apply a staff ratio to that – that dispersion of funding levels. And on top of that, how do you accommodate that important aspect of quality of life, not just quality of care. And this is where you
35 have to accommodate in a ratio allied health, exercise physiologists, for example, not to mention pastoral care workers. It's – the variety that's out there, to my mind, doesn't lend itself to staff ratios, and you would be creating an administrative swamp in trying to go down that path.

40 We used to have something similar to that prior to '95 under the old CAMs system, but – under which effectively each facility was funded on a deficit funding basis. It was based on a certain number of hours of care and certain number of residents so each facility was getting a certain amount of money which had to be audited. If you didn't spend the money it has to be paid back. If you've spend too much the auditors
45 came in and asked all sorts of questions and you had big arguments about what was care and what wasn't. It was a nightmare and there were court cases going on. Instead of going down that path we decided, or the government decided to fund

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individuals on their – based on their care needs and which – and at the same time they introduced accreditation and complaints – the complaints scheme which was to be the way to support quality of care, rather than trying to control inputs.

5 DR McEVOY: I think you said at the outset of your answer to my question that there needed to be an upskilling of personal care workers as a part of dealing with this problem.

MR MERSIADES: Yes.

10

DR McEVOY: If upskilling is part of the answer to this ratios conundrum, I'm wondering what that really means. Does that mean that you or Catholic Health supports registration and mandatory qualifications for personal care attendants or does it mean – what precisely does it mean?

15

MR MERSIADES: We would support credentialing and registration of the unregulated portion but you can't do that overnight because they're not out there. So you would have to phase it in. And part of that phasing in is making it more attractive for people to take aged care up as their career. It's all – it's all a circle, I

20 mean, you can't just pick out one little aspect of it. It's a virtual circle that you have to work on.

DR McEVOY: What do you do in order to achieve that, then? Addressing that particular question.

25

MR MERSIADES: Well, you have to start increasing the remuneration. You've got to change the perception out there that aged care is the last place that you want to work in. I mean, that's a community perception that's held out there. If you go to a barbecue and I've heard, you know, you say you work in aged care, they sort of look

30 at you, because despite – the fact is that there's a lot of negative publicity out there and a lot of mixed messages which is clouding the reputation of the sector as a desirable place for people to work in. But there's also – the effort has to be put in through the new Aged Services Industry Reference Committee, working with the sector, to actually change the curriculum and to ensure that – that the – that the

35 people graduating through – through the VET system are appropriately skilled to deliver care in – given the – the residential profile we have these days.

DR McEVOY: Can I leave that aspect of the problem for a moment and go to dementia care.

40

MR MERSIADES: Yes.

DR McEVOY: You deal with this in about paragraph 20 of your statement and identify clearly enough that there are instances where older people with dementia are

45 not receiving appropriate care. What are the factors that Catholic Health attributes as the cause of this problem?

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MR MERSIADES: I think there are two aspects of it. One is the ready availability of – of people who are skilled, you know, the Brodatys of this world who are skilled in the care of people living with dementia. These are special – this is specialist information that's required. Now, we do have the SBRT, Severe Behaviour Response Teams, which the government has introduced in the last couple of years and – which – that providers can access for people who are demonstrating severe and challenging behaviours, which is not uncommon for people with – living with dementia. Quite often it can be that their underlying clinical conditions which are hard to identify, and – but – so we need to get more specialists being available, coming into that in-reach issue, coming into aged care to support the local staff. But there's also an important – it's also important to upskill the local staff as well, you know, whether it's through their formal training or through – through education and support provided by the specialists through the SBRTs, for example. I think there's probably a need to expand the reach and availability of the SBRTs.

DR McEVOY: Are some of the problems that you advert to in connection with appropriate dementia care linked to the use or reliance on chemical and physical restraints in residential facilities?

MR MERSIADES: I think you've heard from other – other witnesses that this is a – a problem in the sector. And the fact is that I think – well, it's recognised that they're overused and they're of questionable efficacy for most people. If we are going – if we're looking to reduce their use, I think we – the answer has to be that we upskill the capacity of the staff to be able to manage without resorting to – to sedation and psychotropics. I'm not a clinician but there's evidence out there which suggests that appropriately applied and there are non-pharmacological responses which can be effective, but I've also heard that they can be time consuming and, therefore, time equals dollars, and as I said, it does require people who are sufficiently skilled to be able to explore those options.

DR McEVOY: Commissioners, I don't have any further questions for Mr Mersiades.

COMMISSIONER TRACEY: I won't detain you much longer, Mr Mersiades, but I wonder whether you were in the hearing room this morning when Ms Sparrow gave evidence?

MR MERSIADES: Yes.

COMMISSIONER TRACEY: And she mentioned that trial and she said that she thought occurred in Tasmania in about 2011 of teaching nursing homes. I wonder – she indicated that it was successful, but there had been no follow-up and – would the institutions that you represent be amenable, either in part or as a whole, to providing their facilities for such training in a way to expand and do the upskilling that you've been referring to?

MR MERSIADES: Well, most definitely because amongst other things it's a good recruiting approach. If you have students placed in your facility, in your home to deliver services, and you treat them well and they enjoy their experience, there's a fair chance they will come back. Now, I'm aware of that – that particular trial that was done but I'm not quite sure what the outcomes were, like Pat, but it's not unusual for there to be partnerships now between training institutions and various home – various aged care homes. Because there is a requirement under the – under the – under the various curricula that a certain number of hours are spent in an aged care home, you know, working on the ground, so to speak.

COMMISSIONER TRACEY: Thank you. Well, we've detained you a lot longer than we promised but thank you very much for so much very useful evidence which we will take into account and I think on a number of issues, not least financing, we may need to have some further evidence from you later in this process. Thank you very much.

MR MERSIADES: Thank you Commissioner, I'm more than happy to help as much as I can. Thank you.

COMMISSIONER TRACEY: Thanks.

<THE WITNESS WITHDREW [4.16 pm]

COMMISSIONER TRACEY: Nothing more today, Dr McEvoy?

DR McEVOY: Nothing more today, no.

COMMISSIONER TRACEY: The Commission will adjourn until 10 am tomorrow morning.

MATTER ADJOURNED at 4.16 pm UNTIL WEDNESDAY, 20 FEBRUARY 2019

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