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

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

MUDGEE

10.03 AM, TUESDAY, 5 NOVEMBER 2019

Continued from 4.11.19

DAY 62

MR P.R.D. GRAY QC, counsel assisting, appears with MS Z. MAUD and MS E. HILL
DR K. HANSCOMBE QC appears with DR BROPHY for Australian Unity
MR T. BATEMAN appears for LiveBetter Community Services

COMMISSIONER PAGONE: Good morning.

MS HILL: If the Commission pleases, I call Phillip and Sue Dunlop.

<SUZANNE MAREE DUNLOP, SWORN [10.04 am]

<PHILLIP ALFRED DUNLOP, SWORN [10.04 am]

COMMISSIONER PAGONE: Ms Hill.

<EXAMINATION BY MS HILL

MS HILL: Good morning Sue, good morning Phil.

MS DUNLOP: Good morning.

MS HILL: Phil, I will start with you. Could I ask you please to state your full name.

MR DUNLOP: My name is Phillip Alfred Dunlop.

MS HILL: And could I just you to move slightly closer to the microphone when you're answering those questions.

MR DUNLOP: Okay.

MS HILL: Thank you. And how old are you, Phil?

MR DUNLOP: I'm 73 years old.

MS HILL: And you're married to Sue.

MR DUNLOP: Yes.

MS HILL: And I'll turn to you, Sue: could I ask you to state your full name.

MS DUNLOP: Suzanne Maree Dunlop. Age, I'm 72.

MS HILL: How long have you been married to Phil for?

MS DUNLOP: I think 53 years now, I think.

MS HILL: And you're giving evidence together this morning.

MS DUNLOP: Yes, we are.

MS HILL: And you've indicated to me that you would like me to refer to you as Sue and you as Phil.

MS DUNLOP: Yes, thanks.

MS HILL: Would it be fair to also expect that you two might finish each other's sentences at different times.

MS DUNLOP: That's possible.

MS HILL: Now, Phil, you've prepared a statement for the Aged Care Royal Commission that sets out your and Sue's experience of receiving aged care services, doesn't it?

MR DUNLOP: Yes, I have.

MS HILL: Operator, could I ask you to please display document ID WIT.0595.0001.0001. Phil, do you see a copy of your statement on that monitor before you?

MR DUNLOP: Yes, I do.

MS HILL: And you've got a hard copy of your statement there as well.

MR DUNLOP: Yes, I have.

MS HILL: Were there any changes you wanted to make to that statement?

MR DUNLOP: No, not at this stage. No.

MS HILL: And are the contents true and correct?

MR DUNLOP: Yes.

MS HILL: Commissioners, I tender the statement of Phillip Dunlop dated 25 October 2019.

COMMISSIONER PAGONE: Yes. Well, that statement will be exhibit 12-10.

EXHIBIT #12-10 STATEMENT OF PHILLIP DUNLOP DATED 25/10/2019 (WIT.0595.0001.0001)

MS HILL: As the Commission pleases. Operator, could I ask you to also display document ID WIT.0596.0001.0001. Sue, do you see a copy of the statement that you've made on the monitor?

MS DUNLOP: Yes.

MS HILL: And you've got a hard copy in front of you there?

MS DUNLOP: Yes, I have.

MS HILL: And in that statement you set out that you've read what Phil has had to say in his statement and you agree with what he has had to say in that.

MS DUNLOP: Yes.

MS HILL: Were there any changes that you would seek to make to your statement?

MS DUNLOP: No, no.

MS HILL: And are the contents of that statement true and correct?

MS DUNLOP: Yes, they are.

MS HILL: Commissioners, I tender the statement of Sue Dunlop dated 25 October 2019.

COMMISSIONER PAGONE: Yes. The statement of Sue Dunlop will be exhibit 12-11.

EXHIBIT #12-11 STATEMENT OF SUZANNE DUNLOP DATED 25/10/2019 (WIT.0596.0001.0001)

MS HILL: Sue, over the course of the time that you've received aged care services, you've received home care services from three different providers, haven't you?

MS DUNLOP: Yes, I have.

MS HILL: And as part of your evidence this morning, both yourself and Phil, we're not going to refer to them by name, are we?

MS DUNLOP: No, we're not, no. I've got them in front of me here, yes.

MS HILL: And Phil, you both live in a country town.

MR DUNLOP: What was that, sorry?

MS HILL: You live in a country town, Phil.

MR DUNLOP: Sorry.

MS DUNLOP: It's outside a country town, actually.

MS HILL: You're on a farm.

MS DUNLOP: Yes.

MS HILL: How long have you been living out that way for?

MR DUNLOP: Since 2014.

MS HILL: To get to your property, Phil, the access is via a tar road of about 16 kilometres.

MR DUNLOP: Yes.

MS HILL: And a dirt road for the final five kilometres.

MR DUNLOP: Yes.

MS HILL: How far would you be from your nearest neighbour?

MR DUNLOP: Probably about a kilometre. Sorry, our nearest neighbour is our daughter. She's 300 metres up the road and then, other than relations, is about a kilometre.

MS HILL: Sue, you've got limited mobility.

MS DUNLOP: Yes.

MS HILL: Could I ask you to describe those health conditions that lead to you having limited mobility.

MS DUNLOP: Well, the mobility, really is, of course, I mean, I've got diabetes and a lot of different things but the mobility problem is my arthritis. I started with arthritis a few years ago, and it just slowly got worse but not real bad, and a few years ago it started to just take off. It started in my knees and my spine and then has taken off and most of my body has got it now. So I'm not very mobile at all. I can walk with the walking stick. I don't have to at home inside. I can manage, but if I go outside, I do have trouble and I need to use a walking stick anywhere and can't walk very far.

MR DUNLOP: And you've got the problems with your rotor cuffs.

MS DUNLOP: And I've got two torn rotor cuffs, and I've got the one big problem is that I'd have warfarin for – I'd have to take warfarin blood clots so I can't take anti-inflammatories and most of the pain management things just don't work. I've been under a pain management doctor and they can't give me anything that actually works on me, so I – just constant pain all the time.

MS HILL: But you get on with a smile on your face.

MS DUNLOP: I do. Yes, you have to, I'm afraid.

MS HILL: Phil, would you describe yourself as a carer for Sue?

MR DUNLOP: Yes, I am, yes.

MS HILL: Sue, you first accessed aged care services in late 2017 because your daughter got you onto My Aged Care.

MS DUNLOP: Yes, yes. I wasn't coping that well and I didn't sort of realise that I wasn't coping so well and I can remember she came to me and said, "Mum, I think it's about time that we got hold of aged care and got some help for you". I was actually a bit horrified. I said I wasn't my mother but anyway I agreed and I'm glad I did, and I'm glad and it's, you know, it did help.

MS HILL: And did you end up receiving a home care package as a consequence of that?

MS DUNLOP: We started off with the one that you paid $10 a day for. That's what I was – all I really needed at that stage and that gave me three hours a day – a week, sorry, housekeeping; cleaning the house, doing the things that I can't do very well. That worked out really well. That was with UJ, am I right?

MR DUNLOP: It doesn't matter.

MS DUNLOP: Yes.

MS HILL: That was with the first provider.

MS DUNLOP: That was with the first provider. Everything worked really well there. I had a girl that worked – was just fantastic. She – she probably – she lived actually in Lyndhurst. Yes, she was very, very good.

MS HILL: Do you recall what level?

MS DUNLOP: I was on level - - -

MR DUNLOP: Two.

MS DUNLOP: - - - two. Two, at that stage.

MS HILL: And then in January 2018 your daughter says to you that you should be assessed again.

MS DUNLOP: Yes, yes.

MS HILL: How did that go down?

MS DUNLOP: I was getting worse. Well, I agreed with her then, that was fine. I realised then that I was still having a lot more trouble.

MS HILL: What was your daughter's concern?

MS DUNLOP: Well, I had had quite a few falls and I had been stuck outside with a fall. It was just luck she came down to visit, I was home on my own. So she said, you know, "I think we had better do something again". Which we did.

MS HILL: You were assessed again.

MS DUNLOP: Yes, I was assessed again, and I was passed for a level four.

MS HILL: And was a level four package available to you at that time?

MS DUNLOP: No. They put me onto a level three and, as I said, there was about nine months wait for a level four which there was, that was nine months I got the level four.

MS HILL: And at that time did you move from the first provider to the second provider?

MS DUNLOP: Yes. The first provider on the $10 a day, they stopped doing that particular package, so - - -

MS HILL: Why was that, do you know?

MS DUNLOP: I don't know, I couldn't get an answer why but they couldn't service me anymore because of that. They just wasn't doing that type. At that stage I didn't know that I was going to be re-assessed. So that was when I had to change. So we had me re-assessed as we changed providers.

MS HILL: And how did you find out what services were available to you when you needed to change from that first to second provider?

MR DUNLOP: Initially – sorry, initially, the second provider came out and they gave us a bit of an overview of what was available and what we could possibly get and what they could – they could do for us at that time.

MS HILL: And what sort of services did you then receive, Sue?

MS DUNLOP: Still three hours a week.

MR DUNLOP: Mainly cleaning and housework.

MS DUNLOP: Just the cleaning.

MR DUNLOP: Yes.

MS HILL: And at that stage were you content with the level of care, the level of services that you were receiving?

MS DUNLOP: Yes, everything seemed fairly well at that stage, yes.

MR DUNLOP: There was a couple of things that Sue needed that we hadn't – we didn't get but, yes, the actual care, the carers that were coming in were doing a pretty good job.

MS HILL: In your statement, Phil, you describe that in mid-2018 a change of management at the local branch of the second provider meant that the service started to decline.

MR DUNLOP: We – we tended to find that there was a – a reduction in communication. Yes, there had been a little bit of problems in the – in the local branch office, we understood. There was a change of personnel and then we couldn't really talk to anybody. There was never anybody available that, you know, was able to do anything for you.

MS HILL: How would you try and raise issues?

MR DUNLOP: Say again.

MS HILL: How would you try and communicate with the second provider at that time?

MR DUNLOP: Initially, we would phone – we would the phone we'd get a receptionist and she would say she'd pass the message on and a coordinator would get back to us, but that didn't happen. So we did try then emails, and mainly our emails weren't responded to.

MS HILL: And then in December 2018, Phil, you were advised that there was a problem with that second provider accessing your property?

MR DUNLOP: Yes, we – we got a phone call saying that the two people that had been out to service Sue that day had nearly rolled their vehicle on the way back. Now, the road is a dirt road but it's an all-weather dirt road and it's been used for –

by the neighbour up the road for the last 17 to 20 years with no problems. And I couldn't understand how they would have, but anyway, they were adamant that they had nearly rolled their car and so services were suspended immediately as of that time and it didn't matter what or how I tried to rationalise with them; there was no other logistical possibilities to reinstate services and that was about 20 December. So it sort of left Sue over the Christmas period with virtually nothing.

MS HILL: And what did that mean for how things were at home?

MR DUNLOP: Say again.

MS HILL: How did that mean for how things were at home?

MR DUNLOP: Well, it just meant that I, obviously, did a little bit more, probably.

MS DUNLOP: Can I just say something on that. I was the one that received that phone call. It wasn't a pleasant phone call at all. I was just told very abruptly of what had happened and that my services would be suspended, and she did not want to speak about it anymore.

MS HILL: How long had you been receiving home care at that point in time?

MR DUNLOP: About nine months.

MS DUNLOP: I think it was about nine months. I haven't got it in front of me so my memory is not, you know - - -

MR DUNLOP: Yes, about nine months from that provider.

MS DUNLOP: - - - unless you go back on paperwork. Yes.

MS HILL: Phil, in your statement you describe that in late December 2018 you got onto the Aged Care Quality and Safety Commissioner.

MR DUNLOP: When – yes, when we couldn't interact with the local branch I looked around to see how we could sort of get something done to help Sue and I got onto the Aged Care Quality and Service Commission. They were located – that particular office was located in Canberra, and he said he would contact them and see what he could do. He rang back sometime later and said that he had contacted them, and they should contact us. Services had been stopped supposedly until such time as a risk assessment was done on the road. As far as I know there was no risk assessment done but around about the 12th of – or early January anyway, I got a phone call and they said they were ready to reinstate services.

MS HILL: And that was from the second provider.

MR DUNLOP: From the second provider, yes. And as far as I know, no risk assessment had been done on the road because there was a locked gate and the part that they said was really bad was only probably 50-60 metres from our front gate. So I don't know how they got up the speed to nearly roll their car in 50 metres but still, that's another story.

MS HILL: Sue, would you like to respond there?

MS DUNLOP: No. As I said, too, you know, I've looked at the road. We had had some storms come through and we had had some trenches, you know, sort of how the water runs down but a four-wheel drive, no, I can't see how anyone could have rolled a four-wheel drive on that little bit of – you're going slow, you watch when, you know, where you went on the road and even if you hit the biggest pothole that was there, it's not – in my opinion, it's not going to roll a car.

MS HILL: And were your services ultimately reinstated, Sue?

MS DUNLOP: Yes, they were for one week.

MR DUNLOP: Yes. We – when I got the phone call to say that they were about to reinstate – or they were interested in reinstating services, could Sue meet them in the local township. And because of her mobility she sort of said. "No. It's not really all that good." So the coordinator came out to see us the day before services were started. She came out in a small two wheel drive sedan on the same road that the girls had nearly supposedly rolled their car. And I asked her during the meeting how did she go on the road, did she nearly roll her car or did she have any problems. And she was very begrudging in saying no, she didn't have any problems.

So services were reinstated the next day on 17 January. They came for one day and the procedure was to go to the neighbour up the road about a kilometre away. They serviced her. She got an hour for two – with two carers, then they came to our place. Sue got three hours and then they left. And, apparently, on the trip away, they nearly rolled their car.

MS HILL: Phil, you keep a gun at your property, don't you?

MR DUNLOP: Yes, I do.

MS HILL: For what purpose do you keep a gun?

MR DUNLOP: It's for stock protection. It's a tool that I use on the farm to, you know, get rid of problems.

MS DUNLOP: Foxes.

MR DUNLOP: Foxes and wild dogs we have. We don't see that many wild pigs, but they are around, yes. And so the gun is there just for stock protection.

MS HILL: And do you recall where your gun would have been on that date that you had the representative of the second provider come to your property?

MR DUNLOP: Yes. I had had it out that morning. We had a fox coming in after the chickens and I had had the gun out. And it takes – and I told the provider that the gun was always stored in the gun safe as per the law, but on this occasion I had missed the fox and I was going to have another go at him a bit later in the day, I thought, because he went down into bottom corner of the paddock. And so, instead of putting the gun away, I put it in an internal room unloaded where I could get to it quickly if he showed up again, because it just takes so much time to go get the keys to the gun safe, go and get the gun, get the ammunition and then come back. And by that time they're not – you know - - -

MS HILL: In your statement, Phil, you say that you received an email from the second provider after they had attended the property on 17 January.

MR DUNLOP: Yes. Apparently, whilst they were there they noted the gun. They didn't say anything to us. I would have thought it would have been sensible to say, "Look, we're not happy about that being there. Would you lock it away." And that could have solved the problem. But they apparently saw the gun, said, "Bye, Mr and Mrs Dunlop. See you next week" and went off and reported it to the police.

MS HILL: And what did that mean for the services that Sue was able to receive after that time?

MR DUNLOP: They said that they were going to suspend services immediately, because of ongoing issues with the road and the gun.

MS HILL: And, Phil, did you receive a bill for Sue's services at the end of - - -

MR DUNLOP: Yes. Yes. When we got the bill for January – or the account for January, we noticed an additional charge, because in order to reinstate services they said they needed a specialist four-wheel drive driver. And there was an additional amount of $216 or thereabouts added to the bill for transport for this particular driver. He was coming – I can't remember how many kilometres, about 200-odd kilometres he came to Blayney, picked up the other carer, then came out and then did the return on the way home. And there was no mention of any additional charges or transport costs prior to them attending on the day. And the neighbour up the road, who they also serviced, didn't have any charges or costs for transportation of carers on that particular day.

MS HILL: And were there any other issues you observed with the bills that you were receiving at that time, January/February?

MR DUNLOP: Yes. We did have – and, because they suspended services on that day, on 17 January, we got the bill for January. Then when we got a bill for February, there was three additions for services that were never provided. And then

in March there were also three additions for services that were never provided. And I initially started trying to find out why they had been added on, because at this – you know, from 17 January there was no visits at all to our property.

They still continued to charge us all of the interface fees, which add up to about $1000 a month, for talking and what have you. But the only things that appeared on those bills were the additional visits that never occurred. And we never got a final account for – services were completely suspended on 20 March. We did get a bill for March which had the additional three charges on it. We never got a final statement in April showing any credits back for those additional charges that had been made.

MS HILL: Sue, was why it important to you and Phil to raise the issue around those service charges?

MS DUNLOP: Because it was so hard to get it refunded, I think. This was the big thing. We just had to fight and fight to have those charges reversed. They just wouldn't take any notice of it. And then not getting that final bill also made us very suspicious. But the only thing we did receive was like an Excel sheet. And it had the three charges on it, nothing above it, nothing below it – it was a photocopy of it – saying this was refunded. Now, we – as I said, we did – and Phil said – we did not get a final account, even when we changed providers. They gave us the amount that was transferred over, but we were never given that final bill with those credits on.

MR DUNLOP: And the reason it was important was that these additional charges appeared on the account. If we hadn't spotted them, you know, they would have just stayed there. And we were sort of thinking it's not right and there would be a lot of people out there that wouldn't be scanning their accounts and noticing that there were additional charges added on for no reason.

MS DUNLOP: I mean, I think that you get a lot of the older people that if they're on their own and things like that, they just don't look at their accounts and take note of them and don't understand them. And I think there's a lot of people around. So they wouldn't have picked it up. And, I mean, that's all money out of their package. So, yes, I think it was just more because of the amount of problems we had having it reversed. Can I just go back to one thing about that visit of the - - -

MS HILL: Certainly.

MR DUNLOP: 17 January.

MS DUNLOP: - - - 17 January that I had. When I changed over to my level four package, the paperwork for me to sign was sent out with the actual girls that do the cleaning, the – what was she called?

MR DUNLOP: The coordinator.

MS DUNLOP: The coordinator, anyway. She didn't come out which normally they come out and talk to you about what it – yes, what the changes are and everything and get you to sign it and that. Well, it wasn't. It was brought out by the girls that were doing the cleaning for me to sign and send back. So nothing was explained to me. But they also then charged the package for her to come out and sign it, which was quite a bit of money, a few hundred dollars. But I didn't have that visit. So, again, that was wrongly charged. And Phil had said to them, "Reverse that charge unless she comes out."

She did come out, as Phil explained, in her small car. Now, when she came out I was talking to her about things, and she picked up her handbag and was walking out the door still speaking to me as I was trying to ask questions and told me if I wasn't happy, change providers. That's not caring.

MS HILL: What did you want from the communication with that second provider?

MS DUNLOP: From this particular person? More the fact that I needed more time. My house was still a bit of a mess. I was getting worse. I couldn't do most of my things. My house was getting in a bigger mess. I didn't have enough time. Sorry.

MS HILL: Take your time.

MS DUNLOP: Sorry. I was like this. Yeah. I was getting into a bigger mess. I couldn't look after any of the animals outside or do anything. And that's very frustrating. And all I wanted was more time. I had a larger package and I wasn't getting anything out of it.

MS HILL: Did you notice a difference between the services you received between the level three and then the level four package?

MS DUNLOP: There was no – no increase from the first than what I was getting from the first provider on a level two. I was still getting the same services on a level four.

MS HILL: Phil, can I turn to you and ask you about communication issues that you've described with that second provider. What would you have liked to have been able to – how would you have liked to have been able to communicate with the second provider?

MR DUNLOP: Well, I would have liked to have been able to talk to them when you rang up with a problem to, you know, have a bit of a chat about the problem or whatever, but it just never seemed to happen. Whenever you rang up you got a receptionist who said that the girl was no longer – or wasn't available, she was out office or whatever, she would call back. But it never happened. So there was no interfacing, no intercommunication, between us and the provider as to the problems that we were having or what things we would like to be done or anything. Yeah.

MS HILL: And did you ultimately get onto a third provider?

MR DUNLOP: Did, yeah. Once the second provider terminated services as of 20 March, we started with a third provider. And they are always upfront. They return calls or they're – you know, we get put straight through to them or they return the calls or, if you email, they return the emails. They're, you know, very, very good intercommunications.

MS HILL: Sue, can I ask you what you – how you went about finding that third provider?

MS DUNLOP: That third provider, Phil went on, I think, to the internet to find that provider and when we found them we called them. They were very – they just kept calling us. And they sent everything they possibly could by email to tell us all about them and everything. Very, very upfront. The only thing with this provider is we had to find our own staff. They had to have, you know, their police checks, their insurance, everything still, but we needed to be able to find our own staff. Now, I had a bit of trouble finding those staff. So what I did, I put an ad on Facebook. And I – yeah – had heaps and heaps of staff contact me – yeah – people contact me for the job. So that worked really well.

MS HILL: Were you able to identify staff or, even take it back a step, when you're looking for a provider - - -

MS DUNLOP: Yes.

MS HILL: - - - a provider or staff, an employee or provider that was locally based?

MS DUNLOP: Locally, no. They – well, the providers had to be – no, the provider wasn't. They're actually a Melbourne company, the one we found. And they sent – they've got a chap that they send around to every new one to assess everybody again, you know? So he just flies from Melbourne to wherever and came out. He spent – he only came from Melbourne for the day for us. He then drove out and saw us and assessed it as to what he thought, how I was.

And then ..... that time that he spoke to us Phil said to him "Sue uses a ride-on mower to get around the property", you know? I had done that for years. And our mower broke down. And he said is it possible to get it fixed with the package? And he said, "Oh my gosh, yes." He said, look, he said, you know, if it's an old one, he said, "You can even get yourself a new one, if you'd like one." Now, within a week with this third provider, I had a brand new ride-on mower to get around the yard. Where before the second provider you got nothing. Yeah.

MR DUNLOP: We couldn't even get a toilet seat or shower seat for Sue out of the second provider and the reason she uses the ride-on mower is for stability because, you know, we're on a farm. They're very stable, big wheels and solid, much better

than, say, a mobility scooter or whatever, so yes, and very durable. So yes, they provided that and it got her back into moving about again.

MS HILL: Sue, before you jump onto Facebook and advertise that way, what were you doing to try and find - - -

MS DUNLOP: It was more asking people. We put signs up. We had a sign in the local post office and we had a sign in the local pub. And just got nothing, absolutely nothing. So that was when I sort of thought about it and we were talking about ads in the papers and things like that, and I thought well, I might as well try Facebook because people had – I'd seen some ads, gone through that, so I tried that. I didn't have to go any further.

MS HILL: Were you aware of any other mechanism by which you could have searched for locally or staff that were close by?

MR DUNLOP: Yes, there was – there's an online platform where people that are workers within the care industry advertise, but there wasn't anybody that was advertising on that platform at that stage. The new provider that we were talking to, they will provide counselling or they'll provide help at a – an hourly cost if you need it. They will come out and do the work, you know, the legwork for you if you require it. There was another mechanism, a local group that employed staff that supplied a girl for a couple of weeks and then I don't know what happened to her but anyway she stopped coming when Sue – Sue had to go into hospital at one stage, and she came and was doing the house and then that stopped but this local – it was another provider that was just supplying, you know, legs and some feet, basically, as required.

MS HILL: And did you or your daughter jump onto My Aged Care at any point in time when you were looking for the third provider?

MS DUNLOP: No, not that I can remember.

MR DUNLOP: I think it came through the My Aged Care website. When we were looking for the third provider we went onto the My Aged Care website and they list all of the providers that are available.

MS DUNLOP: In our area ..... into our area.

MR DUNLOP: Where they're based and where they operate, and we got onto this particular third provider.

MS HILL: So you've put the ad up on Facebook and you're inundated with responses.

MS DUNLOP: Inundated, yes. Lots. I mean, not to say that they all would have all been suitable. They may have all said, well, they didn't want to go and get their

insurance or whatever but, no, I actually got a friend – or someone that I actually knew, who you wouldn't sort of say a friend, I suppose, but she was an acquaintance, so I knew her. She had everything she needed. So I went with her and I've still got her, yes.

MS HILL: And - - -

MS DUNLOP: I now have six hours of help a week, plus a handyman.

MS HILL: And how do you communicate with your third provider?

MS DUNLOP: Usually by phone. I – what I normally do is email their – their accounts for the ones that do the housekeeping and the handyman, I email the accounts down to them and then they just pay it to the account – to their account.

MR DUNLOP: So the way this provider operates is different to the normal package operator that takes over the package and sends people out. They are there in the background, they do all the work. If you need anything, you contact them and they supply it, and if you find the personnel that you need to do whatever it is, they then give you the receipt or whatever which you email down and the third provider then makes the payment.

MS HILL: And are you content with that as a practice?

MR DUNLOP: Very good.

MS DUNLOP: Yes, it works beautifully. As we said, we always get emails back from them. If we phone and she's not available, she always phones us back. Answers any questions that I want. I haven't got a fault at the moment with them at all and, yes, we've been with them – I can't remember now how long, but yes.

MR DUNLOP: Since the end of March, yes.

MS DUNLOP: And I haven't got a complaint, whatsoever.

MS HILL: Why was it important, Phil, for you to come along and tell your and Sue's story this morning?

MR DUNLOP: I think it was just to get the story out there of the problems that we were having. When we moved to this particular property, Sue liked the property and it's a long way out of town, but it suits us. It's very – very relaxing and you never see anybody and we're quite happy about that. And it allows Sue – if she has got the care that she needs, it allows her to stay in the house that she likes instead of having to go into a nursing home or whatever. So it was important to try and, I suppose, nail down the problems that we were having and most probably what other people were having that, you know, you just – you couldn't get information, you couldn't – you know, you weren't being responded to.

MS DUNLOP: I've forgotten.

MS HILL: Take your time, Sue.

MS DUNLOP: You're right. I had some question, I just can't think what it was.

MR DUNLOP: But anyway - - -

MS DUNLOP: That's what I was going to – sorry, you right? See what – we lived for 42 years in the Blue Mountains and our house burnt down in 2013. I'm sorry, it upsets me a bit still. Our house burnt down in 2013. We spent 12 months living in a motorhome outside – our daughter is in Trunkey – trying to work out where we wanted to live. We had no idea what we wanted to do. We didn't want to build there again. Mainly – I mean, we lived there knowing that we could lose our house anytime but you don't realise what it means when you do lose everything. So when I found this farm I absolutely loved it. It's got a beautiful view over hills. It's just got that feel. I knew I should be there when I saw it, even though it was run down. I do love it. I don't want to move. I love having animals around me.

But it is so, so hard when you can't get any help out there. And you know, there is other people out on farms that can't move and I think this is what these packages were brought out for, to try and keep people in their own homes, which is a very good idea. I would hate to be in a nursing home. I've seen my mother in one because she had had a stroke. It's not home. So no, and I think that's one of the main reasons I – just with what we've been through, I don't want other people to have to keep going through that when they just live out of town a bit. That's basically it.

MS HILL: Commissioner - - -

MS DUNLOP: Sorry.

MR DUNLOP: The – the comment that was made by the coordinator of the second provider is a little bit pertinent when she came out to see us on 16 January about reinstating services. She came in and she said, "What would have - - -

MS DUNLOP: Sorry.

MR DUNLOP: - - - made you move right out here?". So as far as she was concerned, you know, we were in the middle of nowhere and it is only 21 kilometres. It's not an enormous – and that was the other thing that was a bit strange, they charged us this huge fee to bring a four-wheel drive driver many miles when we had been serviced by a girl who lives 10 kilometres up the road who owns her own four-wheel drive and drives it and she serviced us for a number of months, and yet they didn't use her even though on the 16th Sue said what about using that particular girl, and they decided, no, to bring this chap from wherever, Woop Woop, whatever, yes, at enormous cost.

MS HILL: Commissioners, that concludes my examination.

COMMISSIONER PAGONE: Yes, thank you, Ms Hill. Mr and Mrs Dunlop, thank you for coming to give evidence to the Commission. Stories like yours are important for us to hear. It does help us enormously to understand the situation that you find yourself in. I can see that it has been emotionally difficult for you to tell us and we are very grateful that you've told us your stories. It will help our work a lot. Thank you very much.

MS DUNLOP: Thank you very much.

<THE WITNESSES WITHDREW [10.45 am]

MS HILL: Commissioners, there will now be a morning tea break which will allow for the set-up of the panel that's to give evidence following.

COMMISSIONER PAGONE: Yes. All right. We will adjourn now until 11 o'clock.

MS HILL: As the Commission pleases.

ADJOURNED [10.45 am]

RESUMED [11.01 am]

COMMISSIONER PAGONE: Yes, Ms Hill.

MS HILL: Commissioners, before I call the next three witnesses, there are some appearances to be announced.

DR K. HANSCOMBE QC: Commissioners, I appear with DR BROPHY, pursuant to a grant of leave of 24 October for Australian Unity.

COMMISSIONER PAGONE: Thank you, Dr Hanscombe.

MR BATEMAN: May it please the Commission, Bateman on behalf of LiveBetter Community Services.

COMMISSIONER PAGONE: Mr Bateman.

MS HILL: Commissioners, I call Dean Chesterman, Helen Miller and Jaclyn Attridge. They're present in the witness box and if they could be sworn and affirmed.

<DEAN CHARLES CHESTERMAN, AFFIRMED [11.02 am]

<JACLYN HOPE ATTRIDGE, SWORN [11.02 am]

<HELEN ELIZABETH MILLER, AFFIRMED [11.02 am]

<EXAMINATION BY MS HILL

COMMISSIONER PAGONE: Yes, Ms Hill.

MS HILL: Mr Chesterman, if I can start with you. Could I ask you to please state your full name.

MR CHESTERMAN: Dean Chesterman.

MS HILL: And what is your role?

MR CHESTERMAN: My role is general manager of branch operations.

MS HILL: And whereabouts – and who do you hold that role with, Mr Chesterman?

MR CHESTERMAN: Australian Unity.

MS HILL: And whereabouts are you based?

MR CHESTERMAN: I'm based in Melbourne.

MS HILL: And could you provide a brief description of your professional background.

MR CHESTERMAN: Yes. My background. I've been with Australian Unity for over eight years, before that with accounting professional services firm KPMG for a number of years. Qualified in human resources and business management and have spent the last three or four years working in the sector in home and disability services.

MS HILL: And can I ask you to please describe the organisation that you're representing this morning, Australian Unity.

MR CHESTERMAN: So Australian Unity is a wellbeing organisation. We've been operating for over 175 years. Among other services that we provide to our members and customers, we provide a range of aged care service, which include retirement living, aged care homes and in-home care services. In this region, though, we only provide in-home care services and we do that through two business structures: one our Aboriginal home care business and the second, our home and disability services business, which I'm a general manager of. And the range of services that we provide in this region include domestic assistance, personal care, personal assistance, respite, social support, transport.

MS HILL: And when you're referring to "this region" you're, in fact, referring to the inner regional area where Mudgee is located.

MR CHESTERMAN: Yes.

MS HILL: And Australian Unity took over the New South Wales state-delivered home care services, didn't they?

MR CHESTERMAN: Yes.

MS HILL: And when was that?

MR CHESTERMAN: I believe the official date was February 2017.

MS HUTCHINS: And would you be able to give an approximate idea of what the market share is for Australian Unity in New South Wales more broadly?

MR CHESTERMAN: I don't know the exact figure of that.

MS HILL: Thank you. Operator, could I ask you to please display the following three document IDs and the front pages, WIT.0517.0001.0001, WIT.0548.0001.0001, WIT.0540.0001.0001. Mr Chesterman, do you see a copy of your statement located on the right-hand side of the screen there?

MR CHESTERMAN: Yes.

MS HILL: And you've got a hardcopy of your statement there in front of you.

MR CHESTERMAN: Yes.

MS HILL: Were there any changes you'd seek to make to that statement?

MR CHESTERMAN: No.

MS HILL: And are the contents of that statement true and correct?

MR CHESTERMAN: They are.

MS HILL: Commissioners, I tender the statement of Dean Chesterman.

COMMISSIONER PAGONE: Yes. The statement of Mr Chesterman will be exhibit 12-12.

EXHIBIT #12-12 STATEMENT OF DEAN CHESTERMAN (WIT.0517.0001.0001)

MS HILL: As the Commission pleases. Operator, if I can ask you to leave those three statements on the monitor. And, Ms Miller, if I can turn to you and ask you to state your full name.

MS MILLER: Helen Elizabeth Miller.

MS HILL: And what is your role, Ms Miller?

MS MILLER: I'm the head of operations for age and community services for LiveBetter Community Services.

MS HILL: And whereabouts are you based?

MS MILLER: In Orange.

MS HILL: And what's your professional background, briefly?

MS MILLER: My professional background is I'm a registered nurse. And I hold a Bachelor of Health Management, Gerontology Certificate and a Juris Doctor. And I have worked in subacute aged care services for 35 years.

MS HILL: And could you describe the size and scope of the organisation that you represent.

MS MILLER: LiveBetter Community Services is a not-for-profit based organisation that only deliver community services to rural, regional and remote communities in New South Wales and in Queensland. We do not provide services in metropolitan areas. It's been the operation for approximately 30 years. It provides a range of services, disability, aged care community services, child and youth services, transport, home modifications and maintenance.

MS HILL: Ms Miller, you prepared a statement for the Royal Commission also.

MS MILLER: Yes.

MS HILL: And do you see a copy of your statement located on the left-hand side of the monitor?

MS MILLER: Yes, I do.

MS HILL: And you've got a hardcopy of that.

MS MILLER: That's correct.

MS HILL: In front of you. Were there any changes thaw seek to make to that statement?

MS MILLER: No.

MS HILL: And are the contents of that statement true and correct?

MS MILLER: Yes, they are.

MS HILL: Commissioners, I seek to tender the statement of Helen Miller, dated 22 October 2019.

COMMISSIONER PAGONE: The statement of Ms Miller, dated 22 October, will be exhibit 12-13.

EXHIBIT #12-13 STATEMENT OF HELEN MILLER DATED 22/10/2019 (WIT.0517.0001.0001)

MS HILL: As the Commission pleases. Ms Attridge, turn to you, and ask you to state your full name.

MS ATTRIDGE: Jaclyn Hope Attridge.

MS HILL: And what is your role, Ms Attridge?

MS ATTRIDGE: My role is the head of operations for home and community care at Uniting.

MS HILL: And whereabouts are you based?

MS ATTRIDGE: My base is in Sydney.

MS HILL: And could you please also briefly describe your professional background.

MS ATTRIDGE: Yeah. I have a Bachelor of Health Science and worked in aged care in various roles now for over 20 years. I've been with Uniting now for seven years in various roles, both in service development and operations. Prior to that I

was with the Department of Health at the time working in complaints and in the quality review team, and previous to that with various roles with aged care providers.

MS HILL: And could you describe the organisation that you're representing this morning.

MS ATTRIDGE: Sure. Uniting is the service arm of the Uniting Church in New South Wales and ACT. We have aged care services right across New South Wales and ACT in all planning regions, both residential, home care and independent living. As well as that, we provide services for younger people, people with a disability and family services. In relation to the home care services, we provide both home care services and Commonwealth home support services, as well as a small amount of services run by Department of Veterans Affairs and Health.

MS HILL: And, Ms Attridge, do you see a copy of your statement in the centre of the monitor there in front of you?

MS ATTRIDGE: I do.

MS HILL: And you've got a hardcopy of your statement, also, there.

MS ATTRIDGE: Yes.

MS HILL: Were there any changes that you'd seek to make to that statement?

MS ATTRIDGE: No.

MS HILL: And are the contents of that statement true and correct?

MS ATTRIDGE: They are.

MS HILL: Commissioners, I tender the statement of Jaclyn Attridge.

COMMISSIONER PAGONE: That will be exhibit 12-14.

EXHIBIT #12-14 STATEMENT OF JACLYN ATTRIDGE (WIT.0540.0001.0001)

MS HILL: As the Commission pleases. Ms Attridge, Ms Miller and Mr Chesterman, I would like to commence the panel discussion this morning by asking you about three propositions that the Royal Commission is testing and interested to hear your views on. Starting with what we'll call proposition one, Ms Miller, could I ask you to respond to the proposition that consumer-directed care for home care packages should be replaced by a system of block grants through a competitive tender process to address the issues of thin markets and scale diseconomies.

MS MILLER: I believe that the principles of consumer-directed care are good. I do not believe that block grants are an answer. I do not believe that the industry should go back to block grants. It's, obviously, to acknowledge that there are definitely issues in relation to service delivery and funding of those services currently, but I think there are some very good principle that we should maintain. And I think that we need to specifically address some of the inequities that occur in the provision of services in rural, regional and remote areas. I don't believe we should go back to block funding as a totality.

MS HILL: And, in respect to the description you've given of consumer-directed care being something that's good, can I ask you to expand on why you hold that view.

MS MILLER: Because I think that the principles are around choice. And I believe that everyone has a right to a choice. And I think that yes, I understand that the markets are thin and particularly in rural, regional and remote, but I do not believe it takes away from the fact that consumers should have a choice.

MS HILL: Ms Attridge, could I ask you to respond to the same proposition.

MS ATTRIDGE: Yes. I think that we would concur – well, I would concur. I think a conversation about how funding is allocated is a different one in terms of the principles of service delivery. There's been great advancement in terms of community care since deregulation and consumer-directed care in terms of the options and possibilities for consumers. I don't think a funding model should take that away from people. There's issues within home and community care that are prevalent both in metro and regional services that need addressing, as well as issues of thin markets in more regional towns. But you wouldn't want to lose that underlying principle of choice and control for consumers by changing a funding model.

MS HILL: What's your view of that proposition, Mr Chesterman?

MR CHESTERMAN: I support the views that have been expressed. I think control and consumer choice are paramount to ageing in place and ageing in place with dignity from a consumer's perspective or a customer's perspective. I also think the issue around equitable care in rural and remote is of more importance than the funding mechanism. And that equity is what we should be addressing.

MS HILL: How do we address the need for equitable care in rural, regional and remote areas when there are these issue that you've spoken of and the three of you address in your statement with respect to thin markets? And I'll turn to you first, Mr Chesterman.

MR CHESTERMAN: I think, firstly, there needs to be greater recognition of the differential costs in delivering services in – particularly in remote and very remote areas of Australia and New South Wales in this case. And so things like the viability

supplements need to be reflected and reconsidered to more appropriately address those cost differentials in delivering services. I also think there at times are longer waits for customers to access services or access assessments. And I think we should be considering more responsive mechanisms to allow for consumers to access funding at the time of need, so they can get the care that they need at the right time.

And that bit might be better delivered through time bound supplements to their funding that would be quickly delivered to allow for the increase of care that's required, allow for providers to ideally re-able or provide services that re-able customers to a pre-existing position, and avoid consumers going through being re-assessed to a higher level of funding that may not actually be needed on an ongoing basis.

MS HILL: Ms Attridge and Ms Miller, you both sat there and nodded, particularly at the at the end of what Mr Chesterman was saying. Starting with you Ms Miller, can I ask you to respond.

MS MILLER: Look, I concur with the comments that have been made, so I won't repeat, but just to add, I think, really we do need to look at workforce shortages and skilled workforce shortages. I believe that is a real barrier particularly in rural, remote and more regional areas to access the right staff. That is the biggest challenge as providers that we – that we have, and I – for us to enable the correct service delivery is going to require the right skilled workforce at the right time and in the right place to ensure that that delivery occurs. That, I think, is a piece that we really do need to do quite a lot of work across Australia but as a government and also as providers.

MS HILL: Ms Attridge?

MS ATTRIDGE: Yes, I – the thought I had was that there's a higher degree of complexity in home and community care at the moment just due to the wait times that people are having to suffer through while they're waiting for home care packages. I think it adds confusion in terms of what the pathways look like and how they make their decisions. So I think that there's just issues of access at the moment that need resolution.

MS HILL: Starting with you, Mr Chesterman, as representing Australian Unity who provide home care services in both metropolitan and regional and remote areas, is it reasonable – or can someone who lives in Mudgee, an inner regional location, reasonably expect the same level of access to home care and the same quality of home care services as someone who's living in Sydney?

MR CHESTERMAN: I think in more inner regional areas it's closer to being able to expect those equitable and similar services. I think as you go further out to much more remote or very remote areas that becomes – the difference between those becomes much more amplified.

MS HILL: What's that difference that you observe?

MR CHESTERMAN: Whether the places where people live even have those services in existence in those areas or certainly within close proximity to those towns. Often consumers are needing to travel quite long distances to access services that might not be as far away from more inner regional areas or metropolitan areas for that matter.

MS HILL: We've heard in senior counsel's opening address to the Commissioners that Mudgee – and, indeed, you've said this morning, Mr Chesterman, Mudgee is an inner regional location. If we take the example of Dunedoo which is about an hour out of town here, about an hour and a bit from Dubbo, that's an outer regional location. Can someone who's in Dunedoo reasonably expect the same level of access and availability of home care services presently, to your observation, Mr Chesterman?

MR CHESTERMAN: I think it depends on where providers are recruiting and establishing their workforces. So I think there are examples where that could be the same access if we're able to recruit and have available workforce, but there would obviously be travel associated with that to access probably more specialist or allied health services which would be more realistically based in bigger centres like Dubbo, for example.

MS ATTRIDGE: I think the experience is when things are good, it's good. I think the challenges that we've had in some of the more regional areas and remote areas is that they're far more prevalent or at risk to service breakdown because the hubs are smaller, you're relying on a smaller pool of staff. I think, for me, that's where the risk is for consumers in those more regional areas.

MS MILLER: Yes, I would agree. I know that at LiveBetter what we try to do is that if we receive a home care package in a place such as Dunedoo we would immediately try to recruit someone locally in relation – depending upon the services that are required by that particular client, but that's often not successful. So then you would need to be delivering that service from – with a carer who may be living here in Mudgee or may be living in Dubbo, and then you have the additional transport costs. The other thing is, dependent on the services that are required if, for example, there's a piece of equipment or home modifications are required to ensure that a bathroom is safe that sometimes can mean there's a much longer wait in relation to accessing those services and that kind of assessment.

For example, if you're looking at an assessment for a bathroom and safety, you know, the access to allied health in these areas is extremely difficult and there's often a long waiting list. So we can often have clients who are waiting for six or seven months just to have the assessment, so therefore they're in a bathroom that is considered unsafe. And we then have a worker who is working in that environment as well trying to provide the best possible care that they can for that client but doing so in an unsafe environment for the client and for the actual – for the worker.

MS HILL: Mr Chesterman, you've mentioned the viability supplement; does the viability supplement impact on a decision by Australian Unity to provide services to a particular region or remote area or not?

MR CHESTERMAN: No, it doesn't for us, but I think it impacts consumers because costs are going into individual budgets and so what ends up happening, in effect, is those increased costs for the same services being delivered in more remote areas cost the package more and so when you compare an individual package and the care that someone in metropolitan who has lower costs generally to someone who lives more remote, the actual care that the person in the remote is able to access is generally lower due to those costs.

MS HILL: Ms Miller, with LiveBetter only operating in regional and remote areas – and I draw on the motivation highlighted by LiveBetter in your statement in providing the best possible care no matter where the person is located, does LiveBetter have no-go zones?

MS MILLER: No. Obviously, we'd undertake an assessment but no, we consider every single referral that we would receive. We would undertake an assessment to see whether or not we can deliver those services depending upon what they are, but no, we don't have a no-go zone at all. Sometimes, we may get a referral in Lightning Ridge and if we're unable to find a carer to provide those services, then we would work with the customer to look for other alternatives.

MS HILL: Ms Attridge, can I turn to you and along the same vein, how does Uniting make business decisions to ensure the sustainability of the organisation in a regional or remote area without cutting services or impacting on the quality of care that Uniting is able to provide?

MS ATTRIDGE: It's difficult. We do have challenges of the viability of our services, particularly those regional ones. I think we do the best we can in terms of maximising the infrastructure that we have, essentially. The vast majority of services that Uniting does in New South Wales is regionally based so remote work is a small proportion of what we do. We're also fortunate that most of our bases, bar Broken Hill, are kind of accessible from Sydney. So we do our best in terms of, you know, using the resources that we've got centrally.

MS HILL: Does the fact of having that metropolitan base and Uniting being a larger organisation mean that it follows that Uniting has got more resources available to it or at its disposal and you're able to do a better job?

MS ATTRIDGE: I think we're fortunate to have the infrastructure and the governance around the services that we do, yes, and that absolutely comes with scale.

MS HILL: Mr Chesterman, what is Australian Unity's experience of being a larger organisation?

MR CHESTERMAN: I think similar. I think there's definitely access to efficiencies of scale that we do experience which certainly do help in the provision of services in more remote areas as compared to just providing services in metro.

MS HILL: As you stated in an earlier part of your evidence this morning, Australian Unity took over the State of New South Wales community care services and that State base previously provided about 70 per cent of community care services. As part of what the State of New South Wales offered before Australian Unity took over, you say New South Wales went to places perhaps, would you agree, that no-one else went to in the delivery of aged care community care services?

MR CHESTERMAN: Yes, I believe there would be.

MS HILL: Is that true now in Australian Unity's experience?

MR CHESTERMAN: Yes.

MS HILL: Is that a sustainable business model for Australian Unity?

MR CHESTERMAN: I think it is. I think it certainly helps in those areas where you may be the only provider to build up more density within those thinner markets for the provision of workforce and viable roles for people in those communities. So I do think it's still viable, yes.

MS HILL: When you talk about being the only provider, Mr Chesterman, I want to draw on a description you use in your statement where you refer to "Australian Unity can be seen as being the provider of last resort". What does that mean in practical terms for Australian Unity?

MR CHESTERMAN: I think it's something that came over with the business when it transitioned to Australian Unity, and I think for us now, in particular, it really means that we're the only provider that's got an established workforce in that community. So we often are providing not just our services but in other cases providing services for other organisations to members within that community. The challenge for us in those circumstances is there are no other partners that we can work with in the community, particularly from a contingent workforce perspective that we're able to in other areas where there are multiple providers.

MS HILL: Is it a formal responsibility or obligation of Australian Unity to provide services to those areas because you've taken over what was a State-run entity?

MR CHESTERMAN: I don't believe it's a formal obligation of ours, currently.

MS HILL: In your statement at paragraph 138, Mr Chesterman, you detail circumstances which have led to Australian Unity discontinuing the provision of NDIS services, and I'm mindful that you say in your statement also that Australian Unity continues to offer disability home care to Aboriginal care recipients.

MR CHESTERMAN: Yes.

MS HILL: But at the end of May of this year, Australian Unity has pulled out of providing NDIS. Those issues that you highlight at paragraph 138 which I won't seek to summarise because we've got your words up there - - -

MR CHESTERMAN: Thank you.

MS HILL: - - - on the screen but those issues around the complexity of care, workforce issues, the viability of providing disability care services in the NDIS, they come up in the delivery of aged care services as well, don't they?

MR CHESTERMAN: They do.

MS HILL: Is it – can we expect that Australian Unity will pull out of the delivery of home care services as well, where those circumstances persist?

MR CHESTERMAN: No, that isn't the case, no.

MS HILL: Why not?

MR CHESTERMAN: I think the main difference that we experienced in working in – within the NDIS that is different from the aged care sector is that the pricing mechanisms in disability are fixed prices, and our experience, particularly in more remote areas of our operations, were that those mechanisms didn't appropriately factor in cost of service delivery. And separate to that, they were based on modern awards which establish, from a workforce perspective, minimum standards and our agreement with our workforce provides higher rates, different penalties and so it was quite complex materially because of the way that pricing structure was, which is different to what we experience in aged care.

MS HILL: What conditions do you say on behalf of Australian Unity that are needed in the mechanisms around the delivery of aged care in an aged care marketplace to ensure the equality of availability and quality of care delivered in regional and remote areas?

MR CHESTERMAN: I think, primarily, workforce considerations, how we're able to better attract and retain workforces within those communities through incentives or other arrangements that make the employment proposition for a worker in the aged care sector more viable than it might be at the moment. I do think a key challenge is the utilisation of that workforce is different in those areas, and that's primarily because of we don't experience the same density of hours in smaller areas for roles to be established as we do in more regional, certainly, remote areas. So I think mechanisms would need to factor in both of those issues.

MS HILL: The three of you in your statements cite the attraction and retention of workforce in regional and remote areas as an ongoing issue and indeed, Ms Miller,

you've mentioned it earlier this morning. How does LiveBetter get people better prepared and interested in working in regional and remote areas?

MS MILLER: I think it's – I know that we're doing an awful lot of work at the moment in relation – even working with New South Wales Government around training opportunities and, you know, specifically targeting people, school leavers and others. But it's also about ensuring that there's a career pathway, that it's attractive for people to wan to not only cone and work in the sector, but stay in the sector. You know, I think that, you know, we need to consider that we have an ageing workforce, as well, and we clearly need to ensure that we have staff coming through who are able to take up those roles and stay in the sector, not use it as an interim or as a stepping stone to something else. So I think there's a lot of work that we need to do, not only as providers, but also as a government and as a community in respecting and valuing the work that our age care workforce do.

MS HILL: Ms Miller, is local training in regional and remote areas a solution to attracting a workforce who will stay local and reduce the churn in workforce?

MS MILLER: Local training – yes, I think that local training – local training, I think, is important, but we also need to recognise that sometimes we need to draw on the skills and experience outside of the aged care sector. So, I mean, I certainly would like to see that there's a much more integrated service delivery model amongst health, aged care, disability and even our carer service. At the moment they're extremely siloed. And I think there's a lot of expertise sitting in all those areas and we need to break down those silos and ensure that we provide an integrated care model, but also appropriate training opportunities for our staff that can be provided locally through, perhaps, the local health district or through, perhaps, a mental health service or a primary health network.

It's around ensuring that the education that you provide is complete and also local. But I still go back to the point that if there's not an attractive career pathway for an individual, they make take all that local training and then go to the city or go to other centres. So I think it's important that you look at both. You just can't look at one in isolation. Absolutely important that we look at the whole of workforce. And training is a component, but it is not everything in relation to ensuring that we keep and retain skilled staff in our aged care sector.

MS HILL: Ms Attridge, how does Uniting make aged care in regional and remote areas an attractive proposition for a potential worker?

MS ATTRIDGE: I think it's really tough. There's issues of pay, particularly at entry level that make it hard to compete with other industries. I think Helen's right. Particularly, our experiences have been around attracting a skilled workforce has been exceptionally difficult in the more regional areas. I think that the vast majority of aged care work is getting because they want to make a difference. So making sure that we give people those opportunities. We're looking at models at the moment that maximise direct care worker's capacity to help consumers make decisions and add

value in terms of the work that we're doing. We think that will help, but it's a systemic problem that doesn't have an easy answer.

MS HILL: Can you ask you to describe, as much as you're able to, those models that you're working on.

MS ATTRIDGE: Yes. Sure. So what Uniting is doing at the moment is looking at ways to allow the decision-making related to services to happen far closer to the service delivery point. So historically we had a model that had a very centralised way of making decisions and kind of a pointy end in terms of where decisions came to. The work that we're doing at the moment is looking at maximising a consumer's capacity to choose what their services will look like and then giving our support workers the autonomy to work with our consumers to make that happen.

MS HILL: Mr Chesterman, drawing on what Ms Attridge has just stated in her evidence about workers are attracted to aged care as a sector to work in, because they have that interest, they want to work with people, and a remark you made earlier about offering incentives to people to come and work in regional and remote areas, what's Australian Unity doing to draw out that interest and that level of enthusiasm in respect of offering incentives?

MR CHESTERMAN: A couple of things that we've trialled. One in particular I think I put in my statement was identifying that in some cases work needs to be done to help people who are interested in coming into the sector to actually just get ready for employment. That could include a raft of things. It could even include helping them get a licence. Driving is a key part of working in this sector. So more pre-employment support through a program, which I did put in my statement, an example of launch to work, which is less about qualifications. It's actually about readiness to join an organisation and enter into the sector.

The other thing that we know is really important to – back to my point earlier about how do we make it more viable from an employee's perspective, accepting a role with us, is we have a workforce strategy that aims to have 85 per cent of our workforce permanently employed. And so we've got a raft of initiatives that are helping with that across our entire footprint.

MS HILL: And are you able to highlight a particular initiative or initiatives that are – how they're actually making that change?

MR CHESTERMAN: Yes. One important one is our enterprise agreement for our care workers. It currently and did have when it transitioned with the home care New South Wales business – had requirements for block permanent hours. So the first block that you needed to have before you could offer permanent work was 30 hours. We've been working to negotiate more flexibility into that, so that we can offer permanent hours at lower levels of that to give a stronger commitment to people in different parts of our footprint in the context of their employment with Australian Unity.

MS HILL: Ms Miller, would you like to respond? I saw you furiously taking a note there.

MS MILLER: Look, we've certainly looked at – we're looking at a range of options around – including encouraging our current staff, to refer someone, to send a CV in, so that we can consider it and look at what alternatives there are. We're also working much closely – more closely with our home care workers. So we like to bring them into the office wherever possible, so that they get to liaise directly with the coordinator around the care delivery model for a particular client, so involve them in the problem solving, involve them in their insight and inputting into how the care is being delivered.

We've also just recently introduced what we call assessment centres. So after we've put out an advert for recruitment of staff, we will bring them in as a block group. So we may do a phone call just to sort of determine who we feel over the phone is appropriate. But we bring them in. And that's to ensure that we employ staff who have the same value based system, that they are carers, that they understand the value of caring. And even if they're not experienced or don't have a certificate, if they've got that right value base and they do care for providing the best possible care that they can for their clients, then we will work with them to train and support them to ensure that, you know, we've got a viable workforce that stays.

Because we – and that does work. We're finding – we've only just started this in Orange and we're going to roll it out to our other centres, including Broken Hill. And we are finding that it's working, in that we are retaining those staff longer and we're getting satisfactory feedback from our clients in relation to that. What is required, of course, is that there's a lot of training that is an education for this particular cohort. But it seems to be working. It's early days, but I'm feeling very positive that that's something that we will continue to roll out.

MS ATTRIDGE: And I think it's really important to note, too, that the issues with workforce are not ones that are, you know, just in the regional towns. We have similar workforce and recruitment and retention issues in metro areas, as well. There's a big pool to draw from, but it's just as competitive.

MR CHESTERMAN: And the only other point I would make on that is, which is for providers, as well as other considerations, is we need to be less reliant on recruitment and trying to solve the problem in the moment that we need the workers and actually acknowledge more that our future workforce – we need to do more to build that future workforce, partnering with RTOs in advance of the need. We now have access to data from all our operations, we know what our turnover is. We should know what our customer growth looks like. We should be able to predict to some extent ahead of the need what workforce we would need, so that we can better train and skill that workforce ahead of that need coming into our organisation, ultimately.

MS HILL: Mr Chesterman, you described that you should be able to do those things. Is that something that you're able to do at the moment?

MR CHESTERMAN: In terms of predicting – we do. We've invested quite a lot in building data and insights around our operations. And so we are able to relatively confidently forecast what our workforce requirements are in all of our – all of the footprint of our operations.

MS HILL: And what – how do you take that data that you get from that forecast and bring it back to what the local community needs in a particular area, whether it's Mudgee or Dunedoo, and what the workforce of that particular inner regional or outer regional or remote location is telling you?

MR CHESTERMAN: I think the best use of it would be, you know, if I consider the context of working with an RTO as an example, that we would be able to better partner with them both on a needs perspective, but I think from a future skilled worker of our organisation, that we're able to make more upfront commitments that there will be a job for them at the end of their skill and qualification training. So I think that – having that context in mind when you're considering entering the sector and skilling up ahead of an opportunity to know that there would be an opportunity or a commitment from an employer in that region I think is quite powerful.

MS ATTRIDGE: I think that that's a really good example of that dereg has forced us to do as an industry, you know, is to be more sophisticated in terms of the way that we deliver service and think about what it needs to looks like moving forward. You know, Uniting has done a lot of work in terms of understanding what strategic workforce planning would look like. And that was something we definitely didn't do before dereg.

MS HILL: Ms Miller, Mr Chesterman has given the example in his evidence just then of partnering with an RTO. Asked you question about local training. Is local training an option to LiveBetter at the moment?

MS MILLER: It is on a limited – I know that LiveBetter, as I said in my statement, that we did look at becoming an RTO, but it was cost prohibitive at the end of the day. However, we certainly have some very talented people within our education, learning and development who we – and we do have learning and development officers in some of our more outreach areas, as well, to provide that on the ground sort of experience.

I think training locally is important, but we also need to consider the expertise that is required in relation to that training. And, yes, I agree that I think partnering with RTOs and other forms of education providers is critical in relation to ensure that we get the right mix of education that is required. I don't think that we could be all things to all people. And I think it's important that we do start to work – and I know that we are working – with other RTOs in relation to that.

But I think it's also the entry level. You mustn't forget that entry level; it's attracting that person in the first place to get them interested, the right person, to have them interested in coming into the aged care sector and then supporting them with ongoing education and training. That's, as I said before, I see it very much two part: attract, but retain by providing the right support. And then, hopefully, you increase your retention rates, which is ultimately what we do want to do.

MS HILL: Can I turn then to the second proposition, being that should consumer-directed care for home care packages be augmented by a provision of flexible funding for providers to deliver a combination of services?

COMMISSIONER PAGONE: Perhaps just before you go to the second provision, just to explore one of two or these workforce matters. We heard this morning from Mr and Mrs Dunlop about a model where the provider is sourced by the person who needs it. You, I think, Ms Attridge, talked a little bit about that, but I'm not sure whether any of you actually embraced that. Is that from your perspective something that's feasible or not feasible or - - -

MS ATTRIDGE: I think it depends on the consumer. I guess what consumer-directed care has allowed us is kind of a range of services in terms of having opportunities to meet different types of needs for different types of consumers. It's not a model that we use. We directly employ our staff, but there absolutely is a place for those people who wish to have that degree of control and autonomy to do that.

COMMISSIONER PAGONE: But from your point of view you don't use it.

MS ATTRIDGE: We don't use it, no.

COMMISSIONER PAGONE: None of you?

MS MILLER: Well, we certainly – at LiveBetter, for example, if a client says, "We would like to have our home care package with you, but we have this worker that we would like to continue with," then we would certainly work with the client to see if we – how that – how that would work. I've certainly had the experience as well, not in central west, this was in Riverina Murray, but we certainly had a client who wanted a family member to be their carer and we certainly worked with them in relation to how that would look. So I agree, I think it's dependent upon the consumer. Some of our consumers would not have that capacity or capability or - - -

MS ATTRIDGE: The support.

MS MILLER: - - - ability. Yes.

MS ATTRIDGE: Informal support.

MS MILLER: Informal support to make that happen. But if a client was to come with us with that then we would work with them to see how we could make that work, absolutely.

COMMISSIONER PAGONE: Mr Chesterman, did you want to add to that?

MR CHESTERMAN: No, I was just going to say I agree around – really is reflective of the consumer's circumstances and what they're looking for and what supports they have around to make those different models more successful.

COMMISSIONER PAGONE: And without necessarily going into all of the details of the particulars, in general terms, what are the kinds of either workplace relations or regulatory or insurance difficulties of adopting that kind of model?

MR CHESTERMAN: Well, I don't know the particular model but I would, you know, workers compensation, a raft of different insurances would need to be considered. I don't know how those different models work, but I think those things would definitely need to be considered by the consumer and understood by the consumer and also the worker who might be - - -

MS ATTRIDGE: Yes.

MR CHESTERMAN: - - - accessing work through those types of models.

COMMISSIONER PAGONE: I suppose it was unfair to ask you. I didn't intend to actually direct it towards you, because your organisation I don't think has ever done that, but the others sort of dipped their toe in that kind of space and I wondered what, having dipped your toe, resulted in you having to follow through.

MS ATTRIDGE: I think, as Helen mentioned, there's different ways of doing that through brokerage arrangements with other providers or negotiating with that worker to come on staff. That subcontracting-type arrangement that that person was talking about previously is not something that we would do. We've got an underlying EA and we employ our staff directly, but we've become creative and flexible in terms of finding ways to meet those needs if that's what the consumer wants.

COMMISSIONER PAGONE: Thank you.

MS MILLER: And we always ensure that they're – we meet the compliance in relation to insurance, in relation to criminal record checks. So it's just – I suppose it's about thinking outside the square and working with the clients to, you know, deliver what they need.

MS ATTRIDGE: I think we're kind of greedy, like we want the best of both worlds; we want the flexibility and the autonomy to respond to need but we don't want to give up the governance and support that's really, really important for people who are vulnerable.

COMMISSIONER PAGONE: Thank you.

MS HILL: Just drawing further from that in terms of the experience of what consumers see when they jump onto My Aged Care in regional and remote areas, do consumers of home care services in regional, rural or remote areas have any way of identifying, from your perspective as a provider, the cost differential between home care services. I might start with you, Ms Attridge.

MS ATTRIDGE: Yes, they do. So there's information that's provided on My Aged Care now that allows for comparison across the different charges that a consumer would find and that's new, so that's only come into effect this year, yes.

MS HILL: And Ms Miller?

MS MILLER: I was just going to say, it only enables the consumer to review three providers at once and, yes, so that's what the My Aged Care website can do.

MS HILL: And does that, in your – to your observation allow home care recipients to work out who's the most economical approved provider for them in the circumstances?

MS MILLER: I think - - -

MS ATTRIDGE: No.

MS MILLER: I think it depends on the consumer.

MS MILLER: I think that – in my experience, I've seen that if you have a family member acting on behalf of the – of their parent or their – whoever they're caring for, they will go much more extensive in relation to that, and some of them will create a spreadsheet where they've got a number, you know, like a whole range of providers and they will do the comparator and then they will come to you and negotiate. But if you are dealing with an older person who is living on their own and doesn't have that kind of support then, no, they won't have that capacity, I don't believe, to do that cost comparator. And I also – I know that My Aged Care have done a lot of work in the last few months to enable it to become a much more user-friendly internet service. I'm not sure that it's achieved that.

I think there's still work to be done in relation to making it easier to use, and I think if you go and you view it from their eyes – from a consumer's eyes, it is complex. Even though you've got all the costs and charges there, it doesn't necessarily make it – it doesn't convert that into what it would look like for the care that they receive. That's something that the provider then does with them in relation to the budget and quote.

MS ATTRIDGE: There's such a varying number of providers in areas too, particularly in some of the metro and some of the regional; it's the numbers of

providers that are there that make it really, really difficult to navigate and, like we've seen, there's such vastly different models of service delivery, too, that make it really difficult to compare.

MS HILL: Bearing in mind those responses of Ms Attridge and Ms Miller and the observations that the three of you have made in each of your statements with regard to travel costs impacting on home care package budgets, Mr Chesterman, is there a way in which the access to My Aged Care could be improved, in your view?

MR CHESTERMAN: I think the complexity that we've just heard about is – is quite challenging for a consumer when you think about an individualised plan because what's displayed on there from a provider is their core services, their hourly rates, travel fees, etcetera. What is more often the case with the services that are provided to a consumer is that after discussing their needs and putting in an appropriate care plan there may be multiple providers that are coming together to deliver more holistic services against those needs, so not just one provider.

And what's not available at the time of doing a comparison, for example, is knowing what those additional providers are, how they charge for travel, what additional costs they will include in their fees for – for the consumer when that holistic service approach is considered.

MS HILL: Does the consumer have any ability to know or to find out, based on the information that's on My Aged Care, just how far a provider, whether it's LiveBetter, Uniting, Australian Unity, will have to travel so as to provide that home care service?

MR CHESTERMAN: No, I don't believe so.

MS MILLER: No.

MS HILL: In the time that we've got left, can I return to that second proposition which is seeking your views on whether consumer-directed care for home care packages should be augmented by a provision of flexible funding for providers such as yourselves to deliver a combination of services. Starting with you, Ms Miller, can I seek your views on that as a possible alternative.

MS MILLER: I think that this is a very interesting model and I think that it has some merit. However, I think it's always going to be the devil will be in the detail in relation to how that is administered. And I think that, clearly – I know that that model exists in some very remote areas in Western Australia where I'm sure it would work exceptionally well but if we look at New South Wales and if we look at outside of metropolitan Sydney at what point does that – is it triggered, when is that decision made, what's the basis of that decision? I think there are some complexities in the detail that would need to be examined. I think some flexible funding, I think, is important for rural, regional and remote. Maybe it's more around the transport, maybe it's more around the cost of getting workers to go to various places.

So I think there's always – perhaps it's not the complete model, but maybe there's aspects of the model that could be applied that would work extremely well, and I think that that would require a much more detailed conversation, particularly with providers in relation to how that would look and how we could make that work. But I think – personally, I think that there's some – there's – there's some interesting aspects of that model that I think would – would benefit from further exploration and detail.

MS HILL: Ms Attridge, could I seek your views, please.

MS ATTRIDGE: Sure. I think there absolutely is examples where the market just won't support service delivery, particularly in those services that are more remote that absolutely need intervention. I think a one-size-fits-all approach is the wrong approach and I think the important part about this is asking the community what it is that they think and working with them and the other services that are in the area to look at opportunities or potential solutions that work for those communities because they are just so vastly different.

MS MILLER: Sorry, just to add, they can be extremely different. Like, we could talk from Cowra to Dunedoo to – they can vary, like, even Dubbo compared to Orange is a completely different market so those considerations need to be taken in in relation to any model that would be applied. There would need to be a strong flexible approach because no community in rural, regional, remote areas are exactly the same, no matter how close they are even.

MS ATTRIDGE: Particularly in those kind of regional centres; I think the issue that we're actually having at the moment is one of scale, like, is there too much competition there in terms of allowing a provider to have a scale enough that makes it viable, ongoing. I think there's a question of maturity, I think, of the system that we haven't answered yet.

MS HILL: Mr Chesterman?

MR CHESTERMAN: I agree with the comments that have been made. I think just to call out further the, you know, there is a place, I think, for more flexible funding to augment the option that you've expressed that go to very community specific programs or activities and potentially those services that have some type of infrastructure or capital expenditure to bring those services to those communities. So, for example, transport which is in many communities so crucial to access and some of the challenges that I think were raised around home modifications as well.

MS HILL: Can I draw back to your observation, Ms Attridge, that there's the potential for too much scale. What do you mean by that?

MS ATTRIDGE: Well, I think what's the level of competition that allows for people to have, you know, the right level of choice and options available to them, but also gives providers, particularly in those smaller markets, a degree of certainty and

scale that those services can be viable, I think is a question, you know, that needs resolving.

MS HILL: Is it better then to collaborate rather than compete with providers?

MS ATTRIDGE: Yes, absolutely.

MS MILLER: Absolutely. Absolutely.

MS ATTRIDGE: Historically, community care collaborated exceptionally well. Deregulation and competition has kind of squashed that a bit. We don't do that - - -

MS MILLER: No.

MS ATTRIDGE: - - - as much as we used to.

MS MILLER: No.

MS HILL: How could providers collaborate in the current marketplace?

MS ATTRIDGE: It's an evolutionary piece too. I think we're kind of learning how to behave in a more marketised environment. It's a challenging space at the moment.

MS HILL: How were you able to collaborate exceptionally well before deregulation?

MS ATTRIDGE: I guess because we – there wasn't the competition for the packages back in block funding. I'm not suggesting that it was perfect either because it certainly wasn't. But you would – you would talk to other providers if you had a consumer that was in need that you couldn't meet the need, you would pick up the phone and talk to the other providers to see what options were available. There was good networking opportunities there that don't kind of exist the way that they used to anymore and the sector development looks different now with competition.

MS HILL: In the current marketplace is it possible to both collaborate and compete?

MS ATTRIDGE: I think we need to because I think that that's the only way that you will get the outcomes for consumers that everybody wants. It's just finding the how in a market environment, I think is the difficulty.

MS HILL: What is your observation of that, Mr Chesterman?

MR CHESTERMAN: Look, I agree, I think there's a need and a place for collaboration and competition. I think it allows providers that have different specialisations or capabilities to complement services of other providers in those communities and really what communities need when you think about access is that

multidisciplinary capability set that's accessible in those communities and I don't know that one provider could ever really do that.

MS HILL: Are you able to give an example, Mr Chesterman, of how Australian Unity presently strikes that balance between collaboration and competition?

MR CHESTERMAN: Yes, I think one I gave earlier is just on a contingent workforce perspective where you're able to work in partnership at times with different providers to share resources, in effect, to some extent as opposed to being the only provider within that community, particularly when you think about geographies and travel and different consumer needs or changing consumer needs; that can quite rapidly mean there's a need that you haven't been servicing in a community before that you don't have an established workforce that you could collaborate with a provider who may have that specialisation or workforce in that area.

MS HILL: Ms Attridge do you have an example of that balance between collaboration and competition?

MS ATTRIDGE: To be perfectly honest, I'm not sure that we've struck it yet. I think that it's an evolving piece and we're still learning. I think that lots of good stuff happens at a local level in terms of local relationships, particularly, I think, in the more regional towns. But, yeah, I'm not sure that we're there yet.

MS HILL: Ms Miller?

MS MILLER: I certainly agree. I think that we are in that evolution of improving, but the one example I can think of and that I have in my statement, as well, is around end of life care, and certainly in relation to the fact that HammondCare provide that last 48 hours. And that's something that we would, you know, definitely be collaborating with and referring our customers to. And I think that that's an important piece.

So there are those small examples. And I would agree; I think in some regional towns where you've got a strong working relationship with other providers and certainly the health, for example, there's more – there's more capacity to provide a much more integrated care model, but it's very dependent upon the particular region or community that you are providing that service in.

MS ATTRIDGE: And relationships.

MS MILLER: As always, it always comes back to the positive relationships that you have and build with all of those other networks.

COMMISSIONER BRIGGS: In much of our evidence, we've heard many cases where people are allocated a particular package, and, as we heard this morning, a higher level package and they still get exactly the same services that they got on the

lower level package. And often that is because the provider simply doesn't provide anything other than a core level of services, and they haven't either the sophistication or the interest to negotiate further. Do you feel, in your roles, that the system facilitates that kind of engagement or is the competitive approach to acquiring new customers and delivering a service the thing that dominates?

MS ATTRIDGE: I think it does allow for that. I think it very much comes down in terms of the skill of the coordinator or the case managers that's doing that. Yeah. That's a tough conversation to have in terms of being able to balance that in terms of assessment of needs versus competitive pricing, setting up a service that's viable, ongoing. But, yeah, it very much is dependent on the person who is doing that initial assessment for the provider.

COMMISSIONER BRIGGS: And that would suggest that the sites of the case managers and assessors need to be raised a bit to actually focus more on that kind of range of services and how they might be delivered.

MS ATTRIDGE: Yes, and drawing the information out of the consumer and understanding exactly what it is that will keep them safely at home. And I think it's an issue that will only expand over time as the needs of the customers start to increase. And, hopefully, fingers crossed, with the implementation of a level five package we will be, you know, supporting people to far higher needs at home, which is absolutely what people want.

MS MILLER: And it's often consumers don't know what they need either.

MS ATTRIDGE: Correct.

MS MILLER: And that's a common thing. So it really is the skill of the coordinator to ensure that they work with that consumer to provide them with that. We've just recently at LiveBetter introduced a services booklet, which is, basically, a booklet which runs through a range of services, but it enable to say the consumer, our client, to have a look at what potentially is there. And we actually give them capacity to write. So that we give that to them on that first assessment so that they can then go through and have a look. And there's a whole wide range of things. Now, many of those services are not something that we would provide directly, but we would broker with other services to ensure that they get that. But it's about giving people choice and it's about ensuring that they have the information upon which they can make some wise decisions, and giving them time to make those decisions. I think that's extremely critical, as well.

COMMISSIONER BRIGGS: Is it – is part of what's behind that the need for a person to build up trust with the provider of services?

MS MILLER: Absolutely.

COMMISSIONER BRIGGS: That's what I think.

MS MILLER: Absolutely. And it's around good communication, trust, a good relationship. And then it – it makes everyone's work and – easier and much more fulfilling. But, more importantly, it ensures that we provide the right service to the client. And we work with them, because as their needs change it's really important that we go back and we reassess with them and we work with them to add services that are required. Or they might give you a call and say, "You know, I've just been reading your booklet and I just thought I would really like to have an exercise physiologist." Okay. How can we make that happen? "My doctor has said that's a great idea."

MS ATTRIDGE: I think the other thing that we've learn over time, too, particularly with the changes around deregulation, is that the relationship and the contact and where that trust sits is actually with the direct worker, the people that are coming into their houses every day, and how that information is shared and how changes are identified and addressed. Like, there's just such a criticality in terms of that role of that support worker.

MR CHESTERMAN: I agree. I agree. The mechanisms for our care workers of going into the homes of customers every day and seeing potentially changed needs is crucial to the right plan.

COMMISSIONER BRIGGS: So this feedback between workers on the ground is a similar issue that occurs in residential aged care, right? So it's a question about what mechanisms do you have to ensure that that feedback goes back to the case manager or, you know, your key personnel. Can you give us a bit of a flavour for that.

MS MILLER: Yeah. Look, we certainly – I mean, I think we're evolving and we're changing our structure and how we provide our services on an ongoing basis. But what we're doing currently is that we have our coordinators or case managers who are responsible for a set number of home care packages. We then have those workers that are providing that care wherever possible. They actually are reporting to that case manager, so that we've got that direct link between the case manager and the actual home care worker who's delivering the services.

This then ensures that there's that good communication on a regular basis in relation to any changes that the home care worker is seeing or any changes that the client perhaps is acknowledging that is working for them. And it's around – once you've got that relationship between your case manager and your home care workers, it enables much more free flowing information to occur and the home care worker to actually ring the coordinator and say, "Look, I'm really concerned about A, B, C and D." But it is around, we find, how we structure that and how we ensure that that communication occurs.

MS ATTRIDGE: I think the space that we're also exploring, too, with our model development is actually what are decisions that are safely made at the point of service that don't require the escalation and permission. You know, for most of our consumers they are the experts in their care, so let's allow them to make the

decisions that are safe for them. Because the easiest way to mitigate risk is to respond to it. You can do that at the point of service. That's actually really important.

And then, on top of that, making sure that there's safeguards and delegations and responsibilities that support workers feel really comfortable that if they're not sure or they are comfortable with this, that there's opportunities for them to escalate and seek advice from more skilled workers. But I think that decision-making at the point of service delivery is actually really important.

MR CHESTERMAN: And we have a similar model where our care workers are sitting in teams that are connected to the case manager, who's looking after those customers. We also have technology. So our care workers have mobile phones and they're able to make notes at the end of the service and send them straight back into the case manager, which could be identifying that something's changing in their experience with that customer.

MS HILL: That means of being able to send notes back to case managers to coordinators is obstructive though, isn't it, when you don't have the data connectivity or telephone connection?

MR CHESTERMAN: Yeah. It is for a period of time for us. So you can still use the device in an offline capacity and when you come back in or out of the black zone or back into a receptive area it automatically pushes that data through. So it's not severed or lost, but there can be time delays in black spots for the transmission of data.

MS ATTRIDGE: There's also ways to usually kind of download the information that you need prior to going into the black spot, so you make sure that you've got the information that you need to deliver your services, as well.

MS HILL: Commissioners, that concludes my examination.

COMMISSIONER PAGONE: Just before we let you go, between the three of you, both individually and collectively, there's a huge amount of experience and knowledge about how the sector is providing and responding to needs. And I dare say that you've got a keen sense of all of the things and issues that impinge upon you in different directions. What would each of you say is the absolute essential must have to be changed?

MS ATTRIDGE: Can I go first?

MS MILLER: That was quick.

MS ATTRIDGE: I know ..... I think that it's just heartbreaking to know of consumers that have need that's just not being responded to. At the moment I think it adds complexity into the system. I think it's helping – like, making people become

frailer far quicker than they should. And the other thing that we're seeing a lot of now, too, is the impact that that's having kind of further upstream in terms of the provision of the CHSP services. I think that underlying intent of wellbeing and re-ablement for CHSP is at risk of being lost, because at the moment it's a stopgap for packages. So that would be my vote.

MS MILLER: I – sorry, go on.

MR CHESTERMAN: I was going to say I completely agree. I think the change that's needed is making sure people get the right care when they need that care. And we see that with waitlists. And we even see it with consumers who have joined our organisation with a higher assessed need, a lower level package and within a period of time keep getting moved between packages, which in itself is inefficient. And you're constantly having conversations that you're limited by what you can provide to those customers that have those greater needs. So I concur that that's one of the most significant changes that needs to be made.

MS MILLER: The only thing I would add is that – and I completely agree – is that when I sort of read your interim report and heard that, you know, there was going to be more home care packages released, from an operational perspective, I thought client perspective, fantastic; from an operational perspective, I thought, "Oh my God. Workforce." Honestly, that's really what I woke up thinking.

So, yes, obviously, for me then it's about workforce, it's around supply. But it's around ensuring that we look at it in totality. It's around making sure that we have an attractive pathway for individuals who want to come and work in aged care for all the right reasons and that we sustain them, but we then continue to train and develop them, so that we are able then to replace case managers and able to replace a whole range of people.

MS HILL: If the waitlist was – pardon me Commissioners – if the waitlist was resolved overnight, bearing in mind those workforce issue that you've just described, Ms Miller, how long would it take to gear up to be ready to deliver that?

MS MILLER: If it happened overnight - - -

MS HILL: In your organisation, I should say.

MS MILLER: We would not be ready. We would need to have time to ensure that we continued to recruit. I'm sure my human resources department would require me to, you know, enable them to assist us in that rapid recruitment process. But, at the end of the day, if we don't have the workers out there and then it's not going to be a sustainable option.

MS ATTRIDGE: Yes. I don't think it's an issue of a provider not having enough. It's an industry or a sector not having enough.

MR CHESTERMAN: I think there'd need to be more transparency around when and where are those packages going to be released, so providers can be more proactive in setting themselves up in readiness for some of those changes.

COMMISSIONER PAGONE: Well, thank you. It's been very, very informative and helpful. The task is not yet over, so, having been asked all these questions today, our doors are still open to you. And if you've got some ideas about what you think we should be told, you should feel free to tell us. In the meantime, thank you each of you for coming along.

MS MILLER: Thank you Commissioner.

MS HILL: Mr Gray will lead the next witness.

COMMISSIONER PAGONE: Yes, Mr Gray.

DR HANSCOMBE: Might Dr Brophy and I be excused, Commissioners.

COMMISSIONER PAGONE: Yes. Of course. Yes. And, indeed, I should formally excuse the three witnesses, who I think are otherwise here under subpoena of some kind. So you're free to leave without fear.

<THE WITNESSES WITHDREW [12.14 am]

MR GRAY: Commissioners, I call Dr Rachel Winterton. Commissioners, we're running a little behind schedule. We may need about 40 to 45 minutes with Dr Winterton.

COMMISSIONER PAGONE: Yes, of course.

<RACHEL ELIZABETH WINTERTON, AFFIRMED [12.15 am]

<EXAMINATION BY MR GRAY

MR GRAY: Yes. Dr Winterton, what is your full name?

DR WINTERTON: Rachael Elizabeth Winterton.

MR GRAY: You've made a statement for the Royal Commission, haven't you?

DR WINTERTON: Yes.

MR GRAY: I'll ask that that be displayed on the screen in front of you; WIT.0589.0001.0001. Subject to some redactions of personal details, is that a copy of the first page of your statement?

DR WINTERTON: That's correct.

MR GRAY: Do you wish to make an amendments to the statement?

DR WINTERTON: No, I do not.

MR GRAY: To the best of your knowledge and belief, are the contents of your statement true and correct and are the opinions in it opinions which you truly and sincerely hold?

DR WINTERTON: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Statement of Dr Winterton dated 29 October will be exhibit 12-15.

EXHIBIT #12-15 STATEMENT OF DR WINTERTON DATED 29/10/2019 (WIT.0589.0001.0001)

MR GRAY: Thank you, Commissioner.

Dr Winterton, these are matters that you've set out in your statement but I will just briefly ask you to confirm them. You're a research fellow at the John Richards Centre for Rural Ageing Research, La Trobe University, Victoria; is that right?

DR WINTERTON: Yes, that's correct.

MR GRAY: You're also the convenor of the Regional, Rural and Remote Special Interest Group of the Australian Association of Gerontology; is that right?

DR WINTERTON: Yes, that's correct.

MR GRAY: Thank you. You have a doctoral degree and you have a research background in the field of rural ageing and aged care and you've been working in that area since 2009; is that right?

DR WINTERTON: Yes. That's right.

MR GRAY: Thank you. Now, I want to ask you about a concept that you address in one of your papers. It's a paper that's available in the general tender bundle at tab

30. It's the concept of contested spaces in rural ageing. Is one aspect of the concept of contested spaces the notion that there are, in effect, three sources of supply of services relating to rural ageing: private providers, government and volunteers?

DR WINTERTON: Yes, to some extent although I think the private sector would be hotly disputed in some rural communities, but yes.

MR GRAY: And when one thinks about the provision of aged care and those potential sources of service provision, would you just explain to the Commissioners what is the concept of a contested space in that degree?

DR WINTERTON: So the contested space essentially relates to the fact that older people have a right to access services within rural communities and the contested aspect is the conflict and contestation, if you like, over who is actually responsible for delivering aged care services in rural communities in the context of some of the issues associated with marketisation of rural aged care, issues attracting the volunteer sector and continued withdrawal of services.

MR GRAY: And in the paper do you make the point that the government currently seems to have a policy mode of withdrawing and seeking to hand over to private service provision, and that's one aspect of what you say; is that right?

DR WINTERTON: Yes, so there's multiple factors at play there in that the – there is a push to the private sector in the context of some of the market-based approaches that are happening in rural areas and the market is having an effect in that it's a thin market, as I'm sure we are all aware. So there is an inevitable consequence that a lot of services are being devolved to the voluntary sector in rural communities because there isn't anyone else to provide them.

MR GRAY: How are those other potential sources, that is, the volunteer sector in rural communities coping with that dynamic?

DR WINTERTON: With great difficulty. There has been a traditional model of, I guess, reliance on volunteers to provide aged care support, certainly in rural communities, particularly in relation to filling gaps in local service provision, making sure that older people in rural communities can access transport, can be provided with Meals on Wheels, to do all of these things but there are some real concerns internationally and certainly within Australia as to whether this trend can continue in the context of some of the broader societal trends around people working later, different preferences for volunteer involvement, and the movement of younger people and families out of rural communities in search of work and employment, that sort of thing.

So there is some question internationally and certainly within Australia as to where the volunteers to support the rural aged care sector will actually come from moving into the future which will significantly disadvantage older people in communities that rely on this sort of support.

MR GRAY: And with respect to the concept you just mentioned of thin markets, is it the case that the for-profit sector is not terribly well represented in rural and regional areas?

DR WINTERTON: That's correct, generally.

MR GRAY: Yes. I'm going to ask you later some questions about coverage.

DR WINTERTON: Yes.

MR GRAY: But the concept of coverage is what, that there may be some aspects of service provision in rural and remote areas that simply don't have supply, don't have a service provider to provide those aspects of service; is that a fair summary?

DR WINTERTON: At a very localised level and it varies quite considerably across rural communities, and whether they are regional, rural, remote, but some local communities may not have a actual locally based provider.

MR GRAY: And is there any obligation of last resort, that is, to be a service provider of last resort covering the country in respect of community care?

DR WINTERTON: To my knowledge, no.

MR GRAY: I want to ask you about the Australian Association of Gerontology and in particular the special interest group of which you are the chair. You've referred to its purpose in your statement. In a nutshell, what's the role of the special interest group and how does it approach its task?

DR WINTERTON: So the rural – the regional, rural and remote special interest group was formed in 2016. We are – we received – the Australian Association of Gerontology receives funding under the dementia and aged care support fund which funds the work of the RRRC. We have a policy officer that works with us but our remit is to stimulate discussion and dialogue around issues associated with ageing and aged care in rural, regional and remote Australia. So part of our remit is that we hold regular workshops, seminars, and engage external advocacy organisations relating to rurality and aged care to actually look at some of the pressing issues relating to the provision of aged care in rural, regional and remote Australia and to look at potential solutions to addressing some of these issues.

MR GRAY: And is your membership made up of not only academics but also aged care leaders, practitioners and, indeed, policy-makers and advocates?

DR WINTERTON: Yes, so the actual special interest group membership per se is restricted to members of the Australian Association of Gerontology. So as part of our membership we have aged care service providers, academics working in the field, advocacy organisations, but our activities that we hold regularly throughout the year are open to anyone that wishes to attend, and so we normally attract policy-

makers to these as well as people working in the space. So from aged care organisations, geriatricians, that sort of thing. So we do have quite a broad – I guess, a broad membership in relation to the work that we do.

MR GRAY: I want to ask you about two of the particular pieces of work of the special interest group. Firstly, a workshop held in 2017 on, in effect, the question of equity or inequity of access to aged care services, and then a little later I'm going to ask you about another workshop held in 2019 in relation to workforce issues in rural areas.

DR WINTERTON: Yes.

MR GRAY: I will start with the 2017 workshop. This is a previously tendered document, operator. It's RCD.9999.0075.0001. The document on the screen, Towards an Action Plan for Aged Care for Rural and Remote Australia, is that the documentary work product of the workshop that I just mentioned in 2017?

DR WINTERTON: Yes, it is.

MR GRAY: Thank you. And in terms of the reference there to Action Plan, is that an intended action plan under the National Aged Care Diversity Framework?

DR WINTERTON: It was intended as such, yes.

MR GRAY: Yes.

DR WINTERTON: So it was intended to feed into that.

MR GRAY: Yes. And is that still a plan or a work in progress that there should be such a national plan formulated under the diversity framework?

DR WINTERTON: Yes. Our contention is within this report that there are distinct issues associated with the provision and access to aged – aged care services and supports in rural contexts. So we are – we are very keen to see that included under that.

MR GRAY: Thank you. Operator, if we please go to page 0003, do we see here, in effect, under those four topics, research and data, residential care, home care, and workforce, some of the key themes that were identified during the workshop. And if we go to 0004, do we see the recommendations that came out of the discussions in the workshop on those matters; is that right, Dr Winterton?

DR WINTERTON: Yes, that's correct.

MR GRAY: Thank you. Now, I want to ask you about some of these in a little more detail. Firstly, there's the point you've just mentioned about the diversity framework action plan. Next, there's in recommendation 2, a recommendation that:

The government should undertake a review of rural and remote aged care service access and quality.

Then there's – I'm not taking them in order but I'm going to ask you about them all together – then there seems to be a related recommendation at the end, recommendation 6 which is:

To improve the evidence base for aged care service delivery by a national research and data strategy for aged care.

And in a minute I'm going to ask you about the minimum service access standards but just taking recommendation 2 and recommendation 6 together first, what's the intended scope and purpose of those recommendations and why are they necessary?

DR WINTERTON: So the workshop – the workshop discussions that we had which were based around some of the issues and challenges associated with delivery of aged care in rural and remote contexts but also looking at the evidence base for that, we were – one of the key challenges I think that we looked at is that we don't really know a lot about the innovative work that is happening in rural areas and what the challenges are in relation to service delivery from a research perspective. So we know that there is innovative work happening in rural and remote regions in relation to the provision of aged care but it's often not evaluated, it's not published at a larger scale. So it's hard to scale and it's hard to look at that and consider how that might be applied in other contexts.

But part of the challenge, too, for researchers in looking at evaluating models or trying to ascertain what the issues around access and quality actually are is that it is very hard to gather the data on this. So within the research evidence base on rural, regional and remote aged care issues, it is predominantly qualitative, they are primarily small studies. So we don't see large numbers of large nationally representative studies around some of the issues and challenges associated with rural and remote aged care service delivery, quality and access. So the reason for our recommendations in this space, particularly in relation to recommendation 6 which is on the screen, is to actually – we actually want to know as researchers and we think it would be beneficial to know what – what is being provided in rural areas, what – what sorts of services are being provided, what the levels of access actually are in rural, regional and remote communities, and then actually being able to access the data to – to actually examine that.

So it's very hard to gather this level of data at the moment. It's very piecemeal. And so, consequently, we see studies are very short term. We don't know in relation to some of the innovations that are happening or in terms of how aged care is working in rural, regional and remote areas. We don't know how that's working on a longitudinal basis and what the outcomes are for older people and how it is benefitting older people, so actually measuring how access and equity is being achieved.

MR GRAY: So would one example of that be the point I raised about coverage earlier? Is it the case then that we don't have a clear picture of the extent of coverage of particular tiers of service throughout the country?

DR WINTERTON: Yeah. And I think part of the challenge, too, is what we had questioned as part of this workshop is, you know, how do we know what the coverage is within rural, regional and remote areas in relation to aged care? So what is the minimum level of coverage that is required to ensure quality of access and outcomes for older people in different rural communities? What actually is required at the local level in terms of minimum access? And how do we know what minimum access is?

MR GRAY: So that leads me to recommendation 3. And I would like to ask you about the concept that's referred to there as a minimum service access standard. What is – what's the concept of minimum service access standards?

DR WINTERTON: So we had a lot of discussion within the workshop in relation to how we know services are provided, how do we know that services are provided on equitable basis to older Australians in rural, regional and remote areas,. And the National Rural Health Alliance has proposed similar standards in relation to rural health coverage. But the idea of these minimum service access standards that were discussed within the workshop, they're distinct from quality standards, though, obviously, quality is an important consideration. But they should really reflect what levels and types of aged care service provision should be available within communities of various sizes and degrees of distance from – from major population centres in terms of ascertaining what is a minimum level of access and what should be provided in certain places.

MR GRAY: So would an example of a use of that be that if I lived in a remote or an outer regional area and I was unsure what reasonable expectation I should have of getting access to a certain kind of aged care, I would be able to look at this minimum service access standards resource and understand what those expectations should be?

DR WINTERTON: I think it's about identifying what the rights of older people are to be able to access services in their – in their different communities. So actually being able to understand clearly what sorts of services people should be able to access and should be provided in order to enable them to age successfully in their communities.

MR GRAY: And would a resource like that also aid in the task of working out whether, calibrated by reference to degree of remoteness, there was, basically, an equitable approach being taken across the country to making sure there wasn't too much regional variation in access?

DR WINTERTON: Yes. I think something like this enables us to look quite clearly at what is being provided and looking at what's not equitable, where gaps are in relation to service provision and I guess why that is, too, to some extent, is looking at

some of these regional variations in relation to aged care service provision and identifying why that is, but also enabling us to address it.

MR GRAY: If you found that a particular part of a particular state for some reason wasn't meeting the minimum service access standard, you would know that there was an inequity for the people there and it could be addressed.

DR WINTERTON: Yes.

MR GRAY: Would that be one of the benefits?

DR WINTERTON: That would be one of the benefits, yes.

MR GRAY: Thank you. Now, you also, in this workshop, produced recommendation 4 on government policy and funding. And in the course of discussion on that matter, there appears to have been reference to themes that we've already heard in some of the evidence, in some of the – including evidence this morning – about provision of policy – beg your pardon – formulation of policy and funding based on principles of cooperation and collaboration between service providers, rather than competition. Just stopping there, can you just elaborate on whether there was discussion about how one might go about trying to work out when there should be cooperation and collaboration on the one hand or competition on the other or could there be a blend of both? How would that be approached?

DR WINTERTON: Yes. I think within the workshops and certainly the research evidence would suggest that cooperation in rural communities is really integral in addressing some of the systemic issues associated with providing services in these regions and making sure that older people get their care they need, particularly, I guess, in relation to the different services that are required for older people in terms of the complex needs that arise in relation to their care.

It was seen within the workshop, and certainly within the existing research evidence, that it is quite beneficial in relation to sharing resources and addressing some of the cost and administrative challenges associated with delivering aged care services in rural regions. Whereas, I guess competition can be advantageous from the perspective of consumer choice in rural regions. The discussions that were had within the workshop and that are starting to emerge in the academic literature would suggest that that does not always exist in rural communities.

MR GRAY: Thank you. Just – it's not particularly related to this issue, I don't think, but there's an aspect of the contextual background facts that you mention in your statement about residential aged care. It's on page 0008 of your statement. At paragraphs 27(c) and (d) you refer to regional and remote areas having lower usage rates of residential aged care services. But, at the same time in the other discussion you've set out in your statement, you've explained that there's actually proportionally less aged care services being made available in at least outer remote – beg your pardon – outer regional and remote areas.

DR WINTERTON: Yes.

MR GRAY: How do we reconcile this apparent inconsistency or perhaps paradox about the fact that, proportionally speaking, less services seem to be made available and yet there also seems to be a lower take-up of residential aged care?

DR WINTERTON: So I guess there are a number of – it's a complex issue in relation to older people in rural areas – proportionally are less likely to enter residential care. And this, largely, if you look at the literature, is discussed in relation to the fact that older people in rural – particularly rural and outer regional or remote areas need to move to access residential aged care facilities.

So in my statement, I outline – which is up on the screen – outline that the more remote you are, the further you will have to move, which is very problematic for older people, in that it's taking them away from their communities in which they may have always lived, away from their families, potentially their social network. So there can be a reluctance to move into residential care from that perspective.

There are also issues associated with accommodation costs prohibiting entry into residential aged care. Older people may be reluctant to use the entirety of their home equity to fund their residential aged care placement, particularly because the cost of housing is much less in rural and remote Australia. However, a lot of literature has said that this reluctance to enter residential care may be associated with potentially greater levels of informal care or a preference for informal care where that can be provided. In a lot of cases that may not necessarily be possible.

And the ability of the community, and as I've mentioned previously, the volunteer sector in enabling older people in rural communities to stay at home. So it's a complex issue. So the fact that they are not – they are entering residential care, I guess, they're less likely to enter is a good thing, potentially, where they are adequately being supported to stay in their homes and they are happy there and being well looked after. But if it is a restrictive issue, in that they can't actually enter residential care and they need to be there, then that is problematic.

MR GRAY: So to the extent that there is actually a need for the person in question to enter residential aged care, and, therefore, it's problematic if they can't, perhaps it's obvious, but this tends to drive us to a solution whereby there should be more dispersed smaller facilities. And that would – I think you're positing the suggestion that it's really transportation and travel and remoteness that's driving the lower occupancy rates that we see to some extent in rural .....

DR WINTERTON: To some extent, but I don't think that's the whole picture. No. But certainly I think the research evidence would suggest that where there is a local facility that people feel is well staffed, well supported, there is an increased likelihood that older people may enter residential care, if it's required. Yes.

MR GRAY: Thank you. Can I go now to the 2019 workshop on workforce.

DR WINTERTON: Yes.

MR GRAY: And, Operator, if you please bring up general tender bundle tab 29. That's the document that was produced by that workshop - - -

DR WINTERTON: Yes.

MR GRAY: - - - isn't it, Dr Winterton?

DR WINTERTON: That's correct.

MR GRAY: Just before we dive into an aspect of that workshop, can I just ask you to comment on some of the contextual information that you've mentioned or cited in your statement. At general tender bundle tab 56, from the residential aged care perspective, there's some material. It's of a qualitative nature. As I think you foreshadowed earlier, quantitative information is a little sparse - - -

DR WINTERTON: Yes.

MR GRAY: - - - in this area. But it's qualitative information based on interviews with residential – former residential aged care workers from the public sector racks system in Victoria; is that right?

DR WINTERTON: They are currently employed, yes.

MR GRAY: Currently employed.

DR WINTERTON: They were currently employed.

MR GRAY: Thank you. And could you summarise for the Commissioners what was the gist of the methodology employed, what sort of questions were they being asked and what was the outcome in terms of reasons for potential resignation or retirement from that role in residential aged care in rural settings.

DR WINTERTON: Yes. So this was a small qualitative study completed by colleagues of mine at La Trobe University where they interviewed – I think it was under 20, I believe, current aged care workers aged over 55 years employed within public residential aged care facilities in Victoria. The aim of this piece of work was to look at, I guess, their current levels of job satisfaction and their motivations for staying in their current role.

There's a lot of work been done recently around the age – ageing of the residential aged care workforce. So this was – this piece of work was intending to look at what would retain these workers in order to keep them in the workforce. And it had a specific focus on looking at the intrinsic, so – so intrinsic factors related to why they – why they enjoyed their jobs or why they were staying in their jobs, so things like altruism and the personal fulfilment in their role, and then looking at some of the

extrinsic rewards, so things that would impact their job satisfaction that were not necessarily related to their motivations for aged care work.

And this piece of work identified in relation to intentions to stay employed within the residential aged care sector, while some of their motivations – well, their motivation for employment was largely intrinsic. So they got incredible personal fulfilment out of the work. Their job satisfaction was also very heavily influenced by some of the extrinsic issues. And they cited issues related to excessive workload, issues around remuneration, and conditions within the workplace as reasons that they would consider resigning.

MR GRAY: Were there some observations by the authors that the value placed on those sort of altruistic incentives to remain in the workforce, that they seemed to be deteriorating and that this placed a heavier – this placed a heavier focus on the need to bridge the remuneration gap?

DR WINTERTON: Yes. So while, you know, that intrinsic aspect of the work is often what does bring people into the aged care workforce and there is a certain reliance on this, I think, as a society and this is certainly the rhetoric around it is that people do this sort of work because they are drawn to it, that that is an intrinsic motivation. The extrinsic issues are really significant to keeping people actually in the work. So it doesn't – I mean, in essence this work has demonstrated that while they may have an intrinsic bent for this sort of work, if the conditions aren't right and people cannot support themselves and they're finding the work physically demanding and stressful, then they are not going to stay.

MR GRAY: Thank you. And at tab 57 there's a similar study in the sense that it's a qualitative study based on a limited series of interviews, from the perspective of the community aged care sector.

DR WINTERTON: Yes.

MR GRAY: In this case it's service managers who were interviewed; is that right?

DR WINTERTON: Yes, so this was another small qualitative study that again – again conducted by my colleagues at La Trobe, that looked at, I guess, the service needs of service managers within residential aged care facilities. So the research was looking at some of the challenges associated with the provision of community aged care services. So this study was conducted in the Riverina and looked at, I guess, some of the issues being faced by community aged care managers within this region.

MR GRAY: What were the key conclusions around recruitment challenges and in particular with respect to younger potential recruits?

DR WINTERTON: So essentially this piece of work found that there was a significant preference in this particular study for older workers because they had more life experience, they were easier and more effective to retain. There were some

issues identified in terms of attracting a younger workforce that they weren't being adequately prepared for the nature of working in rural regions, from the perspective that often they hadn't conducted their placements in rural areas, they weren't accustomed to what aged care work was like in rural areas, and they couldn't remunerate them to the level at which they expected, so retention was quite poor.

They also discussed issues in relation to younger workers in terms of ensuring that they had secure employment. So the fact that they weren't always able to offer ongoing work that wasn't casual, part time and that the hours fluctuated was a significant barrier to recruitment and retention of younger workers within the community aged care workforce.

MR GRAY: I want to now go to the workshop document, and the recommendations that were made in that document or at least two of them. If we please go back to – it's tab 29, please, operator, and if we please go to page 0009, we've got a fairly broadly framed recommendation, recommendation 3 at the foot of page 0009:

> *Implement immediate actions to improve recruitment and retention in the aged care workforce generally across Australia, including improving the public perception of the role, remuneration, career pathways and access to professional development and recognising aged care nursing as a specialty.*

I want to ask you about some propositions, and test them with you to see what your views are about their workability and appropriateness.

DR WINTERTON: Yes.

MR GRAY: Firstly, would it, in your view, be appropriate and workable to establish a widespread system of rural training scholarships for the various tiers of the aged care workforce, and a condition of the scholarships would be that the trainee after receiving training would work in a particular rural location and stay in that location for a period?

DR WINTERTON: Yes, I think that would be effective in addressing some of the issues around remuneration, potentially, and making sure that people that can be trained in the contexts in which they will be working, yes, I think that would be effective.

MR GRAY: Perhaps in conjunction with that or separately, what about a proposal whereby there was a program of funding to help facilitate linkages between rural aged care providers on the one hand and reasonably geographically proximate TAFEs or RTOs in the same regional areas on the other whereby you could have a pathway from the training – training within the walls of the TAFE or facilitated by the RTO linking through to on-the-job training in the aged care provider. Would that work and be appropriate, in your view?

DR WINTERTON: As long as the RTOs were available locally and that there was the capacity, I think, for providers to feed back to the RTOs what their specific training needs were, because I think the providers themselves will have very significant insight into the sorts of support and training that's required to work in rural contexts, yes.

MR GRAY: There would be a cost in the sense of time spent within the aged care provider in supervising and providing some on-the-job training as an element of that.

DR WINTERTON: Yes.

MR GRAY: Would it be appropriate for the government to step in and fund that additional – that additional workload?

DR WINTERTON: Yes. So I think – I think that's the really critical point here, is I think that if we are going to be pushing for students to be trained in rural regions, in residential aged care, community aged care, there – it's critical that these providers are supported to provide that training. The research evidence and much of the evidence I think that the Commission will already have heard suggests that this is a sector experiencing significant pressure in terms of workload. So they will need to be supported to actually support these students.

MR GRAY: I want to go to the next topic that was addressed in the workshop, which is right under recommendation 3 there's then some text about it. Beginning at the foot of page 9 and then going over the page to page 10 it says:

> *The following actions identified at the workshop relate specifically to rural and remote aged care service settings.*

Then there's the first point:

> *Develop a rural workforce centre.*

And then there's a number of additional points made by way of explanation of that, ending with a suggestion that:

> *Primary health networks could be a potential coordinating agency for this model.*

And all of this culminates in recommendation 4 which should appear just after that text on page 10, operator, if you could please display that for Dr Winterton. Which is:

> *Develop a rural workforce centre model through which aged care, health and community service organisations can partner and pool funds, staff and effort to develop a local workforce which is shared across organisations and which delivers integrated services to outlying communities and households.*

So Dr Winterton, giving a little more detail around this concept of a rural workforce centre, what was the nature of the discussion at the workshop on this topic?

DR WINTERTON: So this recommendation stemmed primarily from the discussions that we had around the need for collaboration rather than competition in relation to the delivery of rural aged care services, but also in recognition of some of the challenges associated with delivering services in these regions, associated with securing a workforce that could be offered secure employment, secure viable positions that were full time, for example, in terms of some of the costs associated with delivering services in rural regions. So it was thought that a model where workforce could be pooled would address some of the administrative issues associated with delivery services in this region, such as administrative costs associated with service provision, costs for travel, even some of the administrative costs associated with developing position descriptions, you know, payroll, monitoring, that sort of thing.

So this recommendation was also based on some feedback that some of our workshop participants had similar models of being employed overseas to address some of the systemic challenges associated with delivering services in rural regions. But this recommendation also stemmed from the perspective that from providers within the workshop but also from the research evidence that these integrated models worked very well in rural communities as long as they can be conducted in a way that respects the needs and capacities of that community, so – because they all are very different, as you will know.

MR GRAY: Can they work alongside the market model driven by competition for provision of home care package services, in your view?

DR WINTERTON: I'm not sure that I'm the best person to comment on that, given that I'm not a service provider, but I think that would certainly be something that would need to be ironed out in relation to how that might work from the perspective where organisations can complement each other, rather than compete in rural settings. I think there is potential for it to work but it would require some massaging.

MR GRAY: Thank you. Now, this rural workforce centre model is about collaboration between separate organisations.

DR WINTERTON: Yes.

MR GRAY: And pooling – potentially pooling of funds between them at least on discrete aspects - - -

DR WINTERTON: Yes.

MR GRAY: - - - of those support elements of the services they're providing as you mentioned.

DR WINTERTON: Yes.

MR GRAY: I now want to turn to a slightly different take on a similar topic which is the idea of the way in which the individual organisations can be funded and I want to ask you about another proposition and test that with you. It's a question that relates to this idea of the potential patchiness of coverage for community based and home care services.

DR WINTERTON: Yes.

MR GRAY: What about – what are your thoughts on the following proposition: that the government should assess the markets for the services covered by the Home Care Package Program in regional and remote areas and in the absence of compelling evidence that there's a workable and competitive market for the suite of services across the home care package levels in each particular area, then the government should vary and augment the current market-driven consumer-directed model in that area to ensure that there's a sufficient supply of services to meet demand in that area. At a high level of principle, what's your views on the appropriateness of that principle, and I will come to the workability of it in a minute.

DR WINTERTON: I think it comes back to the argument about minimum standards. I think it needs to be assessed whether there is a viable market in particular places and what that should look like, because I think that's part of the issue. We're not sure what a market should look like in rural areas and, you know, how many services should there be, how many providers, you know, what does that look like for rural communities. And yes, I think at a high level of principle, if it looks like certain areas are experiencing difficulties, then I think, again, coming back to my argument around, you know, the contested spaces and whose responsibility is it to deliver these services and I think there needs to be a responsibility assigned if it is demonstrated that the market is thin.

MR GRAY: So if I may, just reframing my understanding of what you've said, at a high level of principle, it seems like a reasonable idea that it has to be anchored in a more systematic or systemic view of what equitable access for different areas across the country should be, trying to make the level of access to be expected at areas of particular remoteness throughout the country as uniform as possible.

DR WINTERTON: Yes, and I don't think we really know what that looks like at the moment. I think – and it will differ, I think, between places and communities but I think we do need to have some sort of understanding as to what equitable access looks like through some form of minimum standards, yes.

MR GRAY: Yes. So if it were a very, very remote location and according to the minimum service access standards, there might not be a reasonable expectation of receiving a particular kind of community aged care, and that might inform the answer that you would give to whether this recommendation should be implemented in that area; is that how I'm to understand your evidence?

DR WINTERTON: Yes, so as I've said, I'm not sure exactly what that would look like and I think everybody should have a reasonable expectation that they can receive some level of services.

MR GRAY: Okay. Can I just ask you about two ways in which it might be possible to implement such a proposition if it were thought appropriate, and just ask you whether they're workable. One would be periodic block funding based on what's previously been referred to as the allocation of home care places, and that remains the way in which home care funding is provided to multi-purpose services. Would that be workable?

DR WINTERTON: Yes, so I think the block funding is integral in ensuring that a secure workforce can be provided in rural settings, which is integral not only from the perspective of enabling people to be recruited and retained, particularly from outside of rural communities, but also in terms of the continuity of care for older people in these regions, in terms of enabling them to build trust and relationships with their service providers which is really integral in terms of picking up, you know, where care needs change and all that sort of thing. So I think that form of funding would be very beneficial, yes.

MR GRAY: Thank you. And another mechanism might be that through, perhaps, the agency of the primary health network or perhaps through some other decision-making agency, a preferred provider for a rural or remote region could be chosen. They could be provided with a pool of guaranteed annual funding and on top of that, they could compete like other home care providers for packages to be directed to them by consumers. If they became the preferred provider they would have to be the provider of last resort with a service guarantee obligation throughout the relevant area. Would that be workable?

DR WINTERTON: I think there needs to be a level of service provision that's guaranteed. I'm not sure about the preferred provider terminology necessarily, but I think – I think there needs to be a viable option for people and, obviously, where there are other options available, they need to be promoted. But I think the point I think you're trying to make is that I think there needs to be one provider that has some form of responsibility for providing care within a setting. So I agree with that component of it, yes.

MR GRAY: Thank you. Finally, what about the following proposal: a proposal that the MPS program itself provides a reasonable starting point for dealing with this problem of thin markets, and that perhaps an expansion of the MPS program is warranted into areas where there isn't otherwise a guarantee of coverage for required home care and community services. The MPS, of course, is a building and would have health services and aged care residential services but they're also able to provide community services and that flexible array of services and funding sources might provide the scale that's necessary to guarantee services in remote and regional areas. Is that workable?

DR WINTERTON: At a high level of principle, I would say yes. I think one of the key considerations in that regard with the MPS is that there needs to be the training and support in relation to aged care nursing specifically in relation to dealing with some of the complexities of aged care service provision, but yes, I think, yes.

MR GRAY: I have no further questions. Thank you, Commissioners.

COMMISSIONER PAGONE: Dr Winterton, thank you very much for sharing your knowledge and research with us. It has been very interesting. We may have some further questions for you in due course, but it's been very informative. Thank you very much indeed. You're free to leave too.

DR WINTERTON: Thank you, Commissioners.

COMMISSIONER PAGONE: Thank you.

<THE WITNESS WITHDREW [1.03 pm]

COMMISSIONER PAGONE: We will now adjourn until 2 o'clock.

ADJOURNED [1.03 pm]

RESUMED [2.01 pm]

MS HILL: If the Commission pleases, I call Lyndon Seys.

COMMISSIONER PAGONE: Yes. Thank you.

<LYNDON JOHN SEYS, SWORN [2.02 pm]

<EXAMINATION BY MS HILL

MS HILL: Mr Seys, could I ask you please to state your full name.

MR SEYS: Lyndon John Seys.

MS HILL: And what is your role?

MR SEYS: I'm the chief executive officer of a multipurpose service in Victoria, Alpine Health.

MS HILL: Could you provide a brief description of your professional background.

MR SEYS: I will keep it brief. I've worked in the public health system in Australia and England since I first started work in 1972. I've spent the last 38 years working in management and administration and have spent the last 20 years or thereabouts as a chief executive or a senior public servant.

MS HILL: And it's in your capacity as CEO of Alpine Health that you prepared a statement for this Royal Commission.

MR SEYS: I have.

MS HILL: Operator, could I ask you to please display document ID WIT.064.0001.0001. Mr Seys, do you see a copy of that statement there in front of you?

MR SEYS: I do.

MS HILL: And were there any changes or additions that you seek to make to that statement?

MR SEYS: No.

MS HILL: Are the contents of that statement true and correct?

MR SEYS: Yes.

MS HILL: Commissioners, I tender the statement.

COMMISSIONER PAGONE: Yes. The statement of Mr Seys of 28 October will be exhibit 12-16.

EXHIBIT #12-16 STATEMENT OF MR SEYS DATED 28/10/2019 (WIT.064.0001.0001)

MS HILL: Mr Seys, could you describe Alpine Health for the Commission.

MR SEYS: Yes. Alpine Health is a multipurpose service, part of – one of a number in Australia, a joint State-Commonwealth initiative for small rural health services, incorporated in Victoria under the Health Services Act. And we provide a wide range of aged care, acute hospital, community health services and education and training primarily to people living in the local government area known as the Alpine

Shire, but in more recent times extended to people who live in the Indigo Shire in Victoria.

MS HILL: And that's in the north-east.

MR SEYS: It is in the north-east, yes.

MS HILL: What aged care services does Alpine Health offer?

MR SEYS: We provide residential aged care services in three – three of the larger communities in the Alpine Shire at Mount Beauty and Bright and at Myrtleford for those of you who know the region. They're the three separate units, 20 high care beds at Mount Beauty, 30 high care beds at Myrtleford and 40, effectively, low care beds at Bright. And in – in the community environment, we – we are now the provider of Commonwealth Home Support Program in both the Alpine Shire and the Indigo Shire, as each novated their service deliveries over to us, the Alpine Shire in 2017 and Indigo Shire in 2018. And we're a packaged care provider, having been a packaged care provider since – I'm trying to guess – 2003, 2004. And we provide a range of services in the community that, in the health promotion domain, that are directed to older people.

MS HILL: In your statement, Mr Seys, you describe Alpine Health coming about as a process of amalgamation to that multipurpose service.

MR SEYS: Yes.

MS HILL: And that was in 1999.

MR SEYS: Yes. Yes. In nineteen – with the introduction of the MPS program in the – in the early mid-1990s, through – there were three health services all operating under the Health Services Act in the Alpine Shire. And they came together in '95 and '96 and agreed to amalgamate to create a new service, and in the process took up the opportunity of becoming an MPS. So on 1 November 1999 the well changed for our customers, for the boards, for our staff members, as one organisation was created out of three – well, actually it was out of four, but one organisation was created. And – and the whole functioning of the relationships between the entity, the new Alpine Health, and government changed as the funding arrangements changed. So it was a very interesting time for – for the – for the people of the Alpine Shire.

MS HILL: Is it fair to say, Mr Seys, that before the amalgamation took place, that those three health services – the delivery of care from these three health services wasn't working?

MR SEYS: I don't think it would be fair to say that. I think what I would say is that in the – in those years up to 1996 service delivery was limited. There's very small hospital-based services, smallish residential aged care services, and a relatively small district nursing service and a very small day hospital service out of Bright. And that

was the – the sum total of it. It was incredibly limited. And the MPS program seemed to the boards at the time to provide an opportunity of expanding out their interests, after amalgamation.

MS HILL: Our job – our role at the Aged Care Royal Commission is to work out how to fix it, how to fix the delivery of aged care services. Alpine Health 1999, going through that process of amalgamation, how did Alpine Health in your experience identify how to overcome those issues, those limitations on services that you've described?

MR SEYS: I think I would like to preface my answer to that question by sharing some observations about what it was like in 1999. There was great expectation that the world would change across all of our communities. At the same time, I think it's pretty clear to me that nobody fully understood the implications of moving from that activity-based funding models that were existing and in both aged care and acute hospital care, if – because the state had only recently moved to activity-based funding for hospital-based care to a block-based pooled flexible model.

And one of the things that occurred subsequent to amalgamation 1996 and with the – with the funding model is the amount of money that came into the new service for residential aged care actually dropped and dropped significantly, to such a degree that, effectively, the organisation went progressively broke. So from a point of – from the point of being incredibly excited about what was moving forward, by the end of 1997 the organisation ran out of money and the community was in uproar. And, of course, there were ongoing effects associated with that, including the failure of the organisation to be able to financially report its affairs without qualified audits for the 1996/97 year, the '97/98 year. And that was the background to my arrival there in 1999.

So there were a series of – I think I talk about three big problems. One was the money problem and all of those things attached to it. There wasn't enough money to make the world go around. And the organisation wasn't meeting its compliance – financial reporting obligations. That was the first thing. The second thing was that there was no expansion of service delivery. The Commonwealth and the state expected a service plan that showed how that was going to happen, and that didn't happen. It couldn't. And so that was a second thing.

And the third thing was that the community was in uproar. So by the time we got to 1999, instead of having a cohesive community across the – or the three townships, a cohesive view, each of the communities had set up a focus group to make sure that they actually retained what they had before and to make sure that they got their fair share out of the new amalgamation. So those were the really big issues that had to be resolved. So that sets the scene.

So our task – my task was (1) to restore our financial credibility. There was no finance function, seriously, it seemed at the senior level in the business. So my job was to fix it. So I recruited a young man – younger – a young – anybody younger

than me is young – who had come out of the ambulance industry as a CEO with an accounting background. And over the three months we had from March 1999 until the end of June/July, we reconstructed all of the financial affairs of the business. We could show the board for the first time where the money was coming from and where it was going to, and we had a financial plan for the next year. So financial planning and getting the skills into the organisation was the first key.

And – and then, of course, we moved on to the bigger – next big issue was how do we develop service delivery. So that meant having a service plan. And that took a year or two. And in the end the state and the Commonwealth agreed – State and the Commonwealth agreed to fund planning for that and we worked up a plan. And that led to what we've used – called euphemistically in our business revenue planning. There had been a lot of expenditure planning, a lot of cuts and that kind of stuff. We moved to thinking where the revenue was going to come from. And that started to change our world.

And by the time we had reached agreement with the state – with the Commonwealth, the Commonwealth agreed to let us convert 30 – the funding for 30 low care places that we had at Bright to 30 high care places. And that solved half of the funding problem. The state helped us with some money to get us over the line. And for the next couple of years we managed, but we were still in operating deficit, but at least we were on the road. And then over a period of time we were able to increase the – increase the money coming into our hospital-based service delivery to a point where we were operating favourably. So that was the beginning. A lot of stuff has changed since but that's how we overcame the front end of the issues that is we confronted in – that I confronted in 1999.

MS HILL: In your statement at paragraph 21, you set out the stated aims of amalgamation. And I don't seek to read those out to you, but if I can jump to the present day, 2019, and those stated aims are there - - -

MR SEYS: Yes.

MS HILL: - - - on the monitor before you.

MR SEYS: Yes.

MS HILL: In your view, present day, is Alpine Health meeting those aims?

MR SEYS: We start at 21(a); yes. We've been able to maintain – we've been able to maintain all of our service delivery except for birthing. We still provide what is known as a capability level one service, antenatal, postnatal care but every other service has been sustained. The birthing dispute basically because of the demographics and, you know, and – and at the end in 2016 we delivered four babies over seven months in three hospitals and, you know, our community understood, and we had been working with them around this issue for many years. So we've been able to do that. We've been able to develop them too, of course, as you've noticed

from before. We only had three basic services to begin with but now our service delivery is well expanded.

Our financial viability is – has improved. We're not using other people's money any more. We have our own which is good. We still struggle from year to year as various pieces of government policy change around aged care and hospital care and now our education service delivery models, but we consider ourselves viable and we did go there. We have consolidated our workforce. We have – and expanded it. We're don't just any more provide workforce in terms of nurses and other workers. That workforce has expanded to include teachers and home care workers and – and maintenance workers for the Home Care Package Program.

And I've always – I've always said that all of that has been made possible by the original underpinning principles of the MPS program which was to bring money into a pool. You know, we've always talked about block funding, especially around residential aged care and – and hospital care, but really it's – it's fixed funding from those two sources and it's pooled with money – moneys that we can earn in different ways in order to apply what we would call – apply to community service need and that's where the wins have truly been.

MS HILL: Can I turn then to ask you to expand on a remark you've made about the workforce and the fact that you've expanded the workforce. How have you done that?

MR SEYS: Well, in the early years, we – we invested in our own – in staff development and we would employ agencies like the TAFE sector and the university sector to do that for us. We've always struggled with getting sufficient numbers of registered nurses to meet our needs and as the – as the industrial frameworks in Victoria have evolved over the last 20 years, we've needed more and more nurses for our workforce and when you look at our workforce it is primarily part time. So, you know, I generally use the rule of thumb that for every part-time nurse we have we need another nurse in order to fulfil our obligations.

So we've always relied on the tertiary education sector to do that until – until it became a problem for us industrially when we couldn't get enough nurses to meet our obligations to our agreements with the Nurses Federation. And we had heard about this thing called the IRON program that some of our country friends in Victoria had discovered as a way of bringing nurses who were internationally – that is, nurses from overseas, and we thought that that might be a way. So with the help of one of our other agency friends, we built a – we built a – a program, an education program under the ANMAC guidelines, and it actually proved to be a really important part of our future. It gave us certainty in our workforce and, indeed, it – it helped us, you know, improve our service delivery models because there was certainty for our customers in residential care and in – in hospital care accordingly.

So we went there and we went to the IRON program, and we only did it initially to satisfy our own needs. We weren't – you know, it wasn't wholesale but we

discovered that after the first couple of goes at it, other agencies were now looking for nurses that we were graduating. So that evolved into a business, effectively, and – and that business generated enough revenue for us and surplus to underpin the losses that we had incurred in our other service delivery models and to continue to do that, with some hiccups, today. And at the same time it also gave us a good – a good capital base from which we could build an RTO which we have done, the Alpine Institute, and that has given us the capability now of preparing for – preparing our community for employment in the health and the aged care industry, and we do – we deliver certificates III and IV and we're now – right now running our first diploma of nursing program which is bringing all of – bringing local people into our business, not directly to work for us but through education and they become part of our workforce.

And – and so we've got now a very complex and committed business that brings together internal staff development needs, our long-term nursing workforce planning but also our – our aged care workforce needs and planning. So when – just as an example of how effective that was, so when the Alpine Shire and then the Indigo Shire novated their services over to us we had a workforce already there and ready to go. And as the package care program has expanded, you know, from our initial 25 and then 15, so we had 40, now we have nearly 130 clients across the two shires. We have a workforce that's available for that and we know that the work that we're doing in this environment is taking us into the future where the home care package program is rapidly expanding in our environment.

MS HILL: Mr Seys, the Commission has heard evidence in the third Melbourne hearing of a Shepparton-based residential care facility who were developing a traineeship model for their personal care attendants.

MR SEYS: Yes.

MS HILL: Where a group of young people would be employed by that provider to complete an apprenticeship-type scheme that involved collaboration with the TAFE and they couldn't get the funding to get it off the ground. Ms Miller from LiveBetter this morning - - -

MR SEYS: Yes.

MS HILL: - - - gave evidence and described in her statement that LiveBetter investigated the possibility of, in regional New South Wales, becoming a registered training operator but the cost of doing so was prohibitive. Could I ask you to share with the Commissioners some examples of what's happening on the ground that allows the Alpine Institute, as it works with Alpine Health, so that it's able to deliver a successful model where others continue to struggle?

MR SEYS: Yes, I think so. We – we didn't approach this issue with an expectation that somebody else would provide us with the money to do it. We had to go out and find it, as I mentioned earlier. That's kind of the first thing. We had within our – in

our existing business, we had expertise. Once we – once we had started this, we recognised we had expertise in our existing workforce to deliver within an RTO environment and where we didn't, we had the money to train people to do that. So we made a decision; we worked out how many teaching staff we were going to need and we paid the Goulburn Ovens TAFE to run certificate IV training and assessment program for our workforce, and we trained 25 of our staff to do that.

Now, not all of them work in that all of the time, but we have a trained workforce. So that was one of the keys. The money to do it is there and then we – then we needed – needed community support. Well, that didn't take long. The – we have extraordinary support from our communities and where we needed some capital, where we did need some additional capital we went to the Bright Hospital Op Shop and asked them to help and they provided the additional – just a bit over 200,000 for us to have a sim lab and to – and the computing equipment and the desks and the chairs that we needed for our student base, yes. And that's how it's possible. We work our relationships across the community. We work our relationships across our other health services, and our students all become employed.

MS HILL: Stepping back from the Alpine Institute and looking at Alpine Health more broadly and the location in which Alpine Health operates, north-eastern Victoria, are there special conditions that operate in north-eastern Victoria that mean that the Alpine Health model isn't transferable more broadly?

MR SEYS: Yes, possibly. I think some – certainly, many of my colleagues would support the view that we are special and therefore have advantage and that's true if you think about it. We're located and we live and work in an environment that has major attractions, a snow industry, the bushwalking/hiking/camping industry, and now cycling has overtaken our world. We have – we have – Mount Beauty is located in, I think, if I remember correctly, an outer regional, but both Bright and Myrtleford are in a regional, and it is an attractive place for the tree change movement, for lack of a better descriptor.

And interestingly enough, as each one of those industries that I've mentioned has developed and grown, then our access to – to specialised staff and to, you know, senior staff for the management and the leadership of our business has improved dramatically as has the number of allied health professionals who are moving into our environment and setting up business. So people would say we have a distinct advantage. But, you know, I've always argued and I think others will too, that it is possible where there is a strong committed local health service, that has the capacity by virtue of policy or money or whatever, if there's a strong local health, we become the focus of all of that development. And – and so I would say, on balance, it is possible. It just takes imagination and will, and a little bit of good luck along the way.

MS HILL: Mr Seys, you've described just a moment ago of – you said we work our relationships within the community.

MR SEYS: Yes.

MS HILL: How do you work those relationships?

MR SEYS: Yes. With a formal – we have and are committed to a formal policy-based community engagement framework. It actually came out of the three focus groups that were established in 1997 that were there to keep an eye on us, and over a period of time we – we work with those. We consistently work with those groups but we work with them to change their focus from just keeping an eye on us but being fully engaged in the complexities of service delivery. At the same time, we – you know, we shifted our focus from – in our planning from just sustainability and viability to a model that made sense of expanding service delivery which gave us this health improvement strategy. And, in fact, our mission now is to improve health and wellbeing in our community. So those things have come out of it.

Those three focus groups and our advisory groups; those advisory groups have worked with us to spawn multiple community groups with interests in specific issues like diabetes, dementia, autism, mental health. It's – I can't keep track with them. We don't try and run them. We are there to help them but we don't try and run them. So we have a structure within which we can engage now and have had for some time. So that means that we have a structure that's fully engaged in our five year planning process. In fact, in the last two – last two, this one we've just completed, 2013, 2018, they ran – they ran – those groups ran our community engagement for us and with us. So – and we do it publicly and people are invited into the room and – and their views have exactly the same weight as everybody else's views coming into what our plans look like.

We do the same thing every year with – with the board's implementation plan and in exactly the same way. And so we have our community fully engaged, we think, and – and we've taken exactly the same approach with – with the development of the Institute which is in part why we have such great support. We don't stop there, of course, because we have partnerships with other businesses, other parts of our environment, and outside of it, you know, we engage regional health services, we engage our visiting medical officers who operate separately. We engage – now we're engaging and running some conjoint services with private allied health providers as that world has changed, too. So – but that all comes out of a deliberate well enunciated community engagement strategy led by – well, we have a community participation officer that we employ specifically for the purpose.

MS HILL: Are there other approved providers of aged care in the region in which Alpine Health operates?

MR SEYS: That we operate or operate - - -

MS HILL: Within the same area, the same geographical location?

MR SEYS: Well, no, is the answer. There's our three services. There is a private provider in Myrtleford but that's not part of our business.

MS HILL: And are there other – so in terms of the relationship that you have with that private provider in Myrtleford, do you have a relationship with that private provider?

MR SEYS: I'm not sure I know how to answer that question.

MS HILL: One thing that has come up in evidence this morning is a discussion around the relationship that providers have with each other in rural, regional and remote areas, whether it's collaborative or competitive, whether it can be collaborative or whether it has to be competitive in the current circumstances.

MR SEYS: Yes. We have a good relationship with the local private provider at Myrtleford at the operational level and, in fact, it's – it's what I would otherwise describe as symbiotic. The provider set up well after Alpine Health; it was 2006 when they opened their doors, 65 beds. We were a bit worried about that at the time, and what the impact would be but, you know, the impact was actually productive. It reduced waiting lists for residential aged care and our experience is it has provided the local community with choice. They can choose. Not – sometimes, you know, our service delivery doesn't suit some clients and sometimes for the private provider it's the same, too. So it's helped manage some often very complex social issues across our community.

We provide – of course, we have a hospital-based service delivery so the private provider relies on us to help them with their really high level aged care needs and that suits them. We work with them. We have a relationship with them around the Institute. They form part of our reference group along with a number of other aged care and rural health service providers. And they – they take our students on placement. They take our RNs, overseas nurses on placement. They take our students out of our certificate-based courses and we provide a workforce for them. They have workforce security there in the same way as we do.

MS HILL: Would Alpine Health continue to be sustainable, in your view, if another approved provider entered the marketplace?

MR SEYS: Yes, well, that's a good question and, again, I don't want to prevaricate but the same provider – I don't know – the same provider has approval from the Commonwealth to build an 80-bed high care facility at Bright. Now, that's a bit bigger than the one at Myrtleford and aged care and service delivery models demand for low care – low care is rapidly diminishing.

Occupancy at Bright today is 60 per cent and of that 60 per cent, a bit under half of it it's in a different environment. So Bright has a low care facility and we can't meet the high care needs of every one of those residents in our facility. So they – they

have to move. And, of course, our experience, of course, with – with the effluxion of time and changing attitudes to
is respite. So we're a little bit concerned about what that might mean for us in the long run. It's not to say we don't have a plan for it, maybe, but – but it will be interesting to see how that plays out.

MS HILL: Can I turn then to funding. You've touched on it earlier. In your statement you consider that the principle of how funding is applied to home care packages, to the Commonwealth Home Care Program - - -

MR SEYS: Yes.

MS HILL: - - - that it ought to be applied to residential care.

MR SEYS: Yes.

MS HILL: Could I ask you, drawing on your practical experience, why you hold that view?

MR SEYS: Yes. We've – as I said earlier, we've been in – we've been providing package care for a while, a long while actually, 15 years. And we've had an opportunity of understanding what that means for us as a service provider and for our client base. And I get to see – as the CEO, I get to see every now and again – well, more frequently these days – but I get to see what that means for people. The allocation of money to the clients in community-based care gives them more control, and you will have heard this from others, I think, it gives people more control but, you know, it – it helps them understand that what is most important to them becomes most important to us as a service provider and that is empowering for – for people at – in their own homes.

They do have control of it in their own homes. There's no question about that. And, as a consequence of that, our service delivery is truly directed to need, not because we've defined what that need is, but because the clients have defined what that means.

And I just think that there's – what's the difference, really, is where I go. What's the difference between that model for people in their own home to a model in residential aged care which is supposed to be their own home, too? And at the success end of it, we have seen people happy. That community-based model doesn't just satisfy the needs of the client that's in front of you, the aged person, but around that aged person, the family members and others who have needs that are built into the decisions around what happens to mum or dad or my spouse. And those things are really important.

So, you know, we have a completely different funding model for residential aged care. It's driven by – to a large extent, it's driven by institutional-based models of assessment: what's going to fit and what's not going to fit. And, as a consequence

of that, there are – you know, a lot of it's driven, even in our world, which we would like to think was flexible, is driven by compliance obligations, so reporting, and not necessarily around that very first question, which is what's most important to the aged care client? That's why I've gone there.

And I think it would be simpler – if you think about it, it would result in us thinking about aged care not just as two separate things in different places, but as a continuum of service delivery, and it would change the way we think about planning for aged care, all of us. I've talked about the beauty of it from a family – if you – you see – if you receive – if you receive a package in funding, then come – what comes with that at home, of course, if you don't have to find the obvious, you don't have to find the deposit for a place in an institution, you still have control of it in your own place.

And those two things working together reduce family friction, especially at – you know, at the end of people's life. So I've argued in my statement along those lines, that I think that there's an opportunity here for us to think differently about aged care and to think differently about its funding. And I think that from the success that we've seen in our program, that – that the principles in that community program have got to be applicable to residential, to somewhere.

MS HILL: What do you want to see in respect of the multipurpose service policy and funding framework in the future?

MR SEYS: Yeah. We're waiting at the moment for the completion of the Commonwealth's – the national review of the MPS program where the issues of funding are really important to us for those – as a matter of detail. Our funding for residential aged care is based on the old – the 1990s RCS scheme at an average of level seven and an average of level three. And it's stayed that way for the last – in our case, for the last 23 years; in the case of some of our peers out there, a little bit longer. It's adjusted each year according to inflation, but the basis of it – and it's fixed.

You know, the whole model of the MPS was to improve viability, but, of course, underpinning was an assumption that you weren't actually full at the time and, indeed, you would have less reporting and compliance obligations, all of which have changed over a period of time and, in fact, didn't exist for Alpine Health at the time, because, as the only aged care providers in the Alpine Shire, they were full. So it wasn't hard to see in retrospect. It wasn't hard to see the troubles that came from it. So we are keen to see the national review make some recommendations around the funding model for the MPS program for residential aged care. There's no question about that.

MS HILL: Do you consider that that funding model should be reformed by eliminating the inconsistencies between the MPS funding and the aged care system of funding?

MR SEYS: Yes. Yes. I do. I'm happy to expand if - - -

MS HILL: I'm mindful of the time, Commissioners. I probably have about five more minutes with Mr Seys, if that's - - -

COMMISSIONER PAGONE: Yes .

MS HILL: I'm content for you to expand, Mr Seys.

MR SEYS: Sorry?

MS HILL: Please expand.

MR SEYS: Yes. Can you just read – can you just give me the question back again, Counsel, do you mind?

MS HILL: That multipurpose services - - -

MR SEYS: Yes.

MS HILL: The funding choice should be reformed by eliminating the inconsistencies between the MPS and the aged care system.

MR SEYS: Yes. Yes. Well, if you just sort of kind of think back over where I've gone over the last few minutes, the funding model for MPSs were designed to improve viability and sustainability and yet the funding drops. There's no capacity in there at all for matching money to need in the same way as it occurs in, say, the private mainstream domain and, if you look at it in the community, aged care package domain. For the same client in the Alpine Shire would get money directed specifically to need if they stayed at home, against what would be allocated to them in .....

So there's a really big issue there. And, you know, we watch as clients move from one provider to the other. It doesn't happen often in our environment, but from our facility to the private facility. What happens? Same client. Well, that client will benefit from more money going to the private than going to us and vice versa. So these things are really big issues when you think about it. And which is why we've argued with the national review to go here, reform it

MS HILL: With respect to the infrastructure that MPSs have available to them, in your view, do you consider that the Commonwealth, along with the State and Territory Governments, should agree upon and establish a capital grants program to rebuild or to refurbish the older MPS facilities and ensure that MPS infrastructure is suitable for the provision of residential aged care and for care recipients who may have high needs because of dementia or other such complex care needs?

MR SEYS: Yes. There's no question. This is – if I can expand.

MS HILL: Certainly.

MR SEYS: The MPS program is conjoined state/Commonwealth program. At the moment it's kind of fixed around money and compliance, but we know that those – that's just the beginning. What's needed, of course, is flexibility. So, you know, agencies have to be able to provide. And that's where capital is important. You know, we've been able to rebuild two of our facilities with acute and aged care together to meet each other's standards, so that people can receive the service without disruption. It's really important.

In Bright, where we haven't been able to receive any capital over the last 20-odd years, we haven't – we have to move people. We have to move a resident out of Bright's Hawthorn Village up the street and across the road to the hospital by ambulance when they become critically sick, and then we do it the other way round. And, you know, as an example, people have to leave. We get to a point – an individual will get to a point where they can't have that service in Bright, because their needs have gone well beyond our capacity to deliver. So, you know, if – we've argued, well, continuously about this. We're not meeting our obligations as an MPS in that environment. And capital is fundamental. So agreed, yes, between the state and the Commonwealth.

MS HILL: Commissioners, I note the time. They are the questions that I have for Mr Seys. There was a plan to adjourn temporarily.

COMMISSIONER PAGONE: Yes. Yes. Well, there was a plan to adjourn, so we might do that now and then resume at perhaps 10 past 3.

MS HILL: As the Commission pleases.

COMMISSIONER PAGONE: Mr Seys, thank you very much for sharing your experience with us. It's, I must say, quite interesting to see what you've been able to do in a slightly imaginative and different way. Thank you for coming in and assisting us in that way. It's been very informative. 10 past 3.

MS HILL: As the Commission pleases.

<THE WITNESS WITHDREW [2.50 pm]

ADJOURNED [2.50 pm]

RESUMED [3.11 pm]

COMMISSIONER PAGONE: Ms Maud.

MS MAUD: Thank you, Commissioners. The next witness is Sally Ann Goode who is in the witness box.

<SALLY ANN GOODE, AFFIRMED [3.11 pm]

<EXAMINATION BY MS MAUD

MS MAUD: Nice and close to the microphone there. Now, can you state your full name for the transcript, please.

MS GOODE: Sally Ann Goode.

MS MAUD: And, Ms Goode, do you live in the Riverland area in South Australia?

MS GOODE: Yes, I do.

MS MAUD: Have you prepared a witness statement for the Royal Commission?

MS GOODE: That's right.

MS MAUD: Do you have a copy of it there in front of you?

MS GOODE: I do, indeed. Thank you.

MS MAUD: I'll bring it up on the screen as well. It's WIT.0588.0001.0001; can you see that there on the screen? Have you had an opportunity to read it recently?

MS GOODE: Yes.

MS MAUD: And are its contents true and correct to the best of your belief?

MS GOODE: Yes.

MS MAUD: I tender that statement, Commissioners.

COMMISSIONER PAGONE: Yes. Thank you. The statement of Ms Goode will be exhibit 12-17.

EXHIBIT #12-17 STATEMENT OF MS GOODE DATED 25/10/2019 (WIT.0588.0001.001)

MS MAUD: Thank you.

Now, Ms Goode, you've lived in the Riverland area for about the last 20 years; is that right?

MS GOODE: Yes.

MS MAUD: Before you moved that you worked in the OH&S sector, including as an OH&S manager for Myer.

MS GOODE: Yes.

MS MAUD: Are you retired now?

MS GOODE: Yes, I am retired now.

MS MAUD: And since 2009 you've been a member of the Loxton and Districts Health Advisory Council; is that right?

MS GOODE: Yes.

MS MAUD: Before that you were the deputy presiding member of that body.

MS GOODE: Yes.

MS MAUD: And before that you were a member of the Loxton Hospital Complex Board.

MS GOODE: Yes.

MS MAUD: Is the role of the Loxton District Health Advisory Council an advisory role for the local health network?

MS GOODE: We are brought together under legislation. We very grandly are – provide – prepared to advise the Minister on health services but we generally are people who are consulted. If the health service want to know things about what the community wants or if the community comes to us with any particular problems, we're the conduit between the community and the health service.

MS MAUD: And the local health network in your area is the Riverland Mallee Coorong Local Health Network.

MS GOODE: That's right.

MS MAUD: And are there eight hospitals within that local health network?

MS GOODE: Yes.

MS MAUD: Yes. Another important function of the council that you're the presiding member of is fundraising.

MS GOODE: Yes.

MS MAUD: Can you tell the Commissioners how much, approximately, funds you've raised in your time on the council; are you able to give a ballpark?

MS GOODE: We have an exceptionally supportive community in Loxton. Since I've been there – I arrived there in 1999, I know that we had a big fundraising effort and raised $500,000 in two years for a new entranceway. We are one of the few country hospitals in South Australia that has a very large bank balance from the community, seven figure type bank balance.

MS MAUD: Right. And the hospital in your area is the Loxton Hospital; is that right?

MS GOODE: It's the Loxton and District – the Loxton Hospital Complex.

MS MAUD: Right. And how big is that hospital?

MS GOODE: 58 beds in aged care which is co-located, and 22 beds in acute care.

MS MAUD: I see. So the aged care unit is co-located with the hospital.

MS GOODE: Yes. Yes.

MS MAUD: Do they share resources, the two facilities?

MS GOODE: They share resources in the sense that the kitchen – the kitchens serve both units. Sometimes registered nursing staff are shared and, certainly, if any of our residents in aged care need hospital care, they're just wheeled across from aged care into the hospital unit.

MS MAUD: And is the Loxton Hospital Complex managed by a director of nursing and midwifery?

MS GOODE: Yes. We have an outstanding director of nursing and midwifery who oversees both the aged care unit and the acute unit.

MS MAUD: And approximately two and a half years ago the director of nursing, as I understand it, raised with the council an issue of a shortage of direct care attendants.

MS GOODE: Yes.

MS MAUD: The direct care attendants are often called personal care attendants or assistants in nursing.

MS GOODE: Yes.

MS MAUD: It's the same role, yes. The problem that was encountered at that time, had that been an ongoing problem for the Loxton Hospital?

MS GOODE: Not that we had been made aware of on the council. But we are – as is so commonly used, we are an ageing community and our staff are ageing just as much, so naturally there is the usual attrition through people retiring.

MS MAUD: So when that was raised with the council, were there any particular proposals or ideas that were raised as a way of addressing that shortage of staff?

MS GOODE: Well, the director of nursing raised it with us predominantly because we already had a history of providing scholarships to train local staff for shortages within the hospital. We had always been keen to provide undergraduate scholarships for people doing a degree in nursing and we had done that for several years through Country Health SA which was then the overreaching organisation that looked after all the country hospitals. Then we chose, instead of doing that, to fund a midwifery scholarship because our director of nursing told us that we had lost four midwives in one year through retirement. And as with all country hospitals, or country health services, if you start losing your services or losing your staff, then that's just a domino effect that lands up on the whole town.

So we decided that we would offer $10,000 scholarships for local registered nurses to undertake their midwifery degree and we have so far provided two midwives who've completed their training and we have two more currently doing their training and they will probably finish, I think, in about July of next year.

MS MAUD: And the two who've completed their training with the benefit of that scholarship, are they now working - - -

MS GOODE: Yes.

MS MAUD: - - - in the area?

MS GOODE: Yes.

MS MAUD: And what did the scholarship involve?

MS GOODE: $10,000 that we – the local – the health advisory council just gave them $10,000 with no restrictions on it. As long as they were enrolled to do their midwifery degree, they got the $10,000.

MS MAUD: So it wasn't tied to the cost of the course itself.

MS GOODE: No, not in any way at all. Neither was there any bonding requirement because we can't legally bond people in that sense.

MS MAUD: So to ensure that those nurses came back once they had completed their midwifery, was there any way that you were able to increase the prospect of that?

MS GOODE: We chose very carefully. No, they had to be people who were already employed in a Riverland hospital. We weren't – we weren't so insular as to say they had to be employed at Loxton, but in the Riverland there's only really two hospitals that do babies, that deliver babies and we think we're the best one anyway, so it was no surprise that it was nurses from Loxton Hospital that applied and got the scholarship.

MS MAUD: I see. Now, as I understand it, that gave you an idea to address the shortage - - -

MS GOODE: Yes.

MS MAUD: - - - of direct care attendants. What was the program that you came up for to address that shortage?

MS GOODE: Well, when our director of nursing told us about the shortage of direct care attendants she was the one that actually said why don't you consider scholarships for them, because, you know, in the interests of equity postgraduate scholarships are usually – there's all sorts of sources that people can get grants for postgraduate scholarships but at the time there was nothing for people doing certificate III courses. If they went through an employment provider, they might get it provided for them, but that wasn't necessarily the sort of people we were looking for anyway. So we thought, yes, that's a really good idea, how can we look at this a bit more. So we chewed it all over, obviously discussed it very closely with the director of nursing and with the local health service because we thought if we're going to train direct care attendants, we need to train them somewhere and in the hospital was the best place.

So we've got a boardroom that's used as the classroom and all their clinical placement would be done in the aged care unit. So having got that in place with the blessing of the local health authority, we then started looking at what registered training provider would be the best one, and we did a lot more thinking through on this, and then sent out a proposal, as it happened, to two, one a local provider and one to the provider that ultimately won the contract.

MS MAUD: And what was the proposal to do?

MS GOODE: Well, the conditions that we put upon, that – first of all it had to be a registered training course. It had to be a nationally recognised course of certificate III in personal support and off the top of my head it's got some code number like

CHC005 or something like that, but it had to be the nationally recognised one. The provider had to be prepared to send a lecturer up for two days a week or whatever – whatever configuration of days we would all work out in a – in a cooperative way. But we had to have that lecturer on-site and all of the clinical placement had to be done in aged care. So that would take a lot of negotiation with the aged care unit manager and with the staff involved as well.

And we obviously needed to know the costs in great detail because this was going to be community funded, and I think on – I think that's probably most of the things that we were looking for.

MS MAUD: So it was to provide a certificate III.

MS GOODE: Yes.

MS MAUD: To be provided from the hospital's facilities.

MS GOODE: Yes.

MS MAUD: And who was the registered training organisation that you ultimately engaged?

MS GOODE: Well, we ultimately engaged EQUALS International which is an Adelaide-based company.

MS MAUD: Why were they chosen; what were they able to offer?

MS GOODE: They provided an exceptional proposal to us. It dealt with everything we wanted to know. They – they were very, very caring towards their students which to me is an important part of anything. If you care about your students then your students are going to care about what they do. They were actually cheaper than the other proposal and they were very, very cooperative in terms of contextualising the course to suit us. And so there were negotiations going on between our director of nursing and EQUALS to get exactly what we wanted.

MS MAUD: And what was it that you were wanting in terms of the contextualisation?

MS GOODE: It had to be relevant to the whole idea of a direct care attendant in our aged care unit. So they had to be – and, also – sorry – they were also doing the training for working home and community. So, in other words, our students, when they finish, they've got Certificate III Personal Care (Ageing) (Home and Community), so they can work in both areas. And that was part of the contextualisation, to have those two units brought together.

MS MAUD: Were there other ways that the course was tailored to suit the Loxton-specific requirements?

MS GOODE: I'm afraid I'm probably not able to answer that. That would be a question better directed to the director of nursing or to EQUALS.

MS MAUD: Do you know from the work that you did with the director of nursing, though, whether there was to be a particular focus on the standards, the accreditation standards?

MS GOODE: Yes, particularly this last year with our second lot. The new aged care standards which, of course, we knew about last year, came in this year on 1 July. And that was a very big issue for our director of nursing, because she wanted to make sure the students were completely focused on the standards and the fact that it's consumer-centred care and consumer-orientated care.

And that certainly – in the feedback we've had this year from the students, that is overwhelmingly what's gone through to them. They all know that to look after the patients – to look after the patients' choices is what is important. And I might also say that what they're talking about – because we will do this course again next year. And I know that the director of nursing and EQUALS are looking at perhaps involving a major hotel chain that the – the customer service manager of a major hotel chain to come and talk to the students about customer service.

MS MAUD: Right. So the course is provided from the hospital in Loxton.

MS GOODE: Yes.

MS MAUD: And does it involve – how much course time does it involve?

MS GOODE: It's about 19 to 20 weeks of theory, two days a week in the hospital, in the boardroom, and then 160 hours of clinical practice. Now, EQUALS told us that the requirement under the national curriculum is only 120 hours, but EQUALS do not believe that their students are properly work-ready and prepared at 120 hours, so they insist on them doing 160 hours. So some of our students – some of them are already working in the hospital as unqualified care attendants. Some of them are already building up their hours before they finish all the theory. But that's – you know, that's perfectly acceptable.

MS MAUD: And so the clinical placement, where is that undertaken?

MS GOODE: In the aged care unit.

MS MAUD: Right.

MS GOODE: For some of our students, because we spread the net very wide, we had three students this year who have come from Mallee Health Services. So they're from the Mallee, which is an hour to an hour and a-half away for some of them from our hospital. Some of them have negotiated to do some of their clinical placement back in their own hospital. And that's perfectly acceptable, as well.

MS MAUD: You mentioned earlier that the course has been adapted so that students graduate with a certificate III in individual support in ageing and in home and community care. What were the modifications that were made to the course in order to enable that to happen?

MS GOODE: I'm sorry. Again, I can't answer that. That would be the technicalities of – which elements are taken out of the large range. They are electives that – there's basic ones you have to do, like infection control and manual handling and those sort of things, but then the rest of it is electives. So the student chooses what sections they're going to do, but they need to choose sections that are going to enhance the home and community and the ageing part.

MS MAUD: So, as part of the scholarship, are they required to choose certain electives?

MS GOODE: Yes.

MS MAUD: I see. So EQUALS provides the trainer. Where does the trainer come from?

MS GOODE: From Adelaide every week.

MS MAUD: How far is Loxton from Adelaide?

MS GOODE: Three and a-half hours. Two hundred and – 250. I don't know the kilometres, sorry.

MS MAUD: No. Just approximate is enough.

MS GOODE: The hours are bad enough.

MS MAUD: And the trainer is there for two days.

MS GOODE: Yes. The trainer comes up on the Monday. So the class starts at 11 o'clock on Mondays and goes till 5 and comes in the next morning from 9 until 3 and then goes home again.

MS MAUD: Now, I want to ask you about the detail of the scholarship. When was the scholarship program first offered?

MS GOODE: The end of 2018.

MS MAUD: I see. And - - -

MS GOODE: Yes – sorry – about September of – it might have been a bit earlier, because the first graduation was I think at the beginning – this is 2019. The first

graduation was about July-ish of 2018 and then we went straight into the next course, which started at the beginning of 2019.

MS MAUD: And how much is the scholarship that each student receives?

MS GOODE: Right. The scholarship amount is, in fact, the difference between what EQUALS gets from the government in terms of the subsidised course and what extra they add to it. So for – in our first year the difference was $150. And that's what we paid for each student. Plus, we also pay for their criminal police check, because you've got to have the criminal police check to be able to go and work – or to even go inside the aged care unit.

Following feedback from last year's group, they all said that a textbook that some of them bought last year called the Australian Carer was extremely useful. So we added that into the scholarship for this year, which was – again, it's a very expensive book, but EQUALS got it for us at discount rate for a bulk. So that was $75. So this year's scholarship was $225 per student.

MS MAUD: And how do you select the students that will receive the scholarship?

MS GOODE: Right. Well we advertise very extensively. And then the first hurdle, if you like, is they have to have an interview with members of the Health Advisory Council, plus we have one other member of hospital staff who's not a nursing member or – you know, just a member of hospital staff. And we talk to them about why they want to do the scholarship. And I should say, by the way, they have – one of the criteria for even applying is that they must have resided in the Riverland for at least three years. And that's so that we don't get people just coming in for scholarship and then blowing through.

MS MAUD: Is that an inflexible rule?

MS GOODE: No. We look at each case. Like, for example, we did have a case last year where a person rang up and said, "Look, I've only been here two years." And so I was talking to her a bit more and I said, "What brought you up here?" And she said, "My husband bought a farm." And I thought, well, buying a farm in the Riverland is probably an indication that you're going to be around for a little while.

So we look at people's community involvement. We're not interested in their academic ability, because the – the whole process that they have to go through to become eligible for the government-funded part of the training is a literacy and numeracy test, which I'm told by those who go through it it's like adult NAPLAN. So we're not worried about their educational qualifications. We just want to know what kind of people they are. And, really, I suppose, it comes down to the – the interview panel thinking, "Would I like that person looking after my loved one in aged care?" So we do have certain – we go through specific questions, but it's very much dependent on are they good community members.

MS MAUD: And how many applications did you receive for the scholarship in the first year that it was offered?

MS GOODE: In the first year we got 17, which converted to 11 actual applications.

MS MAUD: So 11 were granted.

MS GOODE: Yes.

MS MAUD: 11 scholarships.

MS GOODE: Yes.

MS MAUD: Is there a minimum requirement in order for the program to be viable?

MS GOODE: Yes. There is a minimum requirement of 15 students for it to be economic for the registered training provider to come up and provide the service. And, I might add, that that 15 seems to be standard regardless of where the registered training provider comes from, because the local provider who also sent us in a proposal had the same criteria: must be 15. We didn't get 15, but EQUALS were sufficiently enthusiastic and supportive of the whole thing that we didn't pay any extra in that first year when we didn't get 15 students.

MS MAUD: So the course went ahead with 11 students.

MS GOODE: Yes. Yes.

MS MAUD: And did they all graduate?

MS GOODE: Two dropped out through ill health and that left us with nine. All nine graduated. Two of them then left the area. I thought that was a bad choice, but still. And the other seven were all employed. Well, and I hasten to add, we are not offering employment. We are offering a scholarship for people to be trained, which will lead them to a better prospect of employment.

MS MAUD: So the seven who did obtain employment, where were they employed at the end of the course?

MS GOODE: In aged care.

MS MAUD: In the Loxton area.

MS GOODE: Yes, in the Loxton Hospital complex.

MS MAUD: In the aged care unit?

MS GOODE: Yes.

MS MAUD: I see.

MS GOODE: And I think possibly two of them also picked up casual work at the other aged care unit in Loxton, but, I mean, we're not bothered about where they go to work. We hoped they would come and work for us, but it's a small community and we can afford to be generous.

MS MAUD: And that first cohort of students, were they school leavers or what was that – what were their backgrounds?

MS GOODE: No. They – we deliberately did not target any particular group especially. We – in fact, it was such a suck it and see sort of experiment we were having we were grateful that even 17 turned up and applied. Some – we ended up with – I would think the age range went from 19 to about 50 plus. And they included certainly a young – a young person who had not done well at school, that had been mentored by a post-school adviser.

It included two ladies who had worked in a vineyard for 23 years and were about to lose their jobs, because the vineyard was being converted to almonds. And others were just people who – ladies who – and I'm sorry to say ladies, because I know we have to be non-sexist, but they were people who found that they had more time on their hands now because their children had gone out of primary school and were in secondary school, so they didn't need quite the attention that they were getting before.

MS MAUD: So, to promote the scholarship program, what work was undertaken to raise awareness in the community?

MS GOODE: Well, I'm very well known to the local media. So I was on the ABC. I was on – in the local paper. The ABC then put something about it on its website. They did an interview and that – and, I'm sorry, I'm not very technical, so I think it's a YouTube or something. I don't know. And then I would – I went to places like Rotary and talked about it. Now, it wasn't because I expected anyone from Rotary to apply, but I thought they are the sort of people that have daughters and granddaughters who might – and grandsons and sons who might be interested. And it was also to make sure that the community generally understood what we were doing with their money. Because this is community money that we're spending and we have to spend it very carefully.

MS MAUD: And the seven students who obtained employment in the aged care unit, do you know whether they're still employed there?

MS GOODE: I believe we now have four employed.

MS MAUD: Four. So the program was designed, obviously, to address the workforce shortage. Were there other purposes to the program from your point of view?

MS GOODE: Well certainly from my point of view, I wanted to increase the profile of direct care attendants. The fact that they're not required to have any training at all to work in aged care, I find quite revolting, to be honest. The fact that anyone can just walk on – in off the street and not have any training. I wanted to let the community know that we valued our aged care residents sufficiently highly that we wanted to make sure that everyone who looked after them in aged care was appropriately trained.

It was also a way of providing additional employment opportunities for the local community. And, like all local communities, we have an unemployment problem. And it was to try and attract people to think about the job with a great deal more positiveness instead of thinking it's a job anyone can do. If you want a scholarship from us, you've got to be pretty good to get it.

MS MAUD: And have you got any reason to think that it's been successful in achieving that broader purpose of raising the value of the role?

MS GOODE: I think definitely within the community.

MS MAUD: Why is that?

MS GOODE: Well, everybody knows about it. We're a small town so I go and have a coffee in the coffee shop and people ask me about it. I know the students, who are all well known. They are asked in town, you know, how's it going and all that sort of thing. So I think the community knows very well, thanks to all the publicity we've had, that we have definitely raised the status of direct care attendants. They are people that we think are extremely important. They are vital to the good care of the people who are in aged care.

MS MAUD: And has the program been offered again this year?

MS GOODE: Yes. It's – we did it in – we offered it again in 2019. Again, we did not get our 15. So that cost the health advisory council more because the – EQUALS could not give us the same favours that they did the previous year. I mean, it's a business. They're sending someone up from Adelaide. I understand all that. So we paid extra from the community funds. We will be doing it again next year, and because we think it's such a good program and we think we're going to get publicity out of the fact that you've been kind enough to ask me to come to the Royal Commission, and so we're hoping that we will get more takers. The ideas I've learnt from today, I've got a fair few more people that are going to be in my target line when I get back to Loxton.

MS MAUD: How many students do you have in the course this year?

MS GOODE: This year's course we've got – we started with 13. One left because of a bereavement in his family. One of them, it's still a success, but she had so many

qualifications that she got recognition of prior learning and she's now back working in the Mallee in aged care.

MS MAUD: So this year's student cohort, are they all from the Loxton area?

MS GOODE: No, we have about five from Loxton and the six that come from surrounding towns.

MS MAUD: How were people from the surrounding towns brought into the program?

MS GOODE: Well, the ones who come from the Mallee which is one and a half hours at least away from Loxton, that was with me communicating with the Mallee Health Service's presiding member and the Mallee Health Services paid the scholarship for those three people. They come up on Mondays and I think at least one of them stays overnight in our nurses' home so they don't have to travel back in the dark at kangaroo time. The others have just come from around the local area, like from Berri or Lyrup in the surrounding towns because they saw the ads and heard about it.

MS MAUD: And so it's been broadened at least to the Mallee area through you liaising with your counterpart - - -

MS GOODE: Yes.

MS MAUD: - - - in the Health Advisory Council for that area.

MS GOODE: Yes. I've also spoken just recently to the presiding member of the other Riverland towns at Renmark and I will be talking to Waikerie very shortly about sending someone up for this next – next round of scholarships.

MS MAUD: The practical training component of the course, 160 hours with numerous students all being completed at the aged care unit, do you know how they manage the demands of mentoring those students?

MS GOODE: No.

MS MAUD: That's okay.

MS GOODE: Way outside my scope, I'm afraid.

MS MAUD: You haven't received any feedback as to whether that presents - - -

MS GOODE: Well, in so much that I haven't received any feedback that says, "Don't you dare send any more across", or anything like that, I have to assume it's going well. And I know from the feedback from the students that they absolutely love their time in – on clinical placement because we get comments like it's lovely

being able to talk with patient B or client C or whatever, you know, there's no names ever mentioned. And they've got time to perhaps give them their lunch in a calm and unhurried manner. They can take them for walks. They can do a bit of hand pampering, all the nice things that sometimes time pressures don't allow others to do.

MS MAUD: You've referred to the work that you've done promoting the program and in your statement you describe that role as one of a local champion of the program. Is that a necessary aspect of the success of the program in your view?

MS GOODE: Yes. It won't – I am known as a face of the local hospital, not because of my – anything to do with nursing or anything like that, but because I'm the face of the Health Advisory Council. When it came to doing this whole program, I was the one who liaised with EQUALS in terms of how much they were going to charge, where they could – which rooms could be used, all those sort of administrative things. All the – the negotiations about the education went with the director of nursing. But I was the one who was interviewed by the local paper, by the ABC, all of that sort of thing. I did – I organised all the interviews, I organised the – the information night when we told everyone around it.

Even one of the other things that has to happen, when you do one of these government subsidised course, the literacy and numeracy tests that you have to take is done online and it has to be done in an adjudicated situation, so you can't just do it on your home computer. So I negotiated with our local library – instead of these people having to go down to Adelaide to do it in the registered training organisation's facility which would have been ludicrous, I negotiated with our local library and got the use of four of their computers and so I had students coming in four at a time and doing their test while I sat there twiddling my thumbs, and we did all that in a day. But you see, you have to have someone like me there for – to be able to organise all those things.

MS MAUD: And you've mentioned the community's investment in the program and the effect that that has had. Based on your experience, if a scholarship program of the kind that the advisory council is offering was to be funded by government, do you think it would see the same successful results?

MS GOODE: No. I think you have to have the community involvement. The community funding gives the community ownership of the program. It enables them to feel proud of the staff that they've got in aged care because they've actually helped with their training and they know they've got the right people working in aged care. And I'm not suggesting for one minute that anybody who hasn't had the scholarship isn't the right person but it just gives the community more ownership of the whole thing. If you – if it's government funded, with all due respect to government, it's just another training course and unless they want to do it in the facilities – I think what makes our course so unique is that it's being done in the facility and clearly what we heard this morning from Alpine Health, there – it's on the same basis. They've provided their own training facility. I don't think we're up to that, but it's the same thing.

You've got to have ownership of the training, and unless the government was prepared to do that with every little hospital – and I don't think that's likely to happen, I don't think it would work unless the government actually wants to provide more funding to the registered training providers so that we don't have to pay any bit of the scholarship at all. I would have to work that through. I think it definitely needs community involvement.

MS MAUD: And you've mentioned that the program has helped to raise the profile and the value that's placed on the work of direct care attendants at least in your community. Do you have other ideas about how people could be attracted into doing this job?

MS GOODE: Well, the whole job description needs to be more – far more highly valued, and one of the ways I think that this would happen would be to have, (a) make it first of all compulsory that every person who works in personal care is – has a minimum of Certificate III in Personal Care Training. I think the idea that you can literally walk in off the door with no qualifications at all and get a job where you are intimately caring for someone who is defenceless, washing them and showering them and all that sort of thing without any training at all is just horrible. So I would like to see training being compulsory but I would like to see registration also compulsory.

Nurses have to be registered, doctors have to be registered. All the professions have to be registered and it's a form of accountability. Direct care attendants have no lesser accountability. And coming from South Australia, and I believe that's where the Commission comes from, we know only too well the story of Oakden and it's always been a thorn in my side that some of those carers who were sacked or transferred or went somewhere else could have turned up anywhere. So I would like to see all direct care attendants registered, that they have to renew their registration every year and then those few – and I would say few who do the wrong thing, can be deregistered and we can be sure they won't be working in aged care again.

MS MAUD: Based on your experience working hard to bring people into these roles in your community, do you think a registration requirement would act as a barrier to entry by the kind of people that you're looking for?

MS GOODE: Only if you made it too much money. But I would have thought for a direct care attendant – I've got no – I know when I was still registering as a nurse it was a phenomenal amount but I would think even something as little as $20 a year for a direct care attendant to be registered, I don't see that that would be a barrier. And it's also part of the pride, you've won the qualification, now I can register. Now, I can go anywhere and get a job as a direct care attendant.

MS MAUD: Now, you mentioned earlier on that the course that the Certificate III that EQUALS provides with the benefit of the scholarships that the Health Advisory Committee offers equips students to work both in residential care and in home care. Do you have a view about whether there are particular electives that need to be compulsory in order to equip students for those different roles?

MS GOODE: No, again, you're asking me something that is outside my scope that would be better directed to the director of nursing or to EQUALS.

MS MAUD: Commissioners, that's the examination.

COMMISSIONER PAGONE: Thank you, Ms Goode for that. It's been very helpful, indeed, very informative and good luck with your continued work with the scholarship.

MS GOODE: Thank you.

<THE WITNESS WITHDREW [3.52 pm]

COMMISSIONER PAGONE: Ms Hill?

MS HILL: Commissioners, I call Susan Hood.

COMMISSIONER PAGONE: Yes.

<SUSAN MARGARET HOOD, SWORN [3.53 pm]

<EXAMINATION BY MS HILL

MS HILL: Sue, could I ask you to please state your full name.

MS HOOD: Susan Margaret Hood.

MS HILL: And you've asked me to refer to you as Sue today.

MS HOOD: Yes, please.

MS HILL: What's your age?

MS HOOD: 66.

MS HILL: And whereabouts do you live?

MS HOOD: Dubbo.

MS HILL: And what do you do for work?

MS HOOD: I'm the secretary of the Show Society in Dubbo which is the major agricultural show in our region.

MS HILL: Keep you pretty busy?

MS HOOD: Very busy.

MS HILL: And you're married to Alan.

MS HOOD: Yes, I am.

MS HILL: And you've prepared a statement about your experience and Alan's experience of receiving aged care services.

MS HOOD: I have.

MS HILL: Operator, could I ask you to please display document ID WIT.0594.0001.0001. Sue, do you see a copy of your statement on the monitor there in front of you?

MS HOOD: Yes, I have.

MS HILL: You've also got a hard copy there. Were there any changes you'd seek to make to that statement?

MS HOOD: No.

MS HILL: And are the contents of that statement true and correct?

MS HOOD: Yes, to my ability, they are.

MS HILL: Commissioners, I tender the statement of Sue Hood.

COMMISSIONER PAGONE: Yes, the statement of Susan Hood dated 25 October is exhibit 12-18.

EXHIBIT #12-18 STATEMENT OF SUSAN HOOD DATED 25/10/2019 (WIT.0594.0001.0001)

MS HILL: As the Commission pleases. How old is Alan?

MS HOOD: 71.

MS HILL: And how long have you and Alan been married for?

MS HOOD: 47 years.

MS HILL: Alan retired in 2015?

MS HOOD: That's correct.

MS HILL: What had Alan been doing for work before then?

MS HOOD: His position on Country Energy at the time was an electrical work – work health and safety. He used to go round half of New South Wales checking on all the high voltage equipment and making sure they were safe for people to use in the workplace. Every six months they had to be checked and tagged. And it was a very responsible job.

MS HILL: And how long had he been working with Country Energy before he retired?

MS HOOD: About 50 years.

MS HILL: What led to Alan's decision to stop working in 2015?

MS HOOD: I feel that, due to an accident that Alan had, and being the person that he was, he didn't stop work; he kept working. He was out on the road and he hit his head. And that was in 2014. And then, February 2015, he came to me and said he was going to leave. He wanted to retire. And I thought it rather strange, because he only had another 12 months to go at that time to do his 50 years, but I never said anything and let him go. And I said to him to talk to his financial adviser to see the best time of retirement. And we did. We went to the financial adviser. And he recommended July. And so Alan retired on 24 July. And I could see that Alan was even then struggling with memory.

MS HILL: And what led you to consider that Alan was struggling with his memory?

MS HOOD: Some of the things that he was doing was just not in his character. He was so thorough and precise in everything he did. And some of the things that he was doing around our house or driving was just not in his character.

MS HILL: And did you end up getting that checked out any further?

MS HOOD: He went to the doctor in 2014, about June, and had a CT scan and nothing showed up. But he still had continuous headaches. So he just thought he had to live with that. And then when he got to the February in 2015, he was still experiencing those headaches. By the time he retired, I said to him that he needed to go to the doctors and have an MRI. So that took me a while to get him there, because he was a little bit stubborn, but I eventually got him there. And the MRI showed that there was damage on the left-hand side of his brain. So the GP sent us

to the neurologist in Orange. And they confirmed that, that he had had post-traumatic concussion, because he didn't stop and rest, and there was a probability that it would not repair because of his age. And he was 66 at that time.

MS HILL: And was a plan put in place at that time for how to monitor that?

MS HOOD: They gave him medication to try and relieve the headaches, which it took about eight or nine months to get the right medication to relieve him of the headaches. And then, eventually we, probably about the last time we went to the neurologist, they said his headaches should be resided, they should be finished. But I felt that he wasn't drinking enough fluids and that was causing headaches. So he was forgetting to drink and, therefore, creating more of an issue with his health.

So, yes, I had to put things in place so that I could start monitor how much – and I felt once he had had the liquids he was much better able to go with the – without having a lot of medication with – with the headaches. He's only just, probably in the last three months, been taken off the medication for the headaches.

MS HILL: Can I turn then to the beginning of this year, January 2019.

MS HOOD: Yes.

MS HILL: How would you describe Alan's health and .....

MS HOOD: At the beginning of January, Alan was still swimming a kilometre in the pool. He was always very healthy, fit, hardly drank, ate everything that was correct, not like me. Anything that's sweet I will eat it. But he would not put sweets in his mouth. And that all started to change. And he was getting confused by swimming backwards and forwards in the pool. He was starting to get disorientated. So after 6 January he just said "I'm not going." So he hasn't been in the pool since. And from then on you could see the decline.

MS HILL: And moving, then, to February, Alan said he's got going to swim after the first week of January.

MS HOOD: Yes.

MS HILL: What was Alan's health like in February of this year?

MS HOOD: He was fine in February. It was just his memory was getting worse. And when we were visiting the neurologist, they said he would most likely end up with dementia. That was something I did not even contemplate when we first went to the neurologist. I thought, you know, "Okay. He's got a brain injury. It will get better. His memory will be fine." You do not prepare for the outcome of dementia, especially when you're fit and healthy. But, yeah, from February onwards, you could see he wouldn't even leave the house on his own. He needed somebody with him. He just didn't have the confidence. He was losing confidence.

MS HILL: And you describe in your statement that his health – Alan's health deteriorated quite quickly, quite rapidly over the next few months.

MS HOOD: Yes.

MS HILL: What did you do in those circumstances?

MS HOOD: Well, in – towards the end of May, probably the beginning of June, it was really cold in Dubbo. And I come home one lunchtime and he was outside and he just had a light top on and a light bottom on, no shoes. He was out at the clothes line and I went to the backdoor. And I – the backdoor was still locked, and I thought, "Well, how did he get out there?" So I got him back inside and I said to him you know, "How did you go outside? It's freezing out there." And he couldn't tell me.

So he's gone out the front door and right round to go to the clothes line. I did have clothes on the line, but I don't know what he was going to do with them. And from that day he came down with the flu. And so I had three or four days of him being in bed. And I thought then that maybe this is going to be the start of further difficulties with him. He just wasn't responding to what I was saying to him. And trying to get him in the shower and doing things like that was just becoming difficult. But I persevered with that until the end of June. He had an appointment with the – his GP in June.

And, yeah, from then on, it sort of happened really quickly that he was starting to wander through the night. And one night I got up and he was still sitting in the lounge chair. And I got him up out of the lounge chair and he had an accident. And I was trying to change him and he fell. I think he did hit his head, but he didn't hurt himself. But at that time I had been asked to consider calling an ambulance, but I didn't think at that stage I needed to call the ambulance. But the next morning I needed to call the ambulance, because I couldn't get him out of bed. He just wouldn't move.

MS HILL: And how are you coping at this time?

MS HOOD: At that time I was – I didn't know whether I was coming or going. It was – yeah. And, look, you don't prepare yourself for these sorts of things. I think I'm still young. And I thought he was still young, but, yeah, you just don't prepare yourself for aged care.

MS HILL: And did you ultimately access aged care services for Alan?

MS HOOD: Yes. When we went to the geriatrician, they gave us some information. But, in saying that, they only give you pamphlets to access aged care. It's – there's no guidelines or no guidance of, "Okay. You need to ring this service" or to make the next step. And then, by the time he ended up in hospital, it was – it was probably too late. Well, it wasn't too late. I would have liked to have taken him back home, but I had no option but to put him into aged care facility, because I

couldn't get a package. It was 18 to 24 months before you could get a package to keep him at home. And they more or less advised you that he needed 24 hour care. So the next step was to put him into an aged care facility.

MS HILL: Can I take it back a step when you described that you only received pamphlets .....

MS HOOD: Yes, only pamphlets.

MS HILL: And there was no guidance. What sort of guidance would you have liked at that particular stage?

MS HOOD: Well, there should be somewhere, whether it be an office or whether it's providers of aged care, they should have information for you that this is your next step. This is where you should access information. This is the paperwork that you need to complete before you go to the next step. Because I had no idea of the paperwork that had to be filled out by Centrelink. And everyone has to do that. And, by the time I did that, I would say it would be that thick, the information I had to take to Centrelink. And I think people should be more prepared to go into these facilities to find out where you can access information step by step in going into these facilities.

MS HILL: And how did you and Alan ultimately come to access aged care services for Alan?

MS HOOD: Well, I had tried to get respite for Alan while I – I go to Sydney every three to four months for my work. And I tried to get respite. And I went to a provider in Dubbo to see if they could help me get respite. And they advised me that I had to go round to the care facilities to see if I could access the respite myself. So I used to, in my lunch hour, go round the different facilities and see if I could get respite. But, honestly, there's – nobody wants to know you about respite in Dubbo.

MS HILL: Can I ask you to describe the process that led to Alan being eligible for a home care package.

MS HOOD: Okay. Well, at the end of April he went to his GP for his medication. And at that time when he went there Alan was becoming nonverbal and was not comprehending what the GP was saying to him. So, therefore, they set up a meeting with an ACAT assessment lady that actually came out home. The doctor did all that, which was really good. They came out home and had an interview with us about a week after that. And then she didn't really – they didn't really give him any packages or anything then. They just did an assessment. And he couldn't answer anything then. And that was the beginning of May.

Then she actually said to us that she would set up a meeting with the geriatrician, which was to be around the 20th – 19, 20 August. But, three weeks later, she said – she rang me and said that the geriatrician was actually going to be in Dubbo on 24

May. And so she said, if we could be there at a certain time, which was about 2 o'clock in the afternoon, the geriatrician would see Alan. So we went there and Alan couldn't basically do any of the activities that the geriatrician asked him to do. He was hard to know which was right, which was left, lift his foot, lift his hand. He wasn't – but he's happy, he was happy doing whatever he thought was good. So that's how we started that process. But then I didn't get any further information from there either.

MS HILL: And did Alan ultimately – you described Alan ultimately became eligible for a package.

MS HOOD: Yes, the geriatrician actually wrote a letter and stated that he was suitable for 24 hour package of care, yes.

MS HILL: And that was as part of a home care package or - - -

MS HOOD: Either home care or residential.

MS HILL: And with consideration of the decisions that needed to be made around Alan's health at that time, were you in a position, Sue, where you had to make decisions for Alan?

MS HOOD: I did.

MS HILL: Were you in a position where you could support Alan to make decisions?

MS HOOD: I honestly don't think Alan understood what was happening. The only time he ever understood anything was when I took him out of the private hospital and we went into the aged care facility and he just said to me as clear as anything, "This is the end."

MS HILL: Did yourself and Alan want Alan to stay - - -

MS HOOD: At home.

MS HILL: - - - at home?

MS HOOD: Yes.

MS HILL: What would you have needed to be able to keep Alan home?

MS HOOD: Well, I think to start off with, you need to know what the packages are going to offer. To this day, I still don't know what packages – level four, whatever they – I still do not know what they mean, what are available out there, whether I do – whether it was care through the night or whether it was care only of a daytime, I

have no idea, but what I was basically looking for was somebody to help me care for Alan.

MS HILL: And you indicated – pardon me – you indicated earlier that you were advised of how long you would have to wait for.

MS HOOD: Yes. 18 months to 24 months.

MS HILL: In those circumstances, Sue, was it an option for you to keep Alan at home?

MS HOOD: No. No, I could not physically and probably mentally retain the care that I was giving him which I did for the four years and, basically, the last 18 months was, you know, pretty – pretty heavy-going, yes, because I was shaving him. I was making – helping him get in the shower. I was making sure he ate breakfast, ate lunch, ate his dinner. When he was having his meals, making sure that he had drinks because he just – he didn't know whether – what he was doing.

MS HILL: Alan is now living at a residential aged care facility in Dubbo.

MS HOOD: Yes.

MS HILL: Are you satisfied that Alan is getting the care that he needs at his home?

MS HOOD: That's a difficult one to answer. Yes and no. Yes, he is getting care. Sometimes the care is not to the level of what myself would like. Alan is not aware of the level that he should be receiving. He's only been in there two months and he was walking quite well and, you know, physically strong. He now has a broken hip – well, it's been replaced – and can't walk. So that's two months. And it's – to me that's – that's not the level of care that he should be receiving.

MS HILL: In respect of the care that's delivered by the personal care workers at Alan's facility, what do you want from those care workers?

MS HOOD: Better training. I think with what we've heard here today, some of the providers and especially the last one with these scholarships, and I think all aged care facilities should implement some sort of training, like I think that would be good because I feel – and this is only an observation of mine, it's – and I don't know whether it's right or not – that they're not trained enough to care for the needs of the residents in the aged care facilities. If you sit back and watch, you know, it's – it is – some of them are good. Some of them are really good. Some of them have been working in the system for a long time and are excellent.

But there are a few that struggle to understand what the residents' needs are and understand their conversation, and vice versa, the resident is finding it hard to understand the personal carer.

MS HILL: And why do you think that is?

MS HOOD: I honestly don't think they've been trained enough and had enough education in maybe our English language.

MS HILL: In combination with what you've just given evidence about, the role of training and the role that training could play, do you have any other examples or reflections on what would need to change for you to be satisfied or feel comfortable with the care that Alan receives?

MS HOOD: Look, if I could be certain that Alan was – and all the other residents in the aged care facilities, and it doesn't have to be the one that Alan's in, it's all of them, if I could walk away after being inside any of them and think and know that those residents are being cared for in the best way possible, I would be happy. I could walk away with peace of mind. But some days you go away and you just – you shake your head. You wonder whether they're going to be looked after properly. And it's not only Alan. Like I had my mother in aged care, that was also in Dubbo, and I used to walk away and think what have I done to my mother, you know, it was just so hard.

MS HILL: What motivated you, Sue, to come and share your family's experience this afternoon?

MS HOOD: I need – I need to get out there and say something for these elderly people in these homes. They're vulnerable. And if it means I have to share the – these things, I do not want to compromise Alan's position in the place that he is at but I do – I know I will feel better for coming and saying what I have, and doing my statement.

MS HILL: Thank you, Sue. Commissioners.

COMMISSIONER PAGONE: Thank you, Ms Hill. Mrs Hood, thank you for coming to give evidence. It's very important that we hear these stories – I know how hard it is – and it helps us in our work. The community needs to hear the stories. The government needs to hear the stories, and we thank you for having taken the trouble.

MS HOOD: Thank you.

COMMISSIONER PAGONE: Thank you.

MS HOOD: Thank you.

<THE WITNESS WITHDREW [4.19 pm]

COMMISSIONER PAGONE: The Commission will now adjourn until tomorrow morning.

MS HILL: Before the associate formally adjourns, could I indulge the Commission to formally excuse Mr Seys but also Ms Hood.

COMMISSIONER PAGONE: I'm terribly sorry, yes, I had intended to do that. They are both formally excused from further attendance.

MS HILL: As the Commission pleases.

MATTER ADJOURNED at 4.19 pm UNTIL WEDNESDAY, 6 NOVEMBER 2019

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