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

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

MELBOURNE

9.16 AM, WEDNESDAY, 9 OCTOBER 2019

Continued from 8.10.19

DAY 53

MR P.R.D. GRAY QC, counsel assisting, appears with MS E. BERGIN
MR G. KENNETT SC appears with MR B. DIGHTON for the Commonwealth

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. May I deal with a housekeeping matter at the outset. The general tender bundle for the hearing has been augmented by the addition of five further documents in addition to the ones I mentioned yesterday afternoon. That has occurred overnight and those documents are available to the parties who have leave to appear in the hearing. Might I mention those now and seek to amend the general tender bundle exhibit 10-1 to the extent of adding those documents?

COMMISSIONER PAGONE: Very well.

MR GRAY: They are tab 133, 134 and 135, consisting of three reports referred to by Dr Hartland in his statement at paragraphs 47 to 51; tab 136 and 137 being submissions to the Royal Commission which describe the Victorian Access and Support Program. That's a program that has been mentioned in evidence a number of times and these submissions give detail about it.

COMMISSIONER PAGONE: Yes, thank you. So you would like these added to exhibit 10-1?

MR GRAY: Yes, please, Commissioner, and you have before you a consolidated index.

COMMISSIONER PAGONE: I see. Thank you very much.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Thank you, Mr Gray.

MR GRAY: I call Mr Jaye Smith.

<JAYE ALEXANDER SMITH, AFFIRMED [9.18 am]

<EXAMINATION BY MR GRAY

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you. Good morning, Mr Smith. Is your name Jaye Alexander Smith?

MR SMITH: Yes.

MR GRAY: I'll ask that a copy of your new witness statement be displayed before you on the screen WIT.0427.0001.0001. This should be, once it appears, a copy of your statement dated 4 October 2019 for the Royal Commission.

MR SMITH: Yes, it is.

MR GRAY: Thank you. That's the second statement you've made for the Royal Commission, isn't it?

MR SMITH: Yes, it is.

MR GRAY: Your first statement is dated 10 May 2019. It's already an exhibit, 4-17. That was tendered in relation to the Broome hearing although the tender occurred in Perth. You weren't called to give oral evidence about the statement.

MR SMITH: No.

MR GRAY: Is that right?

MR SMITH: That's correct.

MR GRAY: But you are here to answer questions about aspects of your responsibilities in the Department of Health with respect to catering for diversity of needs. Could I ask you, firstly, to confirm your position and your function. Your first statement, WIT.0128.001.001 at paragraph 4 identifies your position as First Assistant Secretary in the Residential and Flexible Aged Care Division of the Department, and you go on to explain that the Division is responsible for residential and flexible aged care policy, operations, funding and allocation of places. And you go on to say the Division also has responsibility for policy and programs for vulnerable or disadvantaged consumers including people with dementia and people from diverse groups. You have held that position since November 2017. Is that all correct, still?

MR SMITH: Yes, that's correct.

MR GRAY: And the responsibility you identify for policy and programs for vulnerable or disadvantaged consumers, etcetera, does that extend beyond residential and flexible aged care to, for example, home care?

MR SMITH: Yes. It does, yes.

MR GRAY: There's another witness giving evidence later today, Dr Nicholas Hartland; he is another First Assistant Secretary in the Department. He has certain other responsibilities for care in the home; is that right?

MR SMITH: Yes.

MR GRAY: But you have an overarching responsibility in relation to responding to diverse needs; is that right, Mr Smith?

MR SMITH: Yes, in terms of the development of – of policy and providing input to other parts of the aged care group from a diversity perspective and our role in the diversity subgroup; that's correct.

MR GRAY: Thank you. I'll just ask that an organisation chart of the department be displayed. It's exhibit 8-27, tab 154. It's RCD.9999.0168.0001. And just while that's appearing, who do you report to, Mr Smith?

MR SMITH: The Deputy Secretary of the Aged Care Croup, currently Dave Hallinan.

MR GRAY: Thank you. And when you say that your division, residential and flexible aged care, has responsibility for the matters that you've confirmed, does that mean that you're the First Assistant Secretary with the responsibility for those matters because you're in charge of the Division?

MR SMITH: Yes, that's right.

MR GRAY: Thank you. Perhaps we will find the organisational chart later. That's all right. I won't ask you any questions about it. Thank you, operator. If you please call out the purple section second from the right under Ageing and Aged Care, David Hallinan – you can't call that out? It's a little hard to read all of the words but Mr Smith is the ageing and aged care division, the purple section second from the right on this organisational chart.

MR SMITH: Sorry, my Division were you asking about?

MR GRAY: No, the Ageing and Aged Care Group.

MR SMITH: The Ageing and Aged Care Group, sorry, yes.

MR GRAY: Under David Hallinan.

MR SMITH: Yes.

MR GRAY: That's the three columns coloured purple, second from the right on this chart?

MR SMITH: Yes.

MR GRAY: And you are responsible for the middle column under David Hallinan; is that right?

MR SMITH: Yes.

MR GRAY: Where is Nicholas Hartland's position; is that at the foot of the left-hand of the purple columns?

MR SMITH: I'm actually having a lot of trouble reading this, to be honest.

MR GRAY: Yes, it's hard to read.

MR SMITH: Here we go. So that, I think this is an older structure chart. We have had recent restructures which would change that. That had Dr Hartland as a principal adviser in the aged care group and he is now First Assistant Secretary of the in home aged care division.

MR GRAY: Thank you. This organisational chart was tendered in the Brisbane hearing in August. So perhaps it has been updated since then.

MR SMITH: I think that's correct, yes.

MR GRAY: Thank you. We might see if we can obtain an up-to-date one and add that to the materials.

COMMISSIONER PAGONE: By the way, Mr Gray, have you formally tendered the witness statement, the second one?

MR GRAY: Thank you, Commissioner, I've omitted to do that.

Mr Smith, you identified the first page of your witness statement. I omitted to ask you whether you wish to make any amendments to it.

MR SMITH: No, I don't.

MR GRAY: To the best of your knowledge and belief, are the contents of your statement dated 4 October 2019, WIT.0427.0001.0001 true and correct?

MR SMITH: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes, thank you, Mr Gray. So the second witness statement of Mr Smith namely that dated 4 October 2019, will be exhibit 10-17.

EXHIBIT #10-17 SECOND WITNESS STATEMENT OF MR JAYE SMITH DATED 04/10/2019 (WIT.0427.0001.0001)

MR GRAY: Thank you, Commissioner. Mr Smith, the Commissioners and by now members of the public who have been following the Royal Commission, will be familiar with some basic principles but I will just ask you to confirm them. There are

three main modalities of aged care, putting aside for the moment, flexible and transitional. The three main modalities are the Commonwealth Home Support Program, home care and residential care. Do you agree with that?

MR SMITH: Yes, I do.

MR GRAY: And Commonwealth Home Support, as a program under that name, commenced in 2015 but it was the inheritor of a number of previous programs that were run under different arrangements in the various states and territories; is that right?

MR SMITH: Yes, that's right.

MR GRAY: And, in particular, probably the principal description of the programs that were run around the various states and territories under separate arrangements was Home and Community Care or HACC; is that right?

MR SMITH: Yes, that's my understanding.

MR GRAY: You weren't actually involved prior to 2017, I think you said - - -

MR SMITH: That's correct.

MR GRAY: - - - in aged care but you've acquired some indirect knowledge of the history of the aged care system in your current position, have you?

MR SMITH: Yes.

MR GRAY: Now, just very briefly, CHSP is block funded and it's not rationed by number of clients; it's provided by direct agreement to particular service providers.

MR SMITH: Yes, that's right.

MR GRAY: Home care is rationed by numbers of clients and it's assigned to those clients or aged care recipients via a national prioritisation system; correct?

MR SMITH: Yes.

MR GRAY: And residential care is rationed and it is allocated to providers via a centrally planned process which you describe in your first statement in particular and you advert to in your second statement; is that right?

MR SMITH: Yes, that's correct. Yes.

MR GRAY: Now, just going back over some of the background, there was a very important Productivity Commission report in 2011. Following that report, in 2013, the Parliament enacted the Living Longer Living Better amendments; correct?

MR SMITH: Yes.

MR GRAY: And you've referred to that development in your statement at page 5, paragraph 19, and you've referred, in particular, to one of the requirements of those amendments being that there would be a legislated review within three years after the commencement of the reforms contemplated by that legislation; that's right, isn't it?

MR SMITH: Yes.

MR GRAY: And that review was the legislated review of aged care 2017 by Mr David Tune.

MR SMITH: Yes.

MR GRAY: And you've referred to the Tune report in your statement at pages 6 and 7. You identified five recommendations which you describe as relating to areas for improvement directly or indirectly for older people with diverse characteristics and life experiences; that's right, isn't it?

MR SMITH: Yes.

MR GRAY: Now, I will just ask you some questions about the Tune report. You have clearly familiarised yourself in the course of your duties as First Assistant Secretary.

MR SMITH: Yes.

MR GRAY: If we please call up the Tune report which is exhibit 1-35, RCD.0000.0011.0746. If you go to page 7 please, operator. That is 0752, I should say. Thank you. Now, under the heading Moving Towards a Consumer Driven System one of the bullet points states that:

> *Government policy needs to ensure equitable supply of services across different population groups –*

and it goes on, but that's one of the aspects of the overarching approach that Mr Tune adopted, I suggest.

MR SMITH: Yes.

MR GRAY: And if we just delve into that topic a little more deeply, if we go to page 0755, please, operator, at both pages 10 and then across to 11, we see under the heading Access to Services, there's an introductory passage where Mr Tune says that:

> *One of the central concerns for the design of aged care policy is that it ensures access to care for all older Australians.*

And he goes on to elaborate. The second bullet point refers to providers are offered an incentive to ensure that people with limited income and assets receive care. The fourth refers to aged care – I beg your pardon. I'm sorry, I'm on the wrong screen. Just asking more generally about access to services, there's two topics picked up there in particular. There's My Aged Care, the My Aged Care portal for aged care services, and there's reference to the NSAF, the National Screening and Assessment Form. Do you see that down the foot of the passage that has been called out by the operator?

MR SMITH: Yes. Yes, that's in the second paragraph of what I'm looking at here.

MR GRAY: Thank you. And it's also at the end of the passage, issues were identified with the NSAF, etcetera.

MR SMITH: Yes. Yes.

MR GRAY: Are those areas, areas of responsibility for yourself or for Dr Hartland? Who is best placed to give evidence about My Aged Care and the NSAF?

MR SMITH: Dr Hartland.

MR GRAY: All right. Thank you. Now I will go to the bullet points I had in mind. If we go to the next heading please, operator, on page 0756; that's Equity of Access to Care and that's where the bullet points appear. And the introductory words I read out a minute ago are:

> *One of the central designs for the design of aged care policy is that it ensures access to care for all older Australians.*

And it goes on. Then, Mr Tune says:

> *There are several features of the system designed to ensure access.*

The second bullet point is that point about an incentive to ensure that people with limited income and assets receive care. The fourth bullet point is that:

> *Aged care legislation and processes for the allocation of places recognised population groups with specific needs.*

Now, just pausing there; allocation of places, at the time Mr Tune wrote his report, by then there had been various changes, the result of which was that the allocation of places only occurred in the residential care context; correct?

MR SMITH: That's correct.

MR GRAY: But prior to February 2017 the central allocation of places extended also to home care places, didn't it?

MR SMITH: Yes, it did.

MR GRAY: The next bullet point is:

> *Government funding models providing additional funds where people with special needs require additional support.*

And the final one is about dedicated programs supporting access and care for some population groups. Mr Tune goes on to say that few of the – and then he refers to the LLB reforms but that's Living Longer Living Better, isn't it?

MR SMITH: Yes.

MR GRAY: The 2013 legislation.

MR SMITH: Yes, it is. Yes.

MR GRAY: He says:

> *While few of them were targeted specifically at improving access to care for particular groups –*

he says –

> *...it is important to evaluate how access has been effected.*

That's because that reform in 2013 was a step on the way to a more consumer-driven market-based mechanism for the delivery of aged care and it was important to make sure that groups with diverse needs weren't left out in the cold. Would you agree with that?

MR SMITH: Yes, I agree with that.

MR GRAY: And that's still a very important consideration, isn't it?

MR SMITH: Yes, it is.

MR GRAY: The report goes on to say that the review considered what information was available regarding success to care for a dozen different populations. I will come to that in a minute but in the chapter dealing with diverse groups, Mr Tune identifies nine statutorily recognised groups and three additional groups; is that right?

MR SMITH: Yes, that's right.

MR GRAY: Then he says, in the paragraph beginning more generally, he says that:

While good information is available for some groups –

and he only mentions two, although they're big groups, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse populations. He says:

> *There is good information available for some groups but in most cases data are inadequate to monitor the patterns of access for different groups. Now, I'm going to be asking you about that topic in some detail and, indeed you've addressed it in some detail in your statement.*

MR SMITH: Yes.

MR GRAY: But as a very general proposition, is it still the case that there's a marked disparity between the information available for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse populations on the one hand, and the other groups on the other?

MR SMITH: At this point of time that is still the case.

MR GRAY: Okay. Then Mr Tune goes on to say:

> *To address this data deficiency and lay a foundation for ensuring people with special needs are able to access suitable services the government should give consumers the opportunity to identify as belonging to a population group with special needs as part of their client record.*

I'm going to ask you about that as well. I'm a little unsure as to whether that's a question best directed to you or Dr Hartland, but I will come to that in a minute.

MR SMITH: Sure.

MR GRAY: Just focusing on the concept of a client record for a moment, is that a record that's created when a person seeking aged care contacts My Aged Care?

MR SMITH: Yes.

MR GRAY: And are they given a number of some kind?

MR SMITH: My understanding is that they receive an aged care number, and I suppose I will add that the concept there of client record, I imagine would flow through though then to where they end up placed in the aged care system.

MR GRAY: Thank you. And just at a general level, are you able to answer this question: is it the case that putting aside rural and regional groups who are identifiable from their address and Aboriginal and Torres Strait Islander people and culturally and linguistically diverse populations at least – some of whom are going to be identifiable, perhaps, by indicating what language they speak – putting aside those

groups, is there modality or functionality in the client record-keeping system which begins with My Aged Care to record other membership of diverse groups?

MR SMITH: My understanding is that that's possible, yes.

MR GRAY: Is that a question that you know best about or Dr Hartland knows best about?

MR SMITH: From a functionality point of view, Dr Hartland would be best placed to answer that.

MR GRAY: Thank you. This topic that I've been addressing under the heading Equity of Access in the Tune report, apart from those details where you've identified Dr Hartland as the best person to answer the question, is that within your responsibilities by reference to that overarching responsibility you mentioned at the outset of your evidence for meeting diverse needs?

MR SMITH: Yes.

MR GRAY: Chapter 9 of the Tune report deals with equity of access in a lot more detail. That begins at 0891. And if we go, please, to 0894, we see the nine statutory so-called special needs groups, and then the addition of the three other groups identified by Mr Tune. And those groups – I think we probably need to go back one page, I'm sorry, Mr Smith, yes. Do you see there at paragraph 9.20 Mr Tune identifies those statutory groups and then over the page, at 0894, he also identifies, in the last three bullet points people with dementia, people with a disability and people with a mental illness.

MR SMITH: Yes, I see that, yes.

MR GRAY: At the top of that, yes.

MR SMITH: Yes, I'm aware of that, yes.

MR GRAY: And so those are the dozen groups, if I could use that expression, that Mr Tune adverts to earlier when he is analysing and assessing the adequacy of the aged care system's response to special needs and diverse needs.

MR SMITH: Yes.

MR GRAY: At page 13 of the report, there's a list of recommendations and you've, indeed, referred to a number of these, as you mentioned a moment ago. Page 13 – yes, thank you, operator. You don't mention this particular recommendation but I suggest it is relevant to your responsibilities for catering for diversity. It's recommendation 3, Mr Smith. I will just let you read it to refresh your memory:

...but as soon as possible the government discontinued the aged care approvals round for residential care places, instead assigning places directly to the consumers within the residential care cap with changes to take effect two years after the announcement by government.

MR SMITH: Yes.

MR GRAY: Now, let's just unpack that a little. Tell me if I get any of this wrong. A minute ago when we were going through the three main modalities of care, you confirmed that while home care is rationed but assigned to the aged care recipient, residential care, while rationed, is actually centrally allocated.

MR SMITH: Yes.

MR GRAY: And the expression "a residential care place" is used to convey the notion that there's a centrally planned allocation of those places.

MR SMITH: Yes.

MR GRAY: Recommendation 3 is a recommendation that down the track the marketisation of delivery of aged care services will continue and will cover, eventually, the allocation of subsidy for residential care; is that right?

MR SMITH: Yes, it is.

MR GRAY: And while this still, perhaps, is going to be a cap within the confines of this recommendation, that's a residential care cap, there's to be a rationing of the places within the compass of this recommendation, there will be something akin to what happens in home care. There will be an assignment of the subsidy represented by that residential care place directly to the consumer.

MR SMITH: Yes.

MR GRAY: Now, that hasn't happened yet.

MR SMITH: No.

MR GRAY: It hasn't been announced when that will occur, has it?

MR SMITH: No, it hasn't.

MR GRAY: Are you aware, is there policy work within the Department going on about the implementation of that recommendation or the potential implementation of that recommendation?

MR SMITH: Yes, there is. And I can speak to that in general terms. I don't have responsibility for that particular piece of work. But there is what we are calling an

impact analysis being undertaken; that's being led by the University of Technology Sydney. That's to really look at what the implications would be for – of shifting to a market-driven approach for residential care places, similar to the home care model. What the impact would be on the sector, on providers, on consumers, the likely response of the market to that. There has been an extensive consultation process underway which is now closed. UTS is scheduled to report to government by the end of this year with recommendations – with recommendations and options in relation to the pros and cons, I suppose, of moving to that model, and also if you didn't move to that model, what might you do to ACAR to improve it to make it – to make it better and to better deliver what it's intended to.

MR GRAY: Thank you. ACAR is A-C-A-R, the acronym for the aged care approvals round.

MR SMITH: Yes, apologies. Yes.

MR GRAY: No, not at all. Let's call it ACAR. And ACAR is, in fact, a description of the process of central planning for allocation of those places and the actual operation of allocating them to approved providers who apply for them; is that right?

MR SMITH: Yes, that's right.

MR GRAY: And it's done by region called aged care planning region and with reference sometimes to areas of a smaller size, statistical area level 2, according to ABS criteria within those regions.

MR SMITH: Statistical area level 3, actually, but yes, that's right.

MR GRAY: Thank you. So that statistical area level 3, roughly speaking, what's the size of a population in an area at that level?

MR SMITH: I'm sorry, I don't actually have that data off the top of my head.

MR GRAY: That's all right. How many aged care planning regions are there?

MR SMITH: 73.

MR GRAY: And there might be a number of statistical area level 3 areas within any given aged care planning region.

MR SMITH: That's right, and I will confirm for you, but I think it is in the order of 300 or so SA3s in the country and I actually think in my statement in a footnote we have that number.

MR GRAY: Thank you. So there's quite a detailed process which you explain in your statement for analysing the needs in particular areas, sometimes down to the SA3 level.

MR SMITH: Yes.

MR GRAY: And that's done by reference to census information from the ABS; is it?

MR SMITH: Yes, that's right.

MR GRAY: I will just go on to refer to some of the other recommendations in the Tune report and just to ask you about whether you're best placed to answer them - - -

MR SMITH: Sure.

MR GRAY: - - - answer the questions about those recommendations or whether you can shed light on them. Recommendation 22 is the next one. Again, that's not one of the recommendations you identified as directly relevant to diversity but I suggest it might be indirectly relevant in the same way as the proposal for a change to the ACAR system for residential care might be as well. Recommendation 22 is about improving functionality and performance of My Aged Care ICT platform. What does ICT stand for?

MR SMITH: Information and communication technology.

MR GRAY: Is that about interoperability of IT systems between different entities?

MR SMITH: Well, I think there's a couple of parts to that recommendation. One is just to improve the My Aged Care platform generally, but I do see there in that recommendation it talks about information sharing between My Aged Care and other government agencies. So that would go to interoperability, yes.

MR GRAY: And provider ICT systems.

MR SMITH: Yes.

MR GRAY: Thank you. Now, whose responsibility is it to address that issue? Is that Dr Hartland or is that yourself?

MR SMITH: It's not me. It will be Dr Hartland although I suspect with a broader role for the Department of Health's IT area.

MR GRAY: All right. I will see if Dr Hartland can help on that. Recommendation 23 is one that you did identify as relevant to your diversity responsibilities. It's concerning the introduction of an aged care system navigator and outreach services. It's mentioned in your list, as I said. Whose responsibility is it – sorry, I think I said

a minute ago you mentioned it as one of your responsibilities. I'm not sure that you did that, you just said it's relevant to diversity. Who should I direct questions about aged care navigator and outreach services to, yourself?

MR SMITH: That's to me, yes.

MR GRAY: Yes. Thank you. Recommendation 30 is one that you didn't mention but you've already identified Dr Hartland as a person who should be knowledgeable about the NSAF. There has been a review of the NSAF in 2018, hasn't there?

MR SMITH: Yes.

MR GRAY: But in any event I can ask him questions about that.

MR SMITH: Yes.

MR GRAY: Recommendation 31, I'm not planning to spend a great deal of time on this, it's actually a topic that has come up in other hearings of the Royal Commission but there was a recommendation to government to expand the NATSIFlex or the NATSIFACP program and that, in fact, has happened in the most recent budget. There has been an announcement of expansion of that program; that is right?

MR SMITH: The announcement was in the '18/19 budget and funding was appropriated and we've run two funding rounds against that program in that time. So there's another couple of rounds to go over the next couple of years but, yes, the expansion has occurred and is occurring.

MR GRAY: My apologies. The previous budget.

MR SMITH: The previous budget, yes.

MR GRAY: Yes. And recommendation 33:

> *That the government review whether further ways of assisting the delivery of improved services to homeless people are needed in the context of reform to home care and residential care.*

Is that your responsibility?

MR SMITH: Yes. This is one that does sit across the group, and it's one on which we do consult across the group. But yes, I have responsibility for homeless as well.

MR GRAY: Thank you. When you say across the group, Dr Hartland's division could also have responsibilities.

MR SMITH: Yes, indeed. Indeed yes.

MR GRAY: And recommendation 35:

> *That the government give consumers the opportunity to identify as belonging to a population group with special needs as part of their client record.*

I asked you a high level question about that a short time ago. Who is best placed to answer that; is it Dr Hartland?

MR SMITH: From a functionality perspective in terms of what can actually happen in My Aged Care on entry into the system, yes. The policy around that is probably a broader one that does sit across the group.

MR GRAY: Is that accepted as good policy, that the government should give consumers the opportunity to identify as belonging to a population group with special needs as part of their client record?

MR SMITH: Yes. To qualify that with when and how that occurs on a person's journey into the system is important to consider.

MR GRAY: It should be as early as possible and thereafter as often as possible, shouldn't it?

MR SMITH: Yes, it should be as early as possible in a way that works for that particular client, recognising when we're talking about special needs groups, some of those groups have – people in those groups have experienced significant trauma or discrimination or issues in their past, which the very first phone call to My Aged Care might not be the best place to engage in that conversation.

MR GRAY: Yes. So is it policy in the Department that that conversation should occur face-to-face?

MR SMITH: I'm not sure that that's policy in the Department as such. My personal view on that is that, yes, that's how that should occur.

MR GRAY: And is the setting in which that is intended to occur the assessment whether by a Regional Assessment Service or an Aged Care Assessment Service or team?

MR SMITH: Yes, that's how I would see it operating, yes.

MR GRAY: And is it there that the NSAF form plays an important role in prompting those questions being asked; is that right?

MR SMITH: That would be the mechanism to do that, yes.

MR GRAY: And do you have knowledge about the extent of the training of members of the RAS teams and the ACAS and ACAT teams to ask those questions in both a culturally safe way and in a trauma-informed manner?

MR SMITH: At a general level, I understand – sorry, my knowledge is at a general level. I understand that there is training that does go specifically to the special needs groups but also to the question of dealing sensitively with people irrespective of their background or life experiences in terms of identifying particular vulnerabilities that might determine a particular pathway for them through aged care.

MR GRAY: So using different words but are you saying that there is training on asking those questions in a culturally safe way and in a trauma-informed way?

MR SMITH: That's my understanding, yes.

MR GRAY: Right. And who is best placed to answer that question?

MR SMITH: Dr Hartland on the detail, yes.

MR GRAY: Dr Hartland. Thank you. And recommendation 36 is – you've addressed this in part in your statement so I assume it's part of your responsibilities but I'm not sure. It's a recommendation:

> *That the government enhance the capacity of My Aged Care to provide information that meets consumers special needs by allowing pre-qualified –*

and that's in inverted commas –

> *...providers to indicate that they have expertise in delivering services to particular population groups and adding a search function.*

Now, that has actual happened. We know that there has been functionality added to My Aged Care by which a provider can nominate a specialisation, for example, a language. And other examples might be LGBTI. And that that is searchable; that's correct, isn't it?

MR SMITH: Yes, that is correct, yes.

MR GRAY: What about the aspect of pre-qualification before a provider is allowed to do that. I think you say in your statement that that hasn't been addressed; is that right?

MR SMITH: That's correct, it hasn't been addressed.

MR GRAY: It hasn't been addressed. I mean, you've addressed it in your statement so I suppose I will be addressing questions to you on that topic. Is that better addressed to you than Dr Hartland?

MR SMITH: Yes, except to the extent that he has the broader responsibility for, again, the functionality within My Aged Care that would make that possible.

MR GRAY: All right. But you are responsible for the policy as to whether it should happen?

MR SMITH: Yes, yes.

MR GRAY: And what is policy within the Department on whether there should be pre-qualification, that is, some form of verifiable pre-condition met before a provider should be allowed to represent that they have specialisation?

MR SMITH: The Department agrees that we need to do a lot more to be able to quality assure the information that is on My Aged Care in terms of providers indicating that they're able to service particular special needs groups. What the nature of that pre-qualification would be is something that we haven't yet resolved, whether it's a formal accreditation or a way in which providers can provide additional information on My Aged Care that could point to the particular resources they have in their organisation. So in principle, absolutely. It's – it's – the quality assurance of that information is very important to the Department and it does – it is set out in a piece of work that the Department is doing with the diversity subgroup of the aged care sector committee to specifically look at what could be done there.

MR GRAY: But at the moment, this is, I suggest, contrary to the gist of recommendation 36. At the moment, the Department has enabled the functionality on My Aged Care of a claim to be made, that a provider is a specialist, without the important qualification that Mr Tune had in paragraph (a) of recommendation 36 that only pre-qualified providers be able to make that representation. Do you agree with me?

MR SMITH: Yes, I agree that that hasn't happened, yes.

MR GRAY: And that's really contrary to recommendation 36?

MR SMITH: I'm not sure that I would say it is contrary. I think that we are stepping along a path of giving consumers better information. I absolutely accept that quality assurance of that information is critical and that we haven't done that yet.

MR GRAY: All right.

COMMISSIONER BRIGGS: Are you going to do it?

MR SMITH: Yes.

COMMISSIONER BRIGGS: Good. Thank you.

MR GRAY: When?

MR SMITH: So the Department is working with the diversity subgroup on this issue about what the options would be. The first step there was to put some guidelines up in relation to some of the specialisation categories there and those guidelines are in place. They're being monitored but it is the view of the diversity subgroup that we need to do more around some specific links to demonstration of a capacity to deliver services to those groups. That work is underway with the diversity subgroup. It's a feature of each meeting as we go through with that group. So I can't put a specific timeframe on it but it is a priority work – piece of work, rather.

MR GRAY: Are you involved in those interactions with the Diversity Sub-Group of the Aged Care Sector Committee?

MR SMITH: Not usually directly. One of my branch heads attends those meetings.

MR GRAY: All right. Does the branch head do it under your direction and supervision? That is, do that process of consulting with the subgroup under your direction and supervision?

MR SMITH: Yes. That's correct.

MR GRAY: All right. Now, I don't know whether you've had a chance to read transcript from earlier evidence in this hearing, but, on Monday, three members of the Diversity Sub-Group gave evidence, including about the development of action plans in 2018 – and this was not specifically on the topic of developing verification processes for claims of specialisation, but it was on the action plans that – the three action plans that exist for specific special needs groups. And in the course of that evidence, the members of the subgroup who were present in the Royal Commission gave evidence to the effect that the sector represented by the three peak organisations had been resistant to mandatory requirements being included in the action plans.

MR SMITH: Yes. That's correct.

MR GRAY: Yes. Would you expect a similar reaction if there's industry consultation about any suggestion that there be mandatory requirements around verification of claims of specialisation?

MR SMITH: It's hard to say what exactly the industry reaction would be without having done that consultation. There always be, I suspect, industry concerns about additional red tape or work that might be involved. We would obviously be needing to consult with the sector in relation to that.

MR GRAY: When you were giving some evidence before about the way in which the concept of pre-qualification might be addressed, you gave two possibilities. You said some form of formal accreditation or a functionality to permit the approved provider to provide more information about what underlies the representation of specialisation.

MR SMITH: Yes.

MR GRAY: Remember – you gave that evidence?

MR SMITH: Yes. I did. Yes.

MR GRAY: I suggest to you that the second of those options isn't actually within the spirit of a pre-qualification; it's simply a provision of more information. What do you say to that?

MR SMITH: Yes, I'd accept that.

MR GRAY: So I think you said a minute ago that there hasn't yet been any consultation with the peaks or the sector about any of the work of the subgroup on this issue of verification of claims of specialisation.

MR SMITH: So if I can just qualify that - - -

MR GRAY: Yes.

MR SMITH: I'm not aware specifically of the consultations with the provider peaks in relation to that. It's very possible that the subcommittee has had formal or informal discussions along the way. But specific options haven't yet been developed to consult on. So if that's occurred, it would have been at a reasonably high level at this stage, I suspect.

MR GRAY: All right. Are you able to say what your position on behalf of the Department would be if the peaks are resistant to a formal mandatory requirement for some form of accreditation of claims of specialisation?

MR SMITH: I'd need to work through some of this with colleagues across the aged care group, in terms of establishing a formal department position. My view is that the information needs to be better and it needs to be more verifiable. Whether it can be a formal accreditation, I'm not sure what the logistics of that would look like or how that would work, who would undertake pre-qualifications and things like that. So I – without, sort of, understanding that, I find it difficult to, sort of, confirm specifically that that's where the Department would land. Irrespective of that, a way to have quality assurance that is meaningful and actually does point providers – sorry, point consumers to providers that can provide services to meet their needs is an important part of this process.

MR GRAY: Ms Samantha Jewell of Lifeview gave evidence on Monday that there are no checks and balances about claims of specialisation of, in particular, LGBTI. And you, in your statement, say there's no evaluation of those claims; is that right? Are both – I'm sorry. Do you know of Ms Jewell's evidence? Have you read that transcript?

MR SMITH: I haven't read the transcript. I'm aware of the evidence broadly, yes.

MR GRAY: All right. She said any provider can tick the box in the back end that states they are LGBTQI inclusive. There are no checks and balances on that. Do you agree with that?

MR SMITH: Yes.

MR GRAY: And in your statement you've said to a similar effect, that there's no evaluation of those claims.

MR SMITH: Yes.

MR GRAY: Mr Panter gives an example in his witness statement, at paragraph 18, suggesting that the Rainbow Tick would be an appropriate way of, in effect, accrediting claims of LGBTI inclusiveness on My Aged Care. What do you say to that?

MR SMITH: I'm aware that Rainbow Tick is a well-regarded accreditation tool for providers to demonstrate their understanding and ability to provide services. So I accept that if a provider had that accreditation, that that would be an indicator of their capacity.

MR GRAY: By extension, it should be possible, shouldn't it, for each of the special needs groups to make connections with well-regarded organisations that are able to do the work, to form a view as to whether a particular service is inclusive of the particular special needs group and, in effect, contract out the accreditation function to those groups. Is that not an appropriate approach that could be adopted to this issue?

MR SMITH: I absolutely agree that any provider should be able to reach out to groups that are, you know, specialists and experts in supporting special needs groups in – from a training perspective or developing information materials, and that they, indeed, should be doing that if they're providing services to those groups of people. Whether that extends to a formal accreditation is not something I can speak to at this point without understanding, as I indicated before, the logistics of that process, what that would actually look like in practice from a seeking the accreditation perspective through to the verification of that and what that would look like and, indeed, the functionality in My Aged Care. I do accept that it's an issue that does need to be seriously looked at.

MR GRAY: And urgently, doesn't it? Because, at the moment, the claims are just out there on My Aged Care without the important condition that was contemplated by Mr Tune.

MR SMITH: Yes, I agree it needs to happen quickly.

MR GRAY: Now, I just want to ask you about the three modalities of care and some specific questions about catering for diversity under each of those modalities. So start with CHSP, which is the entry-level modality for care in situ in the home and in the community; correct?

MR SMITH: Yes.

MR GRAY: And you deal with a question the Royal Commission raised by notice around the analysis of needs for people receiving services from CHSP providers. At page 19 of your statement through to page 21 of your statement – so that's paragraphs 70 to 72. And you say that – the passage is right at the foot of – yes. Thank you, Operator. Right at the foot of page 19. You say that the Department identifies current demand for services, including the specific needs of the ageing population in different geographical regions, through a combination of data analysis and consultation. And then you identify the particular sources of the information for that analysis.

MR SMITH: Yes.

MR GRAY: And you then refer to specific things that have been done in the CHSP area to cater for certain diverse needs.

MR SMITH: Yes.

MR GRAY: The gist of the framework for catering for diversity in connection with CHSP is that CHSP providers, as a condition of their contracts with the – are the contracts with the Department directly or are they through DHS?

MR SMITH: They're with the Department managed by the Department of Social Services, Grants Hub.

MR GRAY: Sorry.

MR SMITH: Yes.

MR GRAY: DSS.

MR SMITH: DSS. Yes.

MR GRAY: Thank you. But they are contracts with the Department of Health?

MR SMITH: Yes. Yes.

MR GRAY: Yes. And as conditions of those contracts, is it the case that the CHSP provider is required to comply with a contractual version of the quality standards?

MR SMITH: Yes.

MR GRAY: And so that includes catering for diversity in line with the requirements in the quality standards?

MR SMITH: Yes. Yes.

MR GRAY: However, you say in paragraph 41, a little earlier in your statement, on page 11, that CHSP providers are not required to report specifically on their obligations in relation to people with special needs.

MR SMITH: That's correct.

MR GRAY: Just putting CHSP aside for a moment, under the other modalities of care – are providers required to report specifically on their obligations in relation to people with special needs, under those other modalities of home care packages and residential care?

MR SMITH: Not to report. The reporting reference here relates to a contract, and that's – it works differently in home care and residential care. But that requirement is assessed by the Quality and Safety Commission, as part of the accreditation and re-accreditation process.

MR GRAY: All right. So there's no proactive reporting obligation; it's a matter of what happens when the Quality Commission audits or otherwise assesses compliance with quality standards.

MR SMITH: Correct. And speaking specifically for residential care, then, yes, that's the case. I don't – I'm not aware that there's reporting in home care, but I would have to refer to Dr Hartland on that.

MR GRAY: Okay. Now, just above that paragraph, there's a table. And in that table there's a fairly high-level description – have I got this right? It's a description of, essentially, the percentages of clients in a particular special need group that a particular service provider in the CHSP program provides services to. In cases where there are more than 50 per cent either Aboriginal and Torres Strait Islander peoples, CALD or veterans, that particular service has somehow reported that to the Department? But there isn't any information about the actual gross numbers of clients in this table. There's just information about the numbers of service providers who have reported that particular percentage representation of those special needs groups amongst its client cohort. Is that right?

MR SMITH: Whether it – I'm not sure of the data collection, I'm sorry. Whether it's reporting by providers or whether it's, sort of, data capture through the data exchange that DSS manages or through the RAS process, for example – the assessment process – I can't speak to how that information is there, but, yes.

MR GRAY: Right. And there are – it says in the footnote, footnote 11, at the foot of page 11, that:

Data are based on 1456 organisations funded in the financial year before last.

Which is the most recent for which we've got completed data in most cases, as I understand it.

MR SMITH: Yes.

MR GRAY: And so the gross numbers of services that are appearing in the three columns to the right of the table, they represent a proportion of those 1456 organisations. And so, for example, you can say that, when you look at the CALD column, where there are 50 per cent plus as the proportion of providers' clients in special needs group who are CALD, there are 155 providers for whom that is true, and that's about 11 per cent of the total of 1456 organisations. And so that's why you've said, in paragraph 39 of your statement, for example, 11 per cent of CHSP providers report that the majority of their clients are Aboriginal and Torres Strait Islander people. I beg your pardon. I got the 11 per cent wrong. I'll start that again.

The column is setting out a number of providers, and there's just been a raw comparison of that number, compared with the total 1456 organisations, and you've, in paragraph 39, done a percentage exercise comparing number of service providers appearing in the column with the total number of service providers, 1456 organisations. Is that how you've derived those percentages?

MR SMITH: Yes.

MR GRAY: Thank you.

MR SMITH: Yes.

MR GRAY: Now, I suggest to you if that's the case the table isn't really telling us anything useful about the actual numbers of clients. Do you agree with that?

MR SMITH: Yes. Could I just clarify something from a statement I made earlier?

MR GRAY: Yes, of course.

MR SMITH: When I just sort of wasn't sure how that data was extracted; when you brought up the footnote I see that it is data reported by providers to the data exchange. So just to clarify that.

MR GRAY: Thank you. So if we don't know anything about the actual numbers of the clients, doesn't it follow that the Department is not in a position to evaluate the effectiveness of the CHSP program in meeting the true demand for CHSP services amongst diverse special needs groups?

MR SMITH: Yes, that is a gap and if I could qualify, again, that Dr Hartland has carriage of this program so I want to be careful in terms of the level of detail I'm qualified to provide in relation to this.

MR GRAY: Okay.

MR SMITH: But the reports that come back from providers to DSS report on their outputs in their aged care planning regions and they're not broken down by – as into sort of number of hours to – to clients, it's not broken down by particular special needs groups.

COMMISSIONER PAGONE: Putting to one side the questions of detail, as a matter of policy the government requires an obligation of some provider but doesn't seem to monitor whether the obligation that it has required has been met. How, as a matter of policy, is that defensible?

MR SMITH: Commissioner, I would say it's not defensible. There is work that is underway. The Commonwealth Home Support program has been extended to 2022. The next round of contracts are due to be executed by the middle of 2020 next year. A project has been running for the last month or so to look at – to map the various obligations providers have in their agreements and the obligations that are set out in the CHSP manual to identify where additional reporting would be required to gather more information. So I accept your proposition and it is something that is being worked on.

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you. I just want to go back before leaving CHSP to the origins of CHSP which you have indirect knowledge about, having familiarised yourself with the history of the aged care system. You remember my question to you earlier, the CHSP is in fact the inheritor of a number of separate and different arrangements in the various states, particularly the HACC, the HACC program as it existed in its particular forms in the various states and territories.

MR SMITH: Yes.

MR GRAY: As the person with policy responsibility in relation to meeting diversity, did you consider that the fact that the Commonwealth has inherited these disparate arrangements, provides in a way, a laboratory for you to assess the effectiveness of particular arrangements in the particular jurisdictions, because there are quite material differences in the way CHSP, previously HACC, is delivered in the various states. Did you consider that in taking over your responsibilities for policy design to meet diverse needs?

MR SMITH: No, I didn't consider that specifically. That is something that the program managers are looking at and through a data study that has been – that is being undertaken through Deloitte to try and gather information about what is

happening across the country in terms of CHSP demand for different CHSP clients including people with – from the diverse – sorry, from the list of special needs groups.

MR GRAY: And is that work evaluating the effectiveness of CHSP as it exists in each jurisdiction in meeting diverse needs?

MR SMITH: I'm sorry, I would have to defer to Dr Hartland on the detail of that, I'm sorry.

MR GRAY: Perhaps this is also a question for Dr Hartland, but in Victoria there's, as an element of CHSP, a program called Access and Support, 70 per cent funded by the Commonwealth, 30 per cent supported by the State. Do you know about the Access and Support program?

MR SMITH: I don't, I'm sorry.

MR GRAY: All right. The next modality is home care. Now, before the legislated review in 2017 by Mr Tune, before that was completed, a reform already occurred to the mechanism for assignment or allocation of subsidy in the home care program and, as you confirmed a little earlier in your evidence, the nomenclature changed from place to package. That change occurred in February 2017 and, as you confirmed a little earlier, as from that time it's no longer a centrally planned allocation; it's an assignment to the care recipient, and the care recipient receives the benefit of the package by nominating a particular home care provider and the funds represented by the package are remitted to that provider on behalf of the recipient and, in effect, kept in a monthly statement, kept track of in a monthly statement between the provider and the care recipient. Is that right?

MR SMITH: Yes, that's right.

MR GRAY: Now, that was a very major change in February 2017. Before that, the most recent allocation round or ACAR round was for 2015/16; is that right?

MR SMITH: I believe that's right, yes.

MR GRAY: We have got available in the tender bundle the Essential Guide to that ACAR round. It's at tab 59. I will ask the operator to bring that up. What is the Essential Guide, by the way?

MR SMITH: The Essential Guide is the material that is provided to providers to assist them in filling out their ACAR applications. It describes the way in which the assessment will occur and any particular features of that particular ACAR process such as prioritisation that might be in place.

MR GRAY: Thank you.

MR SMITH: It's quite a detailed document.

MR GRAY: Yes. And you've given evidence, particularly in your first statement, about that and about how it's processed in practice through various assessment steps leading to a decision under delegation by yourself about the allocation of the places by the secretary.

MR SMITH: Yes, that's right.

MR GRAY: Now, I might just need some technical assistance; I might have given the operator the wrong tab number. Tab 59 of the general tender bundle. Thank you. CTH.0001.1001.3840. Perhaps we don't have that document. I will come back to that, if I need to. In a nutshell, the – thank you, I will just ask you to go, operator, to 3914. Thank you. There's an arrangement of this essential guide. It is, as you say, very long and detailed. There's an arrangement of it into chapters. This chapter deals with regional distribution of places along the lines of the process you identified in a general way in your evidence 10 minutes or so ago.

MR SMITH: Yes.

MR GRAY: If we go to 3915 there's a note about the special needs groups and the acronyms that they're given or the abbreviated codes that they're given. And if we go to, for example, looking at Tasmania at 3929, we see that there's quite a deal of specificity, 3929; we see that there's quite a deal of specificity about the special needs groups that are going to be given priority in the allocation of the places both in terms of residential aged care and, remembering that this is back in 2015, in terms of home care places. Is that a correct interpretation of what we see on the screen at page 3929?

MR SMITH: So, if you can just bear with me for a moment because I haven't seen this before.

MR GRAY: Sure.

MR GRAY: Let's take Tasmania home care places, north-western region, so that's the top row of the bottom table on that page. It seems to be saying that there's going to be 57 home care places allocated in that region.

MR SMITH: Yes.

MR GRAY: And they're going to be distributed along the lines of the preceding columns, level 2, 3 and 4, there's a distribution of different numbers.

MR SMITH: Yes.

MR GRAY: And that special needs groups for level 2 and 4 are going to be rural and regional, and financially and socially disadvantaged; and for level 3 are going to

be rural and regional, financially and socially disadvantaged and LGBTI, for example. Sometimes you get even more detail, for example, in the southern region; statistical area level 2s are identified within that region, and that's not to gainsay what you said about statistical area level 3, that's probably relevant under the present Essential Guide.

MR SMITH: Yes, that's correct, yes.

MR GRAY: Back in 2015 it was at level 2.

MR SMITH: Yes.

MR GRAY: So there's a lot of attention being given, I suggest, to a distribution to meet some form of analysis of demand on the part of special needs groups in the process for allocating home care places.

MR SMITH: Yes.

MR GRAY: Now this is a process that still applies to residential care place allocation but it no longer applies to home care place allocation.

MR SMITH: That's correct.

MR GRAY: And I will come back to resi care very shortly but with the national prioritisation system that now applies for the allocation of home care places, there's no attention given to special need per se; is that right?

MR SMITH: Not, not in the allocation of the package, no.

MR GRAY: Okay. So as a matter of policy design in relation to meeting diverse needs, with the advent of marketisation of the delivery of home care places under what's called consumer-directed care, rather than this central allocation process, what's taken the place of this careful attention that was given to meeting the diverse needs of special needs groups on a regional basis in the allocation of home care places?

MR SMITH: So I am not responsible for the home care program and I don't have detailed knowledge of the design that underpinned that. It's – I can only refer to David Tune when he makes a similar recommendation in relation to the residential aged care process; that I guess the market-based approach would encourage innovation and encourage competition and equality that would draw in different consumers for different particular needs. But I can't really comment beyond that, that broader observation that he made.

MR GRAY: Well, let's just think about that and think about the UTS work that you mentioned a short time ago about impacts.

MR SMITH: Yes.

MR GRAY: That is, impacts that might occur if the allocation process for residential care places goes the same way as the change in mechanism for allocation of home care places. These are vulnerable groups by definition. Some of these groups are very likely to have high levels of trauma. Some of them are going to be very ill-equipped to be able to process the information necessary to make the kinds of consumer decisions that would result in a functioning market. Do you agree with that?

MR SMITH: I do agree with that.

MR GRAY: Is that going to be considered in the formulation of any policy to move from centrally planned allocation of residential care places to a market – to a national prioritisation system for residential care places?

MR SMITH: Yes, absolutely.

MR GRAY: And what's the shape of the mechanism that's going to address special needs, are you able to say or is it too early?

MR SMITH: It's too early to point to what that mechanism would be. We really are at a point where government is yet to even make a decision – yet to even consider the report about what whether this is something we would like to head down. I'm not sure whether the report – the extent to which the report goes to those details of special needs groups but I obviously look forward to seeing that when it's available. So it is too early to say that specifically but it would absolutely have to be part of the design of a new process, a new system.

MR GRAY: It has absolutely got to be part of the design and process in a new system and that's why you have got UTS looking very, very carefully at it; is that right?

MR SMITH: UTS is looking at the entire concept broadly. So I – and as I indicated, I'm not sure of the extent to which their report will address those specific issues. But this is the very, very first step of heading down this path and if it is decided to head down that path then there is a lot more work to go in terms of actual design of a market-based system and a consumer-directed care system including how – and in my very strong view including how special needs groups will be picked up in that.

MR GRAY: It would be irresponsible, wouldn't it, to implement a major reform to the allocation of places from centrally planned to consumer-driven without doing all of that groundwork, and working out what the mechanism should be to cater for diverse needs; is that right?

MR SMITH: I refer back to the overarching objectives of the Act which is that all people irrespective of background, race, culture, identity or economic circumstance

should have access to aged care that meets their needs, and my response to that is the design of a change to residential care should occur with that in mind.

MR GRAY: You don't like the word "irresponsible"; it would be irresponsible to implement a change of that kind without doing that work?

MR SMITH: I don't characterise it as irresponsible. I'm saying that it's incumbent on me as the person responsible for residential care to have reference back to the overarching objectives of the Act which is protecting those people who need protection. The design of the system for the allocation of places for residential care where, as you pointed out, people are at their most vulnerable, must take account of that.

MR GRAY: Okay. Well - - -

COMMISSIONER PAGONE: And have you got some idea about how that might be done?

MR SMITH: I'm sorry, Commissioner?

COMMISSIONER PAGONE: Have you got some idea about how that might be done?

MR SMITH: I think there's a lot of work to do and I'm now just giving an opinion as to the sorts of things we would look at. I'm – the approved provider process may be a way in which you would seek to address that. That's a process by which providers apply to be able to deliver government-subsidised aged care services. There may be a role in that process, in terms of the approval having particular requirements or linkages to special needs groups in the absence of the ACAR being able to do that. That's very top of mind and one of, I imagine, many things we would need to be looking at.

MR GRAY: Thank you. Mr Smith, you were asked a question in the notice that was issued to you about whether the ACARs were effective in meeting special needs. I'm paraphrasing, but you recall that?

MR SMITH: I do.

MR GRAY: And I direct you to your second statement at paragraph 61 to 64 where you refer to that matter and you also, in that passage, refer to your previous statement. Perhaps I should say 61 to 63. And the question that was posed was – I beg your pardon, if we go to page 21, a little further on, the question that was posed on page 21, paragraph 14 was:

> *Does the department consider that allocation of places to people with special needs through the ACAR is an effective way of responding to the needs of these groups.*

And then there was a follow-up question. And your answer was somewhat qualified, if I may say so, in paragraph 74. You said:

> *The department considers that a system-wide level the ACAR process is an effective way of in effect creating an incentive.*

Do I take it from the answer you have given there that there hadn't been an evaluation of how effective the prioritisation process under the ACAR was in meeting the needs of diverse groups?

MR SMITH: So if I can respond to that in a couple of ways. I guess just back with reference to the question that I was asked there, is it an effective way of responding to the needs of these groups, I guess the point being it's one part of the way in which that occurs.

MR GRAY: Yes.

MR SMITH: So it's not the only way in which that occurs but ,yes, the case is it's difficult to monitor. We haven't been able to effectively monitor the way in which the allocation of a place for, or places for people with special needs converts to the actual use by those special needs, primarily due to data deficiency.

MR GRAY: So does that mean there's no linkage between – what's the reason for that data deficiency; what's the particular omission that means you can't gauge the extent to which the special needs are being met? Is it because you don't know the extent of the special needs to begin with?

MR SMITH: We don't have a lot of detail about people having identified or being identified as belonging to particular special needs groups which does make the monitoring of that difficult.

COMMISSIONER BRIGGS: Might I ask, in the past, given some of the earlier evidence, did you monitor these arrangements then before the more strongly market-focused orientation; do you know, Mr Smith?

MR SMITH: No, Commissioner, there hasn't been to date.

COMMISSIONER BRIGGS: All right. Thank you.

MR GRAY: So are you saying that this elaborate centrally planned allocation exercise is going on and has been going on, presumably at great expense and in a very resource intensive manner without there being any notion on the part of the Department as to whether it's effective in meeting the needs of diverse groups?

MR SMITH: I guess what I'm saying is that, yes – well, I have indicated that we haven't been able to monitor it and that I will point out and say this point is something that we are looking to address. It is, and has been, intended as an

incentivisation for providers to understand the local need, noting that applications that focus on special needs groups would be prioritised in an ACAR process. The application process itself requires a demonstration of quite a lot of evidence. The Essential Guide sets out the sorts of things providers would need to demonstrate including their linkages to local organisations and groups that could assist with training and information provision, and indeed the assessor's manual gives assessors quite a lot of guidance as to what to look for in terms of this, so I – what I totally accept is we don't have visibility of how that translates in the sector but it is intended as an incentivisation to consider the local need.

MR GRAY: All right. So there's a supposition that because the incentive is created that it must have some effect. Is that a fair description of why the Department has been conducting this elaborate central allocation exercise?

MR SMITH: Yes, that it has some – that it has effect, yes.

MR GRAY: All right. So there's a supposition that an incentive creates a beneficial effect. That then underlines the importance of the evidence you've given about whether there's any follow-up concerning compliance with conditions that are imposed on approved providers attaching to places that they've been allocated on the strength of a representation that priority will be given to a special needs group.

MR SMITH: Yes.

MR GRAY: And what is your evidence on that; is there any follow-up?

MR SMITH: In relation to the special needs groups, no. there is not, there is not monitoring. I will point out it is a priority of access, not a guarantee of access.

MR GRAY: Sure. But that could still be – compliance with giving priority could still be monitored, couldn't it?

MR SMITH: I agree it should be monitored. It hasn't been. The mechanisms haven't been developed to do that. It is a priority for consideration of the next ACAR, whenever that is, to take that into account and have a look at the way in which conditions of allocation are applied, and the mechanisms that might exist to allow for better monitoring and compliance in relation to those.

MR GRAY: Well, I mean this is, with respect, a little extraordinary, isn't it? The supposition must be that there's a carrot offered, an incentive offered to approved providers to focus on special needs groups. The quid pro quo for which will be they get allocated more weight in the allocation of ACAR places if they promise to give priority to a particular special needs group in a particular region in return for getting those places in that region; correct?

MR SMITH: Yes.

MR GRAY: And yet there has been no follow up at all ever in terms of monitoring whether the approved providers have actually been following through with that promise; is that right?

MR SMITH: No – no sort of systemic follow-up, that's correct. I'm advised anecdotally that from time to time state officers who have relationships – sorry, the health grants network in the Department that does have relationships on the ground may be advised of concerns and will have discussions with providers. But there's no – no systemic follow-up has ever occurred; I agree with that.

MR GRAY: Well, you have come on board in November 2017 and I'm sure your agenda has been a very full one, but have you given this omission priority since that time in the exercise of your functions as First Assistant Secretary?

MR SMITH: I – I have and am. The last ACAR that was held, the '18/19 ACAR was well in planning when I started in the role, and it was resolved in – I think announced in March this year, March 2019. I was shortly thereafter also presented with a series of questions from the Commission about the way in which the ACAR process operates and it gave me an opportunity to really look in detail at the way in which, having just been through an ACAR process and signing off the results of that, and then sort of doing a forensic on the way the process works from start to finish and have absolutely identified that as an issue. And I have asked my team, who is in the process of preparing the next lot of advice to government about the next ACAR, to look at the way in which conditions of allocation are applied.

MR GRAY: Well, there's a lot of looking at and advice in what you've just said, with respect. Can you give a guarantee to the Commissioners that in the next ACAR round there will be conditions imposed which are going to be verifiable after the event to ensure that providers are held to their promise to give priority to special needs groups, in the event that they obtain a place on the strength of such a promise?

MR SMITH: It's my commitment to the process and I can give the commitment to the Commissioners that it is a priority for the next ACAR to make sure we have a much more robust process in place in terms of follow-up conditions of allocation for special needs groups.

COMMISSIONER BRIGGS: Is it your responsibility to decide on that, Mr Smith, or would it be the Minister's or the secretary's?

MR SMITH: I'm the delegate of the secretary in relation to the allocation of places.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: Now, there have been gaps in data identified in your evidence, Mr Smith. This is not actually a new topic, is it; it goes back some time, probably pre-dates the Tune report but it certainly got a lot of attention in the Tune report as well, didn't it?

MR SMITH: Yes.

MR GRAY: The Tune report contains quite a lot of narrative on the need for a mechanism to maintain visibility of how care is being provided to what Mr Tune called the different population groups, the vulnerable groups or the special needs groups. I'll just ask the operator to bring up the Tune report again. It's exhibit 1-35, RCD.9999.0011.0746. This is a passage I'm going to take you to that's, again, in the chapter 9, the equity of access for diverse groups chapter. At page 0915 – it should come up soon – Mr Tune refers to a lack of data for a number of groups for assessing whether and to what extent – 0915. Thank you.

> *…whether, and to what extent, their backgrounds or circumstances prevent them from being able or willing to access aged care.*

He said, back when he was doing this review two years ago:

> *In many cases, it has therefore been difficult to assess to what extent the LLLB reforms –*

the Living Longer Living Better reforms –

> *have impacted access to aged care.*

And he made a specific recommendation, didn't he, that consumers should be given the opportunity at the point of assessment to indicate that they belong to a population with particular needs?

MR SMITH: Yes.

MR GRAY: You were asked – that was recommendation 35. You were asked about that question at question 49 of the notice issued to you, which you've extracted in your statement, conveniently, at page 0060. And I'm just going to suggest to you that you didn't really answer that question. Feel free to correct me, if you can, but what you did in response to that question, which was a question about progress in, in effect, implementing that recommendation, recommendation 35, giving consumers the opportunity to identify as belonging to a population group as part of their client record, you said:

> *The government supported recommendation 35.*

This is at the foot of page 60.

MR SMITH: Yes.

MR GRAY: You said it went into that same budget package that you mentioned a little while ago in your evidence - - -

MR SMITH: Yes.

MR GRAY: - - - 2018/19.

MR SMITH: Yes.

MR GRAY: And you said there's provision – or allocation in that package for improvement of My Aged Care, and you referred to your response to questions 19 and 20. Now, your response to questions 19 and 20 are at pages 61 – no, that's not right. Sorry. 24 to 28. And you don't say anything specific in those answers on pages – in that passage from 24 to 28, about - - -

MR SMITH: I'm sorry, are we at paragraph references here or - - -

MR GRAY: Sorry. Well - - -

MR SMITH: Or page references?

MR GRAY: Page 19 - - -

MR SMITH: Sorry.

MR GRAY: Yes. I'm sorry. Because you – if we look at page 25, about halfway down the page there's a heading Accessibility. And under that heading, there's question 19.

MR SMITH: Yes.

MR GRAY: And then there's a passage that goes for a page or so that identifies a number of resources, tools and initiatives. But it doesn't identify anything allowing a client to record membership of a particular vulnerable group. It's more about programs that are going out to the consumer. And then at 20 – that's on page 27. At question 20, there's a question about how is the information on the My Aged Care website compiled. And there's that question about does the Department assess the veracity of the information.

MR SMITH: Yes.

MR GRAY: Of course, we've just addressed that earlier in your evidence, I won't go back to that. But my point here is that there's then a passage responding to that question, which doesn't identify any actions for consumers to be able to record, as part of their client record, membership of a particular vulnerable group with which they identify. It's, again, rather, about information that's on My Aged Care going out, to be available to consumers. So you haven't answered the question, with respect, about what's the extent of progress - - -

MR SMITH: Yes.

MR GRAY: - - - in this recommendation.

MR SMITH: Yes.

MR GRAY: In implementing this recommendation.

MR SMITH: Yes.

MR GRAY: Has there been any?

MR SMITH: So – and I apologise for not answering the question, if that's the view. I'm – my understanding is, and I will – Dr Hartland will be able to fill in some more detail here as well. There are a number of special needs groups that are able to identify on My Aged Care, either specifically or because of other things about them, like where they live – we know rural and remote, and we also have information around financial disadvantage, through means testing. So there are a range of those special needs groups that can identify on the way in. And then through the National Screening and Assessment Form, there are specific questions which go to those same special needs groups, as well as the other special needs groups, to identify particular vulnerabilities that might point them in – into particular linking services or particular care.

Now, that data is captured in My Aged Care, and we are running a project at the moment to extract that data and make it available in the data warehouse for deeper analysis. I am not sure the extent to which that would qualify as a self-identification for those other groups and accept that I think there's probably more work that needs to be done, in terms of addressing those other groups who were not identified on the way in through My Aged Care, to – for that to occur. The data project we're running at the moment will be able to tell us a lot more about where our data gaps are, and we'll be able to extract some really rich information from the screening assessment form and have it available in the warehouse.

MR GRAY: Okay. Thank you. On page 19 of your statement, at paragraph 69 – I'm just inferring from an absence here that, in terms of systemic data, My Aged Care can only give you at least reliable data on two of the special needs groups. Is that a fair inference?

MR SMITH: I'm sorry, I'll have to defer to Dr Hartland on that.

MR GRAY: All right.

MR SMITH: I'm just not sure.

MR GRAY: Could I ask you to comment on some other evidence that's been given in this hearing. Operator, please display WIT.0422.0001.0010. That is exhibit 10-5, Ms Tunny's statement. Operator, please go to page 0010, at paragraph 30(b). Now, if we call that out please, Operator. Thanks. The first point there I'll ask Mr

Hartland about, which is about tracking an individual through the aged care system from point of connection with My Aged Care through to provision of service, is that a question I should direct to him? It sounds - - -

MR SMITH: Yes. That's right. Yes.

MR GRAY: Yes. But I think I should direct the next question to you. There's a proposition that follows that point about My Aged Care, as follows.

> *There is currently no governance mechanism that oversees the interrogation of data to ascertain equitable distribution of support resources to diverse population groups in remote rural, regional, metropolitan areas. In addition, there are no benchmarks against which to track equitable access to resources.*

And then there's an example given about Aboriginal people. Please read on.

MR SMITH: Yes.

MR GRAY: It concludes with there being:

> *…no data modelling yet done to establish the expected rates of access to aged care for Aboriginal people compared to older people from the general population.*

So just stopping there - - -

MR SMITH: Yes.

MR GRAY: - - - is that long proposition correct? Starting from:

> *There's currently no governance mechanism –*

Concluding with the specific example about there being no data modelling for Aboriginal people. To the best of your knowledge, is that proposition correct?

MR SMITH: Yes. To the best of my knowledge, that's correct. Yes.

MR GRAY: And then the next point that's made is – this might be – I'm not sure if this is a question for you. It probably is:

> *Furthermore, government does not monitor the effectiveness of mechanisms which are designed to increase cultural safety and appropriateness of services to diverse groups.*

What do you say about that?

MR SMITH: I'm not sure what mechanisms Ms Tunny's referring to there. It seems to be talking about regional assessment services and potentially ACATs in relation to linking that might – linking services that might be provided to connect - - -

MR GRAY: So that's Dr Hartland?

MR SMITH: - - - people. Yes. Yes.

MR GRAY: That's that same - - -

MR SMITH: If that's what that's getting to. I'm sorry.

MR GRAY: Yes.

MR SMITH: I'm just - - -

MR GRAY: No. That's - - -

MR SMITH: I haven't read that in detail before.

MR GRAY: I asked you that question earlier and you said I should direct it to Dr Hartland, so I will. Briefly, I want to ask you about the Diverse Framework and, in particular, the action plans. And I did ask you a little bit about this at the outset, by reference to that point about the evidence earlier in the week concerning resistance on the part of the sector peak groups to implementation of the framework and, in particular, the action plans being made mandatory. What's your personal view? Should the action plans be made mandatory?

MR SMITH: Be mandatory in accreditation?

MR GRAY: Yes.

MR SMITH: No. My view is I don't think they should be made mandatory in the accreditation process.

MR GRAY: And why is that?

MR SMITH: I guess, reflecting on the broader process around reforming the accreditation standards, which is, really, about what are the outcomes that are achieved for consumers, as opposed to what are the particular inputs, I suppose, or outputs of the process – so the idea of, sort of, checklists of – and this is not just in relation to the diversity standard but across the standards, this – the idea of checklists that demonstrate that there is this plan in place and this plan in place and, therefore, that that might lead to an accreditation. Those things could be used as evidence, but it's really about the outcomes for the consumer.

I think the diversity framework and the action plans are an excellent resource. And the Department thinks they're excellent and we certainly promote them to all providers. They are ways in which providers can demonstrate and – well, they're ways in which providers can actually be providing the higher level and better care. And the extent to which they adopt those, they can be presented as evidence. I don't think they should be made mandatory as part of that process.

MR GRAY: Should there be at least a requirement for anybody who wishes to claim on My Aged Care that they're a specialist provider for a particular group to have implemented their own action plan for that group and for that to have been, in some form, accredited?

MR SMITH: I can only refer back to my earlier answers in relation to this. Again, I'm not sure – if a provider is able to demonstrate that they can deliver the appropriate services to a consumer and are delivering those services to a consumer, whether or not they've, sort of, filled out – completed a particular element of the action plan I don't think is what is relevant. It's the way in which they are able to do that and what the actual outcome is for the consumer. But I accept they're a great tool and I the providers, you know, could use them to achieve that.

MR GRAY: Well, let's think about that, because it could become increasingly important. It's already important what claims are made on My Aged Care about specialisation, because that could lead to a consumer relying on that information in making a decision to go to a particular facility; correct?

MR SMITH: Yes.

MR GRAY: And it might become even more important in the future, under any form of consumer-directed care for residential care. Agreed?

MR SMITH: Yes.

MR GRAY: And My Aged Care is facilitating a positive platform for a representation to be made. You're suggesting that it's sufficient that when accreditation audits occur which might only be ever three years or so, that that can be checked in effect after the representation has been up on the website for an extended period. The problem with that, I suggest, is that consumers may well have relied on that representation for potentially many years, as long as three years, before any validation of the claim occurs. And once somebody has moved to a facility, it's unrealistic to expect that they're going to move out again. It would be very disruptive for that to happen. What do you say to that?

MR SMITH: So I just need to unpack that a little bit. I don't think at any point I indicated that the service finder should be linked to accreditation run by the Quality and Safety Commission and checked after the fact. In fact I'm on a very strong view that quality assurance around the information provided on My Aged Care about what particular specialised services a provider will provide is critical and I agree

completely that people will be relying on that information to make decisions about which aged care facilities to make contact with and have discussions with about, you know, going into care. Back to my earlier evidence on that, the quality assurance process is a priority for the Department.

Whether that should be specifically linked to the action plans, I'm not convinced about that. I am convinced the action plans are a great tool but there may be other things providers can do to – do that to effectively demonstrate that but there is a piece of work we are actively working on.

COMMISSIONER BRIGGS: This, though is a massive issue, not only about the effectiveness of needs-based planning but also about the effectiveness of the allocation of government resources. So if you allocate a lot of resources to special needs groups and can't be guaranteed that those resources are then being brought to bear to support those special needs groups, then there's a serious misallocation of a lot of government money, isn't there, Mr Smith?

MR SMITH: Yes, I agree the resources that are directed to support special needs groups should be brought to bear – sorry.

COMMISSIONER BRIGGS: Yes.

MR SMITH: Should be available to support special needs groups.

COMMISSIONER BRIGGS: So the balance of this issue is the department seems to have moved away from any form of input control to a focus on outcomes but you're unable to monitor the outcomes. Therefore, where is the compliance or the control or the monitoring in this process; where is it?

MR SMITH: In relation – I agree, Commissioner. In relation to the service finder and in relation to the way in which we have monitored priority of access for ACAR, it doesn't occur – it doesn't occur and it needs to occur.

COMMISSIONER BRIGGS: Thank you. Mr Gray, sorry.

COMMISSIONER PAGONE: So in what way are the action plans a great tool? I think you've said it three or four times this morning, that they are a great tool. How are they a great tool?

MR SMITH: The action plans set out a series of specific things that providers can do, depending on sort of how well advanced they are in terms of their capacity to meet the needs of people with – from special needs groups with diverse backgrounds. They provide sort of entry level guidance, so those providers that are, really, at a low base, the kinds of – sort of easy things that they could do quite quickly and effectively to start to upskill and about the way in which they connect with particular organisations and – that are expertise – that are experts, which can assist with training, resources material and they – and then they step through for the more

advanced providers as well, you know, the sorts of sector leadership that they can provide. So for a provider coming off a low base, the action plans give some really straightforward things that can be picked up fairly quickly and effectively to start to upskill and uplift the capacity of the service.

COMMISSIONER PAGONE: So if that is so, why wouldn't you use them as a means by which you engage in quality assurance?

MR SMITH: Well, they are one of the resources available and they are one of the resources that the Quality and Safety Commission can look to, to see whether or not the extent to which a provider is able to meet that critical standard 1 about being able to provide culturally safe and appropriate services. The issue is whether we would mandate that over other things providers may be able to do and other resources they may choose to adopt.

COMMISSIONER PAGONE: You seem to think that they're really good for something but you don't seem to think they're really good as the basis of quality assurance. I'm puzzled about what seems to me to be a mismatch; that you like the idea of the action plans and I gather that you're not going to give them up and yet you don't want to give them the authority at the quality assurance stage. Am I misreading your intention there?

MR SMITH: No, I think the intention of the action plans is to give the ideas and resources to providers as to the sorts of things they could do and, indeed, gives them very specific things that they could do. So I don't see necessarily a disconnect there. It's about providing material to the sector to help them be able to meet the standards and to meet standard 1 and that's one set of materials that we would certainly encourage providers to look at but not necessarily the only one.

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioners. Mr Smith, just to round off on the diversity framework and the action plans, you accept that they're a very useful tool and I think you've gone as far as saying they should, although not under a mandate but they should be implemented; is that right?

MR SMITH: Yes, I would be encouraging providers to use them, yes.

MR GRAY: Yes. Do you accept that, particularly when it comes to, say, the Homelessness Action Plan which is currently in preparation, and aspects of the LGBTI Action Plan, the Aboriginal and Torres Strait Islander Action Plan, these action plans are catering for groups who are trauma-affected – or very likely to be trauma-affected.

MR SMITH: Yes.

MR GRAY: And with the CALD group, a person in the CALD group may be trauma-affected; they're certainly going to need a lot of cultural sensitivity in the care that is provided if they're going to be ever be able communicate their care needs effectively for person-centred care to be delivered. Do you agree with that?

MR SMITH: Yes.

MR GRAY: Now, the Royal Commission has heard some evidence about the resource-intensive effort that is needed to transform an organisation so that it provides culturally safe, sensitive and appropriate care and perhaps even more so in trauma-informed care. Where are the resources for that transformation to come from? Is government offering any resources, any additional resources to providers?

MR SMITH: No. Not specifically, no.

MR GRAY: Is it realistic to expect that an organisational transformation on the scale that's really needed here is going to occur without additional resourcing of some kind?

MR SMITH: I guess I would respond by saying, you know, providers must comply with standard 1 of the standards, which is about providing that – it's already mandated that that culturally safe environment be provided and that's mandated through standard 1; that it's a part of the way in which organisations and businesses structure their businesses and their finances to be able to respond to that requirement. There has been no government decision, no allocation of funding specifically to support sort of organisational transformation, as you describe it.

MR GRAY: Are you aware of the designing for diversity program for human services in Victoria, a program of the Victorian State Government?

MR SMITH: Only generally, I'm sorry.

MR GRAY: Are you aware of the function of diversity advisers in Victoria?

MR SMITH: No.

MR GRAY: Okay. Diversity advisers, you don't know anything about them? You don't know anything about people who are contracted to help transform human services contractors so that they cater for diversity in accordance with Victorian Government policy?

MR SMITH: Not specifically, only at that conceptual level.

MR GRAY: All right. Are there any plans in your division of the Department to learn from the Victorian model for assisting contracted human service providers to cater for diversity?

MR SMITH: Given it's something that I know very little about, and hearing about it and having heard about it in concept in the preparation for today, it's something I would like to have a look at but beyond that I couldn't say without doing that work.

MR GRAY: Okay. I want to ask now specifically about people for whom English isn't their first language and particularly if they're suffering some sort of cognitive impairment so that English has become even more difficult. There's a lot of evidence before the Royal Commission on the inadequacy of funded interpreting services. In your statement, you refer to circumstances in which funding covers interpreting. It's essentially around the contracting for the care arrangement and the formulation of an initial care plan. Is that a fair summary?

MR SMITH: Yes, generally it's about entry to the system.

MR GRAY: And I suggest to you that that's woefully inadequate because interpreting is needed at all stages of care delivery because it's through care delivery that we learn the most about the needs of the person who needs the care. And if you can't communicate with that person, you're never going to learn about their needs. What do you say to that?

MR SMITH: I agree with that.

MR GRAY: So the interpreting program, I suggest to you, has to be far better resourced.

MR SMITH: I – my view is that once recipients are in care, the provider is responsible for ensuring that they're able to deliver – sorry, deliver the appropriate care to the consumer and that includes in relation to access to appropriate interpreting services.

MR GRAY: So do you say that where an approved provider has care recipients who don't have English as a first language and outside those circumstances where, in effect, the care recipient is being admitted into the service, in all other circumstances the approved provider should be funding the attendance of an interpreter?

MR SMITH: No. In residential care there is more flexibility in accessing the interpreting service. When it comes to particular instances of care where an interpreter might be needed, something occurs and an urgent interpreter is needed to support the care of that person, then absolutely the providing contact is, but in terms of the general ongoing day-to-day way in which a provider supports someone who doesn't speak English, that is the responsibility of the provider.

MR GRAY: In terms of – even in those acute situations when a change in clinical circumstances arises or something of that kind and there is an availability to access funded interpreting services, when we come to Aboriginal languages, is it correct to say that there is no interpreting service available for Aboriginal languages outside the Northern Territory?

MR SMITH: No, that's not quite the case but I'm going to qualify this by saying it has been the case and I will start by saying it's not an acceptable state. There are interpreting services now available for people who speak an Indigenous language when they contact My Aged Care. If they require an interpreter, that can be arranged. Interpreting services through the assessment and care planning process have not yet been established but it is a project underway to identify how that might occur. It's not straightforward because of – often in remote – very remote Australia, the distances involved, the need for face-to-face interpreting in particular and the need for an interpreter to spend time with a person to build trust before they're willing to really kind of engage, so it is a complicated model. That's not an excuse for why it's not in place and why it hasn't been done, but it is in train.

MR GRAY: This will probably be my final topic. There has been a lot said about the inadequacy of data about people who are, in effect, already in the system, having already contacted My Aged Care. There's also a real issue about whether there are obstacles to people even being able to take that first step, for example, the Royal Commission this week is receiving evidence from Ms York about people who are homeless or at risk of being homeless, and she is giving evidence that My Aged Care is, in effect, totally inadequate for people who are homeless or at risk of homelessness, that they fail at the first hurdle. They're just not equipped. They don't have a fixed address. They don't have access to a computer. They don't have, perhaps – you shouldn't make an assumption that they're computer literate. They might have a host of other health or even cognitive impairment related issues.

For all these reasons, you wouldn't expect people in that cohort to even make contact with My Aged Care. What is the Department doing to try to understand the needs of people in that category, including, but without limitation, people who are at risk of homelessness?

MR SMITH: So outreach for people who are hard to reach or who find it difficult to access the system is critical and the Department is – the system navigator trials you asked me about very early on and it's one of my responsibilities, they're intended to look at a range of different models that could assist people who have a range of vulnerabilities that make their access to the system difficult. That includes people with – the people who are homeless and it includes things like outreach, actually going and finding people. But, in particular, peer-to-peer support using volunteers with a like experience to engage with people to build trust and to help them access the system.

These are trials but it's a very extensive set of trials intended to inform what a future navigation system could look like. I think there's some 29 of the trials include homeless people as one of their target populations and there's one specific trial which is specifically targeted at homeless people being run out of – here in Melbourne.

MR GRAY: Do you understand from any data analysis the scope of likely demand, that is, demand from that in effect so far invisible cohort who haven't even been able to make contact with the system?

MR SMITH: No, not from data but I do – I do know there is a lot of unmet demand from people who are homeless, and I get that through – not through quantitative data but through – you know, through engagements I have with homeless providers in particular and some of the challenges they see, and what, you know, their on the ground intelligence is about that I – I absolutely accept that there is unmet demand and we do need to understand more about that.

MR GRAY: And is there a program of trying to work out what the scope of that demand will be and therefore what the extra impost on the system both in terms of navigation services and in terms of actual provision of aged care, what that will look like in the future?

MR SMITH: So the navigation - - -

MR GRAY: Not just for homeless people but for any of these other vulnerable groups who haven't been able to make contact.

MR SMITH: Yes, it is more challenging when you have this sort of unknown demand out there that's difficult to get a grip on. The system navigator trials will start to give us an indication, albeit a trial, but will start to give us an indication as to what that looks like in terms of different geographical regions or different cohorts of people, and from there we will be able to start to build some of that evidence base. ABS collect some level of information about homelessness but it's not extensive and I think that they are sort of looking at those options but, look, it's something we need to work on. I accept that.

MR GRAY: Will the navigator trials be evaluated by about mid-next year? Is that – I recall that being an estimate given by a previous witness. Is that still correct?

MR SMITH: Yes, so the evaluations have actually commenced. They're running concurrently so the data feed is starting to come back now from the different – the 62 trials across the country. The data feed is starting to come back and it will be evaluated as it goes. We don't have any actual evaluation yet. It is intended that there be a mid sort of term report which I think it would be late this year or very early next year but we have asked for that to be a substantive report as well so that we can start to, you know, really understand what we want to be seeing as part of the June 2020 report.

MR GRAY: The Royal Commission will most likely be seeking that report at the earliest opportunity. Commissioners, those are the questions I have for Mr Smith.

COMMISSIONER PAGONE: Yes, thank you, Mr Smith for giving your evidence. It has been very helpful. You are free to go.

MR SMITH: Thank you.

<THE WITNESS WITHDREW [11.19 am]

COMMISSIONER PAGONE: I think we have a break now until 11.30.

ADJOURNED [11.19 am]

RESUMED [11.35 am]

COMMISSIONER PAGONE: Yes, thank you, Ms Bergin.

MS BERGIN: I call Heather Jessie Brown. Ms Brown is joining us via video link from Brisbane at the AGS office. There's a solicitor at AGS in Brisbane and I would ask you to please now take an oath from Ms Brown.

<HEATHER JESSIE BROWN, AFFIRMED [11.36 am]

<EXAMINATION BY MS BERGIN

MS BERGIN: Thank you, Ms Brown. Operator, could you please bring up WIT.0537.0001.0001. Ms Brown, is there a copy of your statement there in front of you?

MS BROWN: Yes.

MS BERGIN: And have you had a chance to look over it and ensure that it's a true copy of your statement?

MS BROWN: Yes, it is.

MS BERGIN: Do you wish to make any amendments to your statement?

MS BROWN: No.

MS BERGIN: Are the contents true and correct to the best of your knowledge and belief?

MS BROWN: Yes, they are.

MS BERGIN: I tender the statement of Heather Jessie Brown dated 1 October 2019.

COMMISSIONER PAGONE: Yes, thank you Ms Bergin. That will be exhibit 10-18.

EXHIBIT #10-18 STATEMENT OF HEATHER JESSIE BROWN DATED 01/10/2019 (WIT.0537.0001.0001)

MS BERGIN: May it please the Commission. Ms Brown, I would ask you to now read from your statement directly from paragraphs 4 to 29, please.

MS BROWN:

My full name is Heather Jessie Brown. I am 79 years old. I am a Forgotten Australian. I currently live in a retirement village. At the age of two, I became a state ward in Queensland. At this time, my mother was terminally ill with breast cancer and my father was in the army. My father got leave from the army to care for my mother, brother and me. My father thought my mother would survive surgery but then she died. The state considered that my father was not able to care for my brother and me.

Between 1942 and 1944, my brother and I were moved to two, perhaps three, different state ward homes. At this time, children could be moved as the state desired from one place to another without notifying the parents, without getting parents' permission or without choosing the place where they would go. The State Children's Act 1911 to 1955 or part 2-11. I cannot recall any happy times being a state ward. The whole impact of life in care in state ward homes has been difficult. I don't know why they call it care because there wasn't any care.

Attitude towards aged care. Fear of re-entering an institution. I would be terrified if someone told me I had to move into a residential aged care facility. I would resist it, not literally but I would fight it. I see aged care facilities as institutions just like the ones I grew up in. They are exactly the same to me. I don't like the idea of confinement and the lifestyle. I think it would cause me to have flashbacks of my time in care as a child. It would be like living it all over again. Unless there is no other option, I don't want to have to go into an aged care facility.

I am not the only one that thinks this way. Lots of Forgotten Australians are terrified of when they are no longer able to care for themselves. Some say to me that they would rather be given injections and killed than go back into an institution. There were lots who are worse off than me. Lots and lots have suffered terrible abuse. I feel badly for them.

As a Forgotten Australian, you tend to put off thinking about aged care. I know some Forgotten Australians I feel should be in aged care but the people around them are having to support them.

Fear of not being understood. Aged care frightens me because I realise that not many people understand about Forgotten Australians. If we go into aged care, how are we going to be assured that these places can be trustworthy? Can they understand the trauma that we have already suffered? Can they assure us that we will not suffer that trauma again in aged care? What if you go into an aged care facility where they don't know what a Forgotten Australian is?

This is why I am telling my story. I believe so many people don't understand Forgotten Australians. They have no idea what the state allowed and what the government has done. I myself have been amazed at the number of people that came out for the Royal Commission into Institutional Responses to Child Sexual Abuse. We were a generation that were told not to be seen or heard and we are part of a generation that didn't speak about what happened.

Recommendations. Raising awareness about Forgotten Australians. I volunteer in several areas for Lotus Place. One of those areas is the Historical Abuse Network (HAN). Lotus Place is a support service and resource centre for people who have experienced abuse in an institutional setting, including out of home care. HAN is a network of people who have experienced abuse in Queensland institutions, foster care and detention centres. As part of my role with HAN, I tell my story of my time in care to child safety officers (CSOs) in training.

CSOs are people who provide assessment and case management for children at risk. These training sessions are run once a month. The CSOs are in training for two weeks. My presentation always takes place in week one. I talk about my experience in foster care, as a child taken from home and being placed as a state ward and into children's homes. Telling my story can be emotional. I usually need time to recover afterwards. But I do it to help the CSOs and the police understand what life was like in care and the impact it can have on someone.

At these training sessions, the team leader also talks about the history of these sad places. They talk about various homes and detention centres where young people were placed. I think there should be a training program like the CSO program for aged care workers. This would help them to understand Forgotten Australians. Training would help workers understand how to handle a situation with a Forgotten Australian who might be triggered or distressed. Some common triggers for Forgotten Australians can be shouting or speaking loudly, touch, confined spaces in lifts, bathrooms, police presence or assistance with personal care.

Services and facilities specifically for Forgotten Australians. I currently live in a retirement village but I am alone most of my time. I stay very private and I don't really mix or communicate with others. I am cordial. I say hello and I am friendly but I haven't developed a friendship over the three years that I have lived there. I think the other residents think I am exclusive. It's not that. It is because of my childhood that I isolate myself. It is my personal legacy of being a Forgotten Australian that confines me to my own space. I see this as the beginning of what aged care can mean for a Forgotten Australian.

Forgotten Australians need facilities and services that understand what they have been through. I wish there was an aged care home run by Lotus Place or by Micah Projects. I have found such care at Lotus Place. I have felt like they really understand what a Forgotten Australian is. They know the psychological effects. They understand the anger. They recognise the issues that we face after being sexually abused as a child. Why can't aged care facilities also have this understanding?

When I first came to Lotus Place, I didn't want to be there. I didn't want to be is surrounded by people that had all this sadness. But the more I went to Lotus Place, the more I felt at home and at peace. I felt like we all understand each other. We know what one another have been through. We have all had to fight to have a normal existence, let alone anything beyond that.

Liaison between My Aged Care and Forgotten Australians. I'm thinking that, at my age, I should be contacting My Aged Care. I speak to a lot of friends who say I should be registered with My Aged Care. I will probably end up needing help with cleaning and general assistance around my home. I have been fortunate that I am very mobile and independent, but you just don't know when an emergency might happen; you cannot predict it.

I have been thinking about registering with My Aged Care. I haven't because, well, I feel that these agencies don't understand Forgotten Australians. Having someone liaise between Forgotten Australians and My Aged Care would really help. I do feel different and I feel that if there was an agency for Forgotten Australians in aged care, that would be a great idea.

Non-denominational facilities and services. When I was looking for a place to move into, I was looking for somewhere that was not run by a church. The first thing I asked when I was considering my retirement village was whether it was a church-based facility. It is family-based. Not that I am against the church but it was because of what happened in the churches. Historical physical and sexual abuse was perpetrated by people of the church and non-government organisations. It is hard when you have experienced childhood sexual abuse and then you have the churches that argue it didn't happen.

For this reason, Forgotten Australians cannot be housed in church-owned aged care facilities or have services provided by them. Forgotten Australians need

an environment where they can feel confident, trust the organisation, trust the care givers, and to receive respect and honour. Older people in every generation need to be honoured.

Freedom. My retirement village would suit very few Forgotten Australians. I am in an apartment which is like a studio apartment. I live independently. Independent living suits me. I can move and have total freedom. I can come and go as I like. I eat what I like. I have the freedom for people to come and visit me. I have thought about moving into an independent living unit. It is the next stage where they have facilities to do washing and bring in meals if you need them. It is not actually aged care, it is called independent living. It appeals to me because it would allow me to keep control of my independence.

Support services. Forgotten Australians need access to clear information about all aspects of support services, both in aged care facilities and for independent living. Actual services needed should include a range of free services in a similar manner to the Department of Veterans Affairs Gold Card. I don't say this begrudgingly as I honour veterans, but I do think honour is due to Forgotten Australians.

Services should include dental and hearing services, a registered nurse and visiting a doctor of own choice, 24 hour emergency, counselling, security in all rooms within facilities, TV with a big screen, wi-fi and community computers, G-rated movies, free transport to social outings, shopping, medical appointments and a free telephone.

Within an aged care facility, services should be available such as information regarding aged care support (including legal services, QCAT, pension and after-pension costs), coffee machine and activities (including exercise classes, a free gymnasium and hydrotherapy with qualified instructors).

Understanding about aged care support. Forgotten Australians need help to understand what aged care really is and what a help it could be to them. There is going to be a tremendous influx of Forgotten Australians into care. Most of us are now in our 60s, 70s and 80s, and all these people are going to need aged care soon but they have no understanding of what it is about. Forgotten Australians need help understanding. Additionally, Forgotten Australians need information regarding other entitlements to age pensioners, whether living independently or in a care facility.

MS BERGIN: Thank you very much, Ms Brown. Commissioners, that concludes my examination of this witness.

COMMISSIONER PAGONE: Yes. Thank you, Ms Bergin. Ms Brown, thank you very much, indeed, for sharing with us your story and circumstances. It is very important for the Commission and for the government and for the community generally to hear stories like that and I thank you very much for doing so.

MS BROWN: Thank you, Commissioner.

MS BERGIN: May it please the Commission, Mr Gray will take the next witness.

COMMISSIONER PAGONE: Yes. Thank you.

MS BROWN: Thank you.

COMMISSIONER PAGONE: Ms Brown, I think what happens now is that we simply switch a button and you will disappear from sight here and we will disappear from sight for you. Thank you again and the Commission will continue down here.

<THE WITNESS WITHDREW [11.56 am]

MR GRAY: Thank you Commissioner. I call Dr Nicholas Hartland.

COMMISSIONER PAGONE: Mr Hartland.

MR GRAY: I should announce Dr Nicholas Hartland PSM.

COMMISSIONER PAGONE: Yes. Thank you, Mr Gray.

DR HARTLAND: Thank you very much.

<NICHOLAS GERARD HARTLAND, SWORN [11.57 am]

<EXAMINATION BY MR GRAY

COMMISSIONER PAGONE: Yes, thank you. Mr Gray.

MR GRAY: Thank you, Commissioner. Dr Hartland, you are a First Assistant Secretary in the Department of Health of the Commonwealth.

DR HARTLAND: That's correct, counsel.

MR GRAY: And you're responsible for the in-home care aspect of the work of the Department of Health; is that right?

DR HARTLAND: That's right.

MR GRAY: And your first witness statement to the Royal Commission of 23 August 2019, exhibit 9-6, recounts that the division is called the In Home Aged Care

Division. What are the responsibilities of that division; are they as recounted in paragraph 8 related to funding and management of aged care assessment teams, regional assessment services, the operation of My Aged Care, the Commonwealth Home Support program and the home care packages program, including the national prioritisation system?

DR HARTLAND: Yes, that's right.

MR GRAY: You're responsible, are you, for implementation at a program delivery level of measures catering for diverse needs of particular groups of people; is that right? But not for the policy aspect of designing a system to cater for those needs.

DR HARTLAND: I think that's certainly correct in relation to home care pages in CHSP. I think in relation to My Aged Care, I put a bit more onus on myself for the diverse needs but we would work within a policy framework set by Mr Smith in consultation with us.

MR GRAY: Thank you. Your first statement is already in evidence, obviously. And you gave oral evidence in relation to the matters addressed in that statement in the Melbourne hearing 1 on 9 and 10 September 2019, didn't you?

DR HARTLAND: Yes. That's right.

MR GRAY: You've also made a second witness statement for the Royal Commission, WIT.0486.0001.0001. The first page of that should be appearing on the screen before you now. Are you able to identify that as the first page of your second witness statement for the Royal Commission - - -

DR HARTLAND: Yes. That's right.

MR GRAY: - - - dated 30 September 2019?

DR HARTLAND: Yes. That's right, counsel.

MR GRAY: Do you wish to make any amendments to that second statement, the one dated 30 September 2019?

DR HARTLAND: No. I don't.

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

DR HARTLAND: Yes. They are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. The statement of Dr Nicholas Hartland, dated 30 September 2019, will be exhibit 10-19.

EXHIBIT #10-19 WITNESS STATEMENT OF DR NICHOLAS HARTLAND DATED 30/09/2019 (WIT.0486.0001.0001)

MR GRAY: Thank you, Commissioner. Dr Hartland, were you in court listening to the evidence of Mr Smith earlier today?

DR HARTLAND: I was in one of the rooms annexed to the court, watching it on the live feed.

MR GRAY: All right.

DR HARTLAND: So I can't guarantee that I saw every statement.

MR GRAY: Okay. He identified a number of issues as issues on which you were better positioned to speak than he was.

DR HARTLAND: Yes.

MR GRAY: So I'll raise them with you - - -

DR HARTLAND: Yes. Of course.

MR GRAY: - - - in the hope that you agree with him - - -

DR HARTLAND: Yes.

MR GRAY: - - - and that you're able to deal with those issues. Firstly, I'll ask the operator to bring up the recommendations in the Tune report, because I used those recommendations as a bit of a framework for this part of the examination. Operator, that's at RCD.9999.0011.0746, beginning at page 13, 0758. And you've been in your position since July or August 2019; is that right, Dr Hartland?

DR HARTLAND: That's right. But if you look on my first statement, you'll see that I have some experience in aged care in the past? In - - -

MR GRAY: It says that you were principal advisor, aged care policy, in the Department of Health, from May 2019 to July 2019. And before that, First Assistant Secretary, aged care policy and regulation division.

DR HARTLAND: Yes. That's right.

MR GRAY: You held that position from around 2015; is that right?

DR HARTLAND: Yes. That's correct.

MR GRAY: Now, have you got some familiarity with the implementation in February 2017 of the Increasing Choices legislation of 2016, relating to the delivery of home care packages?

DR HARTLAND: Yes. I wasn't directly responsible at that time for it, but I was in the group when it was implemented. So have some broad knowledge from that. And in preparing for the statement, I looked back over some of the briefings that were done at that time.

MR GRAY: And in your current First Assistant Secretary role in the division responsible for in home care - - -

DR HARTLAND: Yes.

MR GRAY: - - - with particular responsibility for home care packages, I imagine you familiarised yourself with - - -

DR HARTLAND: That's exactly right.

MR GRAY: - - - the origins of the current mechanism for the allocation - - -

DR HARTLAND: Yes.

MR GRAY: - - - of those packages.

DR HARTLAND: Yes. That's right.

MR GRAY: And hopefully you heard the evidence Mr Smith gave by way of confirming a number of propositions I put about the key modalities of aged care and the differences in delivery mechanism for home care package, on the one hand, compared to residential care on the other.

DR HARTLAND: Yes. I did.

MR GRAY: Yes. And you didn't have any difficulty with my characterisation of the home care package mechanism, did you?

DR HARTLAND: No. I – there was one point on the CHSP discussion where, I think, it was left hanging as to whether it was a capped program or not. And it is a capped program via a different mechanism to either care packages or resi. But I don't think that's material to the points you were playing.

MR GRAY: Thank you. But please do clarify, CHSP is capped in terms of overall expenditure, is it?

DR HARTLAND: That's right.

MR GRAY: Yes.

DR HARTLAND: So it's capped by the grants mechanism. Providers get paid grants that are limited each financial year.

MR GRAY: Yes.

DR HARTLAND: Yes.

MR GRAY: But not specifically by numbers of the ultimate users of the services to whom the organisation is receiving CHSP grants provide services?

DR HARTLAND: That's not a hard cap, but providers get paid to deliver a certain number of service outputs. And so if they were to approach that cap, they would run – they would not have the resources to support additional people. So - - -

MR GRAY: Thank you. The recommendations, which Mr Smith identified you, Dr Hartland - - -

DR HARTLAND: Yes.

MR GRAY: - - - as better able to speak to, commence with recommendation 22. Recommendation 22 is that the government improve the functionality and performance of the My Aged Care ICT platform – information communication technology, is that right - - -

DR HARTLAND: Yes.

MR GRAY: - - - platform, with particular emphasis on improving information sharing between My Aged Care and other government agency and provider ICT systems. Is that a matter that falls within your responsibilities?

DR HARTLAND: Yes. It does.

MR GRAY: What is the progress, if any, since the Tune report, on the improvement of the second aspect of what's referred to there, information sharing between My Aged Care and other government agency and provider ICT systems? In particular, the Royal Commission this week has heard evidence from Ms Cosson of the Department of Veterans' Affairs that the two IT systems of DoH on the one hand and DVA on the other don't speak to each other.

DR HARTLAND: So as I understand it – I'll have to review the text of the Tune report. The – a – the background here to this recommendation, I think, was about providers' difficulties with using the portal to claim. And so it was about our interaction mainly with DHS. But I stand to be corrected; I haven't looked at the

supporting argument. In relation to veterans' payments, we are able at registration and screening, if a person volunteers to collect information on whether they're a veteran, though we don't record their number. So we know on the My Aged Care system whether someone's a veteran, as they go through the process.

I think it's fair to say, and this might be what Ms Cosson was talking about, that our customer relationship management system doesn't integrate well with the veterans' customer relationship management system. And so there's clearly a gap there. But we do know, at the back end, when someone gets to a provider and is paid, we have a process whereby we match information through DHS to discover where someone would be entitled to a veterans' payment, and we're able to match that information and use it to determine whether a veteran's supplement is payable.

MR GRAY: When you say you're able to match whether they'd be entitled to a veterans' payment – and then said veterans' supplementary - - -

DR HARTLAND: Yes. Sorry. That was loose language, and you're right to ask me to clarify that. Yes. Yes.

MR GRAY: It's simply the veterans' supplement that you're talking about?

DR HARTLAND: Yes. Sorry. No, I should have been - - -

MR GRAY: No, that's all right.

DR HARTLAND: - - - clearer in my language. Yes.

MR GRAY: Because it's a very specific kind of payment?

DR HARTLAND: Yes. That's right.

MR GRAY: It's available in relation to home care packages as well, at which it's fixed, at present, at 11.5 per cent of the basic subsidy?

DR HARTLAND: Yes. That's right.

MR GRAY: In relation to residential care, it's around $7 per day. It's a fixed amount. It's not a percentage of the particular - - -

DR HARTLAND: Yes.

MR GRAY: - - - ACFI basic care subsidy.

DR HARTLAND: Yes. And so that derives from the different structures of the two payments. Because home care has the four levels, it makes sense to fix it as a percentage of a payment.

MR GRAY: Now, with respect to that data matching that identifies that availability, does that also deal with all of the criteria that are required to be met before veterans' subsidy is payable, via either the home care mechanism I mentioned or the residential care mechanism, including mental health and behavioural criteria?

DR HARTLAND: Yes. And my understanding is that we're able to use information that the Department of Veterans' Affairs holds that would indicate whether a person was eligible for those supplements, and we don't have to separately ask the veteran in our system to provide additional information.

MR GRAY: Is evidence that that's not the case unless the veteran's been asked to consent and has provided consent - - -

DR HARTLAND: Yes. Yes. Yes.

MR GRAY: - - - for DoH to be provided with that information?

DR HARTLAND: Yes. That's true. Yes. It does require them to consent that we would use their data to match with DVA. That's right. Yes.

MR GRAY: All right.

DR HARTLAND: Yes. That's a fairly standard approach - - -

MR GRAY: Well - - -

DR HARTLAND: - - - to Commonwealth data sharing.

MR GRAY: There's evidence in the Royal Commission hearing, to date, to the effect that – this is Mr Nathan Klinge's evidence of RSL SA Care, or RSL Care SA, that he believes there's an underutilisation of veterans' supplement. And he suggests that part of the reason might be administrative burden and unwillingness on the part of the veteran to consent without a proper understanding of what's involved.

DR HARTLAND: I don't think - - -

MR GRAY: Do you have any views about that? Have you done any evaluation of whether veterans' supplement appears to be underutilised?

DR HARTLAND: It's certainly a small payment. It's about 180 people on the books.

MR GRAY: On your home care package?

DR HARTLAND: On home care packages.

MR GRAY: Yes.

DR HARTLAND: So it's certainly a small payment.

MR GRAY: When you say small payment, it's a very small number.

DR HARTLAND: Sorry. Small number of people. Yes.

MR GRAY: It's a very small number of - - -

DR HARTLAND: People. Yes.

MR GRAY: - - - about whom you'd expect there'd be an interest in getting that money.

DR HARTLAND: Yes. I would be surprised if the process for consenting was burdensome, but he may well be right that the veterans are choosing not to volunteer that status. And I think I'd be speculating to, kind of, give you a reason why, but we haven't evaluated it.

MR GRAY: Is there any plan to evaluate whether there's a proper take-up of veterans' supplement in accordance with what you'd expect the need and demand would be in the home care area for which you're responsible?

DR HARTLAND: No, we don't have a defined project. You know, periodically, the government looks at issues around aged care and how it relates to DVA. And in that – those processes, you would normally come up with what you know about the way the systems work together. There was an exercise a couple of years ago that looked at that, but we don't have a project in prospect for the future.

MR GRAY: There's a submission that's in evidence from the RSL about an interaction with My Aged Care. It was a 40 minute or so interaction. Have you had an opportunity to read that? In a nutshell, there was a navigator from RSL assisting a spouse of a veteran to make contact with My Aged Care, to obtain a higher level of in home care than had been provided.

DR HARTLAND: I'm not familiar with the - - -

MR GRAY: No?

DR HARTLAND: - - - substance, but you won't be surprised to learn that complaints or comments on My Aged Care do come across my desk.

MR GRAY: They do come across?

DR HARTLAND: Yes.

MR GRAY: They do come across your desk?

DR HARTLAND: Yes. From anecdotal, we see evidence that people – occasionally, the system doesn't work well for them. And, you know, we try to address it when we can – we can understand what's going on. But - - -

MR GRAY: I won't bring the submission up on the screen for you to read, but I'll just ask you about this. The operator of the call centre didn't wish to take the DVA number of the veteran. And I think a minute ago you said something about My Aged Care not recording the DVA number of veterans who approach it. So is that in accordance with agreed procedures or scripts - - -

DR HARTLAND: So - - -

MR GRAY: - - - that the DVA number would not be taken by a call centre operator at My Aged Care?

DR HARTLAND: Certainly, the agreed procedure and the way in which the script work does not have a space to normally record the DVA number. I don't know whether the advice has been in the positive, "Do not do it", because there would be informal text to do it, but it's not a required process. The script that's used at registration, as I understand it – and people who are watching it, if I've got this – the detail wrong, you know, will obviously advise you. But the process at registration and screening is simply whether they're a veteran or not. It doesn't ask for specific client detail. Yes.

MR GRAY: Wouldn't it be - - -

DR HARTLAND: But I don't know whether we've actually said, "You shall not - - -"

MR GRAY: Right.

DR HARTLAND: "- - - take the number."

MR GRAY: Wouldn't it be useful to record the DVA number, to ensure that there's a better interface between the information held by DVA on the one hand and the information being acquired by the Department of Health through My Aged Care? Whether that's being operated by Healthdirect or DSS, I don't know, but, ultimately - - -

DR HARTLAND: Yes.

MR GRAY: - - - the information that's acquired by My Aged Care becomes information of the Department of Health. Wouldn't it help to know the DVA number?

DR HARTLAND: It may. I think it would get you back to the consent issue about whether the data is being used for and understanding what a person had, in effect,

allowed the Departments to do. So it may well be that it wasn't relevant at – you know, I can imagine a view that maybe it's not relevant at registration, because you'd have to explain to the person we're getting this number because – so I can see arguments both ways. But I can also see the point you're making, that if a client consented and we're able to explain to them clearly what we would do with the information, they would give you greater certainty around the matching of people. Yes.

MR GRAY: So getting back to my initial question about the progress on the implementation of - - -

COMMISSIONER PAGONE: Just before you do that, Mr Gray - - -

MR GRAY: Yes.

COMMISSIONER PAGONE: You've being very cautious with your answer about the instruction that you do or don't give to the operator of the call centre. But if somebody ringing had said, "Here is my DVA number", would the person at the other end of the line be able to do anything with the number?

DR HARTLAND: They – it would probably be a free text where they could put it in, but there isn't a place in the system where you would code it in a way that a machine could read it.

COMMISSIONER PAGONE: No. So your very careful answer earlier on, which was that you're not sure whether there's been a positive instruction, "Do not take it", doesn't adequately convey the fact that, actually, there'd be no reason why you would need to give them a positive indication not to take it, because if they got it there was no place to put it anywhere.

DR HARTLAND: Yes. I think that's right.

COMMISSIONER PAGONE: Yes.

DR HARTLAND: Yes. I think that's a fair comment.

MR GRAY: Back to my question about progress in implementing recommendation 22, with regard to interoperability between Commonwealth agencies, what's been done since Mr Tune made that recommendation in 2017 to improve the interoperability of Commonwealth agency and provider ICT systems? Let's start with Commonwealth agencies.

DR HARTLAND: So I haven't prepared in relation to My Aged Care and Commonwealth agencies. So the work that we've done broadly, that I'm aware of, in response to that recommendation goes to trying to improve the way in which providers interact with My Aged Care. And the government has announced some significant changes to the way in which providers will be paid earlier this year.

MR GRAY: If you could please keep your voice up - - -

DR HARTLAND: I'm sorry. Yes.

MR GRAY: - - - Dr Hartland. Thank you. I think you said something about changes to the way providers will be paid.

DR HARTLAND: That's right. So the government announced it would look to move providers to an arrangement where they were not paid in advance but paid at the time of services were delivered. And we're working through that with the sector at the moment about how that would work. And that was, in part, to address an issue that's cropped up in evidence to – around unspent funds. So that would be the major bit of work. There may be some other things that we've done that I – I'm sorry, I just haven't got background on.

MR GRAY: All right.

DR HARTLAND: There are other areas in which we've been seeking to improve the operation of My Aged Care, but they don't go specifically to that recommendation.

MR GRAY: All right. The next recommendation, which Mr Smith considered that you would be better placed to respond to, is about the National Screening and Assessment Form. Recommendation 30 – on the next page please, Operator – reads that:

> *The government immediately review the National Screening and Assessment Form.*

And, firstly, is the NSAF within your responsibilities?

DR HARTLAND: Yes. It is.

MR GRAY: And you did review it?

DR HARTLAND: Yes. We did.

MR GRAY: And it was amended, in effect - - -

DR HARTLAND: Yes.

MR GRAY: - - - in about July 2018; is that right?

DR HARTLAND: Yes.

MR GRAY: And it now has some fields addressing special needs; is that right?

DR HARTLAND: The form – since the establishment of My Aged Care – and it basically came in at the same time – and the screening process for My Aged Care have always had areas where special needs groups could either – would either be asked or could volunteer information. The effect of the 2018 changes was to add a couple of areas into a particular area of the form, which gave us better information in the form, about three of the special needs groups. And they were the care leavers group, including Forgotten Australians, the parents separated from their children by forced adoption and LGBTQI groups. And that was in the area of where you would record a requirement around support. And it's:

Do you have a special type of support that you would like?

MR GRAY: Operator, please bring up the version of the NSAF referring to home support. That's exhibit 7-1, tab 44, CTH.0001.1000.7587. Dr Hartland, while that is coming up there are two versions of the NSAF. One that's adapted for the use of regional assessment service; is that right?

DR HARTLAND: Yes, that's right.

MR GRAY: That's for Commonwealth Home Support program, and the other for comprehensive assessment by ACATs or ACASs in this state. I think we only need refer to one of them for present purposes. If we go to page 0020, the top half of that screen under the heading Linking Support is that the set of fields you had in mind there?

DR HARTLAND: No, it was further down. So these – this part of the form has been in use for some time and it is an area where we can get information to help our decision-making processes about special needs groups and you can see how they are set out there.

MR GRAY: Just stopping you there. Was this part of the form in materially the same form prior to the Tune Review?

DR HARTLAND: Yes.

MR GRAY: Right. So when Mr Tune refers to data inadequacies and the need to give clients an opportunity to indicate on their client record their membership of a particular group, if they wish, insofar as this resource was available at all times before – at all material times before the Tune report, this clearly wasn't a response to any recommendation in the Tune report directed at allowing clients to record their membership of a special needs group.

DR HARTLAND: No, and the changes that we made that I was referring to elsewhere are later in the form around support needs. So we've refined some questions later in the form that give people an opportunity to say whether they had a particular support need arising from their group. It wasn't this linking support.

MR GRAY: We are just going to find that page.

DR HARTLAND: It is a couple of pages on but I'm not sure I'm going to be able to tell you exactly how many.

MR GRAY: No, we will ask the solicitors to find that by searching for support needs. What about on page 21, thank you, operator; support considerations, pages 21 and 22. Is that what has been added?

DR HARTLAND: It's some questions, I think, on the next page.

MR GRAY: So that one is about cultural or religious values.

DR HARTLAND: Yes.

MR GRAY: And then next is gender identity or sexual orientation, etcetera.

DR HARTLAND: Yes, so it's these ones that I'm revised we've added to clarify – to improve the information that we hold about people with special needs.

MR GRAY: And in addition to the cultural and religious, there's gender identity and sexual orientation and the third question is about a history about childhood experiences, including matters that are encompassed by that statutory expression "care leavers".

DR HARTLAND: Yes.

MR GRAY: What is done with the information captured by those three fields that you've identified as being added since the Tune report?

DR HARTLAND: So these can be used for the ACAT or the RAS to develop a support plan for the person and they can be accessed by the provider in understanding their needs to develop a care plan for the person. I think one of the things that Mr Smith reflected on – I suspect you may go to soon – is it is hard for us to systemically pull out the data from these forms and analyse the population groups. And I think Mr Smith talked about a project that we have in train, which is about getting the information from the national – these forms, the national screening and assessment forms - - -

MR GRAY: He deferred to you on the precise functionality - - -

DR HARTLAND: Yes, fair enough.

MR GRAY: - - - of the ability or inability to extract information from the NSAF, as I recall.

DR HARTLAND: Yes. Okay. So we can go through - - -

MR GRAY: Would you now address that topic yourself. What is the ability or constraint on the ability of the Department to aggregate data so that it can analyse the demand for services tailored to diverse needs from the information collected in this form?

DR HARTLAND: So I think of this as kind of the mnemonic in a way of having three groups for the nine. So we can get pretty good data on access for Aboriginal and Torres Strait Islanders, CALD, and rural and remote people and that's automatically available from the forms.

MR GRAY: Just stopping there, that's actually been the case for some time; is that right?

DR HARTLAND: Yes, that's right.

MR GRAY: Including prior to the Tune Review.

DR HARTLAND: Yes, and just one other thing from the evidence this morning; we can do that with limitations for both home care and CHSP. So we can tell and count how many people from those groups are in CHSP and it was a question that was left hanging a bit from this morning as well. So we have a pretty good ability to understand the service outcomes for those three groups. There are some problems in CHSP because of the nature of the program but we can tell the proportions.

MR GRAY: Just stopping you there, an ability to understand the service outcomes for those groups, can you explain that.

DR HARTLAND: Access outcomes might be a better word. So access to services so we know what percentage of - - -

MR GRAY: Whether they got a service.

DR HARTLAND: Yes. Whether they got a service, yes.

MR GRAY: All right. Now, there's some evidence I will take you to a minute suggesting that there are limitations on the ability to track a client from point of contact with My Aged Care through to provision of a service. Is that - - -

DR HARTLAND: I think that's fair to say – so some of this goes to – it depends on the exact question you want to ask about that client and the group they're in.

MR GRAY: All right. We'll come back to that.

DR HARTLAND: So I'm sorry, that's - - -

MR GRAY: No, that's all right.

DR HARTLAND: We can sort of go off on these little pathways - - -

MR GRAY: I interrupted you. The overarching question is what is the ability or the constraints on the ability of the Department to extract, in effect, aggregated data about diverse needs outcomes from these forms?

DR HARTLAND: Yes, so if the question is access to services, the simplest one, logical one for us to monitor, we've got pretty good ability for Aboriginal and Torres Strait Islander people, culturally and linguistic diverse, and rural and remote. We can, with using other data sources, together with what we hold on My Aged Care give you a bit of a picture for homeless, veterans and low income people, and I believe in my statement we have done a bit of analysis of that. The areas where we have most problems are the care leavers, the parents separated from their children and LGBTI groups, and for those we have information about the individual in the system. And I think that's a kind of basic thing that you'd want, right, because this system is about understanding the person, getting them into service, but we have a lot of difficulty actually aggregating that information and analysing it at a population level.

And that's, I think, the block that Mr Smith was talking about and we have a project designed to address that but it's proved to be a frustratingly difficult issue. It was an issue around 2017 when Mr Tune was doing his review and it was of – I think it was one of the causes that led him to comment that we need to do better on here, and it has been a stubborn problem to solve.

MR GRAY: All right. Now, you say the information is there. Is that making a bit of an unwarranted assumption? I'll just explain what I mean. Each of those three groups, the so-called care leavers who include former child migrants, Forgotten Australians, Stolen Generations, parents forcibly separated from their children, and LGBTI people; each of those groups, I suggest, are likely to have encountered and to be affected by much higher levels of trauma than your average person in our community. What do you say to that?

DR HARTLAND: That's clearly and obviously the case, yes.

MR GRAY: And that's going to be an inhibition on them providing information, certainly across the phone to a call centre, unless the person on the other end is highly skilled, motivated by the right empathic values or empathetic values and probably trained in cultural sensitivity and trauma-informed care. What do you say to that?

DR HARTLAND: So I think the barrier is obvious. I think when I reflect on some of the evidence that I see and, you know, perhaps the Department has been its own worst enemy here, too, because we often talk about My Aged Care just with the lens of a website and a call centre but when you look at the end-to-end processes around it, we don't make an assumption that everybody has to log on or ring a call centre. So we have processes in My Aged Care where a provider or an advocacy group or, I

think, groups like the assistance with care and housing that gave evidence to you before today – yesterday – was it yesterday, Monday perhaps – are able to sit with a person or on their behalf ring into the call centre and get them through to a registration phase.

So there's no assumption that everybody has to go through the same sausage machine for My Aged Care. There are ways in which people can get into the system without having to pick up a phone and wait for 40 minutes now. Having said that, I wouldn't make the positive claim that I can guarantee that in 100 per cent of cases that service outcome is always satisfactory, and there was evidence that I heard on Monday when I was listening to the Commission, that in some groups there's not been a satisfactory result. But the point is that we're not assuming that these very vulnerable groups have to call us.

MR GRAY: All right. Let's assume that they do get the help from an advocacy group of the kind you - - -

DR HARTLAND: Yes.

MR GRAY: You hope they get.

DR HARTLAND: Yes.

MR GRAY: And let's assume that they had made contact, probably with the assistance of that person, with My Aged Care and they've obtained an assessment, an assessment appointment that is. It's at this point that the NSAF that's before us on the screen comes into play.

DR HARTLAND: Yes.

MR GRAY: And it prompts the assessors in a face-to-face context; is that correct, to ask questions about these matters?

DR HARTLAND: Yes, that's right, yes.

MR GRAY: What is their training, are you able to speak to this, what is the level of their training - - -

DR HARTLAND: Yes – yes, in the broad. So - - -

MR GRAY: - - - and expertise and their suitability to be asking these very sensitive questions in a manner likely to elicit the information that is needed?

DR HARTLAND: So – so certainly going back a step – and I know you're at assessment, at the call centre everybody has to go through a training and get accredited in relation to dealing with vulnerable groups.

MR GRAY: Sorry, are we back at the call centre?

DR HARTLAND: I was back at the call centre personally, I know you weren't.

MR GRAY: All right. So we're at the screening point before an assessment occurs.

DR HARTLAND: And if you go to – leap forward to assessment – sorry, that was perhaps a distraction to you. I should have jumped around.

MR GRAY: No, no. That's all right. Were you saying that everybody in the call centre has that level of training?

DR HARTLAND: The call centre people are trained and we refreshed that training this year, and to become part of the call centre they need to demonstrate that they've gone through a unit. For the assessors in the guidance, we give them the manuals. There's a - - -

MR GRAY: Sorry, and that unit, just since you've raised that, what, that unit is around trauma-informed care?

DR HARTLAND: It's on the needs of the specific groups. I don't believe we would use the word trauma-informed care.

MR GRAY: What about cultural safety?

DR HARTLAND: Yes, we would use those – we would direct them to that. So for the - - -

MR GRAY: How long is the unit? Are they really likely to learn what they need to know across the gamut of cultural needs?

DR HARTLAND: Yes. I haven't looked in detail at the units although I intend to try and do some of the training myself so, you know - - -

MR GRAY: What are the qualifications - - -

DR HARTLAND: But they are - - -

MR GRAY: What are the qualifications of the people coming into the call centre before they do their training? Are there any minimum qualifications required?

DR HARTLAND: I'm sorry, counsel, I would have to get advice on that but if your point goes to is this an in-depth training of, say, a vocational education standard, no, it's an online unit that alerts people to sensitivities and guides them through some answers so - - -

MR GRAY: All right. So let's - - -

DR HARTLAND: - - - you were right to ask me not to overegg the - - -

MR GRAY: Let's fast forward to the assessment process where you do have clinically trained people.

DR HARTLAND: That's right. Yes.

MR GRAY: You have to have an RN - - -

DR HARTLAND: Yes.

MR GRAY: - - - on a comprehensive ACAT.

DR HARTLAND: Yes, that's right.

MR GRAY: Yes. You may not have an RN on an RAS; is that right?

DR HARTLAND: No, but you could have an allied health professional. Yes.

MR GRAY: Okay. So let's fast forward to that assessment process, and these prompts exist on the NSAF form that's used during that process.

DR HARTLAND: Yes. So in relation to the assessors, the manuals that are provided to are – explain what a good assessment looks like, in effect, do have embedded in them resources on each of the special needs groups.

MR GRAY: What sort of validation is there that that material has all been read and absorbed by the team members?

DR HARTLAND: We don't – to my knowledge, we don't go and, say, retest assessors with their knowledge about the groups. We do have a quality assurance process for assessment, which asks the providers to look at a sample of surveys and check whether, on the face of – sorry, a sample of assessments and check whether on the face of what is in front of them they could see consideration being given to the relevant areas of the assessment and that does include whether special needs groups were appropriately considered and identified.

MR GRAY: But if they haven't elicited the information because they haven't been culturally safe enough to do so, it's never going to show up, is it?

DR HARTLAND: Yes. I see the point you're making. Yes.

MR GRAY: Because the assessment – that's a separate document, that's not this form – the assessment is essentially what's the level of need and what's the level of care that's going to match that need for this person. And if a need hasn't been identified because the assessor wasn't able to elicit the information, it's simply going to be absent from the assessment and no amount of quality assurance would be able

to detect whether something has been omitted that should have been included. What do you say?

DR HARTLAND: Well, there may be some opportunities about inconsistencies in the form but I accept the point that any quality assurance process you design around a highly subjective process is – I am not aware of any of them that are able to test the underlying facts of the case. So it's a limitation of the approach, yes, I agree.

MR GRAY: Well, I suggest that a more rigorous approach to training the assessors who are on these very important assessment teams in cultural safety and trauma-informed care is warranted. What do you say?

DR HARTLAND: Well, I think there's always opportunities to improve the training of your workforce so I'm not going to reject that proposition, no.

MR GRAY: Now, the point that you made at the outset was that the information is in the form, and I was challenging you essentially on whether that's an unwarranted assumption. Let's assume that the information does get into the form. You've said in any event because of data analytics issues it's not able to be extracted in a meaningfully useful way. Is that the gist of your evidence?

DR HARTLAND: Well, I would, again, be careful with my language here. So it can't be, for some of the client groups we can't extract data to do population analytics so to understand how many people from care leavers are in our systems, right. That doesn't mean that the data in the system is meaningless. I mean it is used to develop care plans and care things and actually that's the whole point of the system is to get someone the appropriate care so I just want to be cautious about saying it's on an individual basis. Yes.

MR GRAY: When I referred to data analytics I was referring to the use of data to identify demand, trends and other aggregated trends. It's not available for that sort of purpose?

DR HARTLAND: No, it isn't, no.

MR GRAY: All right. The next recommendation - - -

COMMISSIONER PAGONE: Just before you go to the next recommendation - - -

MR GRAY: Yes, Commissioner.

COMMISSIONER PAGONE: - - - you said earlier on, Dr Hartland, that getting to know the individual's needs – and I think you used words like a difficult matter to crack or proven to be stubbornly difficult, words like that; what do you ascribe as the reason for that? Is it that the information – the systems that have been created in the past have lacked enough thought? Is it that they've been lacking detail? Is it a

funding issue? Is it that you don't have the resources available to your Department because of staff cuts or caps? What do you think it's due to?

DR HARTLAND: I'm not – every time you touch a large computer, you do quickly confront funding issues. I think the effort – I think this is a stage of development question, and the national queue and My Aged Care are in systems terms really quite recent. I know it started in 2015 but the queue started in 2017. And I think there's always – I've been around DHS, disability payments and aged care for some time in various capacities and you do often confront that a system that you build to manage transactions and customer interactions and to do that in a way that helps, usually the person extracting the information and hopefully the customer in front of you, doesn't necessarily give you – that transactional system doesn't necessarily spit out data in a way that is easy to harvest and you see this in DHS, you see this in the disability services, quite commonly you have data gaps. So I don't think it's an issue about the system being inadequate. It's a big propriety system. It's a customer relationship management system but it wasn't designed to spit out data, and we are just coming now to wanting to do the data better. Obviously, you know, I think no one is going to accept – no one is going to disagree that it would have been desirable to have done this by now but a lot of our efforts have been in creating the system and getting the transactional side as good as it can be, and it is not unnatural that now we would come to the data and try to make it work.

COMMISSIONER PAGONE: I wasn't intending by the question to be critical.

DR HARTLAND: Sorry, I might have been too defensive.

COMMISSIONER PAGONE: I was really wishing to understand what I've understood at the moment as being your evidence about a blockage. That is to say, earlier on in answer to some questions you referred to the project that had been put up and you've said that it was a knotty problem, more difficult to resolve presumably than expected, and I was really wanting to explore in a non-critical way, what it was that was causing the knot to be there so that we can understand and don't end up sort of saying, well, this sort of done without understanding why it couldn't have been done with the clicking of the fingers.

DR HARTLAND: So my understanding is – and I hope this proves to be correct, that it's not absolutely a funding issue, that we would be able to marshal resources to do it. It has been simply the difficulty of mapping where the information sits in the transactional processing side, understanding how that information is constructed. So the point you made to me before about the recording of a vet's number is actually a really nice example of that. So if you recorded a DVA number, so you want to find an example of areas where we could understand vets, if we record a DVA number, that gives it to you, but if you do it in free text as you pointed out that's completely useless.

So you need to understand the format that information is collected in, where it sits in the system, how it gets changed when customer records get updated and then to build

a kind of connection between that and your database that can then relate it to the other things that you need to know about that customer. So the difficulty is, it has been described to me as trying to untangle a box of Christmas lights. It just takes time to understand where the data is, how to draw the data out of that system and then how to put it into a big database. If the Commission was to say you should have done this quicker I don't think there's anyone in the Commonwealth going to say that is unfair. I think we accept that we should have.

COMMISSIONER PAGONE: Just to play back what I think I've understood from that, the project is focused upon designing a system that will gather information so as to produce outcomes through the system that's gathering the information. Is that it?

DR HARTLAND: Yes. So, in essence we're trying to connect our customer relationship management system which you sit down, you talk to the customer, you record what their age is, with another computer that has got a big database of all the customers we have and all the service offers we have, and it's getting those two to talk to each other, that is in essence the problem.

COMMISSIONER PAGONE: And when you say talk to each other, of course, these are two machines so it's not actual conversation going on as you and I are having.

DR HARTLAND: Yes.

COMMISSIONER PAGONE: By talk to each other you mean that you have got inputs of information into a machine that produce inputs or populated information into the other machine so that ultimately outcomes are produced from this internal mechanical process and it is essentially a mechanical process.

DR HARTLAND: Yes, that's right.

COMMISSIONER PAGONE: So the knotty problem seems to be the creating of the mechanical system that will produce the outcomes that you think are going to be desirable, is that it?

DR HARTLAND: Yes, in terms of the data. Yes, that's a good way of putting it.

MR GRAY: Is that a convenient time?

COMMISSIONER PAGONE: I'm sorry to have taken up your time, Mr Gray.

MR GRAY: We still have Dr Hartland after lunch.

COMMISSIONER PAGONE: We do, I'm conscious of that. The Commission will adjourn until 2 o'clock.

ADJOURNED **[12.45 pm]**

RESUMED **[2.01 pm]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Operator, please restore to the screen the NSAF for home support assessment, CTH.0001.1000.7587. Dr Hartland, over lunch you've had a conversation, with my consent, with those instructing the Commonwealth in relation to an aspect of the evidence you gave about My Aged Care and the DVA number.

DR HARTLAND: Yes.

MR GRAY: The question of whether there's a field for inclusion of the DVA number in the instructions or a script available to operators at the call centre. Do you wish to clarify or correct your evidence?

DR HARTLAND: Yes, thank you for the opportunity. So over lunch we've reviewed it; there is, at registration, the capacity to record the DVA number in a structured format. And I hadn't – I simply hadn't remembered that properly when I was briefing myself. It's not a compulsory field, and it's used in circumstances where they may wish to use that number to help establish proof of identity. So if you were to use it in the way that the RSL suggests, counsel, which would be to automatically connect the two programs together, there's a technical capacity to do it but you would still need to deal with the issue about consent because you would be effectively sharing data across two systems. So you would need to come to that issue as well. It wouldn't annul that issue but it would be technically feasible within My Aged Care.

MR GRAY: At the same time as the DVA number was elicited by the operator, the operator could ask for consent, I suggest?

DR HARTLAND: That's exactly right. Yes.

MR GRAY: With respect to the National Screening and Assessment Form, the version of it that we have on the screen for the Commonwealth Home Support Program, before lunch you were answering Commissioner Pagone's questions about what is the nature of the knotty problem involved in extracting data from this form which would enable aggregated data analytics - - -

DR HARTLAND: Yes.

MR GRAY: - - - about special needs groups. And you suggested that the answer lay in interpreting free text that might have been included in the form.

DR HARTLAND: I don't believe it's only a free text problem. It's – but I don't have, in my briefing, a proper map of what exactly the data issue is. I made some inquiries to try and be in a position to explain to you why it has proved to be difficult and the explanation that I've been given and repeated for you, is around the difficulties of finding out exactly what the data looks like. But it's not only a free text - - -

MR GRAY: It's not simply a free text problem.

DR HARTLAND: It's only simply a free text problem, no.

MR GRAY: All right. Well, for the sake of completeness, I will just ask you to have regard to the following aspects of the form and I will just quickly ask some questions about it and then we will move on. If we go to page _0001, in the middle of that page there's a field for "specify risk of vulnerability or other". Now, that's a free text entry, is it? The field underneath there looks like it's just a big rectangle across the page. Is that for free text to be - - -

DR HARTLAND: That would be free text yes.

MR GRAY: How is this form actually filled in by an assessor; is it on a computer screen and the free text is typed in or is it actually a paper form, which is annotated?

DR HARTLAND: The typical practice would be to use a computer. I don't think we mandate either form. They could type it in. I've been to an ACAT assessment to try and get a feel for what they're like and that assessor concentrated on the conversation with the client and retained enough in some very informal notes to actually populate the field – the form later. So there's variability of practice and that's not undesirable because what you actually want is a relationship between the assessor and the client and making sure that you understand the person in front of you.

MR GRAY: Absolutely. I understand.

DR HARTLAND: But you would also find it as a computer form would be the most typical.

MR GRAY: In due course does it have to be submitted in digital form?

DR HARTLAND: Yes.

MR GRAY: Right. Now, we then go to page 0020 and we see that that reference "risk of vulnerability" reappear on that page. In the middle of the page, risk of vulnerability cohort; is there a connection? Is that a follow-up question in relation to the first question, or the first command, specify risk of vulnerability or other, on page 1?

DR HARTLAND: So this is an attempt to codify out of the complexity indicators which are designed to get at the client's circumstances and by their nature could apply to multiple circumstances, it could apply to different cohorts. This is an attempt to be able to understand systemically which kind of group the person fell into and it's a tick box but is one of the – it's one of the areas of data that we haven't been able to kind of connect up properly into a database.

MR GRAY: Okay. And thank you for the answer you gave connecting risk of vulnerability cohort to the text immediately above it. That's what I think you were doing in the answer you gave.

DR HARTLAND: Yes. That's right. Yes.

MR GRAY: But you didn't answer my question - - -

DR HARTLAND: I'm sorry, excuse me.

MR GRAY: - - - which was is there a connection to - - -

DR HARTLAND: The previous question.

MR GRAY: - - - the command on the first page, page _0001. Do you want to go back to that?

DR HARTLAND: Yes, could you just take us back to that.

MR GRAY: 0001, middle of the page it says:

Specify "risk of vulnerability" or "other".

DR HARTLAND: I don't believe there's a hard connection between the two, but this is – this part of the form is wanting to understand why the person has presented for assessment and the priority of assessment and the risks involved in that and you would expect that an assessor would have regards to the cohorts and would probably use them in a standard way but there is no automatic assumption that they flow through because they're trying to test different aspects of the client.

MR GRAY: Did you conduct a review of this form in 2018?

DR HARTLAND: No, I didn't.

MR GRAY: It could be – my learned friend, Mr Kennett, is suggesting that it could be a different form of vulnerability relating to the matters identified above on page_0001, such as hospital discharge, concern about increasing frailty, other.

DR HARTLAND: Look, this is a very - - -

MR GRAY: Yes. And they include a box for risk of vulnerability and a box for other, so that could well be right.

DR HARTLAND: Look, I don't think this is a hugely material thing in the way the form operates. It attempts to gather information about why the person presented for assessment and any special circumstances you need to understand in that presentation, and then it asks a question about, does the person that you've just assessed for needs, need any special help in relation to linking them to other supports or linking them through the aged care system and that's what the linking support section does. And then, as we discussed earlier before lunch, it also talks about given what you understand now about the person, do they have a particular support need. So they might want culturally safe aged care and they're attempting – they've got a similar story to them and the vulnerability cohorts flow through to them but it's not intended that it just be a very automatic process because it's a process for judgment and they're testing different things.

MR GRAY: All right.

DR HARTLAND: So I think you are right to draw our attention to the flow of the form but I'm not sure it's material to the issues you raise.

MR GRAY: Well, it could be material in this way, I'm trying to elicit from you whether it's really a huge impediment to data analytics that the form is formatted as it is, and could it readily be reformatted so that that problem could be overcome. In the middle of page - - -

DR HARTLAND: It's not a problem with the format of the form. It's a problem with where the data of the form ends up and how you – so the form feeds into, effectively, a machine that keeps track of what you know about the assessment and it's in that underlying database that the form supports, getting that data into another database that's the problem. It's not necessarily whether or not it's dropdown or tick a box here.

MR GRAY: Well, let's look at _0020 again; it's on the right-hand page. I suggest to you that with the exception of care leavers and parents forcibly separated from their children, there are actually boxes on that page that cover all of the other vulnerable groups or vulnerable cohorts or special needs groups to use statutory language. That's just a suggestion that I can make good on another occasion.

DR HARTLAND: I think that's readily observable. Yes.

MR GRAY: Just assume that that's right.

DR HARTLAND: Yes.

MR GRAY: And in respect of care leavers, on page _0022, in a field that you drew the Commission's attention to, there's actually a yes/no field for the question:

Does the client have a history of childhood experiences, for example, spending time in institutions, foster care –

etcetera, that would, in fact, pick up the concept of care leavers as well. So that there's – with the exception of parents forcibly removed – or parents from whom their children were forcibly removed, there's, in a yes/no format or a tick box format, information available on this form indicating membership of the vulnerable groups and, furthermore, you've just said that it has to be submitted digitally. Now, why can't that information as a data analytics exercise be harvested and analysed?

DR HARTLAND: So that's the problem and, look, you might – I might be running out of runway in terms of my capacity to explain and understand ICT, counsel, and I apologise if that's the case. So my understanding of the situation is, it's not that when you fill in the form, yes, there are yes/no answers and then there are some structured answers. So the customer relationship management system has a digital record of that data in a standard format but the issue is getting access to that data from that system, understanding exactly how it's constructed and then transferring it to another system in a structured way so the other system can accept it. So it's not only the problem that whether or not the form works, it's actually the underlying system.

COMMISSIONER PAGONE: Yes. So I had understood that answer before lunch, but I had understood that answer to be that it's essentially a programming issue, a computer programming question.

DR HARTLAND: Yes.

COMMISSIONER PAGONE: Indeed, as far as I could work out it's only a computer programming question. So I was a bit surprised by your other answer that costing and funding wasn't the difficulty. Because if it's only a programming question, it's just a matter of how you organise the computer program to, to use Mr Gray's word, harvest the information that's in there. I understand that computer programs may require some technical work in order to be able to get access to the information or to use the information. But it is only that, isn't it?

DR HARTLAND: Yes.

COMMISSIONER PAGONE: And if it is only that, it is only money.

DR HARTLAND: Yes, it is a matter of how much – I don't believe that the cost is the main impediment. The main impediment is the time it's taking us. We have people working on it. We are spending money on it. It is a computing program issue but it is going slowly.

MR GRAY: When did you start?

DR HARTLAND: So the problem was first identified in 2017. It was identified in the context of the Tune report. There was a formal project initiated in, I believe, November 2018, and work started in February 2019.

MR GRAY: So it took a whole year to even get started, did it?

DR HARTLAND: Yes, I wouldn't – you know, one would wish that it had been done quicker but I don't think that's the worst delay that I've seen but, yes, of course, it would have been desirable to work on it - - -

MR GRAY: And actual work, on your evidence, started in February 2019. And how much money is being spent – how many money has been spent since February 2019?

DR HARTLAND: I don't actually – I don't actually have that - - -

MR GRAY: Okay. Well, we'll seek that - - -

DR HARTLAND: That total but we can – you can – we can certainly provide it.

MR GRAY: Yes, I call for that information and we expect that information will be provided to the Royal Commission.

COMMISSIONER PAGONE: And if one wanted to understand the knots to the knotty problem, and this is a question that I actually ask, in fairness to you, and to the Department, but if one wanted to understand that in part to avoid the Commission simply being left with we asked and asked and didn't get an answer that we understood, who could we ask that would produce an answer that we would understand?

DR HARTLAND: Sir, look, the Department of Health – we would make sure that we brief someone who has better ICT knowledge than me.

COMMISSIONER PAGONE: Okay.

DR HARTLAND: It's not uncommon for ICT to fall between, you know, a policy wonk like myself - - -

COMMISSIONER PAGONE: Sure.

DR HARTLAND: - - - who expresses things a certain way – then you've got people that understand how to translate the business rules and then people that actually do the programming. And we all speak different languages. So the experience you're having is not uncommon, unfortunately. But, you know, obviously, from your questioning, it's – the answer's not hit the mark and we would have to give some thought who would be better placed to give you better advice. Yes.

MR GRAY: Dr Hartland, Mr Smith, in his statement, has given the Royal Commission evidence about the government action plan under the diversity framework. And an aspect of that relates to developing a data governance group overseeing integration and analysis of existing datasets. Has that got anything to do with the work you've been referring to, which commenced in February 2019?

DR HARTLAND: I would expect that the work would come under that when it's established, but my understanding is that that work was commissioned prior to the data governance group being established.

MR GRAY: I beg your pardon?

DR HARTLAND: My understanding is the work was commissioned independently of considerations about the data governance group, but it's clearly relevant.

MR GRAY: Yes. And the gist of Mr Smith's evidence is that as, at February 2019, work in relation to the data governance – I've just got to get the expression correct – data governance group hadn't commenced, and it was – that work was to commence in late 2019. Do you have any knowledge of the reason for that delay?

DR HARTLAND: The data? No. I've not been closely associated with the data governance group under the diversity framework, I'm sorry. No.

MR GRAY: Isn't it intimately connected with the attempt to extract the diversity-related information? Or data analytics from the data you have. Shouldn't it be closely – of interest to you what the scope of work of the data governance group is going to be?

DR HARTLAND: Yes, I think that's a fair comment. You know, effectively, there's two parallel bits of work going on. There's the diversity framework, which has observed that one of the Commonwealth's unique roles is to collect data. In parallel to that, there's been, for some time, some efforts to better integrate the National Screening and Assessment Form data into the data warehouse. That's the bit that I'm closely involved in. So, you know, as this develops, you know, noting that I've had this job position since July, I'd expect to be involved in the data warehouse, but I – sorry, in the data governance group, but I'm not quite sure what the issue is – that there have been two parallel bits of work trying to solve the same problem, and we know that we need to talk about it together.

MR GRAY: All right. Is this a case of the left hand not knowing what the right hand is doing?

DR HARTLAND: I don't see any evidence, from – I haven't refreshed my memory about Mr Smith's statement in relation to that, but I don't think - - -

MR GRAY: We'll bring it up.

DR HARTLAND: - - - he - - -

MR GRAY: It's - - -

DR HARTLAND: - - - implied that there was no work going on on it - - -

MR GRAY: - - - exhibit 10-17.

DR HARTLAND: - - - was he?

MR GRAY: Exhibit 10-17, beginning at 0060. I'll just let you have a look at a reference he makes to the Australian Government Diversity Action Plan, 0060. If you could call-out, please, Operator, the question, 48, and the two paragraphs, 231 and 2, beneath that. You see – tell me when you've refamiliarised yourself. I take it you've read the statement before; is that right?

DR HARTLAND: Yes. I have.

MR GRAY: Yes. Tell me when you're ready and I'll show - - -

DR HARTLAND: Yes. I've read those two paragraphs.

MR GRAY: - - - the two exhibits. The first exhibit is tab 1 of the general tender bundle. And, Operator, if you'd please go to page 1841. This is the original plan. And on 1841, under an outcome with an objective of:

> *Collect and use data and evidence on current and emerging trends in diversity to design, implement, evaluate and improve aged care systems and supports –*

The first action is develop a data governance group which will do those things.

DR HARTLAND: Yes.

MR GRAY: It just says, "From 2019." Operator, please bring up tab 25. This is the second exhibit that's referred to in the passage I showed you a minute ago. Go to page 2653. This is described by Mr Smith, in paragraph 232 of his statement, as a document which tracks progress as at September 2019; that is, progress in implementation of the plan I just showed you. And 4(a) at the foot of the page – if the operator could kindly call that out – you'll see, is the corresponding action. Timeline was from 2019, but activities undertaken are not yet commenced. Now, this might be a case of my having made an error in understanding you to be the ICT specialist, so perhaps I should have directed this particular question to Mr Smith, but I repeat my question. Is one part of the Department focusing on a data problem in relation to the NSAF in isolation from an initiative, albeit not yet commenced, which is intended to solve issues around data governance concerning diversity?

DR HARTLAND: Well, I don't think this is primarily an ICT problem. So I might be able to give you some helpful advice this time. Look, as I understand it, this is a governance issue that is in prospect – that action. So they're wanting to develop a formal group to look across the Department at all the data stuff that's going on and make sure they have an overview of it. That's a perfectly sensible thing to do out of the Diversity Action Plan. It's not inconsistent with a separate focus project running along in the background that we've been working on for some time.

My anticipation would be, once the data group has been developed, that that project could fold into or be oversighted by the new data governance group, but I don't see any necessary systemic problem that, at the moment – prior to the establishment of the data governance group, that there's a separate project that's chunking along in the background, trying to solve a problem that's been with us for a couple of years. And I would be alarmed if we dropped the ball on that other project, which, as you pointed out in your previous questions, has been taking too long, while we wait for a wider group to be established. I don't it's - - -

DR HARTLAND: I don't think it's of any concern at all that you would have the two running in parallel.

MR GRAY: The question is, rather, why has it taken so long for the data governance group proposal to even reach – well, it hasn't even reached the point where it's commenced, but it's about to commence - - -

DR HARTLAND: Yes.

MR GRAY: - - - Mr Smith says, in late 2018.

DR HARTLAND: Yes.

MR GRAY: Why has that taken that long?

DR HARTLAND: That's not in my area. I'm sorry.

MR GRAY: All right. That's the question I should have asked Mr Smith. Now, could I ask you some questions on some other topics?

DR HARTLAND: Please.

MR GRAY: CHSP, it remains block funded; correct?

DR HARTLAND: It's grant funded. I tend to be a bit particular with my words on this. For me, block funding implies that you give someone a lump of money without any regard to outputs or service deliveries. It's not that. It's grant funded, which means they get paid in advance, with the expectation that they'll make certain – create certain outputs, I think, was the word from Commissioner Briggs. And they equip against those outputs. So block funding can mean many things to many

people. I don't personally think it was block funding; I think it was a grant funding arrangement.

MR GRAY: Thank you. That's fair. Now, it's a long-term policy aim identified in the Aged Care - - -

DR HARTLAND: Yes. Yes. That's right.

MR GRAY: - - - Sector Committee roadmap - - -

DR HARTLAND: Yes. That's right.

MR GRAY: - - - that there'll be some sort of transition of the mechanism through which entry-level care in the home is delivered, along the lines of consumer-directed care, eventually; is that right?

DR HARTLAND: Well, again, I actually don't like the word consumer-directed care, but that's probably another long conversation. There's been a long-term commitment to integrate the two programs. And the exact form of that integration, what that might look like and how funds are allocated to providers and consumers, has never been adequately described. And there's some background to that. You know, I think - - -

MR GRAY: I won't tax you on that. But it's unclear what form that would take, but there is a long-term policy objective to bring the two programs together, home care - - -

DR HARTLAND: Yes.

MR GRAY: - - - and home support; is that right?

DR HARTLAND: Yes. So – that's right. To either have one program or better integrated programs. Yes. And the final - - -

MR GRAY: I understand.

DR HARTLAND: - - - form's not been decided.

MR GRAY: Now, before any move to make home support integrated with home care, if that involved a change to the way diverse needs are assessed at the entry-level Home Support Program stage, there would have to be an analysis of demand patterns and how diverse needs would be met. Would you agree with that?

DR HARTLAND: Yes. And that, in fact, is why - - -

MR GRAY: That's the Deloitte Report?

DR HARTLAND: Well, the Deloitte Report is our attempt to do that. And the fact that we don't have a good understanding not only in relation to diverse needs but across the program of exactly what's funded for who has actually been one of the major blockers to progress on integrating the two programs, because we've never been in a position to advise ministers about effect and risks of bringing the two programs together. So - - -

MR GRAY: I suggest to you that before a major change in the mechanism for delivery of an important essential human service, such as home support, you would – you, the Department, would need to conduct an analysis to understand the impact of that change in delivery mechanism. It would be irresponsible not to conduct such a - - -

DR HARTLAND: Precisely. Yes. Yes. That's - - -

MR GRAY: Yes.

DR HARTLAND: - - - exactly right. Yes.

MR GRAY: And, of course, no analysis is necessarily going to be absolutely perfect, but an analysis using the best available data would have to be conducted, so that there's a reasonable level of confidence as to what the impacts of the change in delivery mechanism are going to be, before the change happens. Agreed?

DR HARTLAND: Absolutely. Yes.

MR GRAY: Yes. And it would be irresponsible not to do that. Yes?

DR HARTLAND: Yes. Yes. Absolutely. I mean, that's – as I said, that's why, in my view, that commitment to integration – it's been hard to do because of that very hurdle.

MR GRAY: Yes.

DR HARTLAND: No one's been able to advise properly on risk.

MR GRAY: Now, I want to ask you about what happened, according to your – I know you weren't in your First Assistant Secretary position at the time. I think you may have been in a policy adviser position at the time, but I want to ask you about the lead-up to the change in mechanism for the delivery of home care. So I'm moving now from CHSP, up a level of need, to the higher levels of community and in-home care represented by the Home Care Program. Previously, when that was centrally allocated, home care places were allocated, essentially, under the ACAR mechanism, taking into account central planning for diverse needs on a regional basis; correct?

DR HARTLAND: Yes.

MR GRAY: And, in February 2017, as part of the Better Choices Amendments – yes, the Better Choices Amendments – sorry, Increase Choices. Part of the - - -

DR HARTLAND: I missed it too, counsel.

MR GRAY: Yes. As part of the Increase Choices Amendments, the mechanism was changed to what's called Consumer Directed Care.

DR HARTLAND: That's right.

MR GRAY: Now, what was the impact analysis, if any, done by the Department prior to that change occurring, so that the impact of the change could be understood before it occurred?

DR HARTLAND: Well, in home care we do actually have a reasonable understanding of the major groups and their access to home care packages. So we knew where access was. And I believe that's in one of the tables in my witness statement. So we had a good understanding of what people were getting in home care, which we don't in CHSP. I think – I've looked at the briefing at the time and I think it's also true to say that we had a view that the current system as it then related to providing for special needs groups in home care and assisting customers get – with special needs – into it was actually pretty inadequate.

MR GRAY: Pretty?

DR HARTLAND: Inadequate. So when you look at the ACAR results and you go to the provision for a very precise number for a local area for special needs groups in the ACAR round, your mind is automatically taken to, that's pretty scientific and pretty robust, but actually it wasn't a great system for people with special needs. The system worked a bit like resi is today. People would get an entitlement and have a capacity to go and find a provider. But there was no transparency over which providers actually held – for a consumer there was no transparency over which providers actually held a special needs place that they might access to. Consumers had no choice because providers actually held the places.

So if you were a Greek person and you knew there was a Greek provider, if you wanted to go to a Greek provider and that provider was full and had no places, bad luck, that provider had no capacity to provide you an additional place. So we thought at the time that this was actually – one of the big rationales for changing to this system was actually to help special needs. From a provider's perspective, the specialist providers found it very hard to win places at ACARs so they weren't getting into the system. So at the time the thinking was that this new system of a fairer way of putting people on the queue would actually help special needs groups. And I think if you look at my statement, I think you can see that that's actually true for Indigenous people and CALD.

So they've gone up in absolute terms in access to home care and as a percentage of home care packages. There is a problem with rural and remote which I know we are not dealing with today which the Department has already recognised. So I think while that old system of ACARs with the kind of planning around special needs looked good, it actually wasn't and it was actually disadvantaging special needs groups.

MR GRAY: With respect, Dr Hartland, you've made a good submission there, criticising – no, I'm serious, criticising the previous allocation system, the ACAR method of allocation and whether that was validated as actually meeting the diverse needs of people.

DR HARTLAND: That was another problem with it.

MR GRAY: And you've have referred to ex post facto evidence that may be, maybe the introduction of CDC for the Home Care Package Program has had a beneficial effect. We will come to that in a minute. But apart from saying that your thinking at the time was along particular lines and that you knew how many places had been allocated to some groups, and I will come to that table in a minute, you haven't identified an impact study in your answer to my question.

DR HARTLAND: Okay, that's fair enough, and that was your question. I apologise if I missed it. Look, I wasn't – I've reviewed some of the briefing and questions and answers prepared to try and understand the thought process and, you know, that – that was - - -

MR GRAY: I'm glad to hear there was some thinking but was there - - -

DR HARTLAND: An impact analysis.

MR GRAY: - - - an impact analysis.

DR HARTLAND: I'm not - - -

MR GRAY: Because remember your answer a minute ago. If an analysis of that kind using the best available data to a reasonable level of confidence to understand demand patterns and the ways in which diverse needs would be met and whether the capability to meet them would be affected by the change of mechanism, it would be irresponsible – you are happy to accept that expression, it would be irresponsible to implement a change. You can see - - -

DR HARTLAND: I can see the point you're making.

MR GRAY: - - - that that makes it very important to identify whether there was an impact analysis done before CDC was implemented for Home Care Packages.

DR HARTLAND: Yes.

MR GRAY: Was there one?

DR HARTLAND: So, I don't know the answer to that question. We can get it.

MR GRAY: Okay. Now, is the table you mentioned, the table at – this is in your statement. Operator, if you could bring up Dr Hartland's statement, WIT.0486.0001.0001 at page 3932. Not there? If I just give you a separate code number CTH.0001.1001.3932. Is that the table?

DR HARTLAND: No. So if you go to paragraph 53 of my statement - - -

MR GRAY: Thank you.

DR HARTLAND: That is a table that shows the outcome of the ACAR.

MR GRAY: It's 0012, please, operator. And this is – just picking up on the oral evidence you were giving before - - -

DR HARTLAND: Yes.

MR GRAY: - - - this is, in effect, part of your ex post facto argument that perhaps there has been a beneficial influence.

DR HARTLAND: That's right. Yes.

MR GRAY: Yes. But it's not an ex ante impact analysis.

DR HARTLAND: I'm sorry, my Latin is not as well refined as it might be.

MR GRAY: You don't know whether there was one. You don't know whether there was an impact analysis done before the change in mechanism?

DR HARTLAND: No, I don't know whether there was or not. So – and I don't think we can conclude that there wasn't on that basis. But certainly if you look back from where we are now, you can see that there are improvements for two of the sensitive special needs groups in those statistics. You would expect absolute numbers to go up because home care has increased quickly over that period but their percentage share has also gone up. There are – you know, and I think that's a result that would be welcomed, I would hope, by most of the groups commenting on the Home Care Program.

MR GRAY: So you're talking about Aboriginal and Torres Strait - - -

DR HARTLAND: And CALD.

MR GRAY: - - - Islander and CALD?

DR HARTLAND: Yes, that's right.

MR GRAY: And have you done a confidence interval analysis as to the statistical significance of those percentages?

DR HARTLAND: Well, this is an absolute census of all – it's not a sample, so I'm not sure why we would be doing a confidence interval analysis of it.

MR GRAY: Okay, fair enough. So there's a very small improvement in the percentage representation amongst the home care package program of those two groups, in the order of .4 per cent for Aboriginal and Torres Strait Islander and .8 per cent for CALD.

DR HARTLAND: Yes, that's right.

MR GRAY: Yes.

DR HARTLAND: Yes.

MR GRAY: Now, there's no analysis done of the extent of unmet need for either of those two groups, is there?

DR HARTLAND: No. I mean - - -

MR GRAY: That is need that - - -

DR HARTLAND: No.

MR GRAY: Demand that was never met by the Home Care Package Program in the first place.

DR HARTLAND: No. No, I mean, we have had an attempt recently in the context of the Tune report to look at unmet need across three big programs. It didn't go to the level of granularity about Aboriginal and Torres Strait Islanders and CALD. And it won't be welcome news to you to hear that it hit the rocks on the same thing we were discussing previously, which was the capacity to get RAS and ACAT information into a warehouse.

MR GRAY: All right.

DR HARTLAND: So anyway, just for completeness.

MR GRAY: Just for completeness. And just for completeness, apart from those two groups and the rural, regional and remote groups or at least regional and remote, there's nothing at all?

DR HARTLAND: We presented some other analysis to you in that statement about - - -

MR GRAY: Customer satisfaction.

DR HARTLAND: - - - three other groups so – well, we can come to that.

MR GRAY: The tracking report?

DR HARTLAND: I wasn't thinking about that. I was thinking we can tell you a little bit about access for veterans, homeless people and financially disadvantaged people as measured by pension receipt, and we've presented those to you in the statement as well. So we have some data that we can give to you on how six of the special needs groups have fared post the increasing choice measures but as we've discussed, we don't have data on care leavers, parents separated from their children and LGBTI groups.

MR GRAY: And what's the reliability of the data on the veterans and other groups?

DR HARTLAND: The veterans data is measured by the supplement which, as we discussed this morning, is pretty small. So - - -

MR GRAY: 190 people.

DR HARTLAND: Yes. So it's obviously a subset of veterans. So I think we have been pretty careful to transparently qualify that that's not a great measure. Homeless is an issue, I think as you discussed with Mr Smith. That's a very hard group to get data on. By their nature they're not a group that are sitting waiting for you to administer a questionnaire. I'm reasonably confident that the picture – that we understand the picture with low income people from pension rate receipt but I'd readily concede that homeless and vets, we do need to do some work on.

MR GRAY: Okay. Now, in paragraph 51 of your statement, perhaps I should start with 47 on page 0010, under the heading Tracking Research, you refer to, in effect, what amounts to satisfaction surveys. Relevantly the surveys have included potential care recipients and actual care recipients; is that right? But there's also been - - -

DR HARTLAND: Yes.

MR GRAY: There's also been respondents to surveys from providers and professionals. I just want to ask about the recipients and potential recipients. You don't identify – I beg your pardon, I withdraw that. You say that in this passage at paragraph 47 through to 51, you say that there was a baseline established – I beg your pardon, I withdraw that. You say that there's relevantly three pieces of research. The first at paragraph 48, 2017 research, approximately six months after implementation of the increasing choice amendment. And you say that:

Research included confirmed CALD and Aboriginal and Torres Strait Islander participants but due to sample size granular findings for these groups was not reported.

Then there was 2018 research, paragraph 49. That focused on current and prospect home care package care recipients and carers to better understand the barriers to taking up a home care package. So it was a combination of quantitative and qualitative methods used to gather that data. You don't refer to the outcome of that research as necessarily validating any particular outcome, positive or negative, as to whether the consumer-directed care model for delivery of the home care packages has been meeting the needs of diverse populations better or worse; correct?

DR HARTLAND: That's right. So I believe you – that research was a very focus group style research to understand the communications needs of groups interacting with My Aged Care and home care packages. So it wasn't an attempt to systemically understand people's experience in the system. You know, the question was have you done any research? And so we've trawled through our archives to see if there's anything useful we can offer and we've offered three pieces of research. They're actually – the tracking research is actually part of a longer wave of research into how My Aged Care is going that started in 2016.

It was refreshed in 2017, and I believe the 2019 report you have is the final wave of that research. We didn't provide the 2016 and '17 ones because they were outside of the time period asked by the question. But what this shows, I think - - -

MR GRAY: This is now paragraph 51, Dr Hartland?

DR HARTLAND: Yes, that's right.

MR GRAY: Yes.

DR HARTLAND: So, you know - - -

MR GRAY: Can I have the document produced on the screen for you so that we can ask you some questions about it. It is one of the newly tendered documents, Commissioners. It's tab 135 please, operator. CTH.1000.0003.5793. Is that the document you are referring to now, Dr Hartland?

DR HARTLAND: Yes, that's right.

MR GRAY: Yes. Now, can I just ask you some questions about this?

DR HARTLAND: Of course.

MR GRAY: There were respondents to this research including home care packages, carers and recipients. That seems to be evident from page 5798. Can you see that there under Research Scope? Now, that sounds to me like, in terms of home care

package, we are talking about people who are already in receipt of a home care package but there's also a category there for a quota of respondents in relation to the first bullet point My Aged Care recipients. Does that mean people who receive any sort of service from My Aged Care, whether they ultimately get a package or are connected with a residential care service for that matter?

DR HARTLAND: Look, I think that's right, counsel. I do have to be a bit qualified because I only myself reviewed this document last night and went naturally to the last bits around special needs. But the – overall, it's attempting to understand the effects of the changes and the introduction of My Aged Care both on specifically home care package receivers but also people on CHSP who may become at some point in the future, a home care package recipient.

MR GRAY: Does it include people who want to get a higher level of home care but haven't necessarily yet got one? For example people in a waiting list?

DR HARTLAND: I think it includes CHSP people. I'd – I'd need to review the document again just to be able to give you good advice on that. I'm sorry, I should have looked at it more closely last night.

MR GRAY: No, not at all. And in fairness this is just a draft and it's hot off the press, is that right?

DR HARTLAND: Yes. That's right, yes.

MR GRAY: Yes. And in terms of culturally and linguistically diverse and Aboriginal and Torres Strait Islander people, there's a summary of findings - - -

DR HARTLAND: Towards the end.

MR GRAY: Towards the back, yes, 5867. Now, I won't – because we're going to run short of time, I won't go through the statistical methodology in detail but a 95 per cent confidence interval or confidence level was chosen for conclusions to be reached about relativities in movement and relativities in satisfaction ratings between cohorts. Have you familiarised yourself with that part of the report?

DR HARTLAND: No, but I'm – I'm familiar with the statistical problem.

MR GRAY: Right.

DR HARTLAND: Yes.

MR GRAY: And that's a commonly accepted sort of best practice confidence interval, isn't it?

DR HARTLAND: Yes, that's right.

MR GRAY: And in your statement you've said, look, the outcome of this data – or these data, is that – and I'll just ask the operator to go to 5868. You've said:

> *In respect of the groups for whom the report is able to produce conclusions of any kind, ATSI, CALD –*

and you've said rural and remote, but just stick with ATSI and CALD for the moment. You have said:

> *Overall there were no significant variances in the findings from rural and remote, CALD and Aboriginal and Torres Strait Islander participants to that from the general population.*

At the foot of page 5868 there's actually what looks like a pretty low – what's described on the next bullet point over the page at 5869 as:

> *...a low or somewhat lower satisfaction rating for Aboriginal and Torres Strait Islander people compared to the other groups.*

Do you see that? It seems to be 58 per cent compared to 73, 72 and 72; is that right? Looking at the foot of page 5868, am I interpreting that table correctly? Or is it perhaps – yes.

DR HARTLAND: Sorry, I think you need to be looking at figure 83. I think these tables, tables 6 and 7 are about the contact points for these people.

MR GRAY: Thank you.

DR HARTLAND: So I think you need to - - -

MR GRAY: So looking at table 83 - - -

DR HARTLAND: Yes.

MR GRAY: - - - so we're looking at wave 3, and there's very dissatisfied 25 per cent – I see.

DR HARTLAND: Yes.

MR GRAY: So that's a - - -

DR HARTLAND: So these are the results that are relevant to how happy people are with My Aged Care.

MR GRAY: Thank you. Yes, of course. I see. Now, that's, at least nominally, quite a lot lower satisfaction rating on the part of the Aboriginal and Torres Strait

Islander or ATSI cohort, isn't it, compared to the other groups. How do you square that with what you've said in paragraph 51 of your statement? I'll read it:

> *Overall, there were no significant variances in the findings from rural and remote, CALD and Aboriginal and Torres Strait Islander participants to that from the general population.*

Shouldn't you at least have said there was significant variance on the part of the Aboriginal and Torres Strait Islander participants?

DR HARTLAND: So table 83 is carers, not participants.

MR GRAY: Well, let's - - -

DR HARTLAND: So table - - -

MR GRAY: - - - look at 82, then.

DR HARTLAND: - - - 82 would be the one that you'd want to look at for recipients.

MR GRAY: Yes.

DR HARTLAND: No, your point still holds. I think – I've reviewed the document last time and this looks lower than the general population, but the point about statistical significance is that – colloquially, it's been an interesting experience today, having to try to explain ICT, not being an ICT expert, or statistics, not being an expert on statistics.

MR GRAY: It's a point about statistical significance you're making, is it?

DR HARTLAND: It's a point about statistical significance. So - - -

MR GRAY: So when you say - - -

DR HARTLAND: If you had randomly picked - - -

MR GRAY: - - - significant variances - - -

DR HARTLAND: - - - 15 people - - -

MR GRAY: - - - you mean statistically significant - - -

DR HARTLAND: Yes.

MR GRAY: - - - variances?

DR HARTLAND: Yes. That's right.

MR GRAY: And because the sample size, and perhaps its volatility, was such that, in terms of a 95 per cent confidence interval - - -

DR HARTLAND: Yes. So the - - -

MR GRAY: - - - you couldn't say that - - -

DR HARTLAND: That's right.

MR GRAY: Sorry. When you apply a 95 per cent confidence interval, you couldn't say that was a statistically significant - - -

DR HARTLAND: No.

MR GRAY: - - - variation; is that right?

DR HARTLAND: No. The variation in the population would be if you'd randomly picked 15 people you would expect to get these results while they still actually had a mean that was actually on the - - -

MR GRAY: All right.

DR HARTLAND: - - - population sample. So you can't say it's statistically - - -

MR GRAY: Yes.

DR HARTLAND: - - - significant.

MR GRAY: But it - - -

DR HARTLAND: It is lower.

MR GRAY: The point can be put the other way. The - - -

DR HARTLAND: It is lower.

MR GRAY: The samples are such that none of the results about customer satisfaction are statistically significant, in that sense.

DR HARTLAND: I don't think it would – you could calculate the confidence interval for the whole population and find what the expected - - -

MR GRAY: Sure. I mean - - -

DR HARTLAND: Where the mean might lie.

MR GRAY: - - - for the specific - - -

DR HARTLAND: So if the government, you know - - -

MR GRAY: The specific subgroups. The specific - - -

DR HARTLAND: If I was going to say – if 80 per cent of people are satisfied, I would need to qualify that that it could be plus or minus whatever the interval would be.

MR GRAY: All right.

DR HARTLAND: That would be the technically correct way of doing it. So I don't think the document has that in it, but maybe there's a case that it ought to.

MR GRAY: You've got responsibility for CHSP. CHSP is, you might have heard me put this to Mr Smith, in a way, the inheritor of a number of separate state and territory - - -

DR HARTLAND: Yes.

MR GRAY: - - - arrangements that were mostly under the banner of the HACC program, but not exclusively under that banner.

DR HARTLAND: Yes. That's right.

MR GRAY: Have you done an analysis of the strengths and weaknesses in the various jurisdictions, so that you could reach conclusions about what's a model that might be best for the country as a whole?

DR HARTLAND: So the Deloitte exercise that we've referred to a number of times is looking at what is the pattern of provision across the states and territories. They're different in terms of the service types that are funded. So there are different patterns in each jurisdiction. They're different in terms of who gets in. And the unit costs are also quite different across the jurisdiction. So it is a patchwork.

MR GRAY: Can I ask you something specific about Victoria. The Royal Commission has received evidence about the Access and Support Program in Victoria.

DR HARTLAND: Yes.

MR GRAY: Which, in a nutshell, is a navigator service, with some additional - - -

DR HARTLAND: Yes.

MR GRAY: - - - advocacy elements and linkage elements. It's funded 70/30, Commonwealth and state.

DR HARTLAND: Yes.

MR GRAY: Do you know anything about that program and how effective it is for meeting the needs of diverse groups in Victoria?

DR HARTLAND: So this is a bit like the housing program we discussed before lunch, the Assistance with Care and Housing. So – yes, to help you today, I've refreshed my mind about what the programs do. I think, personally, they're a valuable part of the matrix of services, because when you talk about vulnerable groups you do need, you know, as we discussed before lunch – I was, sort of, trying to say, "No. We don't only assume that people call up or log on to get into My Aged Care. We fund other organisations to do it." So this program, like Assistance with Care and Housing, and like what we do with navigators, is about an outreach, to get vulnerable people into the system. I think they're a really valuable part, but we haven't done an evaluation of the effectiveness of that program. And I think - - -

MR GRAY: Do you really need to have the navigator's trial if you've already got a system that is working in Victoria? Or is the problem that you haven't evaluated it, so you don't know if that system's working properly or not?

DR HARTLAND: Well, I think, two things. So, no, we haven't evaluated it to know whether it's working properly or not. We are interested in national systems. So that something works well in Victoria, given their context, doesn't necessarily mean that it will translate into other states. And so, you know, we're trying to build a national aged care system out of the HACC basis. And while I don't think that they're necessarily limited, these programs were set up well before the national prioritisation system and the developments in My Aged Care.

And so I think there, at the minimum, needs to be some retooling of the technology. So I don't – I think, drawing all those together, it's a sensible time to look at that issue again would be once we know the outcomes of the navigators of a new model. And then we can assess whether the new model is so different to what we were doing before that – and we would be – we should expand it or should we actually have the two running side by side. And I just don't think we have that information in front of us yet.

MR GRAY: I want to ask you about something that probably falls within your bailiwick, in, perhaps, a slightly counterintuitive way. It's this. The Royal Commission has received evidence, including evidence from Ms Janette McGuire yesterday. I don't know if you were able to view - - -

DR HARTLAND: Sorry. The name doesn't ring a bell.

MR GRAY: - - - or read that evidence. Ms McGuire's a Forgotten Australian. So she's in, in effect, one of the cohorts that make up the group of people defined in the statute as care leavers. She gave evidence from which an inference can be drawn that there's going to be a significant cohort of people who will be unwilling to enter residential aged care. And I put it higher than that. They're probably a group for whom the trauma associated with re-entry into an institutional setting of that kind would have the most devastating effects. Are you doing planning in the home care space to cater for what will be an increasing number of people described as care leavers, for whom residential aged care may simply just not be an option?

DR HARTLAND: So there's two things going on that bear on that question. But because you like direct answers, we're not specifically planning on what you asked me for. But, certainly, the navigators, which we talk about a lot, is an opportunity to test a new way of gauging whether those people – we're also in the process of scoping a study that would respond to the University of Wollongong's recommendation that we do something like a RUCS study for in-home care.

And, as a part of that study, I'd like to test what do we know about what can – we can effectively provide – what levels of need we can effectively provide for – efficiently in a home setting, because I don't think we've reviewed that question recently. So if you put those two together, there's a bit of a path for that group. But your question was are we specifically commissioning something for that group on that issue, and, no, that's not in prospect at the moment. But when those two things come together, we'd be in a better place to make some judgments about how to look after that - - -

MR GRAY: All right.

DR HARTLAND: - - - cohort.

MR GRAY: Two final questions. I won't put the statement up, because I need to save time, but Ms Tunny gave evidence in her statement, at paragraph 30(b) – I put it up on the screen for Mr Smith earlier. There was an aspect of it that I needed to ask you about. It was an assertion that My Aged Care cannot track a client from the point of connection with My Aged Care to provision of service in the aged care system. Is that correct?

DR HARTLAND: So I don't believe it's correct in relation to an individual client. I think the point that she was making was having a macro understanding of Indigenous people's pathway through the system at a population level. And I think there are some issues about that, though. We have good knowledge, as I said before – I was saying we had good knowledge about Indigenous people in services. The data on access to assessment, for example, shows a much lower share of Indigenous people than you'd expect. And we think that might be a data problem of people not declaring at that point. So I think it's – while we can track an individual through the population stuff, end to end, it's still an issue for us. I assume that's what she's referring to.

MR GRAY: Thank you.

DR HARTLAND: Yes.

MR GRAY: Finally, the mechanism for delivery of home care packages was changed in February 2017. I'm going to call – and I do call for any impact analysis that was done about the effect of that change before it happened on diverse groups.

DR HARTLAND: Yes.

MR GRAY: You say you don't know whether it was done. I suggest it was irresponsible if the change was implemented without an impact analysis having been done. What do you say to that?

DR HARTLAND: I don't think I'd go so far as to use the terms you just used. We did, at the time and we do now, have a reasonable understanding about access to services for people with home care, and we had a good theoretical and – position that it ought to improve their access, and backed up by the feedback we were getting from the sector. So whether there was a formal impact analysis, I just don't know. And I'm sorry - - -

MR GRAY: No, that's all right.

DR HARTLAND: - - - but I think at the time people had information in front of them and good reasons to think that the program wouldn't have – wouldn't decrease access. And home care, going back to – you know, you're right to point out to me – my statement before, about the integration of two programs, but the data for home care is much simpler in one respect; there are other problems with it. The CHSP data and the risks about not knowing what would happen, that risk is much greater in CHSP by nature of the program compared to home care, because home care you still have concept of a person in a place. In CHSP, you don't have any of that concept. You have a concept of a service offer that a person might access. And it's a chore to understand what happens to people in that system. And so there weren't quite the level of risk in home care that there is in CHSP through the lack of data.

MR GRAY: And, finally, the evidence after the fact about the impact of CDC and special needs groups. The evidence is very thin; it's limited to some categories. Even in respect of those, it's unclear whether it's statistically significant. And for the majority of people, it's unclear whether diverse needs are met better or worse as a result of the change.

DR HARTLAND: So you put three propositions to me.

MR GRAY: We've, really, gone through them all. And - - -

DR HARTLAND: So I think you've mischaracterised my evidence in relation to the first two. So I don't accept that the evidence is thin. You know, I think the stats

we've presented in my statement around access for CALD and Indigenous isn't thin. That's actually pretty good, robust data. And we discussed statistical significance before the census; that doesn't apply to the census stats. It does to the monitoring. So I would accept it in relation to that, but I wouldn't accept it in relation to the table in paragraph 53.

MR GRAY: Those are my questions for Dr Hartland.

COMMISSIONER PAGONE: Yes. Thank you.

COMMISSIONER BRIGGS: Okay. If I could make the point – I think you seem remarkably sanguine about the Home Care Packages Program, given that there are more people on the waiting lists than are receiving packages. So we really don't have any true understanding of the character of that program. Moreover, we don't know, within the cohort who are receiving packages, what they're actually getting. So I'm not confident that the CHSP is a lesser model in terms of understanding fair distribution of services than the packages model.

DR HARTLAND: Look, I would agree that understanding more about people on the waiting lists is a big issue. And that's a huge overlapping set with understanding more about CHSP, because 97 per cent of people on the waiting list are – have a right to service in CHSP. And to the extent that you don't understand that overlap, you've got very little understanding about what the queue actually means. So I accept that point. You know, you're right also to point out that there are limitations of data in home care packages. And we're about to commission a study to actually try and find out what is it spent on. So I agree with you on that point. You know, it's – I think CHSP and home care have these interesting mirrored deficiencies. You know, in CHSP we do have data; it's not fantastic, but we do actually have data on what things are spent on. But we can't track the person, because all we have is services.

Home care, we have good data on the person but we don't know what it's spent on. So you know, as a self-confessed data policy nerd, that's a very frustrating position for us to be in. We're trying to address both of those ends, so we get a better end-to-end look at people. And once we've got the Deloitte study in, the study that we're commissioning on what's actually happening in home care and the study I referred to earlier about what is the – effectively, a RUCS for in-home care, I think then you would have a much more stable and robust basis for giving advice to government on what, actually, unmet need actually looks like in home care and what the solutions might be.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Yes. Thank you, Dr Hartland. Thank you for giving evidence.

<THE WITNESS WITHDREW [3.05 pm]

COMMISSIONER PAGONE: The Commission will adjourn till 9.15 tomorrow morning.

MATTER ADJOURNED at 3.05 pm UNTIL THURSDAY, 10 OCTOBER 2019

Index of Witness Events

JAYE ALEXANDER SMITH, AFFIRMED	P-5490
EXAMINATION BY MR GRAY	P-5490
THE WITNESS WITHDREW	P-5534
HEATHER JESSIE BROWN, AFFIRMED	P-5534
EXAMINATION BY MS BERGIN	P-5534
THE WITNESS WITHDREW	P-5539
NICHOLAS GERARD HARTLAND, SWORN	P-5539
EXAMINATION BY MR GRAY	P-5539
THE WITNESS WITHDREW	P-5586

Index of Exhibits and MFIs

EXHIBIT #10-17 SECOND WITNESS STATEMENT OF MR JAYE SMITH DATED 04/10/2019 (WIT.0427.0001.0001)	P-5493
EXHIBIT #10-18 STATEMENT OF HEATHER JESSIE BROWN DATED 01/10/2019 (WIT.0537.0001.0001)	P-5535
EXHIBIT #10-19 WITNESS STATEMENT OF DR NICHOLAS HARTLAND DATED 30/09/2019 (WIT.0486.0001.0001)	P-5541