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TRANSCRIPT OF PROCEEDINGS

O/N H-985237

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

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

ADELAIDE

10.11 AM, TUESDAY, 19 MARCH 2019

Continued from 18.3.19

DAY 11

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

COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: I call Josef Rack.

<JOSEF RACK, AFFIRMED [10.11 am]

<EXAMINATION-IN-CHIEF BY MS BERGIN

MS BERGIN: Have a seat, Mr Rack. Mr Rack, there should be a hard copy of your statement in the witness box. Is there a hard copy of your statement in the witness box?

MR RACK: Yes, there's a hard copy.

MS BERGIN: And is that your statement in this matter?

MR RACK: It is my statement that I made.

MS BERGIN: Do you have any edits or corrections to your statement?

MR RACK: No.

MS BERGIN: I tender the statement of Josef Rack, document WIT.0068.0001.0001.

COMMISSIONER TRACEY: The statement of Josef Rack dated 4 March 2019 will be exhibit 2-15.

EXHIBIT #2-15 STATEMENT OF JOSEF RACK DATED 04/03/2019 (WIT.0068.0001.0001)

MS BERGIN: Mr Rack, when did you first enter the aged care system?

MR RACK: It was approximately in the end of 2010.

MS BERGIN: And when was your ACAT assessment carried out?

MR RACK: The same time, around that, in that area, in that timeframe of that.

MS BERGIN: Who was the first approved provider that you dealt with?

MR RACK: The first approved provider was Southern Cross.

MS BERGIN: Operator, could you please bring up document SCC.002.0001.0283. Operator, could you please leaf through the first few pages of that document. Mr Rack, is this the care recipient agreement that you entered with Southern Cross Care?

MR RACK: Yes, that is the agreement that I signed.

MS BERGIN: I tender the Care Recipient Agreement between Southern Cross Care and Mr Rack.

COMMISSIONER TRACEY: Yes, the Care Recipient Agreement between Mr Rack and Southern Cross Care dated 14 October 2010 will be exhibit 2-16.

EXHIBIT #2-16 CARE RECIPIENT AGREEMENT BETWEEN MR RACK AND SOUTHERN CROSS CARE DATED 14/10/2010 (SCC.002.001.0283)

MS BERGIN: Mr Rack, what services were provided to you by Southern Cross Care?

MR RACK: Southern Cross provided me with a four hourly service a week, and it includes domestic service in the house, mainly house cleaning, ironing and linen and more or less all inside in the house for the assistance.

MS BERGIN: And how long did you receive services from Southern Cross Care?

MR RACK: The services lasted until 2017.

MS BERGIN: Operator, could you please bring up document SCC.0001.0171 – it is SCC.002.001.0171. Operator, could you please leaf through the first few pages of the home care package agreement on the screen. Mr Rack, do you recognise this document as a document you entered with Southern Cross Care?

MR RACK: Yes, I do recognise that.

MS BERGIN: Operator, I want you to go to the signing page, which identifies Mr Rack. That's page .0180. And could you please also turn to page 11. Thank you. I tender the consumer agreement dated 2 December 2014 between Southern Cross Care SA and NT Incorporated and Mr Josef Rack.

COMMISSIONER TRACEY: Yes, the consumer agreement between Mr Rack and Southern Cross Care dated 2 December 2014 will be exhibit 2-17.

EXHIBIT #2-17 CONSUMER AGREEMENT BETWEEN MR RACK AND SOUTHERN CROSS CARE DATED 02/12/2014 (SCC.002.001.0171)

MS BERGIN: Now, Mr Rack, when you entered these agreements in 2010 and 2014 with Southern Cross Care – when you entered these agreements with Southern Cross Care, what explanation were you given about the agreements?

MR RACK: That they will take care of all my domestic requirements, and that they will do any – any job that I ask them to do, and provide me with a consistent service every week.

MS BERGIN: And what home care package level were you allocated by the Commonwealth?

MR RACK: I was allocated a level 2 home care package.

MS BERGIN: And did the number of hours of domestic assistance you were given by Southern Cross Care change during the period of their service to you?

MR RACK: The total hours did not change but the hourly rate was divided into five blocks but with the same rate of hourly charge. Instead four hours, it was then five hourly blocks, 50 minutes blocks which amounted up to $206 and something cents for the four hours.

MS BERGIN: Okay. Operator, could you please turn to the statement of Mr Rack at JRA.0002.0001.0435. So, Mr Rack, is this an example of a statement that you were given by Southern Cross Care?

MR RACK: Yes. Yes, these are the statements I received regular monthly. I received the statement every month.

MS BERGIN: Every month. Operator, could you please turn to the next page, .0436.

Is this an example of the form of the statement that was given to you by Southern Cross Care?

MR RACK: Yes, that's correct.

MS BERGIN: When you said a moment ago that you were invoiced in five – that the invoicing changed from hourly blocks to - - -

MR RACK: 50 minutes blocks.

MS BERGIN: To 50 minutes blocks - - -

MR RACK: Yes.

MS BERGIN: - - - is this an example of the 50 minute block that you were referring to?

MR RACK: Yes, that is the example and that's how it worked from then onwards.

MS BERGIN: So when we look at, for example, the transaction dated 5 January 2017, there are five entries for that date; is that correct?

MR RACK: Yes.

MS BERGIN: And is this what you are referring to as the 50 minute blocks.

MR RACK: Yes, that's what I referred to and those are the hourly charges which were previously 60 minute hour and now it is for 50 minutes but the same rate of charges.

MS BERGIN: So when you refer to the hourly invoicing, I want to take you now to the December 2016 statement.

DR McEVOY: Operator could you please bring up document JRA.0002.001.0432. Mr Rack is this your statement from that period?

MR RACK: Yes.

MS BERGIN: Operator, if you could go to the second page of that invoice, please, and if you could bring up the entries for the 1 December 2016, which are at point 5 of the page. Mr Rack when you mentioned before that you were charged in hourly blocks - - -

MR RACK: Yes.

MS BERGIN: - - - up until January 2017, is this what you are referring to?

MR RACK: Yes, these are the charges I used to have, the hourly rate, the 60 minutes rate and then they were divided into the 50 minutes but the same hourly rate.

MS BERGIN: Operator, could you please bring up the December 2016 statement on one side of the screen and on the other side of the screen bring up the January 2017 statement, which is .436. So Mr Rack, just to be clear, when you talked about the change that occurred between December 2016 and January 2017, is this what you're referring to, the change in the invoicing?

MR RACK: These are the documents. Yes, these are the documents.

MS BERGIN: And what explanation were you given about the change in invoicing of domestic assistance?

MR RACK: Southern Cross gave the information that they changed their accounting system, and it is a new system to improve my ability to maximise the government funding.

MS BERGIN: And did you notice any change in the domestic assistance that was actually provided to you?

MR RACK: There was no change in the assistance which I received at home.

MS BERGIN: Okay. Operator if you could please zoom in on point 5 of the page, .0436. Under the heading Charges and Other Costs. Now, Mr Rack, what did you understand the monthly SCC case management fee to represent?

MR RACK: I understand that that is the cost of providing the service to me, for level 2 package.

MS BERGIN: And what did you understand the monthly SC management fee level 2 to be?

MR RACK: Come again, please?

MS BERGIN: Sorry, what did you understand the monthly SCC management fee level 2 referred to as $100; what did you understand that to be?

MR RACK: Monthly SCC – well, that's what I understood that is the case manager that handles my affairs monthly.

MS BERGIN: From your perspective, was there any difference between the $536 entry and the $100 entry?

MR RACK: No.

MS BERGIN: Now, as you are aware, we gave a copy of your statement to Southern Cross Care.

MR RACK: Yes.

MS BERGIN: Because by way of procedural fairness they have an opportunity to respond to that statement.

MR RACK: Yes.

MS BERGIN: Now, their statement will be tendered later. Their statement will be tendered later this morning but, operator, could you please bring up

RCD.0011.0009.0131, and could you please go to page 3 of that statement and bring up paragraph 5.9.

Mr Rack, this is the explanation that Southern Cross Care have provided for the $536.60 monthly fee. I will read it out loud if that would assist and I will let you read along with me as I read it out loud. It says:

> *Like the administration fee, the case management fee structure changed with the introduction of the RN model in 2016. The cost was structured on a sliding scale, depending on the level of the home care package, again determined by reference to an approximated number of hours required to case manage a client at a particular level. Level 2 package clients were estimated to require 92 hours of RN contact per annum with an hourly rate of $70.*

And I take the reference to RN contact to mean registered nurse contact. This equated to $536.66 per month. Mr Rack, I want to ask you, what contact did you have with a registered nurse during your time receiving services from Southern Cross Care?

MR RACK: Over the whole seven years, I had a registered nurse about three or four times in my house.

MS BERGIN: What other contact did you have with a registered nurse apart from in your house, that might have been over the phone?

MR RACK: Nothing.

MS BERGIN: None that you are aware of.

MR RACK: No other contact, no other service.

MS BERGIN: How many hours in total would you estimate the RN contact?

MR RACK: For the full seven years?

MS BERGIN: For the whole seven years?

MR RACK: Maybe 20 hours.

MS BERGIN: Maybe 20 hours in seven years.

MR RACK: Maybe 20 hours.

MS BERGIN: So approximately three hours per year, is that your evidence?

MR RACK: That's what I would say.

MS BERGIN: Thank you, Mr Rack. Now turning back to the example invoice from January 2017, if you could bring that up, operator, I will give you the document ID. Thank you. Now, we discussed before the charges and other costs case management fee and management fee level 2 as $636.67.

MR RACK: Yes.

MS BERGIN: Now, in January 2017, what fee was taken from your package for domestic assistance?

MR RACK: For the domestic assistance, it was the four hourly – the four hours in $41 blocks.

MS BERGIN: And those $41 blocks represent 50 minutes at a time; is that right?

MR RACK: Yes, 50 minutes a time, and the four hourly block counted up to $206.02.

MS BERGIN: So during the month, that statement shows that Southern Cross Care visited you on three occasions; is that right? If you could check that for me. How many times did Southern Cross Care visit in January 2017?

MR RACK: I can't recall that they came out in January to me.

MS BERGIN: Have you got your diaries with you today in court?

MR RACK: I've got the diary – diaries in here.

MS BERGIN: Did you want to check the entries for January 2017, just to clarify?

MR RACK: Yes, if the lady can give me that 2017.

MS BERGIN: I just want to ask you to take a moment to check how many times Southern Cross Care visited you in January 2017.

MR RACK: Do you refer to the service that they provided?

MS BERGIN: Yes, Mr Rack.

MR RACK: Not the RN, not the nurse?

MS BERGIN: Yes, not the nurse.

MR RACK: Just the services?

MS BERGIN: Yes.

MR RACK: Okay. Nine, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22 - - -

MS BERGIN: Mr Rack, I'm just asking you how many times did Southern Cross Care attend in January 2017.

MR RACK: 26, 27, 28 – 29 times.

MS BERGIN: 29 times.

MR RACK: Yes.

MS BERGIN: In January. Just taking the period - - -

MR RACK: Just in January?

MS BERGIN: I'm sorry, Mr Rack, for the confusion.

MR RACK: I thought for all year. January, it was on the – one, two, three, four. Four times in January.

MS BERGIN: Four times. Mr Rack, are you able to see the invoice that's on the screen there?

MR RACK: Yes, I can see that, the first page, or the second page in that, yes.

MS BERGIN: Yes, the second page. And operator, could you go to the third page of that invoice. Or is that the final page? That's the final page. So, Mr Rack, does that invoice on your screen, does that accurately represent how many times Southern Cross came to you in January 2017?

MR RACK: One, two, three – there should be another page behind it.

MS BERGIN: Okay, there should be another page behind it.

MR RACK: Yes.

MS BERGIN: So taking from this statement, then, there should be another entry of services.

MR RACK: There should be another – a short – only a small page.

MS BERGIN: Okay. Now, I will take you to – what document should we go to, to check for you what the charges for domestic assistance were for January 2017?

MR RACK: The total?

MS BERGIN: The total.

MR RACK: The total it shows here, $618.75.

MS BERGIN: Yes, so - - -

MR RACK: And that's only on the first page. That only represents three – three visits.

MS BERGIN: Yes. And you think there's another page?

MR RACK: There should be another one.

MS BERGIN: Operator, could you go to page .0437. There's no further page. So it appears that there's a note at the bottom saying that corrections discussed will appear on your next account. You obviously – you kept good records – did you keep diaries or - - -

MR RACK: I've got here that in January, I got here these services on – on 29 December, 1 – 5 January, 12th, 19th and the 26th.

MS BERGIN: Okay. So the services for the domestic assistance for 26 January in 2017 doesn't appear on this invoice.

MR RACK: No, but there should be a page like this where the invoice is on the third page.

MS BERGIN: Okay. Now, Mr Rack, I want to ask you about a different topic, which is the topic of interest. Did Southern Cross Care provide you with information about interest that accrued on your package?

MR RACK: Never. Interest was never, ever mentioned to me in any form from anybody.

MS BERGIN: Did Southern Cross Care hold funds for you – did they set aside funds for you to be held into the future?

MR RACK: Yes, they did hold that money but they did transfer it to the next provider which I took on.

MS BERGIN: And how were you encouraged to set aside unspent funds by Southern Cross Care?

MR RACK: Southern Cross Care encouraged me to put 10 per cent of the government funding aside for emergency situations, if I break a leg and I suddenly need a taxi or I transport, I would have spare fund there to use it without going into a further upgrading of the package or anything in that form. So it was meant to have the funds there ready whenever I become disabled or to use the fund for my purpose.

MS BERGIN: And during your period with Southern Cross Care, did you need to access any of those unspent funds from your package?

MR RACK: I did. I did get always invoices where it shows up the unspent fund called contingency fund. It was called contingency fund.

MS BERGIN: Okay. Now, turning to the topic of workers who attended at your premises while you were receiving services from Southern Cross, how many workers did you have attend at your premises during the seven-year period?

MR RACK: I have lost count of that. There's so many different workers coming to the house without the name tag, without any identification. They just arrived up at the given time and when I opened the door, there was another strange person there. "Who are you?" "I am from Southern Cross." But no – no other identification or uniform or anything like that, for any of them.

MS BERGIN: Okay. So just taking that one – pausing there for a moment, clarify. Who was the first worker that attended for you from Southern Cross Care?

MR RACK: The very first worker was a name called Denise.

MS BERGIN: And how did you identify Denise as being from Southern Cross Care?

MR RACK: Come again?

MS BERGIN: How did you know that Denise was from Southern Cross Care by looking at her?

MR RACK: They came out with a group of people from Southern Cross and introduced her with another care worker.

MS BERGIN: And was Denise wearing a uniform when she attended?

MR RACK: Yes. Yes, she had a Southern Cross uniform.

MS BERGIN: And how long did Denise provide you with domestic services for?

MR RACK: Approximately four years, or a little bit more, until she then had an accident on another client's place and could not work for a long period of time. After she recovered, she got a part – a light duty job with Southern Cross, closer to her house. So, therefore, she didn't come to my place any more.

MS BERGIN: So after Denise wasn't able to attend at your house any more, who attended for Southern Cross?

MR RACK: There was another Southern Cross person coming in there but only for a few – a few months, it may be four, five months. And then she left as well. She just – I just got another worker.

MS BERGIN: So this brings us to about four and a half years during the period that you received services from Southern Cross.

MR RACK: Yes.

MS BERGIN: So between the four and a half year mark to the end of the seven years, what was your experience of Southern Cross workers?

MR RACK: Constant change of workers, so many really unqualified people. They did not know what to do in the house. Some of them came in dressed like party girls, as if they go for a party but no idea of what to do in the house.

MS BERGIN: So when you say they were dressed like party girls, when they attended at your house, were they wearing a Southern Cross uniform?

MR RACK: No.

MS BERGIN: How did you know they were from Southern Cross.

MR RACK: Only by word of mouth when she said "I'm from Southern Cross". That's all.

MS BERGIN: Operator could you bring up document RCD.0011.0009.0015. Mr Rack, as I mentioned, Southern Cross Care were provided with your statement and they've prepared a schedule.

MR RACK: Yes.

MS BERGIN: Which you should be able to see on your screen there in the witness box.

MR RACK: I can see that?

MS BERGIN: That schedule has name that have been redacted or blacked out to protect privacy - - -

MR RACK: Yes.

MS BERGIN: - - - but I counted 25 entries on that schedule. Are you happy – what is your comment?

MR RACK: I could not agree or disagree with this because it is a document here put up by a professional person to make it look impressive.

MS BERGIN: Okay. So could you give an estimate of the number of workers that attended from Southern Cross Care during your seven years; could you estimate how many?

MR RACK: It's just the Southern Cross workers or all the workers?

MS BERGIN: Just the Southern Cross workers.

MR RACK: I think it would be around seven or eight Southern Cross workers. All the others were either from an agency or just some person from somewhere.

MS BERGIN: Okay. Now turning to your second service provider. Who was your second service provider?

MR RACK: Assist Home Care.

MS BERGIN: How did you find out about Assist Home Care?

MR RACK: I had many queries and questions for aged care people and for the Ombudsman. During some of those telephone conversations I asked, "Could you give me a name of a good provider?", and the name of Assist Home Care came up. I contacted them, and we came to an agreement and I was happy with the arrangement that I got provided with them.

MS BERGIN: And why did you change service providers?

MR RACK: Why did I change to?

MS BERGIN: Why did you change from Southern Cross Care to Assist?

MR RACK: Because of the high cost of the charges. The administration fee was 50 per cent of the government funding, and hourly rate was also fairly high.

MS BERGIN: How many hours of domestic services did you receive from Assist Home Care?

MR RACK: We cut it down to three hours a week.

MS BERGIN: What services did you receive from Assist Home Care?

MR RACK: Exactly the same service what I received from Southern Cross. It was only three hours a week but all the other services was provided the same way that I received from Southern Cross.

MS BERGIN: Okay. And what record-keeping did you do?

MR RACK: I keep all the receipts. I kept a diary, a yearly diary, and put down the – who came to the house, what – what time, how many hours they spent in the house.

MS BERGIN: Operator, could you bring up document JRA.0002.0001.0134. Could you describe this document to the Royal Commission please, Mr Rack.

MR RACK: This is an estimated cost that I worked out according to the spreadsheet that I received from Assist Home Care which I only received in the middle of the year, 2018.

MS BERGIN: When you say you only received it in the middle of the years, when did you start receiving services from Assist Home Care?

MR RACK: From Assist Home Care it was around September 2017.

MS BERGIN: And, operator, could you bring up the agreement with Assist Home Care that was on the screen a moment ago, .0004. Operator, could you please scroll through the first few pages of this document. Mr Rack, is this the community aged care package agreement that you entered with Assist Home Care?

MR RACK: Yes.

MS BERGIN: I tender community aged care package agreement between Assist Home Care and Josef Rack.

COMMISSIONER TRACEY: Is it dated?

MS BERGIN: The date of the letter is the 25 August 2017, Commissioner.

COMMISSIONER TRACEY: Yes.

MS BERGIN: And the signing page on the copy I have is not dated but if you go to page 13 of the document.

COMMISSIONER TRACEY: That doesn't take it any further. So I will just identify it as the undated aged care package agreement between Assist and Mr Rack and that will be exhibit 2-18.

EXHIBIT #2-18 UNDATED AGED CARE PACKAGE AGREEMENT BETWEEN ASSIST AND MR RACK (JRA.0002.0001.0004)

MS BERGIN: Mr Rack, what statements did Assist Home Care provide you with for the domestic services they provided to you?

MR RACK: They only gave me a spreadsheet in middle of '18, 2018. But the discussion was that I will receive the same services what I had before.

MS BERGIN: What statements were you given between August 2017 and mid-2018 by Assist Home Care.

MR RACK: None, although I keep asking for it but I never got it.

MS BERGIN: Who did you ask for a statement from?

MR RACK: I ask Greg Holmes for it.

MS BERGIN: What was the first statement Mr Holmes gave to you?

MR RACK: In the middle of 2018, in the changeover of the financial year, that's when I received the first – the first spreadsheet.

MS BERGIN: Operator, could you please bring up JRA.0002.0001.0036. Is this the spreadsheet you're referring to, Mr Rack?

MR RACK: These are the spreadsheets they got, yes.

MS BERGIN: And was it your evidence, Mr Rack, that you were given this document towards the end of the financial year in 2018?

MR RACK: Around that time, yes.

MS BERGIN: Around that time.

MR RACK: May be a week up or down.

MS BERGIN: Operator could you please zoom in on the bottom right-hand corner of that page. Could you please scroll down to the very bottom of the corner. Could you please bring up the date in the corner, the bottom right-hand corner of that document?

Mr Rack, there's a date in the bottom right-hand corner of that document.

MR RACK: Yes.

MS BERGIN: 13 May 2018.

MR RACK: Yes.

MS BERGIN: So what was your understanding of the reason it's dated 13 May?

MR RACK: The way I understand on – that's the date that document was printed.

MS BERGIN: And were you given this document some time after - - -

MR RACK: After.

MS BERGIN: - - - that date.

MR RACK: Some time after that, yes.

MS BERGIN: Thank you, Mr Rack. Now, you mentioned earlier the name, Mr Holmes. Who was Mr Holmes?

MR RACK: He is the manager of Assist Home Care.

MS BERGIN: And what was your first contact with Mr Holmes?

MR RACK: When I first signed up with him. That was in August '17.

MS BERGIN: Now, operator, could you please go to JRA.0002.0001.0134.

COMMISSIONER TRACEY: While that is coming up, Ms Bergin, do you want to tender the spreadsheet?

MS BERGIN: Thank you, Commissioners, I would like to tender the spreadsheet.

COMMISSIONER TRACEY: Yes, the Assist Home Care spreadsheet dated 13 May 2018 will be exhibit 2-19.

EXHIBIT #2-19 ASSIST HOME CARE SPREADSHEET DATED 13/05/2018 (JRA.0002.0001.0036)

MS BERGIN: Mr Rack, is this a note you prepared?

MR RACK: Yes. That's a note that I prepared.

MS BERGIN: For what reason did you prepare this note?

MR RACK: This is for my own satisfaction to see if the money that I supposed to get transferred from Assist Home Care to the new provider, if that is correct. So I counted all the months together that I was with Assist Home Care, added the contributions together, deducted whatever payments there was and that's how I then arrived with the figure that it was $1117.92 different.

MS BERGIN: So why did you need to prepare this note, Mr Rack?

MR RACK: Because I spoke with Assist Home Care provider, the manager of Assist Home Care, and told him I don't agree with that amount of unspent funds that he wanted to transfer, that I don't agree with that sum. And I then started to check through the spreadsheet and I could identify every day where a discrepancy was in the charges that he put on the spreadsheet.

MS BERGIN: Okay. Just to unpack that statement, Mr Rack, the manager you refer to, was that Mr Holmes?

MR RACK: Yes.

MS BERGIN: And when you mentioned the transfer of unspent funds, is that because you were looking at transferring to a new provider?

MR RACK: Yes.

MS BERGIN: So this was a note you did sort of reflecting on your time with Assist Home Care; is that right?

MR RACK: Yes.

MS BERGIN: So how long did you receive domestic services from Assist Home Care?

MR RACK: The services?

MS BERGIN: How long did you receive domestic assistance from Assist Home Care?

MR RACK: Approximately one and three-quarter year.

MS BERGIN: And when you said a moment ago that you calculated a figure of $1117.92, is that the figure that's towards the bottom of the page on your screen?

MR RACK: They were on the screen, on the spreadsheets. There were charges in there which don't related to the actual services that I received.

MS BERGIN: And what did you do once you had made that calculation?

MR RACK: I went in contact with the manager of Assist Home Care and he said, "I'm going to look into it", and the weeks went by and nothing happened. And then I – when he transferred the sum of $15,038, I said, "Look, I am not agreed with that sum. We better have a talk" and he never – he never came to the party to talk. And in the meantime, I also received a letter from the aged care department that – saying that Assist Home Care is not longer allowed to – not longer allowed to employ new home care packages until this internal things is sorted out.

MS BERGIN: Okay. I will ask you about that letter in a moment, Mr Rack, but I just want to ask you what the footnote, or what the entry at the bottom of this page is about.

MR RACK: The footnote?

MS BERGIN: Yes, you have got an entry, 1 January 2019, telephone call.

MR RACK: That's when I received a phone call from a person who stated he is a government assistance to get Assist Home Care's internal affairs sorted out, and that Assist Home Care is trying to come to a consensus to pay the difference of the $1117.

MS BERGIN: Okay. Now, Mr Rack, I will take you to the letter. Operator could you please bring up JRA.0002.0001.0080. Mr Rack, is this the letter that you're referring to?

MR RACK: Yes.

MS BERGIN: And did you decide – was this the reason you changed service provider?

MR RACK: That's when I was already on the move to change the service provider.

MS BERGIN: Operator, I will ask you to turn to page 00.81. I tender letter from Department of Health to Mr Rack dated 9 October 2018.

COMMISSIONER TRACEY: Before you do that, do you want to also tender the handwritten note?

MS BERGIN: Thank you Commissioners, I do wish to tender the handwritten note.

COMMISSIONER TRACEY: All right. Well the handwritten note prepared by Mr Rack regarding the correctness of the material in the spreadsheet will be exhibit 2-20.

EXHIBIT #2-20 HANDWRITTEN NOTE PREPARED BY MR RACK REGARDING THE CORRECTNESS OF THE MATERIAL IN THE SPREADSHEET (JRA.0002.0001.0134)

COMMISSIONER TRACEY: And the letter from the Department of Health to Mr Rack dated 9 October 2018 will be exhibit 2-21.

EXHIBIT #2-21 LETTER FROM THE DEPARTMENT OF HEALTH TO MR RACK DATED 09/10/2018 (JRA.0002.0001.0080)

MS BERGIN: So when did you finish receiving services from Assist Home Care, Mr Rack?

MR RACK: It was around 22 October '18.

MS BERGIN: And who was the next service provider you dealt with, Mr Rack?

MR RACK: I chose to go for HenderCare.

MS BERGIN: Operator, could you please bring up HEN.0001.0001.0098. Could you please turn to the third page of that document, which is headed Page 1. Mr Rack, is this the home care agreement you entered with HenderCare?

MR RACK: That is one of them, because we – we made then another agreement after the three months probation. We then made another agreement.

MS BERGIN: So how many agreements have you entered with HenderCare?

MR RACK: There should be only two agreements.

MS BERGIN: Two. I tender the first home care agreement entered between HenderCare and Josef Rack dated 31 October 2018.

COMMISSIONER TRACEY: Yes. The home care agreement between HenderCare Pty Ltd and Mr Rack dated 31 October 2018 will be exhibit 2-22.

EXHIBIT #2-22 HOME CARE AGREEMENT BETWEEN HENDERCARE PTY LTD AND MR RACK DATED 31/10/2018 (HEN.0001.0001.0098)

MS BERGIN: Mr Rack, what services do you receive from HenderCare?

MR RACK: I received only two hours of services.

MS BERGIN: And what are those services?

MR RACK: The services are cleaning, basically cleaning the hard floor, the bathroom and the kitchen.

MS BERGIN: And who manages HenderCare, Mr Rack?

MR RACK: For the first three months, HenderCare claimed that they managed it but in actual fact I still got my own worker and my own providers. I did – I did search, researched my own people who come to the house.

MS BERGIN: Mr Rack, was that a trial?

MR RACK: It was meant to be a trial before HenderCare would agree to let me self-manage the package.

MS BERGIN: And who manages your home care package at the current time, Mr Rack?

MR RACK: At this time?

MS BERGIN: At this time?

MR RACK: At this time I do all the research and I do all the work and select the people providing they got the proper accreditation of police check, insurances and all that sort of thing. But I do all that myself.

MS BERGIN: What management fees are you charged, Mr Rack?

MR RACK: I am charged 10 per cent of the funding from the government, is the charge for the HenderCare, and they call it administration fee.

MS BERGIN: And what happens to the other 90 per cent of your package, Mr Rack?

MR RACK: That is to my disposal. I can use that for anything that I like. Tree pruning, gutter cleaning, window cleaning. As long as it is for the purpose of my personal health benefit, not for any other luxury or any other – other things. It has to be in the connection for my personal assistance.

MS BERGIN: Mr Rack, thank you for your time this morning. Commissioners, that concludes my examination of Mr Rack.

COMMISSIONER TRACEY: Mr Rack, in your statement, you explain that after a period of regular assistance from the same lady from Southern Cross, you got a whole stream of people - - -

MR RACK: Yes.

COMMISSIONER TRACEY: - - - who you were not familiar with.

MR RACK: Yes.

COMMISSIONER TRACEY: Who just turned up and didn't know what they were required to do, and you explained in your statement that a lot of the time allocated for work - - -

MR RACK: Had to be - - -

COMMISSIONER TRACEY: - - - was spent with you having to explain - - -

MR RACK: In explaining. Yes.

COMMISSIONER TRACEY: - - - to these people what you wanted to do.

MR RACK: Yes.

COMMISSIONER TRACEY: Now, may I assume that the consequence of that was that work you needed done, and in the past had been done by the regular lady - - -

MR RACK: Yes.

COMMISSIONER TRACEY: - - - was not done.

MR RACK: No, it wasn't done, completed. It was missed out – some of the jobs were just missed or they were done in such a low-grade fashion that I have to ask them, "Have you done that job?" and I was told, "Yes, I done it" and I said, "Why is it still dirty and dusty here if you wiped it over?" If I did say anything like that, they wouldn't turn up the next day. I got another girl, another person to come in.

COMMISSIONER TRACEY: And did you register any complaints with Southern Cross about - - -

MR RACK: Many times.

COMMISSIONER TRACEY: - - - what was going on.

MR RACK: Many times.

COMMISSIONER TRACEY: And what reaction did you get?

MR RACK: The reaction was, "We can't provide constant services. The people are getting sick. People are having accidents and all so we cannot provide you a constant service." But they did, in the first four years, four and a half years. But after that, there was people from agents, from cleaning agents coming out to my place; all sorts of people from all over the world.

COMMISSIONER BRIGGS: Mr Rack, you are clearly very good with mathematics, congratulations.

MR RACK: You can put one and one together, isn't it?

COMMISSIONER BRIGGS: That's exactly right. So you're somebody of my own heart. But do you have other friends who are receiving care packages and do they do the same record-keeping that you do?

MR RACK: Not many. Only a few people and especially older people are not able to do that.

COMMISSIONER BRIGGS: Yes. So if they don't receive regular accounts, it's very hard for them to be satisfied.

MR RACK: I have – I have got a statement from a cleaning lady. Her mother is in that position where she can't control the invoices, and she just pays as it comes in. But she has got no clue what she is paying for. And when her daughter checks it out, she finds a lot of irregularities, and the statements are always so complicated written out, that you have to go two and three times through the whole statement to understand it. And that is a very time-consuming exercise.

COMMISSIONER BRIGGS: And I imagine if you can't reconcile, then there is potential for unscrupulous - - -

MR RACK: You just pay. You just run out of funds and that's it.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising out of that, Ms Bergin?

MS BERGIN: No further questions, Commissioners. May Mr Rack be excused.

COMMISSIONER TRACEY: Mr Rack, thank you very much for your evidence.

MR RACK: Thank you, sir.

COMMISSIONER TRACEY: It has been of great assistance to us in understanding the shortcomings faced by many people who are receiving care in their homes, and we trust that in the future you will get better service.

MR RACK: I hope. Thank you, sir.

COMMISSIONER TRACEY: Yes, Dr McEvoy. You're free to leave the witness box, sir.

<THE WITNESS WITHDREW [11.03 am]

DR McEVOY: Commissioners, I call Mr David Moran and Ms Caroline Ford. Commissioners, perhaps just before they're sworn, my learned friend may wish to announce an appearance.

COMMISSIONER TRACEY: Yes.

MS H. STANLEY: May it please the Commission, my name is Stanley, and I appear on behalf of Southern Cross Care.

COMMISSIONER TRACEY: Thank you, Ms Stanley, that leave has already been granted and thank you for announcing your appearance.

MS STANLEY: Thank you.

<CAROLINE FORD, SWORN [11.05 am]

<DAVID MORAN, SWORN [11.05 am]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Operator, would you please bring up RCD.0011.0009.0131. Mr Moran and Ms Ford, is this a statement that the two of you have prepared and signed for the Royal Commission?

MS FORD: Correct.

MR MORAN: Correct, yes.

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

MS FORD: No.

MR MORAN: No.

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

MS FORD: Correct, yes.

MR MORAN: Yes.

DR McEVOY: Commissioners, I would tender that statement.

COMMISSIONER TRACEY: Yes, the witness statement signed by Mr David Moran and Ms Caroline Ford on behalf of Southern Cross Care and dated 18 March 2019 will be exhibit 2-23.

EXHIBIT #2-23 WITNESS STATEMENT SIGNED BY MR DAVID MORAN AND MS CAROLINE FORD ON BEHALF OF SOUTHERN CROSS CARE AND DATED 18/03/2019 (RCD.0011.0009.0131)

DR McEVOY: Thank you, Commissioner.

Mr Moran, I might begin by addressing one or two questions to you. Could you please tell the Commission how long you have been in the aged care sector and what roles you have had?

MR MORAN: Yes, I have been in aged care sector approximately 22 years, predominantly in the retirement living sector, which did have an assisted living component and working with a not-for-profit; that was probably one of the largest community care providers but more running the retirement and assisted living components of that before coming to Southern Cross Care. I came into Southern Cross Care in a similar role, as an executive and gradually assumed the leadership role in the organisation.

DR McEVOY: So you're now the CEO of Southern Cross Care, are you?

MR MORAN: Correct. As from – as indicated in the statement.

DR McEVOY: Yes, as from 1 May 2017, I think it is.

MR MORAN: Yes.

DR McEVOY: And could you just give the Commission an overview of Southern Cross Care.

MR MORAN: Sure. In terms of the services or the history?

DR McEVOY: Well, both.

MR MORAN: Okay. So the history of Southern Cross Care started in 1968, initially providing housing services for older people, and then it gradually moved into residential aged care in the 1970s and continued that way right through until today, and over the last 20 or so years have been providing home care services as well. One of the things we try and champion through our services at the moment is reablement and trying to reable older people so when they come into our service, we try to get them more active and fit so they can stay independent as long as possible. As first as the traditional components of care that would have performed years ago around traditional care and clinical roles. So we do measure – try and measure wellbeing through a wellbeing index in our services as well.

DR McEVOY: Ms Ford, I wonder if you could give the Commission an indication of your own background in health care and the work you do at Southern Cross Care.

MS FORD: Okay. Yes, I've been working in community and aged care services for about 30 years, and I've worked nationally and overseas in that space. I've taught and I've also had a background in population health. I've worked on Pitjantjatjara lands, always in aged care. I've managed for 10 years the regional

diabetes service for Queen Elizabeth Hospital and all their regional services. And I've been working at Southern Cross Care since 2015, and in the role as group manager for connected living community home support services since 14 February 2017. And I'm also a nurse practitioner, and I have been authorised since 2004.

DR McEVOY: Thank you, Ms Ford. Mr Moran, if you go to paragraph 2.1 of your statement, which you will see there displayed on the screen, you make the point that Southern Cross Care was established as a not-for-profit organisation in 1968, and that Southern Cross Care reinvests any surplus funds back into the business. When you refer to surplus funds there, what exactly do you have in mind?

MR MORAN: Surplus funds for any profit that we make out of the businesses that we run within Southern Cross Care. So it all goes back into future services or more products.

DR McEVOY: Can I take you down to paragraph 3.1 of your statement, which is towards the bottom of the page; it has just been highlighted. You say there that Southern Cross is a relatively small provider of home care services compared to other providers in Australia and it forms only a small percentage of the organisation's services. What percentage would home support services be of Southern Cross Care's total turnover?

MR MORAN: I will just give you some indicative numbers. So we have approximately 1500 residential aged care beds that would have people in them. We have a population in our retirement living of a similar number. So that gets you to about 3000. And then we would have in our, we have got the 220 home care packages that are mentioned in this statement, and we have at any one point in time approximately 600 Commonwealth Home Support clients getting low-level services from a different funding stream. And we also have clients that are in allied health, which are funded through a mixture of CHSP and private services. So you're really looking at a fifth, probably a fifth of our service in terms of numbers of people receiving services.

DR McEVOY: I'm sorry, you would be saying, would you, that about 20 per cent - - -

MR MORAN: Approximately, yes. That's based on the recipients.

DR McEVOY: Yes. Well that's based on recipients. What would the position be in relation to turnover?

MR MORAN: In relation to turnover, it would represent less than that. So - - -

DR McEVOY: You can give approximate figures.

MR MORAN: Approximately, so in home care it would probably be more like five per cent, at a rough estimate.

DR McEVOY: Can I take you to the subject of home care package fees. Now, you deal with this in paragraph 5.1 of your statement, which is at the bottom of page 2. Now, you list there a series of fees, which you break down into three categories. There's an administration fee, which you say you previously called the management fee, there's the case management fee, and there's the service fee for the service provided. And you give the example of Mr Rack from whom we have just heard, and you note that he was being charged for domestic assistance attendances. Can I ask you to walk the Commission through each of those categories of fees, and what sorts of things they cover.

MR MORAN: Yes. So the administration fee, that covers the rostering service and that is a straight charge. That's a $100 charge that was on Mr Rack's statement after December 2016.

DR McEVOY: Just in relation to that $100 charge, I think in paragraph 5.6 of your statement you say that from December 2016 that fee has been fixed at $100 for those on level 1 or level 2.

MR MORAN: Yes.

DR McEVOY: And we saw that in the statement which was tendered earlier.

MR MORAN: Yes.

DR McEVOY: A statement of Southern Cross Care to Mr Rack. Is that $100 fee the actual cost that it costs your organisation to administer care for Mr Rack, or is that just an approximate cost?

MR MORAN: I understand that it is because it's meant to cover - - -

DR McEVOY: That it is what?

MR MORAN: That it is the actual cost.

DR McEVOY: So it's $100 that you are charging for everybody in Mr Rack's position?

MR MORAN: Yes, so it covers the rostering of services. It's a flat fee. So it covers - - -

DR McEVOY: I accept that it's a flat fee. What I'm really driving at is by what reference you charge that flat fee. How do you come up with the figure of $100? It's a fairly round sort of a number?

MR MORAN: Yes. Look, I understand it to be a recovery for the cost of the rostering team. Now, whether that has been – it does look pretty convenient that it's $100, I must admit, but I understand that's what the cost covers.

MS FORD: It's also the cars, overheads, the administration staff also included in that cost as we refer to in 5.2.

DR McEVOY: These – I was going to say, these are the costs that you outline in paragraph 5.2.

MS FORD: Yes.

MR MORAN: Yes.

DR McEVOY: So you would – that would include what you might term your back office function.

MS FORD: Correct.

DR McEVOY: But it's other things - - -

MR MORAN: Part thereof. So it includes a back office function of the rostering. It doesn't include the function that's in the case management fee which also includes management as well. And it doesn't include the – there's an hourly rate – in the hourly rate component there's administrative components in there as well.

DR McEVOY: Well, just one thing at a time. I was going to ask you about the case management fee. Can you explain – I'm conscious that you provide some information in paragraphs 5.8 and 5.9 of your statement about what that case management fee comprises. But do you just want to try and summarise what the case management fee represents.

MR MORAN: Yes. The case management fee represents the cost of the registered nurses that are – that coordinate the packages on behalf of us.

DR McEVOY: All right.

MR MORAN: That is a direct cost based on the formula in the witness statement.

DR McEVOY: Okay. So that's a direct cost. And it includes the cost of the registered – that case management fee, I understand you to be saying, includes the cost of the registered nurses. Operator, could you please bring up JRA – and you can keep this on the screen with the witness statement – JRA.0002.0001.0436. So if you could just highlight the charges and other costs there in about the middle of the page.

So you see there that at the end of January 2017, Mr Moran, there's a $536.67 amount for Mr Rack. Now, in paragraph 5.9 of your statement, and you've just referred to this, you've said that it includes contact with a registered nurse and what you say precisely in 5.9 is that:

Level 2 package clients were estimated to require 92 hours of RN –

that's registered nurse, I assume –

...contact per annum with an hourly rate of $70. This equated to $536.66 per month.

And you say that can be seen on Mr Rack's statement which is what we have up here and you say that was a regular monthly fee. Now, you were here to hear Mr Rack's – you heard Mr Rack's evidence earlier, I think, didn't you?

MR MORAN: Yes. Yes.

DR McEVOY: And you heard Mr Rack say that over the whole seven years he had a registered nurse maybe three or four times and that there was no other contact, and he felt that in total the registered nurse contact was about 20 hours. So about three days per year. Three hours, I'm sorry, per year. Did you hear that evidence?

MR MORAN: Absolutely, yes.

MS FORD: Yes.

DR McEVOY: Just going back to paragraph 5.9 of your statement, is it your evidence that he was, in fact, getting 92 hours of registered nurse contact or is it rather that that was just some sort of average that you applied across clients?

MR MORAN: Look, it would be an average but can I add a bit of context?

DR McEVOY: Yes. Yes.

MR MORAN: Just to – this came in in December 2016. So it wasn't a case of the contact over seven years. So obviously he had services from 2010. We brought in this registered nurse model in December 2016. So he really didn't receive this service for a very long time at all. And he would have had contact with coordinators that were not registered nurses that we replaced with registered nurses. My concern was, when I listened to Mr Rack's evidence, I hope maybe he didn't know that they were registered nurses that were doing the coordinator roles because that's what he was being charged for, and that's what I kind of got out of his evidence and that's something that the Commission probably needs to - - -

DR McEVOY: Ms Ford, I could see you nodding at some times and not at others. Do you wish to enlarge upon what Mr Moran just said.

MS FORD: No, we tried not to have the registered nurse flavour. We would say we were wellbeing partners. So maybe he wasn't aware that they were actually registered nurses. So we refer to them in communications as their wellbeing partner. And perhaps he didn't understand that that's what we were doing. But the registered

nurse, the wellbeing partner, would provide all the advocacy services for them, for Mr Rack, all the communication, all the vendor negotiations that was required. A lot of the things that were done administratively before, the RN took it as a one-stop shop so they could provide everything and good continuity for Mr Rack. He may not have known that, indeed, his wellbeing partner was a registered nurse; I admit that. But there would have been on initial introduction, I imagine but because we have referred to them in the wellness model as a wellbeing partner, he may have misunderstood.

DR McEVOY: So just to be clear, is it actually your position that as per paragraph 5.9 of your statement, Mr Rack, in the period, I suppose you would say, Mr Moran, commencing October 2016 – perhaps we should do it on a monthly basis. So you would say that in November, December and January – November and December of 2016 and January of 2017, Mr Rack was having a level of contact with registered nurses albeit that he didn't perhaps know that they were registered nurses, that would have equated to 92 hours of registered nurse contact per annum: is that what you are saying?

MS FORD: Can I answer that?

MR MORAN: Yes.

MS FORD: It may not have been to that amount because for a level 2 client there is a great variance in their acuity and their morbidity and their sickness. And I agree that the level 2 is across all and that amount and that fee. And sometimes he may have needed more support in the advocacy role, and explanations and we had case discussions, not so much the formal clinical registered nurse traditional requirements of wound dressings and things like that, but he did require other forms. I'm not sure exactly to the seven hours per month but I know that on times when we were doing case management and we organised advocacy with ARAS, and we asked him to come into the consumer advisory group, all the preparations that go around that is done by the registered nurses. So that background work is included in that fee.

DR McEVOY: So do you have records that would indicate whether, in fact, Mr Rack did get the seven hours per month for which he was apparently charged from late 2016 at the rate of $536.67?

MS FORD: Well, we could go back through the case notes and try to see how many entries there were. We could add them up. We could also look at how many meetings that we coordinated for him. We don't keep records of, you know, phone calls and time by minute or anything, we don't want to go down that track but we could give an approximation only.

DR McEVOY: What about if somebody like Mr Rack was ringing to attempt some sort of reconciliation with you between the fees that he was being charged and statements, would that have been effectively charged to him as a part of this seven hours?

MS FORD: If we were charging by each conversation. If it was engaging the wellbeing partner, RN coordinator, then that could have been included in there. If it was particularly with the administration finance officer, if it was something that the coordinator couldn't address at the time, they may have referred it on. That might have gone more towards the admin charge.

DR McEVOY: So you would accept that it's possible that the registered nurse component of that case, monthly case management fee might have included, in effect, a fee for querying the fee?

MS FORD: A fee for?

MR MORAN: With it built in within, built within?

DR McEVOY: Yes.

MR MORAN: Possibly, yes.

MS FORD: It fluctuates, month to month. Sometimes with a client with a level 2, they might be palliating and require so much services, and other times like Mr Rack who was quite fit and healthy for all of our level 2, he is very fit and healthy, you could see that his requirements were much less. So it is that balance. Some are very sick; some aren't. And we have to try and get that happy medium. But others do require less clinical resources but more intense advocacy and explanation, you know, repeated.

DR McEVOY: So do you disagree with his recollection that over the seven years, he had a registered nurse come and attend on him in his home three to four times?

MS FORD: No, I don't disagree with his recollection. Because we started the RN model in December 2016 he had only had that year with us after and he would have had an RN doing a review. We changed from annual review to six monthly review when we brought in the RN model. So he would have had somebody there six monthly, and I have certainly been out to his house, and I had also been involved in case management in that time with him since I started in 2017.

DR McEVOY: So is there anything else you would want to say about the case management fee and what is in that?

MS FORD: No, I think just to reiterate that it is – it's difficult to have a fixed amount for everybody. Unless we go to the legal model of billing by the minute, I don't think we can have – it's hard to get that equity, and I understand how people would feel, you know, hard done by if they don't think they've got that, you know, each month. I understand that.

DR McEVOY: So the next thing you say, the final thing you say in paragraph 5.1, or the final fee you deal with, is the service fee for the service provided.

MS FORD: Yes.

DR McEVOY: So what do you mean precisely by that?

MS FORD: The service fee is the unit hourly cost.

DR McEVOY: So if he is getting house cleaning, the unit hourly cost of X, he is charged that.

MS FORD: Or the unit service fee for the actual service, whether it's 50 minutes.

DR McEVOY: Yes, yes. And do you put some sort of margin on that or you just charge; how does that work?

MR MORAN: There is a margin within that fee for the components of administration that are not in the case management fee or the admin fee, which means - - -

DR McEVOY: Let's perhaps make this a bit real. Take the service that was being provided to Mr Rack, which was the house cleaning service, what was the fee that he would have been charged for that?

MS FORD: 41.25 per session.

DR McEVOY: 41.25. Can you tell the Commission what that 41.25 is made up of.

MS FORD: Sure, we have got it listed here. That's for the wages of the home care assistant or domestic assistants specifically. Have we got a list here of all the things that go in there?

MR MORAN: No.

MS FORD: We haven't? It would be all their on-costs and there is - - -

DR McEVOY: When you say on-costs, what do you mean actually?

MS FORD: Well, the on-cost to provide that service. They bring free cleaning products for every client.

DR McEVOY: So that would include the cleaning products?

MS FORD: Yes. Also the annual leave, sick leave, PPE that we provide - - -

DR McEVOY: So these people are permanent employees of yours, are they, to whom you have obligations to pay annual leave and sick leave?

MS FORD: Yes, yes.

COMMISSIONER BRIGGS: And superannuation in that so it's a complete employment package as part of the basic daily fee.

MS FORD: Yes.

COMMISSIONER BRIGGS: Thank you.

DR McEVOY: And transport?

MS FORD: Reimbursement of mileage.

DR McEVOY: That would be included in the 41, or that would be on top of.

MS FORD: That would be included, yes.

DR McEVOY: Is there anything else that we've – there's insurance, presumably, we haven't mentioned.

MS FORD: Yes, I think so. I think so. We have – yes, we will get back to our accountant on that, if you like, for the whole breakdown.

MR MORAN: Which insurance do you mean, sorry?

DR McEVOY: Well, the workers compensation.

MR MORAN: Yes, yes. Absolutely, for the staff member.

DR McEVOY: Now, I think you mentioned there might be some further administration fees – or at least there might be some component of that 41.50 that is also administration fees; is that correct?

MR MORAN: Yes.

DR McEVOY: Can you just explain how they're different to the other $100 administration fee charge.

MR MORAN: So the administration fees are more the costs that aren't in those other fees. So it would be like for Caroline and her – some of your support as well, and there's also for central support just around accounting and finance, IT, HR costs. So just roughly they would make up 20 per cent of that hourly rate charge, at a guess.

DR McEVOY: Well, just while we are on the subject of that fee, can I just ask you about the numbers of different workers who were coming to see Mr Rack. You will have heard him, I assume, say that there were so many different workers, "I've lost count", and that there was a constant change of workers. I think you have prepared a document that my learned friend, Ms Bergin, put to Mr Rack. Operator, could you please bring up RCD.0011.0009.0015.

Do you recognise that document, Ms Ford and Mr Moran?

MS FORD: Yes.

MR MORAN: Yes.

DR McEVOY: Did either of you – one or either of you prepare it?

MS FORD: No.

DR McEVOY: So where has this document come from?

MS FORD: From finance.

DR McEVOY: From finance within Southern Cross Care.

MS FORD: Yes.

DR McEVOY: Commissioners, I would seek to tender that document.

COMMISSIONER TRACEY: I think it is already in, but I may be wrong about that.

DR McEVOY: I'm not sure that Ms Bergin did in fact tender that document, Commissioner.

COMMISSIONER TRACEY: Very well, the document entitled Mr Rack – analysis of schedule will be exhibit 2-24.

EXHIBIT #2-24 DOCUMENT ENTITLED MR RACK – ANALYSIS OF SCHEDULE (RCD.0011.0009.0015)

DR McEVOY: So, Mr Moran and Ms Ford, whichever is the more appropriate person to answer the question, can you just explain to us what this table shows?

MS FORD: Well, my understanding is that it's an overview of how many consistent workers attended for Mr Rack's services. Down the bottom, it shows the consistent workers that were referred to previously when Mr Rack was in discussion about the first four years of great continuity. And so in total there was 83.8 per cent of all his services with continuous staff. But then, as he discussed, he had quite a large number, 20, was it 25 there, of ongoing different workers that came to his home.

DR McEVOY: Yes, I think Mr Rack disputes aspects of that. He accepts that he had Denise for some considerable period of time but then after that, things became a

bit more variable. What would you say in relation to Mr Rack's concern in that regard?

MS FORD: Well, it is our ultimate aim about providing consistency of home support workers for every person. That's our aim, hand on heart. We want, and we moved to a neighbourhood cluster model of workers. We don't guarantee, nobody owns a worker, you can't own them because they do get sick, they go on leave, they have babies, they study. So they move; they are quite a transient population. So we try to cluster three workers for each person in a neighbourhood region. So that they can back each other up, if available, and also have a rapid responder who can also come in, if they give late notice that they're sick or their family member is sick or something, unplanned leave. So this is not ideal by any stretch of the imagination but given this is over seven years, 83 per cent is not too bad.

However, going forward, I wouldn't like to see this number of different workers for anybody because that is our aim. We know that is the number one thing that people want, is continuity of workers. They want a relationship. They want a trust. You know, I don't want to let people into my home that I don't know. So I think this – there was a difficult time when we transitioned from one model to another, and we moved to the neighbourhood cluster model where we allocated workers to each region, and worked in local neighbourhoods. And you can see by the agency report that our agency use went right down and it has improved ever since. So the new model is working to provide that. I agree in this time here, he did have a lot of workers but definitely the way of the future is consistent workers, you know, a small group but, again, a person doesn't own them. So - - -

DR McEVOY: So is it your evidence that, in fact, you are actively working to monitor these sorts of numbers?

MS FORD: Absolutely.

DR McEVOY: And lower them, in effect.

MS FORD: Yes, we're waiting for beautiful software to come that will automate rostering and put them in the right person, show consistency, report on consistency. That's what we want. We're currently scoping to get that in place.

DR McEVOY: When did you expect to get that in place?

MS FORD: Well, we have seen five products now, so we just need to make a decision. We've got a board agreement to move forward with that so we're all excited.

DR McEVOY: Can I just take you, finally, to the issue of interest, which you deal with, I suppose, in about paragraph 7.3 through to about 7.6, 7.8 of your statement. So you say in 7.5 – first of all, the context of all of this is that you've got unspent

funds, you say, in paragraph 7.4, sitting in your general operational account and that it fluctuates from month to month.

MS FORD: Yes.

DR McEVOY: Then you say in 7.5 interest is paid monthly by the bank but it is calculated daily and would normally accrue at a rate of .75 per cent and one per cent. Then you say at the end of paragraph 7.5:

> *Interest income is consolidated into a general pool of profit which is then reinvested by Southern Cross Care in accordance with its purpose.*

Can you just expand on what you mean when you say the interest is reinvested in accordance with your purpose.

MR MORAN: So we effectively use any surplus and profits from the organisation to develop further services or to – it goes back into Southern Cross Care to actually grow our services or into new innovations or whatever our objects are and what our plans are for a given year. So it's just used in the general pool of money that we receive that's surplus.

DR McEVOY: Can you recall in broad terms how much you have sitting in this account or these accounts in unspent funds?

MR MORAN: Approximately 2.2 million. And that is, from my last investigation, a level 1 average is about $1000 per client. For level 2, it's approximately $3000 per client. For level 3, $8000, and level 4, $20,000. So I suppose what it highlights is that the high level packages which bring in a lot more money, they're actually retaining a lot more and not spending the money. So the bulk of that money is really in that level 3 and 4 band which I think is reasonably consistent across the sector. However, the $10,000 is our average, is about $5000 higher than what the sector average is.

DR McEVOY: So that $22 million, if it's getting - - -

MR MORAN: 2.2.

DR McEVOY: I'm sorry, the $2.2 million, if it's earning interest at about one per cent, that's, you would accept, about $22,000 per annum.

MR MORAN: I believe your calculation, yes.

DR McEVOY: I don't have any further questions of these witnesses, Commissioners.

COMMISSIONER TRACEY: Do your staff who attend the homes of clients normally wear uniforms?

MS FORD: Absolutely. I was shocked to hear that somebody came in party gear. That's – whether it is an agency staff member or, our workers, we have a corporate uniform with Southern Cross Care branding on the polo as well as a badge, and they carry ID, a driver's licence as well. So, yes, I was shocked to hear – and I not like to think that any of our staff are not wearing uniforms. We do do spot checks on staff, like after they've provided services. I haven't come across that. So, yes, we will investigate that further, definitely.

COMMISSIONER TRACEY: It would appear that at least some of these people that turned up on Mr Rack's doorstep with no identification.

MS FORD: It's not good enough.

COMMISSIONER TRACEY: That's not satisfactory.

MS FORD: No, it's not good enough.

COMMISSIONER TRACEY: When they get in, he spent most of the time available explaining to them what to do because they had, not unsurprisingly given that they had not been in his residence before, no idea of what was required of them. They had had no briefing. They had just been told to go to his house. Now, that's not quality care, is it?

MS FORD: No. We do provide all staff with an overview of what they're meant to provide before they go, in a schedule of service. Then when they get there, to every client has an in-home care folder and in that folder which has got nice little tabs in there, outlines the services that are required and the care plan – or now we've changed it to be called the support plan, because we want to get away from care, more support, and that steps out very clearly what a worker, the instructions that they need to do, day-by-day. So if you come in Monday, you look at exactly what you need to do. So they should be going straight to that folder and reviewing what they need to have. We have made improvements to make that easier to read, but I do understand if it hasn't got the level of the detail where the power point is, or how that particular vacuum works, it may take, you know, time to explain that.

But the majority of the instructions are very clear, which should be used by all the workers, the in-home folder and where they sign off the work that they have done for the day. So they should be eyeballing that, scanning through it, reading it and clarifying anything, but they also ask, "Is there anything else you want done today, Mr Rack?" That's a standard question. They have to ask, "What else can we do?" so they, you know, if they have some different preferences for the day they need to attend to that as well. But maybe in that case, I know that Mr Rack was very house proud and particular. He liked the way things were done. And we did change the care and support plan over the time to have more detail, more depth of instructions in there for each day, but obviously not enough of detail that didn't, you know, prevented him from having to explain to new workers.

Maybe we need to reiterate more to staff to focus only on the care – you know, reading that first, rather than, you know, making the client give those instructions each time they go there.

COMMISSIONER TRACEY: What control have you got over the training and briefing of agency staff who attend your clients' premises?

MS FORD: We provide them with a handbook of our expectations. We also have regular engagement with our preferred agency provider. We have one preferred agency provider. And we ask that we're on the same page with providing products, protective equipment that they might require, the work instruction we have made to – on how to clean a house, specifically, from how to assess a situation, how to clean room to room, what order to go in, what products to put in your tote to carry around, to how to address, you know, cleaning windows or fans. Those sorts of level of detail in the work instruction we share, yes.

COMMISSIONER TRACEY: And are you confident that that material is passed on to those agency employees?

MS FORD: I think that we could do a lot better. I think that we could, you know, have more competency, review more frequently. I think that – I think going to have that one provider has been a really good step for us because it builds relations, builds the understanding of the expectations, the high level of expectations that our clients have in cleaning. We are moving towards getting our cleaners from a registered training provider so that they have that higher level of competency. So there is always room for improvement in there, and I think that, yes, I think that's something we need to do.

COMMISSIONER TRACEY: Does the fact that you have to resort to agency staff indicate that there is a shortage of people out there with the necessary skills to do this work? The Commission has heard evidence that it is often difficult for agencies to obtain appropriately qualified staff and the predictions that that's only going to become more difficult in the future.

MS FORD: Carers are gold.

COMMISSIONER TRACEY: In your organisation's experience, is that the real world?

MS FORD: We don't seem to have problems attracting staff. They are all – a lot of them are casual and that's what they want to do. So they're working less and less hours. So we're getting more staff but less availability. We don't necessarily have problems recruiting. Having that predictability – because clients, one minute might be in hospital or go on social leave for two months and the level and requirements of service provision fluctuate daily. Our needs, we have to have – be quite responsive and that's why we developed that new model of the rapid responder, so we have got nine full-time workers who work centrally, and they can respond to any region

anywhere. So not the neighbourhood model but they can go anywhere we direct them. Somebody calls in sick at 6 o'clock, they can go there and they will go across all regions.

That has been a really good model and we are trying to bolster that because we think that that full-time permanent work gives – they get to know the clients in each region. They know our expectations. The aim is not to have as much agency as possible. It should be only for emergency situations where that fluctuation, we really haven't been able to have that foresight and predictability of the staffing need. So we really want to keep it in-house and that all of our staff who are trained and we have confidence in, are doing all of those services. But it's that level of unpredictability of the clients' position and how many services they need each day, that does change. Thank you, Commissioner.

COMMISSIONER BRIGGS: Mr Moran, could I come back to the issue of unspent funds, and I thought your witness statement spelt out quite clearly the arrangement that Dr McEvoy identified and you followed up about the interest on those unspent funds; it in effect, becomes the interest that Southern Cross accrues to themselves. Are there any government rules and regulations about the interest on those funds?

MR MORAN: No. So there's a guidance from the department about how you treat moneys when someone passes away or goes to another provider and interest isn't in that. So I don't know what the standard industry practice is, but I would say it would be relatively common that you wouldn't be refunding interest. I think it's something for the Commission to note that we're in a low interest rate environment so it probably hasn't been an issue but if you get into a higher interest rate environment it will be a far greater issue. So it's probably something it would be good for the Commission to have a view on that.

COMMISSIONER BRIGGS: Yes.

MR MORAN: And particularly someone like Mr Rack who is financially literate, picked up on it and articulated it really well, and it's a fantastic case study around transparency and the difficulty around funding. We're struggling to explain and for everyone to understand the ways of admin fee, you try and make it more transparent, you try and allocate and sometimes that makes it harder. So it's – I think it's an industry-wide issue that we need to try and improve, and it's something that's valid for the Commission to really have a look at closely.

COMMISSIONER BRIGGS: You also pointed out that the people with – your clients, with level 4 funding have much higher levels of unspent funds, on average $20,000. Do you think that's because they're more likely, as clients, to be using respite care and they really feel they need to have those funds set aside to pay for those more substantial costs of service?

MR MORAN: Look, I could not comment on whether they're getting respite. Certainly saving for a more substantial, I suppose, clinical event. And, again, what

that highlights, and this isn't a Southern Cross Care view but a David Moran view but I think that's something again for the Commission to look at, around, you know, if you've got this amount of money being held, that has been largely government funded, and the equity around people that are waiting to receive care, and there's money sitting in bank accounts, that isn't being spent when it has been needed, when other people do need that, I have a fundamental issue with that.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising, Dr McEvoy?

DR McEVOY: Nothing arising, Commissioner.

COMMISSIONER TRACEY: Thank you both for your evidence. The Commission will adjourn until five past 12.

<THE WITNESSES WITHDREW [11.52 am]

ADJOURNED [11.52 am]

RESUMED [12.09 pm]

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioners, I call Clare Lynette Hargreaves.

<CLARE LYNETTE HARGREAVES, AFFIRMED [12.09 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Operator, would you please call up document WIT.0071.0001.0001 – yes, that's the document. Ms Hargreaves, do you recognise this as a statement that you provided to the Royal Commission?

MS HARGREAVES: Yes, I do. Thank you.

DR McEVOY: Now, just leaving any typographical errors aside, do you need to make any amendments?

MS HARGREAVES: No, I don't need to.

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

MS HARGREAVES: Yes, they are.

DR McEVOY: Commissioners, I would seek to tender that statement of Clare Lynette Hargreaves.

COMMISSIONER TRACEY: The statement of Clare Lynette Hargreaves dated 14 March 2019, will be exhibit 2-25.

EXHIBIT #2-25 STATEMENT OF CLARE LYNETTE HARGREAVES DATED 14/03/2019 (WIT.0071.0001.0001)

DR McEVOY: Ms Hargreaves, could you give the Commission your full name.

MS HARGREAVES: Clare Lynette Hargreaves.

DR McEVOY: And you work for the Municipal Association of Victoria?

MS HARGREAVES: That's correct.

DR McEVOY: And what is your role within the MAV?

MS HARGREAVES: I'm the manager of social policy at the MAV, and the MAV is the peak body for Victorian local government by legislation, so we represent the 79 councils.

DR McEVOY: And how long have you been in the MAV?

MS HARGREAVES: I've been since 1994, and in this role since the early 2000s.

DR McEVOY: And do you have particular qualifications?

MS HARGREAVES: Yes, I hold qualifications as a social worker, a Bachelor of Arts and Diploma of Social Studies.

DR McEVOY: Could you give the Commission an indication of the role played generally by the MAV?

MS HARGREAVES: So, along with the other associations in other states and territories, we together form the Australian Local Government Association, and by that process represent the sphere of local government around Australia in COAG negotiations and such. And similarly at the Victorian level, we are representing the sphere of Victorian local government in negotiations with the State and with the

State to the Commonwealth. And as well as that we are supporting the 79 councils in the broad range of their work and providing advocacy for them but also development of their skills and capacities as local governments.

DR McEVOY: So, in effect, you are a peak body representing all Victorian local municipalities.

MS HARGREAVES: That's correct.

DR McEVOY: Can I take you to paragraphs 11, 12 and 13. This is really page 2 of your statement. Now, you say in paragraph 11 that the object of your statement, really, is to advocate for a commitment by the Commonwealth to the ongoing recurrent funding for expansion of the Commonwealth Home Support Program, preferably implemented through a national partnership agreement and bilateral agreements with each jurisdiction. So that's really the position of the MAV - - -

MS HARGREAVES: Yes.

DR McEVOY: - - - on this question.

MS HARGREAVES: That's correct.

DR McEVOY: We will come to the other states in due course but are you able to say whether the position that the MAV adopts in this respect is shared by your kindred organisations in each of the States and Territories?

MS HARGREAVES: Yes. The national body of the Australian Local Government Association has just now included such a sentiment in their Federal budget submission. And even though, as you are alluding to, there are varying roles played to a certain extent in the Home and Community Care Program as it was previously by councils in other States, there's significant commitment to ensuring that these services are well delivered in each area even though it might be done slightly differently in the different states. So perhaps just referring to the history that these services have been provided since post-World War II and since 1985 in a very secure and stable arrangement between the Commonwealth, state and local government in what was previously called the HACC program.

That was extremely well developed with appropriate roles really being played by each sphere of government and the local planning and delivery done at the local level with significant involvement and commitment for local government to ensure that all residents have access to services and are given timely support when they contact the council. So the advent of the change to the Commonwealth Home Support Program, the change in arrangements where the Commonwealth have assumed responsibility have caused significant disruption to the previous very successful arrangements. And at this stage the proposal that we're having is that we do need to reintroduce some stability into the system, particularly for the majority of people who receive small amounts of timely service through the Commonwealth Home Support

Program, which is still the majority of the older people that we're talking about, compared to the package programs and residential care.

So the level of uncertainty created by the changes has also greatly impacted on council's ability to plan going forward, given that they have got very large workforces and very large numbers of clients and so on. So the key thing that they're really looking for is ongoing stability and, as I come to, block funding around these services, because they are, as I say, really concerned about the clients and the members of their community and we need some ongoing certainty because of, as you are aware, we have been through the NDIS changes as well and we also serve people with disabilities. So it has caused great disruption to the service sector and to the clients.

DR McEVOY: Well, you've had a few, you've made a few comments in what you have just said about the historical investment that has been made in the sector and that's reflected, I think, in paragraph 12(a) of your statement, which is the first of your recommendations. You say the MAV wants to capitalise on the historic investment and commitment of local government by providing certainty and ongoing recurrent funding.

MS HARGREAVES: Yes.

DR McEVOY: You then say in (b) you want to retain the block funding approach, which you say ensures appropriate access. Can you just explain to the Commission why it is that you see something of a dichotomy, would I be right in saying, between the block funding approach and the present approach?

MS HARGREAVES: Yes. So just to explain, what the block funding approach means, particularly for local government is that we take responsibility for the whole population of older people in our community and that any person who contacts the council will receive appropriate advice and support. So that may be to a formal service that's currently available from the Commonwealth, but it would also be to a range of informal supports if the person is perhaps not quite at that stage and they can use an exercise group or go to a men's shed or something like that. So it's taking responsibility for a whole community of older people. The key problem we see with the current sort of individualised approach is that some individuals may receive very good service but other individuals may receive no service, not even make it through the phone system to ring up a national call centre. Basically, just drop off and no one is responsible for following up.

So it's a completely sort of reverse approach where we have had block funding that local governments embraced and in fact put their own resources in as well to make sure that a community, a group of older people in the municipality, basically, is serviced and that everyone gets a timely response. We have also introduced, I think you're aware, particularly in Victoria and Western Australia, a wellness and reablement model. So if somebody needs home care for a shorter period after having, you know, knee surgery or something like that but then they are able to

improve, then the services are adjusted accordingly. So it's not about just putting people on services for decades; it's also about if they are able to improve and avail themselves of other opportunities.

So it's a completely different approach from our point of view where what we would call public sector oversight and stewardship, I suppose, on behalf of the whole community and essentially block funding enables because you've got a certain amount of money that you can just up and down according to a group of residents – and we are talking about thousands and thousands of clients here of local government, it's not about an individual making it through the system and either getting services or not getting services and possibly nobody knowing if they don't get any. And so that's the basis, I suppose, of the block funding, particularly to the bulk of the population that's sitting in this group before they need more intensive packages or residential care which of course we accept.

I think it's still quite true that the most intensive requirements for services are usually in the last two years of life and I think that's still true, whether you are 83 or 93. And so local government has in fact supported that whole system before people get to that point and can help to refer them when they get to that point but enable them to remain in their own homes in the meantime.

DR McEVOY: Do you say that there's some sort of inconsistency between the sort of block funding approach that you've just outlined and what has sometimes been referred to as consumer-centred care?

MS HARGREAVES: Look, I think it's probably what you call the definition of consumer-centred care and we obviously would also talk about citizens and citizens' rights as well as consumers. We have elaborated further on in the paper that we think that it's a fairly simple matter, this idea of choice and control, which in some ways you can't argue with but our experience would be that older people absolutely value somebody talking to them in their home, listening to what they have got to say. They value the trust in a stable provider, continuity of care. You know, a range of other factors as well as choice, and most will probably need some support in navigating the system and councils, you know, are prepared to sort of go that extra mile to do that work so that the older person themselves, particularly if they have some sort of, any sort of disability, if it's, as I say, hearing or sight impairment – it doesn't need to be dementia or something really serious – but navigating the system can be very complex.

So, yes, our experience is that it has worked very well at the local level with that local contact and understanding of all the options that are available to support the person locally.

DR McEVOY: Just on the subject of councils going that extra mile, as you say, in paragraph 26 of your statement, you talk about the fact that the majority of councils deliver services that they're not funded for.

MS HARGREAVES: Yes.

DR McEVOY: What sort of services do you have in mind there?

MS HARGREAVES: Yes. Well, look, in general the whole program previously was predicated on local government in the early days putting in an extra 20 per cent of service. So councils have put in extra dollars to make sure they can provide a range of services. There are certainly some such as transport and others that are more readily available in some areas than others and the councils may use their own resources to expand according to the needs that they see in their community, which they're very happy to do, as I say, under a cooperative model where we are working together with the State and the Commonwealth.

DR McEVOY: So you say – I think the figure you put on it in paragraph 62 is that councils are contributing in the order of 150 to 200 million dollars per annum. Is this money that's coming from rates or - - -

MS HARGREAVES: Yes, that's right. It's coming from rates revenue that councils have committed. They also work very actively in what we call the positive ageing and healthy ageing, you know, they're providing a whole range of supports to their older community. But this is where, as I've sort of argued in the statement, that this has been supported by a trilateral statement in Victoria between the Commonwealth, State and local government around how we will work together to do what we call retain the strengths of the Victorian system at present. And clearly the councils are concerned and committed on behalf of their local citizens and their communities but they are seeking to be in a formal arrangement with the State and the Commonwealth.

Once things are centralised in Canberra it is very easy for councils just to be treated as just another service provider. And we, of course, really clearly see the two roles. The councils may choose to be direct service providers or have other ways of organising services but they take their sphere of government role very seriously in terms of stewardship on behalf of older people and that is in our statement, I suppose, really the role that we're really wanting to have recognised, that we play a role in planning and coordination of local services to make the best of the resources available, to highlight gaps and to work on those with the State and the Commonwealth. And as I've also said throughout the paper, we think that these services are very much ones that benefit from being delivered closely at their local level and not a step removed and also by not sort of absentee providers, as we would call them.

So the feature of absentee providers has become quite common, particularly in rural Victoria where agencies might claim to be able to deliver a service but they're actually based in Adelaide, for example, or wherever they may be based. They don't actually have a local presence. And the councils usually are the ones, previously, well the home care staff, home care coordinators are usually the ones that it comes back to solve the problem for the individual in their municipality. So we, as I say,

are really looking at this point before any further reforms are made in this area to strengthen this intergovernmental partnership in terms of the sort of stewardship that we think is required and the sort of planning and coordination of the service system to make sure that there are enough providers in each municipality able to provide the range of services that might be needed and councils very much see that as their role.

The choice then they make in this State and other States about which things they choose to deliver direct to themselves, you know, is going to vary. The world is changing. We know that. But it's that oversight to ensure that services are available to their residents and they are not left just having to call, you know, a national call centre and try and work their way through the system. So, you know, we will take that as far as saying that up until now any individual has been able to contact the council, or their family or their neighbour has been able to contact the council about someone they are concerned about and the council would navigate that back end system for them. They wouldn't have been expected to do that themselves and they can certainly do it with them and if they're very capable, of course, advise them on how to do it themselves. But for many people the system is just becoming more and more complex.

And councils are also able to deliver pretty well immediate services in the formal model that they would make sure that people most in need received a service, and that's extended through, I think as we say in the paper, to having a vulnerable persons register with the State to make sure that we don't have people vulnerable in emergencies.

DR McEVOY: You've used a number of times in your answer to my question, this expression "stewardship" of older people. Is it implicit in what you are saying that you think that councils have that closer to their hearts, as it were, than other providers who might be existing in this space?

MS HARGREAVES: Look, of course, there are extremely capable providers who care about the clients they serve. I think I'm more talking about the sort of public sector, the sphere of governance stewardship, essentially, that councils have responsibility in relation to all the residents in their municipality. There would be very few other – in fact I don't think there's anyone else that you can say has that apart from the State and the Commonwealth, so of course a very capable provider will be concerned about the clients that come under their purview but they're not responsible for those that don't or for providing advice to all older people in the community about where to start to enter the service system.

DR McEVOY: Ultimately, your view is that governments can more reliably perform these services; is that fair?

MS HARGREAVES: Yes, absolutely. And I think it goes without saying, when it comes to the hard to reach clients, for various reasons, you know, we have clients through 10 farm gates, 50 kilometres away from the council office that you might need to send two staff to because there's perhaps a person has got particular

difficulties. We refer, I suppose, later on in the paper to the cherry-picking concept, and this is not really being critical, it's really just saying if you are an agency with 100 packages and you can choose who to give them to, you can choose who to give them to; whereas the council doesn't have that luxury. They have the same responsibility as the State and the Commonwealth for ensuring that residents' needs are met and for working out a system where, you know, possibly the hardest to reach and the most difficult clients absolutely are not dropped off the list. And yes, I think, we're really the only organisation in that position.

DR McEVOY: Just going back to paragraph 12, we've canvassed a couple of your recommendations. Can I just direct your attention to 12(c):

> *Retain and expand the CHSP and reinstate annual growth funding for CHSP and discontinue level 1 home care packages and roll the funding allocation to CHSP*.

So your view is that, in effect, the level 1 CHSP is unnecessary or could be better spent in other ways.

MS HARGREAVES: Yes. That's right.

DR McEVOY: I'm sorry, level 1 home care package better spent as part of CHSP.

MS HARGREAVES: Yes. Yes, the actual amount of the package and the service able to be provided is very equivalent to CHSP and in fact when you look at it in detail, as you've had described this morning, often more of the funding actually gets taken in administration. The CHSP is very cost effective, I think, as I've said throughout the paper, in terms of you've got a bulk amount of money, it's largely going directly to the client service. There's not that same capacity, well it just doesn't rely on that administration of an individual package in the same way. So we would suggest that that's rolled in, that the majority of people benefit from – it may only be a small amount of service – entry level service they need under CHSP but they can often benefit from that for many years before they need a more intensive service.

And you know in terms of fiscal planning by the government, any idea that you would go to individual packages throughout this whole system is just, it would send – it would just be impossible financially, if you compare, you know, the numbers of people currently on the CHSP program compared to the number of people in residential care and with packages that I think we have described in the paper. And as well, from our point of view, it's the fact that when you have been blocked funded for a geographic area or similar, you are doing, you know, the planning and service development as well and that's often what's missing when you have a highly individuated model where funding is just going to individuals. So no one is actually planning for the geographic area to make sure that there is a service system available and a range of services available. So I think we need a balance between the two.

Obviously the individuated model has been, you know, very well prosecuted through the NDIS. We understand that, and we understand the importance of people having the rights over their own – the resources that may be, you know, may be possible for them. But without a planned system, you actually end up with nothing for them to appropriately choose from if you're not careful. So that's really the role that councils are very happy to play even, as I say, regardless of whether they choose to be direct service providers in some of the spaces or not. And the – previously we had around six per cent growth funding for the HACC program nationally that continued for many years, since 1985 which catered for the growth in population.

I think that has been pulled back with CHSP at the moment to a lower figure. So we're really, as I say, looking for, you know, longer term stability at this stage and not organisations like councils who are prepared to put in and put in their own money not knowing what's going to happen after June next year, because not knowing what's going to happen after June next year means they already have to plan for very large workforces and so on if there was a major change to this model of service delivery and funding.

DR McEVOY: You're pretty critical, generally, about the home support system, I think it would be fair to say, wouldn't it? You list a series of negatives in paragraph 64 of your statement and you say that level 1 and, arguably, level 2 home care packages are nearly identical. But I think what I'm hearing in what you're saying is that your criticisms extend, really, to this model more generally.

MS HARGREAVES: Yes. Look, I think it's probably a combination of not only the individuated model but the idea – I have resurrected this notion of subsidiarity which is really around the Commonwealth playing a subsidiary role and not taking on roles which should more appropriately be operated at the state or local level. So from our point of view I think it's a combination of the two, that if trying to run something like this centrally out of Canberra – and all the sorts of checks and balances I think we have been hearing over the last couple of days that are required – when nobody has the direct line of sight to the geographic area and to all the residents and the older people coming forward, you know, you're so removed and the cost then of trying to manage that system from a central point.

And I think, you know, over the years it has been agreed that many of these services do need to be run in some sort of bilateral arrangements with each State in Australia just because of the size of our geography and the small nature of the population and the fact that the State and the local government, or course, are involved in many other services as well. The State, of course, you know, in the implementation of the acute health system and, of course, the state see the direct relationship between the services and trying to keep people out of hospital admission and so on so, you know, there's a real incentive for us to get this working really well at the local level. And that tends to be removed if it's just seen as something that is just somehow being run out of Canberra and can all be decided from Canberra.

So it's really just saying that each level of government should play the role appropriate to it. It's not actually, in a sense, being critical of anything. I mean, I certainly remember before the NDIS was introduced that the original discussion was about whether one sphere of government – whether the States should be taking responsibility for disability or aged care and one should be taking the other. You know, that was the precursor to the NDIS. Whereas somehow now we seem to have centralised both disability and ageing at the Commonwealth level with the potential challenges that places on the Commonwealth in terms of oversight and so on. And I think it is having a very direct impact on older people and their carers as far as being able to communicate directly into the system as well. It's not an easy process, as I think has been described, either going through the phone contact or, you know, when you're not able to talk to anybody who actually understands the community you come from, what your issues might be.

So as we have said in the statement, we consider, given that we are representing the sphere of Victorian local government, but we are talking, firstly, on behalf of the Victorian community and their needs being appropriately met and really, secondarily, on behalf of the councils. The councils are very happy to play a role but really the level of concern about continuing to unravel what was a previously successful Home and Community Care program which had operated since 1985, and the inherent dangers in that for the Victorian community, and echoed by our counter parts in some of the other states as well, and I think we are at sort of the eleventh hour and what we are identifying is that one way of stabilising the system would be to certainly maintain block funding for CHSP and continuing on the previous sort of expansion that there was in that by population to stabilise the system.

DR McEVOY: Well, just in terms of the formalisation of the role of local government which as I – I think this is really where I began my question which you've just addressed, you've been talking about the formalisation of the role between local government and the Commonwealth, and you've mentioned the need for bilateral agreements. What do you contemplate in that regard?

MS HARGREAVES: The exact form of what it might be, you know, I'm not an expert in State and Commonwealth possible arrangements but, as we have said in the submission, drawing on our experience in health partnerships and certainly the one on universal access to early childhood education, 15 hours of kindergarten, we are really just, I suppose, pointing out that, of course, we can all work to an overall Commonwealth and national objective about what we are trying to achieve but then the actual implementation of that can be through bilateral arrangements with each State or jurisdiction. And for instance in the issue of 15 hours of kindergarten, it has been quite possible to start from very different starting points in each jurisdiction in terms of, you know, kindergarten being run in Victoria by local government and community, whereas it is run as part of primary school in other States.

So without being an intergovernmental expert, really just to say that we can all line up about what we're trying to – you know, we all probably have essentially the same aims in terms of meeting the needs of older people, but how we might do that could

be more fine-tuned in each State, and certainly for Victoria there is still a bilateral agreement around the assessment of older people and how that's run out in Victoria. So I think – I think there are options there, if we had the opportunity to explore them.

DR McEVOY: Would you accept the proposition that Victoria might be uniquely well placed to play the sort of role that you argue that local councils throughout the country should play?

MS HARGREAVES: Look, I think, yes, the history and level and depth of experience and so on and the commitment to the whole suite of services has been so ongoing in Victoria that we are well placed. But certainly the, what we have included in the statement from our South Australian association and our New South Wales association - - -

DR McEVOY: Perhaps rather than talk about that at a level of generality can I get you to work through each of those State sectors - - -

MS HARGREAVES: Sure.

DR McEVOY: - - - beginning with South Australia, if you like.

MS HARGREAVES: Yes. So, look, probably South Australia - - -

DR McEVOY: About paragraph 51 of your statement, I think.

MS HARGREAVES: Thanks. Yes, so I think South Australia identify, you know, the range of services they have worked with in home providers to the community and Home and Community Care, and certainly advocating on behalf of their citizens. As we've said, while they might not provide quite all the range of services that are provided in Victoria they have similarly had a significant ongoing commitment in this area that would have been supported by previously their relationship with their State government in the same way that Victoria had. And similarly New South Wales - - -

DR McEVOY: With South Australia, you accept that they're no longer in the position that Victoria is in, do you?

MS HARGREAVES: No, they would still be providing, you know, a range of probably social support and other services. So some components of the service offering.

DR McEVOY: Would you say it's a comparable spread of service to Victoria?

MS HARGREAVES: Probably not as extensive, no, that's right.

DR McEVOY: And is that a function of the fact that the state is bigger with a smaller population or is that for other structural reasons?

MS HARGREAVES: I would say that they probably have had a wider range of providers historically so that the council may have played a – not as – yes, a range of services but perhaps not as extensive in some of the councils, yes.

DR McEVOY: I think you were going to turn to New South Wales.

MS HARGREAVES: Yes. I think, really, that's a similar situation without them being here to give evidence on their own behalf, that clearly there has been, you know, a major home care provider as well in South Australia – sorry, in New South Wales, excuse me. So I suppose the overall point being that the sort of public sector oversight and ensuring that the services are available in an appropriate manner is something that certainly the other State associations and councils are expressing a commitment to because of their historical involvement. And you know, as that entry level and certainly contact point for their community about navigating the system whether all the services are provided by the council or not, and unless that role is formally recognised it will just slowly dissipate over time.

DR McEVOY: Are you able to say anything about any of the other States?

MS HARGREAVES: Western Australia, there again, the involvement of the councils but the arrangements there, I think have mostly been driven through the State government given the size of the population and so on, and the spread of population. But as we have alluded to in the paper, it was Western Australia and Victoria that held out for a very long time to actually joining the new system because we were so concerned about the potential consequences of that until there was really no choice in the final financial arrangements with the NDIA. So Western Australia and Victoria, I think, have been leaders in the wellness and reablement model and certainly not perpetuating the idea that people are just sort of put on services and stay on them for 20 years with, you know, no turnover or reviewing or encouraging them to be active themselves, if that's possible.

So a lot of that work has been done jointly between Western Australia and Victoria. I think, again, showing that capacity, if you've got the commitment of the councils to these approaches and the commitment of the State Government that we can come up with good solutions in each jurisdiction as it applies.

DR McEVOY: What you're really proposing, though, aren't you, is the resuscitation, in effect, of a model which more or less has existed in the past. Would you accept that?

MS HARGREAVES: Yes. Without wanting to seem "back to the future" but when you've got a tried and tested model that's strongly supported in the community, the community know where to go as the first point of contact. The whole system is not a complete mystery to them, and it's also based around citizens and the population of the municipality as a group, that provides, you know, readily available access and we can deal with it behind the scenes complications, you know, to assist someone through.

DR McEVOY: Do you say that you – I mean, leave Victoria and perhaps Western Australia to one side, do you say that you are in a position to comment on how feasible it would be to do what you are proposing be done in South Australia, the Northern Territory, Queensland, New South Wales and Tasmania?

MS HARGREAVES: Well, I think the principle is the same, particularly obviously we would advocate that if it wasn't the council that was a direct service provider that it was at least held in the public sector or a community health or not-for-profit type organisations. Quite frankly, I think in terms of the fact that we have also alluded throughout the paper that we have also been doing the demand management for the Commonwealth, effectively, the need to have this system in place for the large number of the older population who are only going to need small amounts of service for many years is really the only cost effective model that the Commonwealth can run with unless a whole lot of older people are going to miss out that they don't know about and my experience in working with the Commonwealth over the years has been absolutely that we agree about access and equity for all citizens across Australia.

So that you do need some designated public sector body, if not local government, having oversight of that in each jurisdiction and then down to the local level, however the best way is for them to structure that, because the Commonwealth cannot know that. They will not know it even by all the people dropping off My Aged Care or not being able to get through or not ringing back because unless an older person is able to actually talk to somebody locally, as you would know, sometimes it takes a long time to convince an older person that they might actually need some support, so that's the sort of process that you go through by the local connections, by the family getting support and so on. So as I say, just looking at it in financial terms as well and cost effectiveness, it's a very cost effective model, the block funding and, as I say, I would argue that we have been doing demand management for the Commonwealth all of this time. So we have been stopping people presenting on their doorstep with the very high need services before they need to get there.

DR McEVOY: The MAV preferred approach, effectively, has local government as the assessor, as the service provider and also would give it, I think, a significant role in determining which services should be targeted for growth funding. Do you see some sort of conflict inherent in that sort of an arrangement; that sort of structural arrangement?

MS HARGREAVES: Well, I think one of the – certainly the processes that have now been put in place, as you are probably aware, is that assessment has been completely separated out as a separate structure, so - - -

DR McEVOY: That would not be so necessarily under the approach that you have in mind, would it? Or would it?

MS HARGREAVES: No, I think that's similar to what has always, in a sense, occurred in the past, because councils would have always seen they actually – you know, they have to wear many hats and they would have the capacity to be assessing overall and then looking at their total population in terms of who is coming in. No, those structural arrangements would be able to certainly to continue to exist. We would certainly want to continue the bilateral arrangement with the Victorian State around assessment and to be able to have the devolved assessment model that we have got which means it's possible for there to be local assessment staff, you know, essentially in each municipality who have a knowledge of that area, so that there's really no difficulty with that.

DR McEVOY: Can I ask you to just move your focus for a bit to workforce issues. What experience or knowledge do you have about the sort of training that's needed to build up an appropriately staffed aged care workforce, if indeed that is an issue?

MS HARGREAVES: Yes, so this is something that Victorian councils have been very active in over many years. So that all the staff that work for councils have formal qualifications in either certificate III or certificate IV to do with home care and personal care. Some also have certificate qualifications in aged care. So over, you know, previous decades we have been through a process of ensuring that all staff have qualifications and also are appropriately remunerated from our point of view for the work that they do. This, in turn, has led to a very stable workforce in terms of continuity of care being able to be provided to older people because of that sort of certainty of, you know, employment and training and confidence, and confidence from the clients in what's being provided.

Again, we would say that the level of uncertainty that's surrounded these reforms over a period of time, you know, is not contributing to the certainty that staff have about where they may be placed in the future, and any model that doesn't have some public sector oversight we do certainly see the danger of, you know, staff workforce qualifications being, you know, reduced right down, you know, for the sake of expediency, potentially, so - - -

DR McEVOY: Is that an issue that is confined to private providers?

MS HARGREAVES: No, not necessarily. No, it's not.

DR McEVOY: It's still an issue that might occur in local government, is it not?

MS HARGREAVES: Certainly, we, like all organisations, have to have all of those quality assurance and checks, you know, in place to make sure that these things don't occur. But raising the bar in terms of having qualified staff to start with, and so on, obviously means that they're in a regular process of supervision and so on. Of course, yes, across a whole sector you can never say there won't be instances where things couldn't be done better. But as I've said, particularly when you come to rural areas, you know there's limited workforces available, people available on the ground, it can be very hard for organisations that, you know, coming newly into the

system or don't have any presence to actually maintain a workforce with any consistency.

DR McEVOY: You would accept, though, I think, wouldn't you, that private providers, whether for profit or not for profit, having now entered the market for these services in such numbers, are inevitably one way or another, here to stay. Would you accept that?

MS HARGREAVES: Yes, I suppose with our experience in, you know, the child care industry and so on, I suppose one of the main concerns from our point of view is, yes, of course, a not-for-profit or a private provider might do a terrific job but they don't actually have a geographic commitment to the area. So what we have experienced, for example, in child care is that, you know, you might have an organisation set up in a number of municipalities; then it might suit that operator to go to Queensland. So in terms of the actual consistency of services, whether it's in aged care or child care or whatever, having some oversight in the municipality about, you know, a core range of services being provided is really important. And I think that's where we come back to the CHSP program that, you know, if at least that is delivered in a block funded way so that there is a range of resources available and the council can at least play a planning and coordination role in ensuring that there are a range of services in the municipality, you've got some levers there and some, you know, ability to do that. On a highly individuated model where private or other providers just choose who they service across Australia in any way they choose, you know, you've got no geographic certainty for your community.

DR McEVOY: So do I take it from what you have just said that you accept that private providers are here to stay, and the appropriate way that you would say that ought be dealt with is by having councils continue to play a significant role, albeit you acknowledge that they would not cover the field; is that a fair summation?

MS HARGREAVES: They would not, sorry, what?

DR McEVOY: They would not cover the field; we would not turn the clock back, as it were.

MS HARGREAVES: Yes.

DR McEVOY: Is that fair?

MS HARGREAVES: Yes, and that's effectively what I mean about public sector stewardship, however you conduct that. In thinking this through, as you were saying, yes, the world has changed and we probably can't turn the clock back. I suppose that's why we have put some effort in the statement into looking at, if the Commonwealth was prepared to consider it, that that relationship with councils around the planning and coordination in their local area would be a very valuable one to pursue in any arrangements with each State. So that there is a body with both planning and oversight of what's happening for their older people, but also able to

alert the State and the Commonwealth when there are real deficits in the services available and be able to look with the State and the Commonwealth about how those services might be brought to be available in the municipality.

DR McEVOY: Commissioners, I don't have any further questions for Ms Hargreaves.

COMMISSIONER BRIGGS: Thank you for your evidence, Ms Hargreaves. How do you see the return to the old approach with HACC working for people in remote areas? It has always been difficult, as it is now, servicing remote areas particularly indigenous areas. How should this work or would it work?

MS HARGREAVES: Well, certainly from the Victorian experience, we would have, obviously, a council that was responsible for that area, and working, as I say with other providers but with the State and the Commonwealth around, as you would say, perhaps injecting not only the HACC services but also, you know, Aboriginal health services, whatever might be required. In terms of if you're asking me about more remote parts of rural Australia, I think that there are frequently additional strategies required to be overlaid on the basic service system because of the geographic spread, as you say, and a particular targeted approach that often involves broader issues in those communities. Again, I would think councils would be wanting to play a stronger role in that. Obviously, we have a whole range of other roles in public health and health and wellbeing and so on, but, yes, if you're sort of alluding to the fact there might need to be targeted strategies to ensure that some groups are covered.

But certainly in Victoria, the approach that has worked for us is that councils are involved as we refer to, to the extent of arising out of the bushfires nearly 10 years ago that we have a vulnerable persons register that has been maintained by councils of people who are very hard to reach in circumstances such as that which is, actually, you know, much more difficult to maintain under these new arrangements.

COMMISSIONER BRIGGS: You travel between the Commonwealth having agreements with the States and then you managing the services locally, and that has absolutely been the traditional way here. Is it possible to conceive of the Commonwealth block granting councils? Or, indeed, indigenous land councils for the delivery of these services?

MS HARGREAVES: Absolutely. And I'm sure there's history under different, as I say Commonwealth health promotion programs of that sort of thing. Yes, depending on, you know, which, where it's seen to be appropriate whether it's Federal or State dollars that should be injected and how that's arranged. But I think, again, that's where, having, you know, a formal written agreement about the roles it sees the government playing is very helpful and, essentially, under the CHSP the Commonwealth is block funding through the local government at the moment to provide the Commonwealth Home Support Program.

COMMISSIONER BRIGGS: I was interested in your comments around navigating services, and you've listened quite carefully to the evidence we've heard the last 36 hours and there's a genuine issue around navigation of services through packages. So do you see the council's role in your proposed model being contained to house cleaning, gardening, whatever services; or do you see it up through the range of packages from what would then be package 2 to package 4?

MS HARGREAVES: Historically, councils have been involved in delivering more package services and some, in fact, residential care. I suppose the way the models has evolved now and, as you say, with more entrants into the sector, it has become more of a mixed market that we are dealing with. We certainly have some councils who are very interested in that and see the benefits of being able to provide the whole range of services, and packages and more intensive services. I think probably, as we've said, the bigger concern would be on behalf of their residents and making sure they get timely advice and support when they need it, and that's probably still going to be a more universal role that local governments are going to be able to play.

I guess the direction of the Commonwealth around this highly individuated approach with potentially in the absence of any service system planning is very hard for local government to relate to and often does lead to councils sort of getting dealt out over a period of time if there are sort of three-year rolling contracts and then they may not be funded in the future. Whereas councils are in for the long haul and making a commitment and needing that sort of ongoing certainty. So I suppose that's why it's an issue we have focused around CHSP and level 1 packages. I'm aware, you know, talking to colleagues such as Dr Anna Howe, she would argue that we should put the whole thing back together again. But we are so concerned that the block funding is retained. We, I suppose chose to focus on that in our submission to make sure that doesn't all get swallowed up as well.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising?

DR McEVOY: Nothing, Commissioner.

COMMISSIONER TRACEY: Yes. Thank you. Ms Hargreaves, we are very grateful to you for giving us your views about a preferred model which we will give serious consideration to in the course of forming our recommendations. We thank you for your evidence.

MS HARGREAVES: Thank you, Commissioners.

<THE WITNESS WITHDREW [12.59 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 2 pm.

ADJOURNED **[12.59 pm]**

RESUMED **[2.05 pm]**

COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: Commissioners, I seek to call four witnesses, however, before I do so, I believe there are some appearances to be announced.

DR K. HANSCOMBE QC: Commissioners, in these proceedings I appear with DR BROPHY for Australian Unity pursuant to a grant of leave to appear given 15 March.

COMMISSIONER TRACEY: Thank you, Dr Hanscombe.

MR S. BLEWETT: If the Commission pleases, my name is Blewett. I appear for Rosemary Dale and United Voice pursuant to leave given, I think, yesterday.

COMMISSIONER TRACEY: Yes, Mr Blewett. Yes, Ms Hill.

MS HILL: If the Commission pleases, I call Sally Warren, Anna Hansen, Heather Jackson and Rosemary Dale.

<SALLY FRANCES WARREN, SWORN **[2.06 pm]**

<ANNA GABRIELLE HANSEN, SWORN **[2.06 pm]**

<HEATHER VIRGINIA JACKSON, SWORN **[2.06 pm]**

<ROSEMARY ANNE DALE, SWORN **[2.06 pm]**

<EXAMINATION-IN-CHIEF BY MS HILL

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

MS WARREN: Yes, Sally Frances Warren.

MS HILL: How old are you, Ms Warren?

MS WARREN: 50 years old

MS HILL: Where do you live, Ms Warren?

MS WARREN: I live in Perth, Western Australia.

MS HILL: What is your occupation?

MS WARREN: I'm a community support worker.

MS HILL: How long have you been working in that role for?

MS WARREN: I've been working with my current employer for two years.

MS HILL: Do you hold any qualifications that are particular to that role?

MS WARREN: Yes, I do. I hold certificate III and certificate IV in community services and certificate III in aged care.

MS HILL: Could I ask you to describe the type of work you do in aged care to the Commissioners, Ms Warren.

MS WARREN: Yes, it can vary. On an average day I might have between six to seven clients. They will involve PC, which is personal care. That involves showering, dressing, breakfast, meals to be made. It could be social support, domestic assistance, which is light cleaning, taking people to medical appointments, taking them to see family members. It can vary but it is mainly structured in the work that I do.

MS HILL: And have you prepared a statement dated 12 March 2019.

MS WARREN: Yes, that's correct.

MS HILL: Operator, could you please display the document ID WIT.0082.0001.0001. Ms Warren, do you see your statement on the monitor before you?

MS WARREN: Yes, I do.

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

MS WARREN: No, I don't.

MS HILL: To the best of your knowledge and belief are the contents of that statement true and correct?

MS WARREN: Yes, they are.

MS HILL: Commissioners, I tender that statement.

COMMISSIONER TRACEY: Yes, the statement of Sally Frances Warren dated 12 March 2019 will be exhibit 2-26.

EXHIBIT #2-26 STATEMENT OF SALLY FRANCES WARREN DATED 12/03/2019 (ID WIT.0082.0001.0001)

MS HILL: As the Commission pleases. Ms Hansen, could I please ask you to state your full name.

MS HANSEN: Anna Gabrielle Hansen.

MS HILL: What is your age, Ms Hansen?

MS HANSEN: 32.

MS HILL: And whereabouts do you live, Ms Hansen?

MS HANSEN: Adelaide, South Australia.

MS HILL: And what is your occupation, Ms Hansen?

MS HANSEN: I'm a home support worker.

MS HILL: How long have you been working in that role?

MS HANSEN: Just over eight years.

MS HILL: And do you hold qualifications particular to that role?

MS HANSEN: Yes.

MS HILL: And what are they, Ms Hansen?

MS HANSEN: I have a certificate III in Aged Care, I have a certificate III in Home and Community Care, and a certificate IV in Home and Community Care.

MS HILL: Could I ask you to please describe the type of work that you do in aged care.

MS HANSEN: My role varies every single day. We do cleaning, we do shopping with clients. We take them out for social. We give them – help them have a shower, that involves getting dressed, getting them in the shower. Sometimes washing their hair, drying their hair. Getting them to have appropriate clothing on, if it's clean, if

it's not clean because some people don't know the difference and some choose not to acknowledge that they do have soiled clothes on. So you have to make that decision quite rapidly. Taking them to see their families in residential care. It varies every single day. And it depends – depending on the client, their needs and what the visit is for.

MS HILL: Ms Jackson, could I turn to you and ask you to state your full name please.

MS JACKSON: Heather Virginia Jackson.

MS HILL: And what is your age, Ms Jackson?

MS JACKSON: 54.

MS HILL: And whereabouts do you live?

MS JACKSON: Brisbane, Queensland.

MS HILL: What's your occupation, Ms Jackson?

MS JACKSON: Personal care worker.

MS HILL: How long have you been working in that role?

MS JACKSON: 24 years.

MS HILL: Do you hold qualifications particular to that role?

MS JACKSON: Certificate II and III in Aged Care.

MS HILL: Could you describe to the Commissioners the type of work you do in aged care?

MS JACKSON: We are pretty much classed as multi-skilled. We do the cleaning and the personal care, escorting clients to different appointments. We might get them ready to go on a respite bus for the day. There's meal prep, assisting medication, which is done by the chemist in a Webster-pak for us to assist to make sure that – and remind clients to take that medication as well. Yes, that's pretty much it.

MS HILL: And did you prepare a statement dated 12 March 2019?

MS JACKSON: Correct.

MS HILL: Operator, could I ask you please display the document ID, WIT.0080.0001.0001. Do you see your statement there displayed in front of you?

MS JACKSON: Yes.

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

MS JACKSON: No.

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

MS JACKSON: Yes.

MS HILL: I tender that, Commissioners.

COMMISSIONER TRACEY: Yes, the statement of Heather Virginia Jackson dated 7 March 2019 will be exhibit 2-27.

EXHIBIT #2-27 STATEMENT OF HEATHER VIRGINIA JACKSON DATED 07/03/2019 (WIT.0080.0001.0001)

MS HILL: Thank you, Commissioners. Now, Ms Dale before I jump to you, if I could go back to Ms Hansen, I believe I skipped over your statement there, I apologise. Did you prepare a statement dated 12 March 2019?

MS HANSEN: 7 March.

MS HILL: 7 March 2019, and I see that the operator has displayed the document ID there, WIT.0081.0001.0001. Do you see your statement there on the monitor before you?

MS HANSEN: Yes.

MS HILL: Are there any changes you seek to make to that statement?

MS HANSEN: No.

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

MS HANSEN: Yes.

MS HILL: I tender that, Commissioners.

COMMISSIONER TRACEY: The statement of Anna Gabrielle Hansen dated 7 March 2019 will be exhibit 2-28.

EXHIBIT #2-28 ANNA GABRIELLE HANSEN DATED 0/703/2019 (WIT.0081.0001.0001)

MS HILL: As the Commission pleases. Ms Dale, could I please ask you to state your full name.

MS DALE: Rosemary Anne Dale.

MS HILL: Did you prepare a statement dated 6 March 2019?

MS DALE: Yes.

MS HILL: I see that the operator has displayed the document ID WIT.0079.0001.0001. Ms Dale, do you see your statement displayed on the monitor there before you?

MS DALE: Yes.

MS HILL: Are there any changes that you would seek to make to that statement; any amendments to that statement?

MS DALE: The ones that have already been made or – yes.

MS HILL: Beyond that.

MS DALE: No, beyond that, no.

MS HILL: Thank you, Ms Dale. And are the contents of that statement to the best of your knowledge and belief true and correct?

MS DALE: Yes.

MS HILL: I tender that statement, Commissioners.

COMMISSIONER TRACEY: The statement of Rosemary Anne Dale dated 6 March 2019 will be exhibit 2-29.

EXHIBIT #2-29 STATEMENT OF ROSEMARY ANNE DALE DATED 06/03/2019 (WIT.0079.0001.0001)

MS HILL: As the Commission pleases. Ms Dale, whereabouts do you live?

MS DALE: Sydney, New South Wales.

MS HILL: And what is your age?

MS DALE: 63.

MS HILL: And what is your occupation?

MS DALE: Grade 3 child care worker – not child care – health care worker.

MS HILL: And how long have you been working in that role?

MS DALE: Nearly 10 years.

MS HILL: Do you hold qualifications particular to that role?

MS DALE: Yes.

MS HILL: What are they, Ms Dale?

MS DALE: I have a certificate III in Health Services, a certificate IV in Disability and a Diploma in Community Care and Mental Health.

MS HILL: What type of work do you do in aged care?

MS DALE: I do a varied role. It changes weekly, daily sometimes, but ranges from personal care, getting people out of bed and showering them, dressing them. Sometimes putting them into wheelchairs if they're a disabled person, feeding them, washing, doing washing for them, doing shopping for them, and I work split shifts so I will come in and do meal breaks at night and put people to bed as well.

MS HILL: Do you hold a position within a union?

MS DALE: Yes.

MS HILL: What union is that?

MS DALE: United Voice.

MS HILL: And what position do you hold?

MS DALE: I've just been recently in the last 12 months was – achieved to be a delegate.

MS HILL: Are you aware of enterprise agreements negotiations that are currently ongoing at the moment?

MS DALE: Yes, I know about them. Yes.

MS HILL: In terms of the clients that you see, Ms Dale, the people that you see that you provide care for, are you able to tell the Commissioners how many people you would see that are receiving home care packages, Ms Dale?

MS DALE: I don't know whether they receive home care packages. The only ones I know for sure, because they're disabled, are the ones on NDIS. But as for the other packages the other clients are on, I wouldn't have a clue.

MS HILL: Would you be able to say how many people you see that are in receipt of the CHSP, the Commonwealth Home Support?

MS DALE: I don't know.

MS HILL: Is that for that same reason?

MS DALE: Yes, yes.

MS HILL: In paragraph 4 of your statement, you identify as being from an Indigenous background.

MS DALE: Yes.

MS HILL: You don't currently see any Indigenous clients, do you?

MS DALE: No.

MS HILL: But that's something you would like to do in the future, isn't it?

MS DALE: Yes, yes.

MS HILL: You have given evidence to the Commission that you hold a Certificate III in Health Assistance, a Certificate IV in Disability and a Diploma in Community Care and Mental Health.

MS DALE: Yes.

MS HILL: When did you obtain those qualifications, Ms Dale?

MS DALE: Okay. I did my cert III, I think it was 2014, then 2015. And I did my diploma in two thousand and – no, it must have been '14 as well. That's approximate. I can't remember the exact dates off the top of my head.

MS HILL: You also did a University of Tasmania course on dementia; is that correct.

MS DALE: Yes, I did two.

MS HILL: What courses were they, Ms Dale?

MS DALE: They were done through the MOOC system, which is an online course in preventing dementia and living with dementia; and I did those of my own free will.

MS HILL: Thank you, Ms Dale. Has your study assisted you in your role as a personal worker for the aged?

MS DALE: Yes, amazingly so.

MS HILL: And how has that been?

MS DALE: It has been really good because it gives you a better understanding, when you walk into a client who does have dementia, for instance, some days they will have a good day, they will remember you. Another day they won't remember you. So you have to take a step back that day and go through slowly what you're going to do with them because if you do things too quick, they get upset, they don't understand and they get very frightened. So it's a day-to-day thing with people with dementia. The other clients, even the elderly client, you have still got to go slow because sometimes we are the only people they see. They don't see – their families have gone, their partners have gone; we're the only people they see. So it's a slow process.

MS HILL: You've given evidence in your statement that you've previously been a mentor to newer or more junior workers in aged care.

MS DALE: Yes.

MS HILL: Why was that important to you, Ms Dale?

MS DALE: It's amazing ..... because like doing that mentoring program has saved me a lot of injury. I've learnt now, that I even take it home and do it at home.

MS HILL: What do you mean by that, Ms Dale?

MS DALE: Well, it's how you look after your body, how you move, how you hold your back. You work with your legs not with your back and your arms, even though you use them, but you take the weight of your job on your legs, because that's the biggest muscle in your body. And by running through that program which – I went to Parramatta under a lady at Parramatta, and she took us through a week course that we had to do to obtain that so that we could say that we were – well, I suppose you would call it qualified to mentor other care workers in your organisation. So that's what I did and, yes, I passed that. And – we used to do it and so we used to go and mentor every care worker to a limit. Every two years, you would go around the whole organisation, and then you would start again and they would get a refresher course every two years.

So it was an ongoing process but they got to know you so well, if they were having a problem, they would come and ask you. You would run into them at the shopping centre or somewhere and they would just say, "Look, I was having trouble doing this today. I couldn't move a hoist. What do I do?" You come up with a scenario that will make it safer for them to use those products.

MS HILL: Ms Jackson you've been working in aged care for about 24 years; are you familiar with the practice of mentoring?

MS JACKSON: Yes.

MS HILL: What observations have you made of the practice of mentoring in your work experience?

MS JACKSON: Well, I was able to do a bit of mentoring myself over the years and it's really great to see the person come on board and to watch them grow if they want to go more higher in the sector, because I believe learning from the ground roots is the best way. And it's just great job satisfaction for them to understand from someone who knows what they're doing and when you're learning on the job, you get better more outcomes.

MS HILL: What observations have you made, Ms Jackson, of the training that's available to personal care workers such as yourself?

MS JACKSON: Well, when I first started it was quite good. We did a lot of in the room training where there was a facilitator up the front and they would, you know, and we would do role plays, especially with the dementia, because we knew that was going to come to the forefront like a can of worms opening by 2015, like aged care. And I just felt more empowered to know that, okay, this is great, we're getting to do role plays and make us feel a bit better getting out there doing a best service we can to each and every person we go to. But unfortunately as the years have progressed we are online with a Saba Cloud and that's about 10 modules a year that we are required to do and it's more like a tick and a flick.

And if you do get into a bit of trouble and what have you, there's no one around you in the offices they're too busy doing whatever they need to do. And you're thinking, "Okay, then", so you pretty much guess the answer and most people, in my experience, most people say to me, when I walk out from that computer, I walk back to my car and it's like it has just gone. Nothing is consumed because it's a module that Saba has put up that they're obviously planning to go on to our online phones or you go into our offices, which my employer does give you time to go in there to do it. But sometimes that is hard to get in there as well. But we are required to do 10 modules per year.

MS HILL: Ms Hansen, when did you obtain your qualifications?

MS HANSEN: I obtained them about a year or so after I started working.

MS HILL: And what was your experience of obtaining your qualifications?

MS HANSEN: The qualifications were done at a training facility at Morgan & Hay. Just going through it in – sorry, a student with teacher environment. It was fantastic, just to get the qualifications that I needed to continue my work in aged care and the training was just excellent.

MS HILL: Do you receive any ongoing training in your role?

MS HANSEN: We do, but it's mandatory training through work and so we can't take it, if we do leave because it's in-house training. And we also, on your phone, on our work phones, we get just training but it's multiple choice and we are meant to be doing it in our own time. Yet some people who don't, who work full-time or work part-time, if we don't do it in a certain amount of time, we get someone from the office saying we need to do this and it's just like, "Okay, I will do it when I can but also I've got to do my job." We do get paid for it but only after we have taken our own time to complete it. But it's all multiple choice. It's very – it's not personal. And I don't really get anything from it because, one, I think that I know everything that they're asking me anyway because I've been in the industry for so long and I've done so many different scenarios with work that it doesn't really – it's not personal, and I don't really get anything from it.

MS HILL: Ms Warren, you've been working in aged care for about two years?

MS WARREN: Yes, that's correct.

MS HILL: And you've previously worked as a drug and alcohol counsellor and, indeed, as a police officer in the United Kingdom.

MS WARREN: Yes.

MS HILL: What was your experience of obtaining qualifications in the aged care sector?

MS WARREN: I found it very helpful at the time because the government pay half towards the costs of learning for your certificate ..... which I found very helpful. My certificate III and IV in Community Services, I went to TAFE in Perth to learn them and I studied full-time to get those qualifications.

MS HILL: Do you receive training in your current role?

MS WARREN: Yes, we do. We have manual handling training review, I believe it's once a year. We have training for stockings – I have actually suggested – put forward maybe mental health training could be an option for us for going out in the field. We have clients with depression and anxiety and I think there's a lot of – I speak just from some of my clients, they just want someone to talk to. It's the loneliness and the isolation and sometimes I believe mental health training is a very

good way to go and it's a suggestion I have put forward to my head office, and they are looking into it at this moment in time.

MS HILL: Witnesses, I want to move to ask you some questions about the conditions of your work. Ms Warren, you go to the homes of people to provide care to them.

MS WARREN: Yes, correct.

MS HILL: Do you always see the same people week to week, month to month?

MS WARREN: Most of the time, yes, I do. I would say there is a high percentage of continuity of seeing my clients but sometimes that doesn't happen. A worker could be sick or someone is on holiday or sometimes we just get sent to a different client in a different area but on the whole my organisation, we do have, mostly, continuity with the clients.

MS HILL: And are you doing the same thing with each client every time you see them?

MS WARREN: Basically, yes, it is.

MS HILL: And what's the minimum amount of time that you would spend with someone?

MS WARREN: The smallest amount of time would be 15 minutes. Now, that could be a welfare check which we just basically have to go in to make sure the person is okay, make them a cup of tea, just keep an eye on them or it could be a 15 minute meal prep, or medication. We might have to administer oral, liquid or topical medication. So, yes, that would be the smallest window that we have.

MS HILL: Is 15 minutes enough time for those activities you've just described?

MS WARREN: I would say on the whole, yes, but sometimes you might be thrown a curly like you can't find a key to a lock box, or the client might have put the paperwork away, and in dementia they might have forgotten to – where they put it. So you might be trying to track down some paper but on the whole I do find the 15 minutes is enough. But that's personally for me, that's what I've encountered.

MS HILL: Ms Hansen, you referred to having split shifts in your roster, in your statement; what is a split shift?

MS HANSEN: A split shift is, basically, just say, for example, if I have one or two clients in the morning starting at 8 o'clock, I have a half an hour shift, and then travel to the next client. And then I don't have anything until, I don't know, maybe two hours later and then I have a couple more shifts later in the day. That's what we call a split shift. So we will get paid for the morning clients and the travel in between.

And the clients after, we do not get paid for the time in between even though, technically, we're on call because they can call us up literally saying "Can you go to such and such", and we have to – well, pretty much we have to say yes.

MS HILL: How does that practically work if that happens?

MS HANSEN: We have our work phone on us at all times when we're working. I've got availability from 8 am to 4 pm and they can call us and say Mr X has fallen down or probably not fallen down but needs someone to go and see them straightaway, are you – can you go and see them. And I'm like, "Yes, no worries, I will be there as soon as I can." But in saying that, I don't rush because that's the worst thing we can do, is rush to a client because we need to have a level head. We need to think straight. We need to go in there and, okay, assess every situation as we're going in there for the first time. And sometimes knowing in the back of your mind that you have an emergency is sometimes dangerous.

MS HILL: If something does go wrong or someone is running late, is there someone that you can contact at your employers to notify them of that?

MS HANSEN: Yes, we can call – we've got on our phones the member's number. If I know the member and they've got dementia or they won't remember that I'm running late, I tend to just call the office to say. Or if they will remember, if they do remember me and I know they remember me, I ring them, which we have on our work phones, just to let them know that we are running late, and our regular clients – I've always said to them, "If I'm running five minutes late don't worry about it. If I'm running 15 minutes late I will absolutely tell you I am running late".

MS HILL: Do you choose to be on a split shift?

MS HANSEN: No.

MS HILL: So how does that come about, Ms Hansen?

MS HANSEN: Apparently it's – they don't have enough work, yet they keep on employing more people. But I am – I only work three days a week and they say they don't have enough work for three days of seven and a half hours minus the meal break for work for me. And I'm thinking to myself, if they don't have enough work for a part-time employee that works three days a week, how are the full-time employees getting work? We can't – I don't know how they expect us to live off split shifts, and this is after constant emails, constant phone calls, saying, "I need work". I've been working with them for over eight years yet I'm still struggling to find work because they – I don't know the reasons, they just don't give me enough work.

MS HILL: Do you think you will stay working in aged care, Ms Hansen?

MS HANSEN: I love my work ,and I love my clients because I get so much value out of my work, working with clients who need the help. I'm very much of a caring person and if I – if I wanted to be rich, I wouldn't be in aged care because I would get another job. But I value my work and I value my clients and I want to help them stay in their homes for longer. That's it. Yes.

MS HILL: Ms Dale, what's the minimum amount of time that you are allocated to a client in your role?

MS DALE: 15 minutes.

MS HILL: And what sort of work are you doing in that timeframe?

MS DALE: It's mainly – I do the 15 minute jobs mainly with a quadriplegic client that I have, and he needs you to go in sometimes just to have medication. Sometimes it's just to give his eyes a wipe, and empty his urine bottle.

MS HILL: And do you feel generally that you've got the time that you need to do the work you need to do?

MS DALE: Yes. Yes.

MS HILL: Ms Jackson do you have the time to do the work that you need to in your role?

MS JACKSON: It varies from client to client. As the panel was saying, we don't know until we open, until that door gets opened, and I am lucky that I have the continuity as well. But if you are continuously going into somewhere, you know, you see the deterioration in some of the clients and it can be quite rapid. And that 15 minutes might turn into 35 minutes. And, of course, the funding that is out there and every minute you go over it, it's every minute they get charged. And so we are on a time clock and it can be quite distressing for myself trying to get the job done if the person is not quite right that day.

MS HILL: Does that impact on the quality of care that you are able to give?

MS JACKSON: Yes.

MS HILL: Have you had any discussions with your colleagues as to the effect of this situation on their wanting to stay working in aged care?

MS JACKSON: Yes. Unfortunately, where I'm employed, the turnover is quite substantial for the simple fact is that it is the wages. The generations under me – under me again, they like to have many eggs in their basket. They don't want to have the one job or the Two jobs in their career. And they've very much stated that it would be great but there's no career going forward in aged care, and the wages don't cut it when they want that family dream home, it's very hard to get a loan and,

you know, with the family and some of them have to do second jobs because they – they just can't – they just can't live and try and get what they want in what they want to do for their lifetime.

MS HILL: Witnesses, I would now like to turn to safety issues in your roles. Ms Hansen, in your statement, you talk about transporting clients in your own car. Does that present particular risks to you in your role?

MS HANSEN: It can.

MS HILL: And what are they, Ms Hansen?

MS HANSEN: Well, it depends on the client because some have dementia, some have mental health problems. It depends, if they're having a good day, as simple as if they're not having a good day, then you have to watch every surrounding, the traffic, if they're buckled in, if they've taken their seatbelt off. It's every single little action that they do sometimes because if they're having a bad day, and if I don't feel comfortable having them in my car, I say so, because it's not worth me losing my life or crashing or having something happen to not only me but the client. If they're not having a good day, I say something and I refuse because it's – it's not worth it. But if they are having a good day, they get into my car. We have – sometimes we have a nice chat. Sometimes we don't but that's – every individual is different. But when they get into my car, I have to basically know the scenario, know where we're going, and I have to think on my feet 100 per cent of the time until I get that client to their destination or – and get them in there safely.

MS HILL: And how do you manage that type of situation?

MS HANSEN: In what – a dangerous situation?

MS HILL: How do you look after yourself in that situation?

MS HANSEN: I take every step that I can. I think on my feet 100 per cent of the time, if I have to. And you have to not only think of myself and the client but also the surrounding people because I'm responsible for that person. Like, if we're going to a nursing home, I'm responsible for that person, taking them in there, taking them to who they want to see, and until that person is in there and until I leave them and then go back into my car and finish that shift, I'm still responsible. So I have to do everything that I can in my ability to make it safe.

MS HILL: Ms Jackson, in your statement you use the word "isolated" to describe the nature of the work that you're doing. Why is that, Ms Jackson?

MS JACKSON: We are the lone workers. We are the frontline workers of this great industry. We are the ones that front up at the front door or the back door, morning, noon, night, sleep overnight. Some people have left the industry because they don't like the isolation. They don't feel as though they've been supported

enough because everything is put through the phone now. Whereas once upon a time we would go into the office maybe two or three times a week in the afternoon. Now, they don't want us in the office. Everything has got to be put through the phone app or phone your team leader. And, yes, some people find that – it's very daunting for some people. They just – they can't cope with that.

MS HILL: At paragraph 32 of your statement, you make a recommendation to the Commissioners to improve the safety of workers. Can I first ask you what motivates you to make that recommendation?

MS JACKSON: Well, this – unfortunately, in this industry, we are dealing with all different walks of life in the home. We are dealing with people who are meandering around people's home. We don't know who is out there in that afternoon, evening shift, which I have stated. I have recommended an emergency beacon. I believe every care worker needs to have that so that they can at least know, on their hip, if they're getting dragged, you can punch that hip and it will go to, as I put forward, Chubb Security which connects to the police so that there is some sort of action can be taken within, say, 15, at least 15 minutes. Because there are some dingy areas that we go to, and people are not leaving lights on and what have you. The provider goes out to say we have got a report in, the hazard report has gone in. We need you to put a floodlight outside, and some of them bluntly refuse to do it yet the provider tells us that we have to go and do it.

And I've brought up and said, "Well, that is not good practice. We are living in a different, different world now. The afternoon, evening shift and the overnights are getting bigger and bigger in this industry". I said "And people are crying out, families are crying out to have their loved ones looked after so they can go out to dinner and go to the movies while you're in there between 6 and 11 pm.

MS HILL: Ms Dale, what's your experience of working on your own as a personal care worker?

MS DALE: It can vary, like the other girls have said. It's very hard and especially if you're working late at night, because I work in the inner city, in and around – I go to Redfern, I go to Maroubra, I've got La Perouse and that, so at the night-time it actually can be scary and, yes, you are on your own, and sometimes you've got to park your car within a distance to your client, it's not right outside the client's home. That takes up time and, yes, it actually can be very scary and that. But the clients need us, so we do it.

MS HILL: Ms Warren, can I turn to your experience of working on your own as a personal care worker and ask you to describe that experience to the Commissioners.

MS WARREN: It can be lonely at times but I do like working autonomously but within a team. As I said in my statement, if I have any problems at all I can ring my team leader or the inquiry line and someone will generally ring back within an appropriate amount of time unless they're really, really busy but like I said it doesn't

bother me to work autonomously but I'm still working within the guidelines of my employer and any issues or any outstanding problems I will just ring straightaway and I will never willingly put myself into a hazardous situation. And if there is a client that is too challenging or I feel the danger of an imminent threat I will say, "I'm sorry but I have to leave now", and I will leave the building. I will not put myself into any danger. But we have this – the backing from head office as well who have said this to us not to put ourselves into any danger. But I am lucky so far that hasn't happened to me personally.

MS HILL: Ms Warren, can I ask you to take the Commissioners to what you do, step by step when you are allocated a new client, a new person to care for.

MS WARREN: When I'm allocated a new person, all the details come up on our Samsung phone which has the ComCare system, and it tells us the name of the person, the date of birth, obviously the address, and it will have on the second page of the ComCare what the visit will be. It will have DA social support, everything that we need to do and the background. And if there is any alerts such as could be dementias, if they're a high fall risk, Alzheimer's, we – us workers, we know before we go into the situation. Obviously, things can change, clients can deteriorate within a very quick period of time. So, but on the whole it doesn't sort of change that much but any questions, I will always ring before and because I like to be well organised, I will check my roster a week before.

But it changes because, you know, it's the nature of the industry. People call in sick or a client might get taken to hospital or they might just cancel the service. So it can vary but I do like to keep informed of where and who I am going to see well in advance. Any issues I will always ring up.

MS HILL: Do you have much to do with agency staff then, Ms Warren?

MS WARREN: No, I don't.

MS HILL: Now, Ms Warren, you've referred in your statement and in your evidence this afternoon to using a ComCare system. Could I ask you to tell the Commissioners what that is.

MS WARREN: Well basically, a ComCare system, it's – I suppose to the olden days it would be equivalent to a little notebook or a personal file. It gives us the background, as I say, the address, it also gives us the GPS tracker. So we don't have to consult any books. We just press the button and it locates the quickest time for us to get there. And ComCare will alert head office. When we get there, we press the start button and literally you will turn up to the service. You will either knock or ring the door, then you press the start button, and that is when the time – what we call the window starts. And then we finish – obviously when we finish it, we press the stop button. But there's also, like, if we go 15 minutes over the service, we have to notify the inquiry line and let them know the reasons why we go – sorry, over, otherwise a client gets charged for that service.

So they are kept abreast and also they know at all times where we are. So if, for argument's sake someone says they're at a client's and they're not, the ComCare and the GPS system will let head office know. I find it a very good system, apart from on the odd days when it just doesn't work but that's life, it's technology.

MS HILL: Ms Hansen, you've described using a work phone. Is that similar to what Ms Warren has just described to the Commissioners?

MS HANSEN: Yes, we're actually using ComCare as well.

MS HILL: And how do you find the phone system?

MS HANSEN: I do find it quite useful in the fact if I haven't been to a client even a week before I get there, I can look up who they are, any alerts. I can look in the notes that previous people have written, any falls, any – like if there's alerts, if they've got dementia, if they've got dogs, anything that I need to know, but I do find it quite useful.

MS HILL: Do all personal care workers of your employer have access to that ComCare system?

MS HANSEN: Yes.

MS HILL: Is that true if there's agency staff?

MS HANSEN: Agency staff don't have access because they don't have the ComCare system – well, that's what I believe. But I don't – I'm not sure what the agency is told.

MS HILL: Ms Dale, you've described a change in your workplace where you now do everything by a phone system. Is that similar to what Ms Warren and Ms Hansen have described in their evidence to the Commission?

MS DALE: Our system is Procura, and it does break down a lot. We have a lot of trouble with our phones. And, yes, everything is reported, hazards, everything is reported on to the phone.

MS HILL: Is that you reporting on to the phone or your employer reporting?

MS DALE: No, I report – if I find a hazard, I've got to fill the form all in on the phone. Don't have the glory of – I can look ahead and see what clients I have got but I can't access their care plan. And not all my clients have a care plan on the phone. I have to ring the office or email my coordinator and ask her, "Okay, going to Joe Blow tomorrow, I haven't been there before, can you give me a rundown on what his service is?" That's not always on my phone.

MS HILL: Is there anything about using that phone that works well for you?

MS DALE: I don't have a problem with the phone. As it's such of itself a signing in and out of my clients, it's no problem at all. It's the extra stuff sometimes that gets to you. If you go to a client and – say, I'm going to a client and I'm giving them their dinner but on my phone I've got to mark off showering, toileting, personal care, shopping, bowel care which is irrelevant to what I'm actually there for that client, and I've got to mark all of them off or the phone won't let me go any further. I can't even finish the service until I have ticked all of those boxes.

MS HILL: What does that mean for the quality of care that you are able to provide for that person?

MS DALE: Well, that has either got to be done in my time, my travel time or the client's time. So either way, it doesn't work when you've got a lot of things to cross off. Most of the time you've got a client who won't have any of those on there. But now the way the system is working now, it's becoming more and more prevalent.

MS HILL: Ms Jackson, you've had experience of using the online – the phone system.

MS JACKSON: That's right, we have Procura as well.

MS HILL: How does that work for you?

MS JACKSON: It works – it works fairly well. Unfortunately it's only three days in advance for us. We're trying to get that extended but nothing has come forward for that as yet. Our tap in, tap out is – we have to do it at the car, and there are sometimes in inner city where the care staff have to park quite, you know, three or four streets away, so therefore it might take a couple of minutes, two or three minutes to get to the client which has already eaten into their time, and then when they suddenly realise that you're saying, "I'm so sorry but I've got to get back to the car", and they go "What's going on?" I said, "I have to tap out when I get back to the car", and so then the phone call comes in, you know, quite upset, da, da, da. So, you know, the powers that be have got to go out and have that conversation to add another, say, eight minutes on to their visit which they're going to be charged 15 minutes.

And every – every one minute or so you're over – I believe it's 60 cents every time you go over. So you are forever checking your phone to make sure that you are out of there. And in some circumstances it's quite unavoidable. And the providers, you know, like, you give the explanation and you put it through the phone and you ring the, you know, our directive that we ring. They go, "Okay, then we will make sure da, da, da" but then when the bill comes in, we're the frontline workers, so therefore they start to get really upset with us. And I just say, "You need to phone this phone number to speak to these people". And, have been, it's a butterfly effect where they're on the phone. They get frustrated. They have to wait so long, they give up. They hang up the phone. It's just all the anxiety just settles in, into the client, which is not good for us.

MS HILL: And what does that mean for you and your ability to perform your role?

MS JACKSON: Well, it's just – it just – I'm just very mindful of – and I'm very good at my time management, I must admit. It's very rare when I do go over, it might be within that two to three minutes, but if I really – if I really can't finish that procedure in that time, I'm not going to rush. I do the job that needs to be done. I'm only there for that, you know, the 15 minutes to 45 minutes and whatever needs to be done for that client, they deserve it. And so, therefore, I will give that service.

MS HILL: Ms Hansen, I could see you nodding your head there when Ms Jackson was giving her evidence.

MS HANSEN: Yes.

MS HILL: What's your experience with the phone and your ability to care with that device?

MS HANSEN: The thing is, I go into a client and they are so worried about running – me running late to the next client or don't go over time, don't do that because I might run late. And I always say to them, "Don't worry about the time. Please don't worry about it. Let me worry about it" because if – that's another thing that they don't have to worry about. And their anxiety will go from – it's just increases so much with such little things that we think about, but it's just one less stress that they have to think about.

MS HILL: How do the clients respond to you when you say that to them?

MS HANSEN: It looks like they are sighing with relief because they understand – they know that I understand where they're coming from. And if I can, I won't run over time. But sometimes you literally cannot help run over time. You try the best you can.

MS HILL: Do you feel that you have enough time, generally, with the people that you are seeing?

MS HANSEN: Sometimes. Sometimes not. It really depends on the client. If they're cooperative or not, because if a client is having a bad day or they're very upset or angry, you have to deal with that then and there, by yourself. You're going into that situation and you have to think on your toes, 99 per cent of the time. If you know the client, then you have some gist of what's going to happen and what they're like. But sometimes if you go into a client and you have literally just met them, it can be very, very daunting.

MS HILL: And do you have any experience of that, Ms Dale? I can see you nodding.

MS DALE: Yes, yes. Exactly what Anna has said, yes. It does happen quite a lot and they get worried and they get upset and, "Look, darl, I'm here for you today. Don't worry about nothing else. We will get everything done. Don't worry about it", and that. But some of them do worry about being charged extra.

MS HILL: How do you manage that, Ms Dale?

MS DALE: I try very, very hard to make sure that I'm out of there on time so that they're not charged any extra. But, as Anna said, some days if a client is having a bad day, it is very hard to get out on time, very hard. And then you say something, and your employer will say to you, "Well, the clients are expecting you at a specific time, you need to be there." It doesn't work that way. It really doesn't.

MS HILL: Ms Warren, do you find in your experience that you've got the time, or the time that you have is adequate for you to provide the level and quality of care that's required?

MS WARREN: I would say for a majority of the clients that we do. There might be one or two clients that they have actually asked me to turn my ComCare phone off so I can finish something or write my notes not in their time. Legally, I can't do that and for insurance purposes I can't do that, and when I have explained that I can't do that, they have got rather upset or rather angry. And I have had to say, "No, management has said I cannot legally do this because God forbid if something should happen, I'm legally not supposed to be on these premises insurance-wise", but there will be one or two people that will try and push it but you just have to be polite and firm and say, "No, I'm sorry, I can't do this", but on the hole people are very understanding, and I think it can depend on the packaging that the particular client has got. They might not be able to – they haven't got the money for us to do what might necessarily be expected of us and it could be a very poor timeframe window that we have.

So we have to do the best that we can to make sure the client is happy. But also, once again, be mindful of the time. So it can be a very delicate balancing act. But I would say on the whole, with my clients, I do get adequate time but you know, one or two, it could be three where it's physically impossible. But when that happens, or it has happened more than two occasions, I will always let my team leader know and I say, "Maybe something needs to be done about this" because I know for a fact it's not just myself that is facing this issue; it is other community support workers as well, and I then notice that an extra 15 minutes has been added – or 10 minutes has been added on to that client, and it really makes a difference because the client is happier. We have gone in to do what we set out to do and therefore it's a completed service and the client is happy.

MS HILL: Are you aware of seeing clients that are receiving the package that they aren't assessed for?

MS WARREN: Not to my knowledge, no. I believe within my organisation that they are all assessed before the CSWs go out.

MS HILL: If I can turn to you, Ms Jackson, having worked in aged care now for 24 years, is it fair to say that there wasn't always a system that involved phones and information technology of that sort?

MS JACKSON: That's right. It was all done through paper, a paper trail. Where we go in once a week, you could get your weekly run ahead and we would have the dinosaur phones, and we would get a phone call to say, you know, "Mr Jones has cancelled today. Are you able to – you know, we've given you another person, da, da, da" and the communication was – was really a lot better.

MS HILL: Why was that, Ms Jackson?

MS JACKSON: Well, because – because through the phones, you can put in so much information through your phones. But when you have the contact with the office more frequently, if they were available because, you know, their work commitments, what they have to do is full on throughout the day as well, it's just that we could always pop into the office when we needed to because we were in a bit more grouped area, whereas I find now, you do get shoot out a little bit further out than you need to or you might be way out of your area because of sick leave or whatever is going on for that day. And I just found that we were able to pop into the office a little bit more regularly. Whereas now they tend to say, "No, you need to put it through your phone".

MS HILL: Do you think that there's a balance to be struck between the paper-based dinosaur phone of years gone by and the current arrangements?

MS JACKSON: Yes, well, look, technology is certainly much better. It's just that on hearing and experiencing through a lot of providers that a lot of cost-cutting is going – is going ahead. So, therefore, the teams that were there were like three and four and five is cut down to maybe three, two, in a base area. And so, therefore, they're on the phone and you're trying to make that call, and there's no one really else that you need to have that contact with.

MS HILL: And that's when you are trying to get back to head office.

MS JACKSON: That's right. Yes. Yes, because, see, in some situations too, you know – going back to timing and that with the clients is that sometimes we have to deal with very difficult families. And most of the time – or some of the time, we are unable to even start the procedure that we are supposed to be starting because the family member is too busy saying, you know, "This has not being done, that has not being done, where is your duty of care? "Excuse me, please, okay, what is your issue? This is the procedure that I can put a request in for someone to phone you, rah, rah, rah", and so by the time that that situation has been calmed down or what have you, it might be that the visit is going into 10, 15 minutes, and you've got to go and

shower this particular person, that's where you go up to that 50, 55 minutes, and you know, okay, that 30 minutes has now gone into one hour.

Then I, literally, if it gets a bit too hectic, I just say, "You need to reframe the way you're speaking to me right now. I will leave this house. I will phone my supervisor and it will be sorted out from their end" I said, "But at the moment your loved one needs my care to help her to be hygienic for the day. You know, she is very incontinent", whatever, and usually I can pretty much deter it, but there are times when, unfortunately, the loved ones that are looking after their elderly, has the mental health issues. And they need the help as well. So it's a real diverse of what we're seeing out there.

MS HILL: Ms Hansen, do you have much contact with your office?

MS HANSEN: Not any more. I'm pretty much out there by myself day in, day out.

MS HILL: What does that mean for your day-to-day role?

MS HANSEN: In my car. In my car from my house to my first client, to my second client, to lunch, in my car. My car is my office.

MS HILL: What would you like to see differently about that type of situation?

MS HANSEN: More involvement in the office. More – just contact. God forbid we have contact with the office just a bit more than a phone call, rarely, if we've done something wrong or if there's an issue or if there's a hazard, they come to us straightaway because they know that we've done something. But if we've done something correctly, we don't hear about them at all. And I know that's a good thing that I don't hear from them, if I'm doing my job correctly. But it's very isolating and very lonely at times. And when I'm seeing my clients, sometimes I know how they feel because I'm sometimes the only person that they see throughout the whole day. And it may be only for 15 minutes, it might be for half an hour.

But if I can, I know how they feel, kind of thing but I would like to see much more communication through the office, even if it's a phone call to say, "How are you doing?" Just, yes, getting in touch, really.

MS HILL: Have you made that request or that suggestion to your employer?

MS HANSEN: Constantly.

MS HILL: What response do you get?

MS HANSEN: The famous phrase that they love say is, "We're looking into it". And I've heard that response so many times, it doesn't make any sense to me any more.

MS HILL: Ms Warren, can I turn to you and turn to, in your statement, you state that about 65 per cent of the people that you see are diagnosed with dementia.

MS WARREN: Yes, that's correct.

MS HILL: What does that mean for how you carry out your role?

MS WARREN: I think it can vary with the client. As you know, and are aware, there are varying stages of dementia. Sometimes it can be absolutely full-blown where they've got, like, one minute of coherency and then it goes again, or some days you can have a very in-depth conversation with them and they will remember something and then the next day or the next time you come back, it can be completely different. But I'm finding with a couple of my clients lately, the dementia that is declining is very, very rapid and it makes your job, as much as it is rewarding, it is very challenging as much as a simple task one day could be a PC shower assistance. If they're having a lucid morning, it's fantastic. I can go in, boom, it's done. The next morning it might not even be achievable, even with the help of a loved one.

You talk to them, because I have that continuity that sometimes they might recognise my face but they're just having an episode, it can be nigh on impossible and all I can do is write in the progress notes so the next workers know, and just inform the team leader, declining behaviour. It can be very heartbreaking because there can be no rhyme or reason. As I say, it just changes on day-to-day. But that one moment, you get like a blessed window, and they're very lucid is – it makes it worthwhile, in a nutshell.

MS HILL: Does continuity of care, so going back to see the same people have a role to play there in your view?

MS WARREN: Definitely. I would say definitely so with dementia, and I know this for a fact, because I had a case with a client and a family last Friday morning it was, and I had only been seeing the parent for three weeks. And they had been with my organisation for just over a month and they said the joy that the mum gets from knowing that there will be workers going around there, even with the dementia, she is recognising our faces. She is recognising our voices, and there has been a real upturn in her mental health. And that's good to hear that because it means that when I am there, the mother is feeling better. It has got a trickle effect on the family because the family are happier and the other ladies that are going in to do their jobs in the same role as myself it's having an impact on this family. It's not just the client; it's the whole family.

MS HILL: Ms Dale, turning to that topic of continuity of care and contact with family members of people that you're caring for, do you have contact with the family of those people that you are caring for?

MS DALE: With some of them; not with all of them. A lot of the clients that I see, they're by themselves. As I said before, I can be the only person that they will see all week, or three times a week, depending on how many times I go to that client. And some of them don't leave their house. So they don't go out anywhere. It's really hard sometimes because they go there and they want you to stay. They want you to talk to them and that, just to have someone apart from a television talking to them, someone that is going to answer you back, and they will tell you stories about when they were little, what they used to do with their mum and dad. It's amazing, even the clients with dementia can remember what they did what they were little, when they were little girls and boys, they like to talk about it or they like to talk about their sport and that, or the old movies. It's the recent memories that they lose. They can't hold on to those ones. But a lot of them, apart from sundowners, can remember what it was like to be a little girl.

MS HILL: In your statement, Ms Dale, you say that continuity of care is important for the people that you are seeing.

MS DALE: Yes.

MS HILL: Is it important for you as well?

MS DALE: Yes.

MS HILL: And why is that, Ms Dale?

MS DALE: I love this job. I used to do a different job altogether and work with young children but now I retrained to do this. These people give back as much as what we give them. You learn from them. You're learning from their old memories about, you know, different types of stuff, any old movies, it doesn't matter what it is, they teach you something each time you see them as well as you're helping them. So you work up a good relationship with them and that. And it's really sad when they're not there any more.

MS HILL: Considering those relationships of trust that you build, Ms Warren, in your statement, you give evidence about completing an elder abuse report.

MS WARREN: Yes.

MS HILL: Could I ask you to take the Commissioners to the circumstances of that report?

MS WARREN: Basically, I was doing a service to – a transport service with a client and I see this particular client once a week, and it was just a general conversation, you know, how are you, how was your week because he calls me action woman because every weekend I'm out doing kayaking or on a stand-up paddle board. He says I like it when you get in my car because you're action woman, so just a general conversation. And I said, "How are you; how has your week

been?" Then he just launched into very upset and very agitated and, obviously, I've got a duty of care, and I didn't sort of ask too many questions. I just let him talk and he, it was quite a long service that we had and as soon as I came home from that service, I completed a very in-depth report to work, and I phoned my team leader and basically it was verbatim. Every word that he had said to me, I tried to remember because there was mention of self-harm. So I had to put that down because that is part of my job description, to do that, to the best of my abilities.

MS HILL: Can I shift topics then and stay with you, Ms Warren, and ask you about what your view is about how to attract workers in the aged care sector.

MS WARREN: I think first up would be the money. For the work that we do, the pay doesn't reflect that at all. And I'm not saying we're asking for FIFO wages; that would be ridiculous. But it definitely needs to – I've always said it needs to be an industry that wants to attract people as opposed to people just taking an aged care job because they can't get anything else or it's just something for them to pay the bills because then you could attract of the wrong kind of workers which I am aware any industry you can. But it needs like a major overhaul. I would definitely say the salaries would be number one. Better working conditions is what I hear from a lot of people but like I said, my employer is good. I have absolutely no grumbles within the organisation that I work with, but you know more salary is always helpful.

Further training is always – is good and very, very necessary in an ageing society that we live in. Because what is training and important for this year, in two years time with clients ageing, will change and that needs to be looked at and reviewed I believe within all organisations and I believe it should be mandatory for people who come in and work in aged care to have a minimum cert III in aged care. I truly do believe that because this is human lives that we are dealing with; not just people on paper. Everything looks good on paper but in practicality these are people, they're family members and they're loved ones.

MS HILL: Ms Jackson, in your 24 years, do you have a view how to attract workers to aged care?

MS JACKSON: The two things are wages and the training. If we had some more ongoing training, mandatory training all throughout the year where we go into a room and have facilitators speak and even the generations under me, when this stopped about four years ago when the SABA online came on, they just said it's so different because we learn so much face-to-face, and do scenarios and it just seemed to sink in a lot more. And the certificate III, I believe, which would be a wonderful thing if it could be like a one year and apprentice where they work on the job and they do the modules and they learn on the job with another carer with them. But of course that means it's two people going out to see one person and, of course, funding doesn't allow that.

And, unfortunately, government bodies have ripped out so much money from the aged care sector, a little bit more is starting to come through now but it's too late.

The home care packages above in that ..... world, there's about 139,000 sitting there waiting there now. Ken Wyatt put the announcement out for 10,000 packages to come down that little portal hole. It doesn't go anywhere near what we need to see in the aged care sector. Wages is a huge, huge thing for the generations that are coming through. As the panel has said we are not asking for $30 an hour. Base rate certificate III should be $28 an hour. Most people are nowhere near that. And it's just – we are the forefront of the industry in aged care. We are the ones that put ourselves out there to look after these wonderful elderly people in Australia. We need to step it up. People out there, providers, need to look at whatever they need to look at so it can retain and sustain fantastic personal carers that knock on that door and say, "Hi, my name is Heather and I'm your carer for the day."

MS HILL: Ms Hansen do you have a view formed over your eight years in aged care as to how to attract workers?

MS HANSEN: Again, it's wages and training because, as I said, we don't come into this industry to be rich. We come into this industry because we care, we genuinely care about people. We want to make their lives better in any way possible, even if it's going in there and helping them have a shower. It's little things like that that actually make their day sometimes. And the more training – there's – sometimes it doesn't feel like there's enough training, even for the people that are just starting off in the industry. Even if we have what they call buddy shifts for minimum six months. But, again, that's funding. That's two people going into one person's home and that's more money. But even if it's on the company's back to say, yes, we will pay for this person for six months to do buddy shifts, like something as simple as that, with buddying up a new person with someone that has been there for so many years or a very experienced worker that knows clients, has a very broad aspect of the work, it just – it would make the world of difference. And learning from someone that has been in the job is so much better than looking at a piece of paper, because you learn so much in the job rather than sitting in a classroom.

MS HILL: Ms Dale, how do you think new workers can be attracted to the aged care sector?

MS DALE: The same again, it does come down to wages. That plays a big part in it. But training as well. They need to have the training. And like we have the buddy system, mind you not for six months, but yes, we do, you can take care workers out with us but it seems to be when we take the care workers out, they're not aware of what they're coming for. Like, I'm a grade 3, which is one of the higher grades in my organisation. So it is part of my job description to take out buddy shifts, to take people out to train them, and that. But the last few times I've done that, and I've said to the care worker, "Look, you've watched me today. I've explained it all to you, now tomorrow I want to watch you." "No, I can't do that. I don't know how to use a hoist." And they need to have some sort of grounding before they start their buddy shifts, before they come out with me or with another one of the girls, and that.

It's the training and they don't have a cert III and I think like it is, that should be mandatory to have a cert III to start in this job and that, because like when you think about it, one day we could be the ones that need the care. So we need to know that there's going to be an experienced, proper trained person that's going to come and look after us. The same as what we're doing for those people now.

MS HILL: Ms Dale, can I ask you finally, what attracts you to working in aged care?

MS DALE: The people. It's just – until you've actually done our job, you don't know what it's like to see these people and get the feeling from them. That's what we need. And that's what I will do.

MS HILL: Ms Jackson, can I ask you the same question, what attracts you to working in aged care?

MS JACKSON: Well, these magnificent Australians that I see every day. I hear the fantastic stories from the great men that did the great wars. I've been lucky to go to people that are between 90 and 110, and they are the ones that built this great country again. They are the ones that did the depression, did the recession. I had a fine 100 year old that I went to many, many years ago that stayed in Darwin when Darwin got bombed and he said to me, he said "My lieutenant and Colonel said to me, you need to build this, and this" he said all the men are at war. He said, "Well, look around you; there's your workers", and there was two and a half thousand women and children, didn't have licences, that went out the door. They went in trucks, they did whatever, they helped rebuild Darwin. That's where he met his lovely wife.

And then I've got a lovely 93 year old that I – that I went from day one, 12 years ago, looked after her and her husband. Husband passed. We looked after her. She got the beautiful dementia, not the bad one, thank heavens. The family just loved myself and other carers that went in there. Palliative care, towards the end, brought her home. I went in on the morning that she passed away. They asked me would you please, are you able to just give mum a wipe down because she had passed and I said "Absolute pleasure". I went in there, the next door neighbour, ex nurse, we did what we did for her, made her beautiful and then – and then I went to her funeral. That is from the beginning to the end, is what I see and that is what makes me get up at quarter past 4 every morning to go to work.

MS HILL: Ms Hansen, what attracts you to working in aged care?

MS HANSEN: The people, and not only the people that I see and help each day, but it's the girls, because I know the majority of the people that I work with, even though I don't see them all the time, I know that they, the majority have the same passion that I do, as the panel is explaining and showing, it's people who have the compassion and want to make this world better. And it's something, sometimes it's very, very simple things but it means the world to people. And I just hope that when I'm old, I get – well, sorry, older, when I reach that age, that I have people looking

after me with the same passion that I have right now. And I just hope that continues and we don't have people just, even though it's not a very big – that we get paid much, people just going in there for the money because that's not what it's about. It's about helping people.

MS HILL: Ms Warren, what attracts you to working in aged care?

MS WARREN: It's the human element of it. It's helping people. And I know a lot of the job is routine. It's the fact that you could be going into a person, as has been mentioned before, they won't see anyone for the rest of the week. They are estranged from their family. They might have mental health issues and your face might be the only face that they see and just put a smile on someone's face, and I've learnt so much about some of my clients in the last couple of years than I have in a long time. And never judge a book by its cover. And I always, I never thought aged care would actually be an industry that I would go into but now that I'm in it, you grow to love it. Like we've all said, it's not financially rewarding but we go in because you do get a love for the clients. All right, you might get the curly ones but human nature. I've never had to make so many cups of teas in my life. Cockney cup of tea we call it.

We have such a laugh and if you can hold someone's hand if they're having a bad day or put your arm around them, it really does mean a lot to these people because it can be a frightening world out there. Just lately, a lot of my clients – because they know the Commission is coming up – are really fearful of going into residential care, they are really, really frightened about leaving their family homes or their marital homes or they live with sons or grandchildren. They do not want to leave home. So you're going in to be calm and compassionate and just a sense of humour, nine times out of 10, if I can make them laugh, I am doing something right in my job. And like I said, I do believe that it should be mandatory to have the cert III to start off with. That's what I truly believe. I do really enjoy my job.

MS HILL: Ms Warren, Ms Hansen, Ms Dale, Ms Jackson, thank you. That concludes the questions I have for you. Commissioners.

COMMISSIONER TRACEY: We are enormously grateful to you for bringing us stories from the coalface and giving us a better understanding of what it is like to provide quality care to the aged in this community. And the dedication that you display on a day-to-day basis is something that this community must be exceedingly grateful for. Thank you for your evidence. And I will check but I don't think there will be any further questions?

DR HANSCOMBE: There are two matters Commissioners but I don't seek at this time to ask any questions.

MR BLEWETT: Not from me.

COMMISSIONER TRACEY: Very well. In that case, the Commission will adjourn until half past 3.

<THE WITNESSES WITHDREW [3.22 pm]

ADJOURNED [3.22 pm]

RESUMED [3.46 pm]

COMMISSIONER TRACEY: Dr Hanscombe, I understand you have some applications to make?

DR HANSCOMBE: Yes, that is so, Commissioners. The Commission may be aware that Australian Unity made a response in writing to Ms Dale's evidence. I seek to tender that response.

COMMISSIONER TRACEY: Yes.

DR HANSCOMBE: The covering letter, which we will need also because it's the only document with a date, is dated 13 March this year. The document ID is RCD.0011.0011.0001. And the substantive response is RCD.0011.0011.0002. That document contains attachments numbered A to K and identified in the response document. The document IDs run sequentially; I don't know if I need to read them all into the transcript?

COMMISSIONER TRACEY: The written response of Australian Unity to the witness statement of Rosemary Anne Dale – does your document bear a date?

DR HANSCOMBE: No, it doesn't, Commissioner, which I why I gave you the covering letter, as the host document, 13 March.

COMMISSIONER TRACEY: Yes, forwarded under cover of a letter from Allens to the Commission solicitors dated 13 March 2019, and the attachments thereto will be exhibit 2-30.

EXHIBIT #2-30 WRITTEN RESPONSE OF AUSTRALIAN UNITY TO THE WITNESS STATEMENT OF ROSEMARY ANNE DALE FORWARDED UNDER COVER OF A LETTER FROM ALLENS TO THE COMMISSION SOLICITORS DATED 13/03/2019 AND THE ATTACHMENTS THERETO (RCD.0011.0011.0001 & RCD.0011.0011.0002)

DR HANSCOMBE: If the Commission please. The only other matter I seek to trouble the Commission with is that in her oral evidence today, Ms Dale touched upon a couple of matters that had not been adverted to at all in the witness statement and, accordingly, my instructors present here today couldn't give me instructions to respond. I seek, if I may, to reserve a right to put in written material in response to those topics.

COMMISSIONER TRACEY: Yes, your client will have leave to do that. It should be done within the next seven days.

DR HANSCOMBE: If the Commission please.

COMMISSIONER TRACEY: Thank you.

DR HANSCOMBE: Might Dr Brophy and I be excused.

COMMISSIONER TRACEY: Yes, certainly.

DR HANSCOMBE: If the Commission please.

COMMISSIONER TRACEY: Yes. Dr McEvoy.

MR BLEWETT: May I also be excused?

COMMISSIONER TRACEY: I beg your pardon. Yes, you are certainly excused.

MR BLEWETT: Thank you.

DR McEVOY: Commissioner, I would now call Mr Gregory Holmes.

COMMISSIONER TRACEY: Yes.

<GREGORY JAMES HOLMES, AFFIRMED [3.49 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Mr Holmes, could you give the Commission your full name, please.

MR HOLMES: Gregory James Holmes.

DR McEVOY: And what's your present occupation?

MR HOLMES: Basically unemployed, project managing, renovating a house. So
- - -

DR McEVOY: And, Mr Holmes, were you formerly the managing director of Assist Home Care?

MR HOLMES: That's correct.

DR McEVOY: And what did Assist Home Care do?

MR HOLMES: So Assist Home Care provided support services, so showering assistance, any sort of domestic assistance, home and garden maintenance services.

DR McEVOY: And you were a director of Assist Home Care, were you?

MR HOLMES: I was the director of Assist Services, I was the manager of Assist Home Care.

DR McEVOY: Were there other managers?

MR HOLMES: My wife was the service manager.

DR McEVOY: And did you have other employees?

MR HOLMES: We did. We had a nearly full-time – another employee.

DR McEVOY: And what has become of that business?

DR McEVOY: That business was sold as at 1 July 2018 to DJ Health.

DR McEVOY: Do you remember a client of the business, a Mr Josef Rack?

MR HOLMES: Yes, I do.

DR McEVOY: Do you remember when you first started providing home care services to Mr Rack?

MR HOLMES: It was around September 2017, September/October.

DR McEVOY: Can you remember what sort of package, what level of package Mr Rack had?

MR HOLMES: I believe he had a level 2 package.

DR McEVOY: And what did you do, what services did you perform for him?

MR HOLMES: It was mainly cleaning services, and some home and garden maintenance services, which he – we provide, I think one of those services, and then he contracted directly with contractors and we paid the service for him for the home and garden maintenance.

DR McEVOY: Operator, could you bring up exhibit 2-18, please. The document reference number is JAR.0002.0001.0004. Do you recognise this document, Mr Holmes?

MR HOLMES: It's on our letterhead, yes. Yes, yes, I remember that, obviously.

DR McEVOY: And what's that document on the right-hand - - -

MR HOLMES: So that would be our community aged care package agreement. So that's something we developed when we started providing home care packages, which we did from July 2017.

DR McEVOY: Do you remember how many home care clients you had?

MR HOLMES: We had 17 at sort of the peak.

DR McEVOY: Do you remember what you were doing for them across the broad range?

MR HOLMES: It would be shower assistance, community access, mainly, and a lot of domestic assistance and garden assistance.

DR McEVOY: And this Assist Home Care community Aged Care Package Agreement, the one that you've got there obviously is the one that was provided to Mr Rack. Would it be correct to say that you provided these agreements to other clients of yours?

MR HOLMES: Yes, that would be correct.

DR McEVOY: And this was a document that you developed yourself, was it, or - - -

MR HOLMES: Well, it was developed in conjunction with other – seeing what was out there in the market. So we didn't develop that ourselves. We basically looked at what was being offered from other providers and developed it from that. So - - -

DR McEVOY: Did you purchase this agreement from some provider?

MR HOLMES: No.

DR McEVOY: You put it together on the basis of other agreements you saw?

MR HOLMES: Yes.

DR McEVOY: Can I take you, Mr Holmes, to clause 9.17. That's on page 5 of the document, if we could go through to page 5. You see 9.17 there, I want to draw your attention in particular to 9.1.7(a) under the heading Fees:

To have your fees determined in a way that is transparent, accessible and fair.

Do you see that?

MR HOLMES: I do, yes.

DR McEVOY: So that constitutes, I take it, a term of this agreement that the contracting party, in this case, Mr Rack, has that right under the terms of the agreement. Would you accept that?

MR HOLMES: I accept that, yes.

DR McEVOY: And, similarly, (b), to receive invoices that are clear and in a format that is understandable, that's a right, that the customer has, in effect. Would you accept that?

MR HOLMES: Yes, I do.

DR McEVOY: And then, finally:

> *...to have your fees reviewed periodically and on request when there are changes to your financial circumstances.*

Once again, that's a right, that the recipient, the customer has; you accept that?

MR HOLMES: Yes.

DR McEVOY: Can I take you, then, Mr Holmes, to schedule 3 of the agreement, which is at page 10. This is the schedule dealing with fees. Now, I would be right to observe, wouldn't I, that there's no amount included as the relevant fees there?

MR HOLMES: About the 2.53, it says basic daily fee but that was his income tested fee.

DR McEVOY: Yes, but in terms of fees payable, that's not included?

MR HOLMES: No, I agree.

DR McEVOY: So would you say that it was the case from time to time that the fees were not included in schedules of these agreements that you gave to customers?

MR HOLMES: Potentially they were and that was certainly an oversight on us.

DR McEVOY: When you say "potentially" are you agreeing with me or are you agreeing with me that it might be possible?

MR HOLMES: It might be possible.

DR McEVOY: And can you recall?

MR HOLMES: I didn't do this myself but they should have been included in there. But I agree with you that they could have been left blank in error. We were obviously new to the system of compiling these contracts and that, we were inexperienced in producing it, and that would not explain the oversight, but certainly - - -

DR McEVOY: Just to be clear, are you saying to me that you think that sort of oversight was commonly one that was made?

MR HOLMES: I don't know. I can't really answer that. It's certainly possible that it could have been but I just – I can't say for sure.

DR McEVOY: You don't have any recollection of that?

MR HOLMES: No.

DR McEVOY: Now, Mr Rack has given evidence to the Royal Commission this morning, Mr Holmes, and one of the things he has said is that he kept on asking you for statements, outlining what services he had been provided and what have you, what charges had been made, but he didn't get what he wanted, and that he finally got a statement towards the end of the 2018 financial year. Do you have any recollection of Mr Rack asking you from time to time for statements?

MR HOLMES: I do remember Mr Rack asking in the early part of the July/August of that year. We had a change of computing system – well, we went from MYOB to Xero when the business was sold. So there was a delay in the actual generating invoices and the invoices then populated in the spending spreadsheets. So there was a delay there.

DR McEVOY: And do you remember him asking you for statements?

MR HOLMES: I remember that, yes.

DR McEVOY: And how often would you have asked you for statements?

MR HOLMES: He might have asked two or three times, that I recall.

DR McEVOY: And do you recall whether you gave him statements when he asked?

MR HOLMES: Certainly endeavoured to but due to the invoices not being produced, I couldn't populate giving him the latest up-to-date spreadsheet during that period. So there was a down period then.

DR McEVOY: When you say the invoices being produced, what do you mean?

MR HOLMES: The invoices generated from – the cleaner would have gone out to provide a service. Then from that timesheet we generate an invoice and that invoice is populated on their spending spreadsheet, and that reflects their overall spend for the year. So that's updated daily on any – if they have a service, it's updated on their spending spreadsheet.

DR McEVOY: Have you been able to find, within your records, statements or other documents that you provided to Mr Rack in response to his requests?

MR HOLMES: Yes. So I think in his statement that he said that we hadn't provided statements for – from January. I went back through the old email system and found that we had sent an email on 4 April, I think it is, for - - -

DR McEVOY: This is the 4 April - - -

MR HOLMES: 2018.

DR McEVOY: 2018. Yes.

MR HOLMES: And that provided his income tested fee invoice plus the statements dating up to 31 March, I believe.

DR McEVOY: And do you have that document with you today?

MR HOLMES: I do, yes.

DR McEVOY: And are there other documents of this nature?

MR HOLMES: Yes, just – I just printed out every email and correspondence that we had had, or every email we had had between Assist and Josef, just to give a bit of a history for the court to show that – how everything was going between us and how happy he was with the services.

DR McEVOY: Just say that last - - -

MR HOLMES: To show that we were all – he was happy, he seemed happy, there was no complaint. There was no issues that he was raising like he raised in his statements.

DR McEVOY: You say, do you, that the burden of these emails is that Mr Rack was happy with the service he was being provided?

MR HOLMES: I believe so.

DR McEVOY: So you've referred to an email of 4 April 2018. You have that in front of you?

MR HOLMES: Yes.

DR McEVOY: Can you tell me what other emails you have in front of you and what they have as attachments?

MR HOLMES: It's just an email on 5 April saying that Josef – from Josef to us saying that he has paid his invoices.

DR McEVOY: This is 5 April 2018?

MR HOLMES: Correct, yes.

DR McEVOY: So he paid within a day?

MR HOLMES: Yes, he's a very good payer. Another invoice for Josef, 28 May.

DR McEVOY: 28 May 2018?

MR HOLMES: Yes.

DR McEVOY: This is an email from you to Mr Rack or Mr Rack to you.

MR HOLMES: No, from us to Mr Rack.

DR McEVOY: What was the subject of that email?

MR HOLMES: It was an invoice for his income tested fee.

DR McEVOY: With a statement?

MR HOLMES: No, there's no statement. Their statements normally would have – I just wanted to note that the statements normally are printed out and posted to all the clients. Not many of our clients have email. So that would be the general way it's sent and that's how he would have got it. He would have emailed ..... it would have been a specific, I suppose, request, can I have it emailed. But the norm everybody got posted a copy of their statements.

DR McEVOY: Or if that was the norm, how often would those people have had those statements posted to them?

MR HOLMES: Well, it should have been monthly. I'm unsure whether that actually happened. It might have been - - -

DR McEVOY: When you say it should have been monthly, do you mean it should have been monthly from the perspective of regulations or do you mean from the perspective of your own operation?

MR HOLMES: Well, that was our aim.

DR McEVOY: That was your practice, was it, as far as you were aware.

MR HOLMES: It was certainly our aim but we might not have met those targets on every occasion. There might have been delays that failed – where it didn't happen so - - -

DR McEVOY: I think you referred to an email to you from Mr Rack of 4 April 2018, an email from Mr Rack to you of 5 April 2018, an email from you to Mr Rack of 28 May. Are there any other emails?

MR HOLMES: Then we go backwards; just another email from Mr Rack, 7 February.

DR McEVOY: Which date, I'm sorry?

MR HOLMES: 7 February 2018.

DR McEVOY: Yes.

MR HOLMES: Do you want to know the content? It's just general content about he was going away for a few days.

DR McEVOY: So not attaching an invoice or a statement, just some exchange of communication.

MR HOLMES: No, just a demonstration of the conversations via email that he was having with the office staff. And there's another email on 5 February about organising his spring cleans.

DR McEVOY: This is 5 February 2018.

MR HOLMES: That's right. Another email on 2 February, with Josef replying.

DR McEVOY: Josef, Mr Rack.

MR HOLMES: Josef Rack replying saying, "Thank you very much". And then another email on 29 January saying we are replacing cleaners with Kerry, with Maylene, and there's some other information on that, on 29 January. And then there's an email on 6 December and this email details:

> *Please find attached amended spreadsheet which shows the correct amended funds available.*

And that's attached, that attachment I've printed out.

DR McEVOY: What's the attachment, sorry?

MR HOLMES: That's the budget spreadsheet, showing his spending.

DR McEVOY: This is attached to the 6 December 2018 email?

MR HOLMES: 2017, sorry.

DR McEVOY: Sorry, 2017 email.

MR HOLMES: Yes. Then on 1 December, expenses.

DR McEVOY: 1 December 2017.

MR HOLMES: 2017.

DR McEVOY: That's an email from your organisation to Mr Rack on the subject of expenses, did you say?

MR HOLMES: Yes, so Josef looks like he has queried the spreadsheet, so it's a spreadsheet he has queried and that's what that email before is resolving that issue.

DR McEVOY: Any other emails or other documents?

MR HOLMES: An email about receiving the funds from Southern Cross Care, when he transferred his package over to Assist Home Care.

DR McEVOY: Dated?

MR HOLMES: 27 October 2017. And then another email on 15 August about switching providers, over to Assist. So information about that from Southern Cross, and it's – I think it's his notification, on the bottom of that email, to Southern Cross that he was changing providers.

DR McEVOY: So you've got about a dozen emails there that you're producing. Commissioners, those documents don't yet have document numbers but I would seek to tender them and we will - - -

COMMISSIONER TRACEY: Well, I will give you leave to do that after there has been time for them to be incorporated in the computer system, and perhaps that may be convenient to do immediately when we commence tomorrow.

DR McEVOY: That is convenient, Commissioner, thank you.

COMMISSIONER TRACEY: It may be you don't want them all in evidence.

DR McEVOY: Thank you, Commissioner.

Now, Mr Holmes, I think you said that in relation to at least one of those emails that Mr Rack had identified some discrepancy. Was that something that happened on more than one occasion?

MR HOLMES: Mr Rack raised some issues about some invoices – not invoices, statements, and we sat down on a couple of occasions and worked through those discrepancies, and resolved them at the time. And Josef Rack left the office. He liked to meet in person, which I was happy to do any time. He would ring me quite often and he's very, very, very, very interested, even if we had a rounding error of one cent, he would want it changed back to the correct value. So we did that for him.

DR McEVOY: And do you recall how many occasions, roughly, there would have been these discrepancies?

MR HOLMES: Maybe two or three times.

DR McEVOY: Do you recall the amount of the discrepancies?

MR HOLMES: They were minor amounts. They might have been – I can't recall.

DR McEVOY: One of those discrepancies was for about $1100, wasn't it?

MR HOLMES: That was when the final budget was transferred over to his new provider.

DR McEVOY: Yes.

MR HOLMES: We came up with a figure that we basically both agreed on in the office and then he, I believe, went off and recalculated everything he had spent within the package and came up with a different figure. Now, when I was put – I investigated – I couldn't get back to his number but as an act of good faith to obviously settle with Josef, I had a good working relationship with Josef, we paid him the – we didn't pay him, we paid his new home care provider, that $1170.

DR McEVOY: You paid that over to them?

MR HOLMES: We paid it over to them, yes.

DR McEVOY: Now, do you recall having dealings in about mid-2018 with the Australian Aged Care Quality Agency?

MR HOLMES: I do, yes.

DR McEVOY: Can you recall what that was about?

MR HOLMES: We had an assessment contact. They came out and looked at our systems and procedures.

DR McEVOY: And do you recall what the result of their assessment was?

MR HOLMES: They raised some issues with the way we were – Assist were operating and gaps in our system.

DR McEVOY: Do you recall in particular what they were?

MR HOLMES: There was some issues potentially with the care plans that we had produced.

DR McEVOY: And what was the nature of the issue with the care plan?

MR HOLMES: Well, some were not produced. Some were not complete enough for them.

DR McEVOY: I think you said you had about 17 clients; do you recall how many of that 17 didn't have appropriate care plans?

MR HOLMES: I couldn't say for sure, no.

DR McEVOY: No idea?

MR HOLMES: At that time probably – I'm not - - -

DR McEVOY: All of them, half of them, don't remember?

MR HOLMES: I don't remember the exact amount.

DR McEVOY: I'm not asking about the exact number, can you remember roughly how many?

MR HOLMES: Yes, I would have to guess. I don't know 100 per cent, sorry.

DR McEVOY: And what other concerns did the quality agency raise with you, Mr Holmes?

MR HOLMES: There was some issues with not providing the Aged Care Charter. I mean, these were, we're experienced in providing services; we've been providing services for 10 years but we weren't fully – we were inexperienced in the compliance mechanisms. So that's – we failed to provide the Aged Care Charter to people which we, after that assessment, everything that was raised with us, we put into our – improving – improvement register and we endeavoured to obviously implement those changes, those enhancements.

DR McEVOY: So you've got the issue of some, you can't remember how many, of these health care plans weren't being provided. You've said that another issue that

you've noted that they raised was the failure to provide the charter. Can you recall whether there were other issues they raised?

MR HOLMES: There may have been but I can't - - -

DR McEVOY: What about in relation to fees; can you remember anything in relation to fees?

MR HOLMES: Potentially that the fees, as you raised earlier, may have not been - - -

DR McEVOY: When you say potentially, are you saying that you can remember that that was something that was raised, or that you can't remember or - - -

MR HOLMES: I can't remember, no, whether that was raised as an issue.

DR McEVOY: You can't remember?

MR HOLMES: I can't remember. But it may have been raised but I can't remember exactly.

DR McEVOY: What about monitoring processes to ensure compliance with relevant aged care legislation, was that something you can recall being raised?

MR HOLMES: I can't recall exactly.

DR McEVOY: Do you recall it being raised that staff weren't aware of their legislative requirements?

MR HOLMES: I can't recall that that was in there but it potentially was.

DR McEVOY: Were you aware of your legislative obligations as a provider?

MR HOLMES: I thought I was, but certainly we were not experienced in the aged care sector when we became approved. So we were seeking to get as much information to ensure compliance, and that included the quality agency coming out and doing a training session with us but that was very brief and we got very limited information out of that.

DR McEVOY: Could you please bring up CTH.1002.1001.3084. So do you recognise this document, Mr Holmes?

MR HOLMES: I recognise it was an assessment contact, yes.

DR McEVOY: Operator, if you could turn, please, to pages 4 and 5 of that document. Perhaps if you could display 4 and 5 together. So you will see there, Mr Holmes, at about point 3 of page 4, there's some findings in relation to shortcomings

that may have existed, or did exist. And then there's a list of those going down the page. If you look over to page 5, you will see there that there are references to a further series of things that weren't done. One very prominent one you will see is that the agreement section to schedule 3, fees payable was left blank. You see that that's raised in the second dot point on page 5?

MR HOLMES: I can read it was left blank, yes.

DR McEVOY: And the third dot point on page 5.

MR HOLMES: Yes.

DR McEVOY: And the fourth dot point on page 5.

MR HOLMES: Yes.

DR McEVOY: And the fifth dot point on page 5.

MR HOLMES: Yes.

DR McEVOY: And the sixth dot point – I'm sorry, the seventh dot point on page 5.

MR HOLMES: Yes.

DR McEVOY: So there's at least, in addition to Mr Rack, there's at least six of your 17 clients where the schedules 3 fees part of the agreement was left blank and not completed. Would you accept that?

MR HOLMES: I accept that.

DR McEVOY: Do you recall receiving, from the Aged Care Quality Agency the final quality review?

MR HOLMES: What was that date? What date are you referring to?

DR McEVOY: 28 September 2018.

MR HOLMES: I do remember receiving it, yes.

DR McEVOY: Operator, could you please bring up – I should say, Commissioners, I would seek to tender the home care assessment contact report, which was CTH.1002.1001.3084.

COMMISSIONER TRACEY: Yes. The Australian Aged Care Quality Agency Contact Report relating to Assist Home Care day-to-day – what was the date, Dr McEvoy?

DR McEVOY: The date of the assessment was 17 May.

COMMISSIONER TRACEY: 17 May 2018?

DR McEVOY: Yes. I think that is perhaps the most convenient date.

COMMISSIONER TRACEY: Will be exhibit 2-31.

EXHIBIT #2-31 AUSTRALIAN AGED CARE QUALITY AGENCY CONTACT REPORT RELATING TO ASSIST HOME CARE DAY-TO-DAY DATED 17/05/2018 (CTH.1002.1001.3084)

DR McEVOY: Thank you, Commissioner. Operator, if you could open up CTH.1002.1001.3146. Do you recognise that document, Mr Holmes?

MR HOLMES: I don't.

DR McEVOY: You do not?

MR HOLMES: I know what it is but I don't remember seeing it. I know that we did receive the final quality review report but I just - - -

DR McEVOY: Can I take you to page 2 of that document, which you will see on the right-hand side of the screen. You see there under the Summary of Findings the service meets one out of 18 suspected outcomes of the home care standards. Do you see that?

MR HOLMES: Yes, I do.

DR McEVOY: Do you remember that finding?

MR HOLMES: Yes.

DR McEVOY: Do you remember what was the one out of the 18 expected outcomes that you did meet?

MR HOLMES: No, I don't.

DR McEVOY: Do you remember what the 17 were that you didn't meet, or any of them.

MR HOLMES: I can see them there, so - - -

DR McEVOY: They're the ones listed, going down the page.

MR HOLMES: Yes.

DR McEVOY: So it's not, you would agree, a fantastic bill of health.

MR HOLMES: There's a story behind it, that we sold the business in 1 July 2018. We believe that we were told that the new owner had a provider licence, which they didn't, and we – their systems and everything were being implemented for this and this review, when this review was conducted, we were operating under all their systems, the new systems and we believed that they would have met all these requirements but they were excluded from speaking at that quality review, which meant we failed all the findings.

DR McEVOY: So I'm not sure that I'm clear about what you are saying. You're saying that the failure occurred because, why?

MR HOLMES: Because we had sold the business. There was Assist Services as such had actually – it was still an entity but it had nothing virtually behind it. We were trying to resolve the issue of what we did to transition these clients to other providers and prior to this being reported, we had already started transitioning our clients to new providers because we couldn't provide that any more because we had no entity and no business to actually provide the support any more.

DR McEVOY: But wasn't all this by reference to an assessment that was conducted on 17 May 2018?

MR HOLMES: That was an initial assessment contact.

DR McEVOY: Yes.

MR HOLMES: And the issues raised in that, we started obviously working towards and we completed a number of those and we had a continuous improvement report that we were working with. We attended the Aged Care Quality Agency training sessions, two-day sessions for two of our staff, and were working towards that but our understanding was it was our error. We believed we were going to be assessed under the DJ Health policies and procedures that we were operating under and the quality agency wouldn't look at those. So - - -

DR McEVOY: How did you form that belief?

MR HOLMES: Well, that's how we were operating at that point in time, Assist Services after the sale was left with only me, basically.

DR McEVOY: And so what was the outcome of this final quality review report?

MR HOLMES: It was that it only met one of the 18 outcomes.

DR McEVOY: Yes, but once that happened, what happened next?

MR HOLMES: Well, prior to this report, we had already – the new organisation that had purchased us, had authorised to transition the clients to other providers, which I wanted to do from as soon as we found out that they were not an approved provider, and we were working with the Department of Health on that and having teleconferences on that, all the way through from 12 July through till this audit took place.

DR McEVOY: Had the settlement of the sale of the business occurred by this time?

MR HOLMES: Yes.

DR McEVOY: So you had been paid?

MR HOLMES: Paid 90 per cent, yes.

DR McEVOY: And, what, you were not paid the last 10 per cent?

MR HOLMES: No.

DR McEVOY: Do you recall the amount that you were paid for the sale of the business?

MR HOLMES: I do.

DR McEVOY: And what was that amount?

MR HOLMES: Well, the actual amount was $2.8 million.

DR McEVOY: $2.8 million for the Assist Home Care business.

MR HOLMES: That's right.

DR McEVOY: Which had about 17 recipients at the time of the sale?

MR HOLMES: Yes. That was probably the 17 clients would have been five per cent of the business. The majority of the business was disability, and various other services.

DR McEVOY: I have no further questions for Mr Holmes, Commissioners.

COMMISSIONER TRACEY: Do you wish to tender this final review?

DR McEVOY: Yes, I'm sorry, Commissioner. Yes, I do wish to tender that report, CTH.1002.1001.3146, the finally quality review report.

COMMISSIONER TRACEY: The Australian Aged Care Quality Agency Final Quality Report into Assist Home Care dated 28 September 2018 will be Exhibit 2-32.

EXHIBIT #2-32 AUSTRALIAN AGED CARE QUALITY AGENCY FINAL QUALITY REPORT INTO ASSIST HOME CARE DATED 28/09/2018 (CTH.1002.1001.3146)

DR McEVOY: Thank you Commissioner.

COMMISSIONER TRACEY: Thank you for your evidence, Mr Holmes. Unless there are any other matters, Dr McEvoy, the Commission will adjourn until 10 o'clock tomorrow morning.

DR McEVOY: No other matters this afternoon, Commissioner, thank you.

MATTER ADJOURNED at 4.24 pm UNTIL WEDNESDAY, 20 MARCH 2019

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