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TRANSCRIPT OF PROCEEDINGS

O/N H-985239

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

10.16 AM, THURSDAY, 21 MARCH 2019

Continued from 20.3.19

DAY 13

MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P. BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL
MR S. FREE appears with MR J. ARNOTT for the Commonwealth of Australia

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioner, we have handed to you a table setting out various documents which were put the day before yesterday to Mr Greg Holmes but which were not tendered, one document that was put to Ms Mary Patetsos yesterday afternoon, and two documents that were put to Mr Josef Rack on Monday and inadvertently were not tendered. So we would seek to tender all of the documents in that list, if the Commission pleases.

COMMISSIONER TRACEY: The documents on that tender list will bear exhibit numbers 2-62 to 2-75, inclusive.

EXHIBIT #2-62 TO 2-75 DOCUMENTS ON TENDER LIST

DR McEVOY: If the Commission pleases. My learned friend, Ms Hill, will call the next witness.

COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: If the Commission pleases, I call Ruth Harris.

<RUTH HARRIS, SWORN [10.18 am]

<EXAMINATION-IN-CHIEF BY MS HILL

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

MS HARRIS: Ruth Harris.

MS HILL: And you're presently retired?

MS HARRIS: Yes, a retired teacher.

MS HILL: And what's your age, Mrs Harris?

MS HARRIS: I'm 65.

MS HILL: And do you live in Adelaide with your husband David?

MS HARRIS: Yes.

MS HILL: And you've got adult children?

MS HARRIS: Yes.

MS HILL: You're the daughter of Joyce and the late David Edwards; is that right?

MS HARRIS: Yes, that's correct.

MS HILL: And you're giving evidence today about your experience with the aged care system for your mother?

MS HARRIS: Yes, with My Aged Care.

MS HILL: And you've also got a mother-in-law who lives in residential care, don't you?

MS HARRIS: Yes, my husband's mother.

MS HILL: Operator, could I ask you please to display the document ID WIT.0074.0001.0001. Mrs Harris, could you ask you to look at the monitor in front of you. You prepared a statement dated 12 March 2019?

MS HARRIS: Yes.

MS HILL: And do you see that statement before you on the monitor?

MS HARRIS: Yes.

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

MS HARRIS: No.

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

MS HARRIS: Yes, they are.

MS HILL: I tender that statement.

COMMISSIONER TRACEY: The statement of Ruth Harris dated 12 March 2019 will be exhibit 2-76.

EXHIBIT #2-76 STATEMENT OF RUTH HARRIS DATED 12/03/2019 (WIT.0074.0001.0001)

MS HILL: As the Commission pleases. Mrs Harris, your mother was invited to attend with you today, wasn't she?

MS HARRIS: Yes, she was.

MS HILL: But ultimately she has made a decision she is not going to come today.

MS HARRIS: Yes, she was keen initially because she loves to do new things but then she realised that probably health-wise perhaps she would get a little bit anxious and it might not be a good thing. Plus our time was changed to yesterday, and yesterday she did attend a friend's funeral, and then changed back to today so it has probably worked out that it's best that she didn't come.

MS HILL: How old is your mother?

MS HARRIS: She will be 92 in May.

MS HILL: Could I ask you to tell the Commissioners about who your mum is.

MS HARRIS: So, mum and my father and my brother and myself migrated to South Australia in 1966, as a family, from South Wales. We come from South Wales originally. My mum was always a working mum back in the days when that wasn't as common as it is today so she has always been a very active working person. My father died when he was 75 in the year 2000 so she has been widowed for the last 19 years. But she has always led a very healthy, active life, very active in her – with her church community, very active in the U3A. Up until she was basically in her 80s she would do folk dancing and fitness class and always drove. She drove up until she turned 90. So she's a very capable, independent, active lady.

MS HILL: Can I take you to the end of 2017. What was happening with you and your mother at that time?

MS HARRIS: Yes, her health deteriorated that year. That was the year she turned 90. She says it's probably the worst thing that happened to her because her health certainly deteriorated. She had always had some heart issues and blood pressure issues. She had been on medication for both of them, but she started having unconscious collapses so – and couldn't stand for long periods, and would get dizzy and really completely changed. She wasn't able to drive any more. She needed help to do things around the house which she had never needed before. She had always been pretty independent. So at that point, after she had had hospital – hospitalisation, we recognised that she needed some help at home.

MS HILL: So what did you do, Mrs Harris?

MS HARRIS: So I rang the My Aged Care number and was told that I could – that mum needed to have an ACAT assessment and so that ACAT assessment was organised and that happened within a week; she had an ACAT assessment. She was

assessed as level 3, medium priority. So that was in November of 2017. And so after that we thought, okay, what else can we put in place? So at that point then she decided to have some meals delivered, which she did privately through the independent living unit where she was living, also offered that support. Obviously, you pay for it privately. And also cleaning once a fortnight. Initially, she just had the meals three times a week: Monday, Wednesday and Friday. And we were told to wait to hear that, she should get a package.

MS HILL: And were you in contact with My Aged Care over this period of time?

MS HARRIS: That first six months, mum's health kind of plateaued out and with those things happening, and the support of myself and my brother, I started making up a roster for he and I so that we – and I lived close by so I went every day anyway. So we kind of were okay waiting for a while. But then she had a further deterioration of her health about five months later, where I thought, no, I need to call My Aged Care again. She got quite ill.

MS HILL: And what did you do then?

MS HARRIS: So she had been in hospital for a while. She came out and had respite so I called My Aged Care again and said, "Look, we have been waiting for six months and we haven't heard anything and now my mum's health has changed, we really need this package". And they said, "There's a three to six month wait for level 2 and 12 months for anything above". I said, "We have already been waiting six months and we haven't had anything". Well, you will just have to wait, kind of thing. So mum came home from respite and they said you could have help through the Commonwealth interim funding. So we accessed that by ringing a provider and there's a certain amount that you're allowed on the interim funding. So mum needed then help with showering and things like that. She needed a lot more. She needed personal care. She needed – really, she needed more help with everything. So we took the maximum that we could get through the interim funding.

MS HILL: And did your mum get the level of care that she needed on that interim funding?

MS HARRIS: No. Like this was the maximum which meant she could have someone to shower her five days a week, Monday to Friday, and someone came to take her shopping once a fortnight, and that was it. So I or my brother, we rejigged the roster. We would go in and get her tea ready and she privately paid for meals five days a week, and then usually I would provide meals on the weekend for her, or sometimes we would buy those frozen ones that you can get. And that's when I thought I need to start. So I then – I would regularly ring My Aged Care as – probably about once a month. And each time I got the answer, "No, it's three to six months and a 12 month wait." Well, by this time we had been waiting eight or nine months and I said, "Well, we have been waiting this long and my mum's needs are really, you know, greater than what they were." And I would get the same response every time.

So I would say, "Can I please speak to your supervisor". So I would be put on to the supervisor and I would explain that we had been on the waiting list for some time, and he would say or she would say, "There's a three to six months wait", the same answer. So I said, "Well is there anything I can do to expedite the process?" "You can make a complaint if you wish". So I said "Yes, I would like to make a complaint, please", and was given a complaint number, which happened twice. There didn't seem to be any further action regarding the complaint number. After the first complaint number, I had a call about a month later saying you made a complaint. I said, "Yes, I'm complaining about the wait time", and they would say, "Yes, it's three to six months for a level 2 package and 12 months for anything higher". And I would say, "Well, we have already been waiting now 10 months". "Well, sorry". So – so that went on for, probably, about five months after her second ACAT. So she had another ACAT at that point.

MS HILL: Did you make any further complaints?

MS HARRIS: Then I decided I would try writing to the Minister. So I wrote to the Minister for Aged Care. I wrote to my local Federal Minister and I made an appointment to go and see my local MP as well.

MS HILL: Was it always you that was calling My Aged Care?

MS HARRIS: Yes, it was.

MS HILL: Would your mum ever call instead of you?

MS HARRIS: No, my mum didn't call.

MS HILL: Why was that, Ms Harris?

MS HARRIS: I think she felt – I think she felt I was probably doing a good job but also she – it's difficult for elderly people. My mum is not deaf but she still finds phone calls sometimes a little bit difficult to manage in terms of hearing the people or they use language, the jargon that people are often unfamiliar with as well. You know, it's – it's a system that none of us have navigated before. I've got to say it's kind of those where you learn on the job because you don't know what to expect when you first get on the list for My Aged Care. I think I quite naively thought that once mum had had an ACAT assessment and the assessment said yes, your mother needs support with this, this and this, that then that support would be forthcoming, relatively quickly. So – and obviously that didn't happen. It comes to basically a dead stop once you're on the list.

MS HILL: Did you ever access My Aged Care online?

MS HARRIS: I looked at the information online but I didn't communicate with them online. I communicated by phone each time.

MS HILL: And why was that, Mrs Harris?

MS HARRIS: Because I feel better talking to a real person rather than typing so, yes, that just suited me better, I think.

MS HILL: Was there any assistance available to you or your mother in using the My Aged Care?

MS HARRIS: No. No. It's just, you know, talk to someone and see how it goes. I mean, on the website there's all sorts of information on there. But quite often you're not really okay, you can do this, this and this, which is what you have already done. There's no indication, well, what do you do once you've done all the things, you know, basically wait. So that's what I had the problem with was the wait time.

MS HILL: What was your experience of using My Aged Care?

MS HARRIS: I felt that – that it was basically a call centre. I was ringing a call centre, not necessarily people who knew the needs of people in the aged care bracket that they were, you know, they basically I got the impression, read from the screen, yes this is your mother, this is her name. She is on the wait list. So it's three to six months for a level 2 and 12 months plus for anything higher. End of story, kind of thing. Which is why I used to say, "Could I speak to the supervisor, please, to see if I could get more information. One time I actually got the wrong information from the person, who was reading off the screen. They obviously made a mistake which was about eight months in. She looked mum up and said, "Yes, she's got a level 2 package", and I went "Really?" But it turned out she didn't. So I didn't think she did.

MS HILL: You've told the Commissioners that your mother had a second ACAT assessment, what then happened, Mrs Harris?

MS HARRIS: So the second – the first ACAT assessment she was assessed at level 3 medium priority. The second ACAT assessment which would have been in May the following year – yes, May or June, I've got here – when she was really unwell and was hospitalised and then had respite when she came out, she had an ACAT then and was – it was increased to level 4. So then she had a level 4 priority.

MS HILL: Operator, could I ask you to please display document ID RHA.0001.0001.0001. Mrs Harris, could I ask you to take a look at the monitor in front of you.

MS HARRIS: Yes.

MS HILL: And could I ask you to describe the contents of the document before you to the Commissioners.

MS HARRIS: Yes, that's the letter we got from My Aged Care in November, telling us that, yes, you have moved up in the queue, and we will get a package within, what did it say, the next 58 days or something. I found – we got that letter – probably just before then mum had a third ACAT assessment, and yes, I found that letter rather patronising in its tone, you know, like, we had been in the queue by then for almost 12 months, or it would have been 12 months in the November when we got that letter and it was, you know, just the tone of it, get ready to receive your Australian Government home care package.

MS HILL: Why did you have that reaction, Mrs Harris?

MS HARRIS: Well, I just felt you've been ready to receive your government home care package for the last 12 months since your first ACAT. You know, it just seemed like here we are giving you something, finally. You know, you should be pleased; you should be happy. But I just think, well, you've already made an elderly person, a person who is over 90 years old, wait 12 months. And I felt quite strongly sometimes when I would speak to the operators on the phone, I would say "Do you realise these people are in your 90s and you're asking them to wait 12 months-plus for a package." Now that's a long time when you are already very elderly. I think I said to them, "You're waiting for them to die." So, yes, I did feel quite strongly and I just felt that – because it wasn't offering you a package; it's saying wait another three months and then we will send you maybe a level 2 one. So it wasn't anything. It's a nothing letter.

MS HILL: You received that letter just after your mother has had a third ACAT assessment.

MS HARRIS: Yes, I think it was the same week, actually, because I mentioned it to the ACAT assessor, "Look, we have just received this letter". Yes, so she had a third ACAT assessment, yes.

MS HILL: What do you say you needed from My Aged Care in place of that letter?

MS HARRIS: The offer of a package would have been good.

MS HILL: Whilst there's this period between the second and the third ACAT assessments, what sort of – was your mother receiving any care under a package at all?

MS HARRIS: Only the government interim – the Commonwealth interim funding. That's all you can access. If you want anything over and above that, then you need to pay for it privately.

MS HILL: Which is what you did.

MS HARRIS: We did with food, yes, and with cleaning, but if she needed any other personal care, like we would have liked someone to come in twice a day, to come in

the evening time as well to prepare tea, help with food preparation but that was just not possible financially.

MS HILL: And why wasn't that possible financially, Mrs Harris?

MS HARRIS: Because I think is about $49 an hour if you, you know, get someone – the support privately, yes, from the carers. It's quite expensive.

MS HILL: In mid-December 2018, you tell the Commissioners at paragraphs 35 and 36 of your statement that your mother continued to wait.

MS HARRIS: Yes.

MS HILL: And that, ultimately, a decision was made that your mother would move to residential care. On what basis did your mother and did yourself and your brother make that decision?

MS HARRIS: So when mum had her third ACAT, she was still level 4 but then she was high priority instead of medium priority. And the ACAT assessors then were quite confident that, "Yes, your mum should receive a package" then. But we hadn't received anything formally yet. And a bed became available where mum had been having her respite, which is also part of the same group that she has her independent living with. And she felt very comfortable there because some of the same people are there that, you know, that she's familiar with. And, basically, I think she decided, well, we can't keep waiting forever. Probably I was a bit concerned that she was doing it for my benefit as well, rather than just for hers, because she felt, you know, we were providing a lot of support for her in terms – well, just like I did all her washing by then and all of those sorts of extra things, appointments, all of those sort of things.

And she said, "So there's a bed there, let's go and have a look at the room", which we did and she said, "Yes, right, I'm going to move." Because you don't know when another bed will become available in that facility, so you've got to take opportunities when they arise.

MS HILL: How long had your mother been waiting for a package at that time?

MS HARRIS: 13 months.

MS HILL: After your mother makes that decision, did you have further contact with My Aged Care?

MS HARRIS: I didn't ring them then until the middle of January. Mum moved in at the beginning of January and we had Christmas in the interim and whatnot. So after mum had moved in that following week I thought I better call them and say, "Well, you can take mum's name off the list".

MS HILL: What happened when you called them, Mrs Harris?

MS HARRIS: So I rang My Aged Care, told them I was ringing for my mum. And the operator brought mum up and said to me, "Are you calling to extend the deadline on your acceptance of your package?" And I said, "I beg your pardon? I don't know what package you're talking about." She said, "Your mum has been offered a level 3 package." And I said, "Not to my knowledge." And she said, "It says here we sent you a letter on 11 December offering your mum a level 3 package." And I said, "Well, we never got that letter." So then she said to me, "Would you like to speak to a supervisor?" So I said, "Yes, please." So I spoke to the supervisor; I said, "I've just been told that my mother was offered a level 3 package by letter that was sent on 11 December." I said, "We've never received that letter and my mum has now gone into permanent care". So - - -

MS HILL: And what did My Aged Care say to you?

MS HARRIS: Well, they basically said, "Well, our records show that she was sent that letter" so – and I said to them, "Well, it's such an important piece of information for someone that I couldn't believe that the only way that you've chosen to inform us of that is to use, basically, snail mail." That there wasn't a follow-up phone call at least to go with it. I've been registered as someone able to talk on my mum's behalf with them right from the beginning. I said, "I think you should have at least given me a call or sent me a letter, at least send the information in two different ways, not just one letter." Which, for whatever reason, we have never received. So - - -

MS HILL: Did you take the opportunity to make a complaint at that time?

MS HARRIS: I did ask then about making another complaint and was given, for the first time, addresses of people that I could write to, a Complaints Commission which had never happened previously. I had only been offered the standard complaints and I said, "That's interesting; I haven't had these addresses before." And at that point I, basically, said, "Well, mum has already made the decision to go into care". And I felt that since the Royal Commission had then been set up, that I would write a submission to the Commission and left it at that. But I did make it clear that I felt when a package is offered they really should make sure that they send at least two different ways of communicating with the people involved, not just by the postal system.

MS HILL: Can I take you to the present day, Mrs Harris. How is your mother now?

MS HARRIS: She is very well, thank you. Yes, she's a very positive, outgoing person, my mum, whose attitude has always been you make the best of the situation that you're placed in. She is very good at doing that. And yes, she is very sociable. She has made friends. She still gets to go to church and everything; they have a roster to pick her up. And so I feel that we are very lucky, very blessed that she has – you know, she made the decision herself, which is a good thing. But my one regret

is I don't feel we ever got to try out the level 3 package to see how that would have gone and maybe she could have stayed a bit longer at home.

MS HILL: Has your mother told you how she feels now about the decision that she made, having found out about the offer of that package after the fact?

MS HARRIS: Yes, because I did – I said to her they say you've got a level 3 package and, I mean, we could have said to the home, "Right, we've changed our mind" because there is a bit of a cooling off period, as I understand it and because it was within the same group, her unit was still there, although the furniture had gone by then. But, you know, once she makes a decision, she wasn't going to go back on it or anything but I think we both said, "Well, we're never going to know what difference it would have made" so - - -

MS HILL: How are you now, Mrs Harris?

MS HARRIS: Yes – no, good. I'm very happy. I think the thing that I feel I wanted to carry on with this because not just in mum's case, there are lots of other people who don't have an advocate for them, because how people, elderly people manage if they don't have family support or someone who is willing to do the paperwork for them, because it's just horrendous; the way that you have to navigate your way through the system is very difficult. So I just felt I wanted to make it known and I'm very pleased to think that now we have the Commission and people's views are being listened to. I did feel when I phoned My Aged Care that no one was listening, basically.

MS HILL: Do you say that there's support that you could have had in order to support your mother during this time?

MS HARRIS: Sorry?

MS HILL: Do you say that there's support that you could have had to help you support your mother?

MS HARRIS: Well, I think it would be better if there was more transparency in the whole system about how it works and what is expected of people because families really don't know what to do until something happens. Because when a person is fit and well and active, you don't need to access these things. Then when something happens and there's a change in their health and you have an urgent need, you want that to be something to happen urgently because the person who is being assessed needs that support now, you know, not six months down the track, not 12 months down the track. So it would be good if – well, it all comes down to funding, I realise that, you know, that's really what we need. And a clearer process of how it works.

MS HILL: And do you have an idea as to what that clearer process would look like?

MS HARRIS: Well, certainly, I think it could be more explicit with how it works. I think they send you on tangents here and there. And certainly when informing people they need to inform people in a wider – I was really quite gobsmacked that they just sent us a letter when a number of times on the phone, I got told, "Your mum can access this information online." And I just, "Excuse me, do you realise you are talking about someone who is 90-plus and doesn't have access online?" And even for us who do have access online it's not that easy. I asked once if I could email them, and they didn't seem to have an email address.

You have to do everything through the website so there's obviously a way of doing it through the website but if you wanted to attach things, because we also had a doctor's letter that said my mum needed more care, you know, but otherwise you would have to fax it to them. It wasn't easy to communicate with them. It's quite a faceless body, I think, you know.

MS HILL: Commissioners, that concludes the questions that I would seek to take this witness to. I'm minded that I did not tender the correspondence that I referred to.

COMMISSIONER TRACEY: The Remembrance Day letter?

MS HILL: Yes, Commissioner.

COMMISSIONER TRACEY: The letter from the Secretary, Department of Health to Mrs Joyce Edwards dated 11 November 2018 will be exhibit 2-77.

EXHIBIT #2-77 LETTER FROM THE SECRETARY, DEPARTMENT OF HEALTH TO MRS JOYCE EDWARDS DATED 11/11/2018 (RHA.0001.0001.0001)

MS HILL: As the Commission pleases.

COMMISSIONER TRACEY: Mrs Harris, thank you very much for your evidence. It's important to us to understand the real world experiences of people dealing with the My Aged Care system, and you've provided us with a very good example of the sort of experiences that people have had, and their carers have had. And we're most grateful to you for that evidence. Thank you for coming.

MS HARRIS: Thank you.

<THE WITNESS WITHDREW [10.47 am]

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioner, I called Mr Graeme Barden.

<GRAEME BARDEN, AFFIRMED [10.48 am]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Operator, would you please bring up WIT.1066.0001.0001. Mr Barden, do you see that there on the screen?

MR BARDEN: I do.

DR McEVOY: Is that a witness statement that you have prepared and had filed with the Commission?

MR BARDEN: I have.

DR McEVOY: And are its contents true and correct?

MR BARDEN: Yes.

DR McEVOY: And you don't wish to make any amendments to it?

MR BARDEN: No.

DR McEVOY: Commissioners, I tender that witness statement of Mr Graeme Barden.

COMMISSIONER TRACEY: The statement of Graeme Barden dated 20 March 2019 will be exhibit 2-78.

EXHIBIT #2-78 STATEMENT OF GRAEME BARDEN DATED 20/03/2019 (WIT.1066.0001.0001)

DR McEVOY: Mr Barden, can you just provide the Commission with an overview of your role in the Department of Health.

MR BARDEN: So I'm the assistant secretary of the Residential and Flexible Care Branch within the department, and I have a range of responsibilities there that relate to aged care.

DR McEVOY: And I think your statement says at paragraph 3 that you've had that role since September 2017. Were you in the Department of Health before September 2017?

MR BARDEN: Yes.

DR McEVOY: How long have you been in the Department of Health?

MR BARDEN: Since March 2010.

DR McEVOY: And have you been in aged care, parts of the department in that period?

MR BARDEN: Since September 2017.

DR McEVOY: But not before.

MR BARDEN: Not before.

DR McEVOY: This statement is dated yesterday. When did you prepare the statement, Mr Barden?

MR BARDEN: Its preparation commenced on Monday of this week.

DR McEVOY: And is it a document that you drafted or did you receive assistance in the drafting or how did that process work?

MR BARDEN: I received assistance.

DR McEVOY: Significance from whom?

MR BARDEN: So we had lawyers assisting and so I provided material to lawyers who prepared draft versions of the statement which I reviewed, made changes to, went – iterated through that a couple of times, and it was clearly put to me that I should not submit nor sign the statement until I was perfectly happy with it from my own perspective.

DR McEVOY: Now, there's a document attached to your statement called the Summary of the Approved Process for Home Care Provider Applicants under the Aged Care Act. You are familiar with that document?

MR BARDEN: I am.

DR McEVOY: Operator, that document is CTH.0001.1000.4975. Commissioners, I would seek to tender that document as a separate document.

COMMISSIONER TRACEY: Yes. The Summary of the Approved Process for Home Care Provider Applicants under the Aged Care Act prepared by the Department of Health will be exhibit 2-79.

EXHIBIT #2-79 SUMMARY OF THE APPROVED PROCESS FOR HOME CARE PROVIDER APPLICANTS UNDER THE AGED CARE ACT PREPARED BY THE DEPARTMENT OF HEALTH (CTH.0001.1000.4974)

DR McEVOY: 4974, Commissioner, is the last four digits of that statement.

COMMISSIONER TRACEY: I beg your pardon?

DR McEVOY: 4974, I think are the last four digits of that exhibit, rather.

COMMISSIONER TRACEY: Yes.

DR McEVOY: Now, Mr Barden, are you aware that on Monday the Royal Commission heard evidence from witness BE.

MR BARDEN: I am.

DR McEVOY: And is it the position that that witness is employed within the approved provider section?

MR BARDEN: Yes.

DR McEVOY: And that is one of the sections for which you are responsible?

MR BARDEN: Yes.

DR McEVOY: So your statement deals substantially with the approvals process to become an approved provider under the Aged Care Act. That's the case, isn't it?

MR BARDEN: Yes.

DR McEVOY: Would it be correct to say that you're closely involved in that approval process?

MR BARDEN: So I'm the executive manager of the branch, and so my involvement is to oversight the program and my specific level of engagement is a weekly meeting with the director who manages the function.

DR McEVOY: So you say you oversight the program and you do that principally by having a weekly meeting with the director. Is that the extent of your oversight or are there other things that you do or are expected to do?

MR BARDEN: Do you mean in respect of the approved provider function itself?

DR McEVOY: Yes.

MR BARDEN: No, no other.

DR McEVOY: I'm sorry? Nothing else?

MR BARDEN: Yes.

DR McEVOY: So would I be right to take from that that you don't really have any involvement in the monitoring of the work that people in the section are doing by way of approving providers or not approving providers?

MR BARDEN: The weekly meeting that I have with the director is an opportunity where the director and I discuss the way in which the applications are moving.

DR McEVOY: Yes, I'm not seeking to make any criticism of you in this respect. I'm just trying to understand the extent, really, to which you are involved in monitoring their work and I think from what you are saying, it probably would be fair to say that you don't have that level of hands-on involvement.

MR BARDEN: That's correct.

DR McEVOY: So if you turn to paragraph 10 of your statement, Mr Barden, you make reference to the director, who is the person you are saying you have this meeting with. And you observe that he is the secretary's delegate for the purposes of the decision-making that goes on in relation to the approval or the non-approval of providers. Is the director the sole decision-maker?

MR BARDEN: So the – yes, in practice, yes.

DR McEVOY: And have you got any idea of how many decisions the director would have to make a day or a week in relation to approved providers?

MR BARDEN: It would be in the order of one to two a day.

DR McEVOY: One to two a day. Now, the witness BE gave evidence to the Commission that there will be a different person within the department who will make the review decisions; that is to say, review decisions for the purposes of an internal review. Do you know who that person would be?

MR BARDEN: So the secretary's instrument of delegation allows these decisions to be made by any officer within aged care at the level of director or above, and those decisions are made by other directors, firstly, within my branch.

DR McEVOY: So other directors who report to you?

MR BARDEN: Who report to me.

DR McEVOY: But not ever you?

MR BARDEN: I haven't done one.

DR McEVOY: You have not done one?

MR BARDEN: I have not.

DR McEVOY: So do you know how long it would typically take a reviewer to make an assessment?

MR BARDEN: No, I don't have a particular timeframe other than the discussions that I have with executive level staff within the section indicate that it could be for a more straightforward application in the order of one to three days. Some that are more complex that may find their way towards being refused, it might be more in the order of five to 10 days.

DR McEVOY: Are you aware of how many applications this section has had in the last 12 months?

MR BARDEN: In the last 12 months - - -

DR McEVOY: If that's not - - -

MR BARDEN: It's not a number that I have.

DR McEVOY: If it's not a convenient period for you to answer the question in the sense that it might be more convenient, for example, to say in the course of 2018 or in the course of 2017/2018, I would be happy if you gave me that indication.

MR BARDEN: That's not a number that I can recall right now but it will be in the order of – no, I would be speculating, I'm sorry.

DR McEVOY: So you've got no idea at all of how many applications there would have been received by that part of the department in approximately the last 12 months?

MR BARDEN: As I sit here today, I can't give you that number.

DR McEVOY: Are you aware of whether the number of applications is on the increase?

MR BARDEN: No.

DR McEVOY: So you wouldn't know whether it's going up or it's going down.

MR BARDEN: No, I know that the number of applications has been reducing.

DR McEVOY: The number of applications has been reducing, you would say, in recent times?

MR BARDEN: Yes.

DR McEVOY: And how recent times would you say that has been happening?

MR BARDEN: Over the last six months.

DR McEVOY: And reducing significantly, would you say, or are you able to give some sort of indication of what level of reduction we're looking at?

MR BARDEN: So at the moment, I understand we're receiving in the order of around 20 applications per month and have been for the last six or so months. And prior, when we were receiving more applications that would be in the order of around 40 per month.

DR McEVOY: So it might be approximately correct to say that the number of applications is halving.

MR BARDEN: Approximately.

DR McEVOY: How many staff are there in this particular section, if that's the right word, of the department?

MR BARDEN: I might refer to the team, if we're particularly only talking about the approved provider - - -

DR McEVOY: Yes.

MR BARDEN: - - - function.

DR McEVOY: Yes.

MR BARDEN: So that team, the staff count that I saw as at January was an assessment staff of 10.

DR McEVOY: And are they all full-time people working in that role or are they casual people taken on; are you able to say?

MR BARDEN: So some are full-time and some are part-time. So that, you know, the work and their personal circumstances can be managed by themselves, and some are departmentally employed staff and some are contract staff.

DR McEVOY: Have you any idea how many are contract staff?

MR BARDEN: Within that January – January number, I believe it was six.

DR McEVOY: That's a fairly high proportion of contract staff, would you agree?

MR BARDEN: I – I don't have a view on whether it's high or not.

DR McEVOY: How long would you expect or how long, typically, did these contract staff stay on contract in the role?

MR BARDEN: I can't give a specific number, but I do know that it's – it's variable for some. It might be in the order of three months; others would be longer, six or more.

DR McEVOY: So those who are leaving after three months, do you have any sense of why they're leaving after such a short period?

MR BARDEN: There are some who – who are experienced approved provider assessors under contract, and they will spend time with us, end of contract, turn to personal priorities, and then return to us again.

DR McEVOY: Are you aware of the 90-day rule that operates here?

MR BARDEN: I am.

DR McEVOY: And are you aware of how many applications lapse, in effect, under the – having regard to the 90-day rule?

MR BARDEN: Do you have a particular period of time in mind?

DR McEVOY: Well - - -

MR BARDEN: It – it's something that I pay attention to, yes.

DR McEVOY: Yes, I mean what would be a convenient period of time. Could we talk in terms of the last 12 months for example?

MR BARDEN: Yes. So in the last 12 months, the number of applications that exceeded the 90-day period – if – if I could refer to – to this financial year instead.

DR McEVOY: Yes. Okay.

MR BARDEN: We'd be - - -

DR McEVOY: So you're talking about the '17/18 year or the '18/19?

MR BARDEN: '18/19.

DR McEVOY: '18/19 year, yes.

MR BARDEN: So '18/19 year. My recollection is that the – the number that exceeded the 90-day timeframe is in the order of 10 to 20.

DR McEVOY: 10 to 20, what – does that say anything to you about the levels of staffing that you've got in that team?

MR BARDEN: It is one of the indicators that I use to observe how the assessments are progressing and the relative resourcing. And, you know, indicative at the moment is within my statement, if I can refer to that, I included a graph which demonstrated the number of applications: both that reached the 90-day period and then those that are determined after the 90-day period. And the – the relative series on that chart indicate that the – the number exceeding that has fallen quite dramatically since the previous financial year and now runs at – at – at low numbers.

DR McEVOY: Is that a roundabout way of answering my question about the level of staffing, such as to say that you think there's adequate staffing, or are you trying to say something else?

MR BARDEN: I – I think that there is adequate staffing within that team, yes.

DR McEVOY: So in paragraphs 11 and 12 of your statement, you talk about training for new staff of this section, and I think you make reference to a standard approach. Is there a developed training plan in place?

MR BARDEN: The approach to training is that which I've laid out. Can I ask, where you say "a plan", what – what are you seeking?

DR McEVOY: Well, I'm really asking you about how you approach or your officers in that department, the director of that team, approaches training. How is training conducted?

MR BARDEN: Right. Thank you. Yes, it's – so the standard approach includes that when a new assessor joins the team, they meet with either or both of the supervising team leader and the director of the approved provider section. And in that initial induction meeting, the new assessor is taken through the legislation that applies to the approved provider process; the operational processes that the team employs; is shown a copy of the assessment template; is provided with examples of pre-assessed and pre-determined applications, both an application that found its way to approval and one which was refused, and that provides the – the – the new staff member with initial materials to enable them to understand how assessments are managed and undertaken.

And then the training continues where the assessor is provided with a new and active application and is asked to consider the material that has been provided within the application to undertake the kinds of research that assessors undertake to check

material that is in the application, and to, having formed a view of the application, talk with the supervising team leader about that, and that's an opportunity, then, for the team leader to provide feedback on the way in which the applicant has approached their assessment. Provides further guidance, if that's required, and then that is augmented by the weekly team meeting, whereby, the new assessor and, indeed, all assessors, are invited to discuss the assessments that they have before them, any challenges that they might have and, through that mechanism, they can share strategies or tactics to deal with any uncertainties they may have in the application.

DR McEVOY: So how long would such a person typically be in training?

MR BARDEN: Well, training is an iterative concept within this function. It – it doesn't really cease. We seek to reinforce the learning approach, if you like, through the conduct of the – the weekly meeting.

DR McEVOY: One of the things you say in paragraph 12 is that there's a guide, the approved provider application pre-assessment and assessment processes guide, and you say at the bottom of that paragraph that the guide is in the process of being updated and so has not been provided to the members who most recently joined the team. How long has the guide been in the process of being updated?

MR BARDEN: For several months. I don't have an exact figure.

DR McEVOY: Meaning more than six months or - - -

MR BARDEN: I don't know for certain, but it could be.

DR McEVOY: So insofar as there are new staff members who have joined the team in the course of, say, the last six months, although perhaps longer, what have they been given?

MR BARDEN: So the guide about which we're talking contains and continues to contain useful information about how an assessor practically undertakes an assessment, how to undertake a search of a professional regulatory organisation's website, that kind of thing. So material that's contained with it is still available to all assessors to use. The updating that's required is to make it, perhaps, a little more navigable for the assessors, but it is available to all assessors. We just haven't included it in the package of materials that is handed over to an assessor in recent times.

DR McEVOY: So does that mean that they're looking at an older version of it or something, or is that how that works?

MR BARDEN: So – yes, there is an older version that continues to be used.

DR McEVOY: And do you know whether it says anything about what they're supposed to say to would-be providers who are asking for assistance?

MR BARDEN: I don't know.

DR McEVOY: In paragraph 13 of your statement, Mr Barden, you talk about the assessors and their supervisor – that's not you; that's the director that you've mentioned.

MR BARDEN: If I can correct you, it's the - - -

DR McEVOY: I'm sorry.

MR BARDEN: It's the team leader.

DR McEVOY: The team leader who, in turn, reports to the director.

MR BARDEN: Yes.

DR McEVOY: Yes, I see. So they have their weekly team meeting which provides a forum to discuss workflows, possible reallocation of applications at risk of exceeding a 90-day timeframe ..... and issues, as well as operational changes. Now, that's not a meeting that you would ever go to or have - - -

MR BARDEN: That's correct.

DR McEVOY: So this 90-day timeframe, are you aware where that requirement originates?

MR BARDEN: So it's required by the Aged Care Act.

DR McEVOY: So insofar as some applications are going – are taking more than the 90-day period, what do you do – what does the team do to deal with those sorts of applications?

MR BARDEN: So in terms of the way in which they assess the application, nothing changes. They continue to assess it to the same – same practice as they would for any other assessment, regardless of where the timeframe is – is situated. At a team level, though, there is consideration of the – where applications sit against that 90-day timeframe, and if there is a need to – to move an application from one assessor to another to facilitate the achievement of the 90-day timeframe, then we would consider doing that reallocation of the task.

DR McEVOY: Operator, could you please bring up CTH.1002.1016.1694. So insofar, Mr Barden, as particular applications are going past the 90-day period, would you accept that that might be indicative of a resourcing problem in the team?

MR BARDEN: It could be one of – it could be indicative of one of a number of matters.

DR McEVOY: One of a number of problems or - - -

MR BARDEN: It may relate to resourcing; it may relate to the complexity of the application.

DR McEVOY: But if there's a provision in the Act that requires 90 days, and you've got more than the occasional application that's taking more than 90 days, would you not accept that that suggests that there might be some resourcing problem?

MR BARDEN: Yes.

DR McEVOY: So one of the things, as I understand it, that can be done, in effect, to obtain some more time is for the applicant to be asked to provide more information. Are you aware of that aspect of the system?

MR BARDEN: I'm aware that that's – that's possible.

DR McEVOY: And are you aware of how many times further information can be requested in order to obtain further extensions?

MR BARDEN: I don't believe there is a limit.

DR McEVOY: Are you aware of whether the process of asking further questions is employed by the team to, in effect, extend the 90-day period?

MR BARDEN: No, I don't believe that's the case.

DR McEVOY: Well, you are aware, is your answer, and you don't think it's the case; is that what you're saying to me.

MR BARDEN: Sorry, can you re-put your question.

DR McEVOY: Are you saying to me that you are aware that that is, in fact, not a practice that they engage in?

MR BARDEN: Yes.

DR McEVOY: So - - -

MR BARDEN: Sorry, can I be clear. That is my belief, yes.

DR McEVOY: So this document that has been brought up, Commissioners, this is exhibit 2-42, it's an email chain that has been tendered in the context of another

witness whose name has proceeded by way of a pseudonym, BC. She was an applicant who gave evidence to the Commission yesterday. Are you familiar with that evidence?

MR BARDEN: I heard part of that evidence, but I – I couldn't say that I'm familiar with it.

DR McEVOY: So, here, the original application was made on 10 August 2017, and then on 28 February 2018, there's a request for further information. So that would be, I think, approximately 171 days after the August application was made. Are you able to say anything about what the likely cause of that delay might have been?

MR BARDEN: I have no familiarity with this application at all. So no.

DR McEVOY: Do you know whether it would be usual process to make a request for further information of this kind in an email?

MR BARDEN: Yes. When you say "in this kind", I haven't read the detail of it, so I can say that - - -

DR McEVOY: Well, perhaps you should - - -

MR BARDEN: - - - requests can be made by email.

DR McEVOY: Yes. Just to be fair, if you would like to take a moment to review this document. Operator, perhaps if you go to the last page – perhaps the second last page, so that Mr Barden can see the 28 February email. In fact, the 28 February email is on page 1696. So you see there at the bottom of the page, Mr Barden, that's – and then over the page.

MR BARDEN: I see that.

DR McEVOY: That's the request for the further information, if you read through that.

MR BARDEN: Thank you.

DR McEVOY: And then going over onto the last page.

MR BARDEN: Sorry, my screen just changed.

DR McEVOY: We might just need to take it a bit more slowly, Operator.

MR BARDEN: Sorry. So I'm checking the email from 28 February, 10.33?

DR McEVOY: That's so, yes.

MR BARDEN: Yes. Is there a further page you would like me to consider?

DR McEVOY: There is a further page, Operator, yes, 1698.

MR BARDEN: Could I ask that I see the previous page and this second page? Thank you. Okay. Thank you.

DR McEVOY: Can I just ask you to note, Mr Barden, at the top of page 1698, which is the page on the right of the screen, you will see there's some paragraphs, subparagraphs (b), (c) and (d), and in paragraph (c), one of the questions that's being asked is what policies and procedures you will implement to identify and ensure regulatory compliance with the parts of the Act relevant to the provision of home care. So if I can just get you to bear in mind that that is a question that the Approved Provider Section is putting to this applicant on 28 February 2018 – 28 February last year. Now, Operator, could I now ask you to bring up CTH.1002.1001.3863. This is exhibit 2-55, Commissioners. Now, what the Commission was told, Mr Barden, by BC was that the application that she made was approved on 16 March 2018. So it was approved a couple of weeks after that email that I just took you to. Now, this next document I brought up, do you recognise the nature of this document?

MR BARDEN: I've not seen this document before.

DR McEVOY: Have you ever seen a home care assessment contact report prepared by either the former Aged Care Quality Agency or by the new agency that has been in effect since 1 January this year?

MR BARDEN: No.

DR McEVOY: So, if you go to – Operator, if you could take the witness to page 3866 of this document. Now, if you see there, about point 3 of the page under Expected Outcome 1.2, Regulatory Compliance – perhaps if you could highlight that, Operator. Thank you. You see there, Mr Barden, it says:

> *The expected outcome requires that the service provider has systems in place to identify and ensure compliance with funded program guidelines, relevant legislation, regulatory requirements and professional standards.*

And then if you go down under the heading Supporting Information:

> *The service provider does not have systems in place to identify and ensure compliance with aged care funded program guidelines, relevant legislation or regulatory requirements.*

So do you understand, Mr Barden, that what the agency is saying in response to an assessment contact that they made on 31 October 2018, and that's on the front of the document that you're looking at, is that, as at that date, the service provider doesn't

have systems in place to identify and ensure compliance with aged care funded program guidelines, relevant legislation or regulatory requirements?

MR BARDEN: Yes, I see that.

DR McEVOY: So this is precisely the issue that has been identified as needing attention by the Approved Provider Section on 28 February. You recall that I asked you to note that?

MR BARDEN: Yes.

DR McEVOY: Now, if it be the case that this provider was approved on 16 March 2018, in a period of roughly six months, that is to say up until the assessment contact visit, which is the subject of this assessment contact report on 31 October, either there has been a significant shift because, in March, the team was prepared to accept this provider should be authorised, and then there has been some sort of drop-off, or, alternatively, there's some difference, if you like, between what the Aged Care Quality agency thinks is appropriate in this respect and what the team thinks is appropriate in this respect. Do you see what I'm driving at?

MR BARDEN: I do.

DR McEVOY: And do you have a view about which of those two it might be?

MR BARDEN: I have no knowledge of how the approved provider implemented the things that it intended to, in that, it stated in its application that it would. So I can't comment on that. And, otherwise, in terms of the second possibility, the – I'm not aware of there being any difference in the way in which the – it was then a quality agency considered these matters compared to My Approved Provider Section.

DR McEVOY: Do you accept that there may be some difference in the way your approval team looks at this and the way the agency looks at this?

MR BARDEN: There's a theoretical possibility, but I have no – I have not – it's never been put to me that there is a difference in practice or interpretation between the two groups.

DR McEVOY: Have you ever asked?

MR BARDEN: Personally, no.

DR McEVOY: Do you think you might ask?

MR BARDEN: Yes, I think I might have – might ask that, yes.

DR McEVOY: Do you know whether, when the team is assessing would-be providers, they tell them that they should join one of the peak provider groups?

MR BARDEN: I – I don't know.

DR McEVOY: Do you know who the peak provider groups are?

MR BARDEN: Yes.

DR McEVOY: Do you know whether they ask would-be providers to subscribe to health updates?

MR BARDEN: I don't know with certainty, but I would be not – not be surprised.

DR McEVOY: Do you know whether the team asks would-be providers to provide them with draft policies or checklists that indicate that they're compliant with the regulations?

MR BARDEN: Sorry, I'm – I'm not sure I understand that question.

DR McEVOY: Well, I'm asking you whether you know, in circumstances where assessments are being made by the team, they ask would-be providers to provide draft policies or checklists that would demonstrate that they're able to be complied with the regulations?

MR BARDEN: Sorry. Yes.

DR McEVOY: You do know and you think that is what they do; is that your evidence?

MR BARDEN: Yes, it is, and I believe that that's, in part, what the application form calls for.

DR McEVOY: Operator, could I ask you to bring up - - -

MR BARDEN: May I just clarify that, please?

DR McEVOY: Yes, sure.

MR BARDEN: The word "draft" is – my comments don't relate to that word, that we ask providers – or applicants, I should say, to provide their policies, whether they are draft or otherwise. I can't answer yes or no to that.

DR McEVOY: Is it just the description of their policies that is sought by members of the team or do they ask for their policies, do you know?

MR BARDEN: I understand they ask for their policies.

DR McEVOY: Their actual policies?

MR BARDEN: I think so.

DR McEVOY: Operator, could you please bring up CTH.1002.1002.0055. I might just ask you to read that first page so you can identify what that document is.

MR BARDEN: Okay.

DR McEVOY: You will see that it's a sanctions decision - - -

MR BARDEN: I see that.

DR McEVOY: - - - that was made by the department in relation to BD Proprietary Limited. So, Mr Barden, this is a sanctions - - -

MR BARDEN: Sorry, could I just complete reading?

DR McEVOY: Yes, I'm sorry.

MR BARDEN: Thank you. Thank you.

DR McEVOY: So this is a sanctions notice that was issued to witness BCs business, that is to say BD Proprietary Limited, on 8 November 2018. And, operator, if you could go to page 59 of that sanction decision. You see there at the bottom of the page, part C, the delegate's findings in relation to an immediate and severe risk. And then if you go over the page to the top of 0060:

> *Amongst the extensive and serious unmet outcomes in the Home Care Standards, I highlight the following significant failures to meet the required standards. You do not have a system in place to identify and ensure compliance with aged care funded program guidelines, relevant legislation or regulatory requirements, and the company director and management staff don't have an understanding of the responsibilities of approved providers of home care under the Act.*

Do you see that?

MR BARDEN: I do.

DR McEVOY: So this is an approved – this is a provider who has been approved in March 2018, having satisfied the relevant team that it's appropriate to be approved. And then this same provider is being sanctioned in these terms before the end of the year. To what extent would you say that the delegate of the secretary who deals with the question of assessment reflects the same considerations that the delegate of the secretary responsible for sanctioning providers would consider?

MR BARDEN: The approved provider application delegate has access to materials evidenced through the application form. Research is undertaken by the assessor and

any further information that has been provided by the applicant through the course of the assessment, and the – but I – I cannot speak to how the secretary's delegate makes a decision about the sanctioning or otherwise. I wouldn't have a clue.

DR McEVOY: I'm not trying to assign blame for this on you, Mr Barden, but I suppose what I would ask you is whether you think that the system is working appropriately where a provider is approved in March on the basis of certain articulated – having considered certain articulated matters, and I took you to those, and then half a year later, six months later, the department finds that this particular provider is putting clients at an immediate and severe risk.

MR BARDEN: This is a circumstance that I would not expect.

DR McEVOY: And which you would say, would you, requires addressing?

MR BARDEN: Now, that I've become aware of it, it is something that I would discuss with my approved provider section, and I would be interested in the – the details that are behind our assessment.

DR McEVOY: Do you know whether the approved provider section talks to the Sanctions Section, as it were?

MR BARDEN: They – in – at my understanding, they do talk to the compliance area, is how I phrase that. Specific details that they engage with, however, I can't – I don't know.

DR McEVOY: Do you know whether the approved provider section works with the sanctions section to develop a process of approvals that reflects the expectations that the approved provider section would have of particular providers?

MR BARDEN: I don't know.

COMMISSIONER BRIGGS: Might I, counsel, just ask a question that follows up your evidence just then, Mr Barden, and that is do you think it might be that the approval staff that you have take a number of things on faith; in effect, that a newly applying applicant might develop policies, guidance and care plans in that first six months, or do you rather not know whether that's the case?

MR BARDEN: So it's my – the assessors will apply their judgment to the material that has been presented to them in the application. And then what an approved provider does or does not do from the moment of approval subsequent is not a matter that the approved provider section would have any awareness of.

COMMISSIONER BRIGGS: Okay. Thank you.

DR McEVOY: Operator, could you take Mr Barden back to his statement at paragraph 16 and just bring up 16. I might just get you to read that paragraph and the subparagraphs, Mr Barden.

MR BARDEN: Yes.

DR McEVOY: So you talk there about strategies being implemented to manage the forecasted increase and you list those strategies in (a), (b) and (c):

> *Improved application forms, and guidelines, a streamlined application, engaging additional staff.*

Just dealing with the improved application forms and introducing a streamlined application form, I'm not sure whether they are really the same thing or whether they're in fact different things, but in any event what sort of improvement or streamlining needed to occur? What did these forms look like previously?

MR BARDEN: So I've never seen the previous forms that were operating prior. But the kind of example that you're referring to is at (b), for example, where a provider is approved to provide one type of care, say, residential care, and that they were applying then to become an approved provider for home care or flexible care, then a bespoke form is created for them so that they didn't have to provide the department with information that we already had. So it was an attempt to reduce the burden on their application preparation.

DR McEVOY: And so do you think that these reforms, these changes, assisted?

MR BARDEN: I – of themselves, they weren't able to prevent the rise in the work on hand that developed.

DR McEVOY: Why was the increase in the volume unexpected?

MR BARDEN: So my understanding is that at the time relevant officers attempted to forecast the effect of the increasing choice reforms. And – but that the – and tried to estimate the increasing number of applications that may come but that forecast was – was significantly exceeded.

DR McEVOY: So in paragraph 19, you say in paragraph 19(a) that additional staff had to be allocated. Do you know how many additional staff?

MR BARDEN: It – it – different numbers at different points in time. So there were a – there were additional staff were first allocated in the final quarter of 2016. Then there were further – those – I should – further contract staff levels rose in the subsequent financial year. And further to that, when I became responsible for this function and identified the 90-day timeframe pressures and the work on hand pressures, I moved some capacity from elsewhere within my branch into supporting the existing assessment team.

DR McEVOY: You may be aware that one of the criticisms of would-be providers that was made by witness BE on Monday, the person from this team, was that it was not uncommon to receive what was referred to as boilerplate applications. Do you recall that evidence?

MR BARDEN: I do.

DR McEVOY: And what did you understand the reference to boilerplate applications to be about?

MR BARDEN: That there may be applications presented to us which, to varying degrees, had the same text included within the application.

DR McEVOY: And are you aware of the practices of consultants in the sector and the way they assist would-be applicants?

MR BARDEN: I am aware that there are consultants who help in the preparation of applications.

DR McEVOY: Are you aware of what sorts of fees they charge?

MR BARDEN: No.

DR McEVOY: Are you concerned about the role that some of the peak provider groups might be playing in this area?

MR BARDEN: No.

DR McEVOY: In paragraph 9 of your statement, you say that the role is to assess the suitability of particular organisations. "Suitability" is a word which it might be thought to be somewhat ambiguous in this context. How is a member of the team really able to tell whether a provider wishing to be approved would be suitable?

MR BARDEN: So the suitability is defined by the legislation, which all the assessors have awareness of through their training and through the work that they do. And the assessment then is made of materials that are provided by the applicant, having regard to the relevant standards and principles that are attached to the Aged Care Act, and so they form a view then as to whether, in their judgment, the applicant has sufficiently demonstrated that suitability.

DR McEVOY: But you would accept, I take it, on the basis of that evidence that, to a very considerable extent on the basis of how the system is administered at the moment, the assessors in the team make their assessment of suitability on the basis of not much more than what the would-be provider gives them.

MR BARDEN: Supplemented by whatever researches they've undertaken in the course of their assessment.

DR McEVOY: And are you aware of what sort of research they do undertake?

MR BARDEN: So they will – so, for example, where – where key personnel relate to people who are professionally registered individuals, then the assessors will search the relevant agency, other agency databases to confirm the statements that are made about those key personnel. They might – if they are aware of a – if there is something in their application about which they think there may be a gap, then they can ask the – the applicant to fill in that gap or provide a bit more information to help – help the assessor form their view.

DR McEVOY: Can I take you, Mr Barden, to the summary of the approval process for home care provider applicants. It's CTH.0001 – yes, that's the document. I think I have already tendered this, Commissioners. Can I take you to paragraph 4, which you will see there at the bottom of page 2. Now, that's a list of the matters that the assessors have to have regard to. Do you know whether the assessors are provided with elaboration as to what the factors that are set out in section 8.3 of the Act actually entail?

MR BARDEN: No, not in detail.

DR McEVOY: If you could move, operator, please, to page 3, the next page of that document, and to paragraph 9. Now, you say there that:

> *In the 2017/18 year, 42 per cent of applications were approved, and the balance are either withdrawn or refused or are a relatively insignificant percentage of applications being made by government authorities which are taken to be approved.*

A 47 per cent refusal rate, which might, in fact, more realistically be said to be a 56 per cent refusal rate because presumably the ones that were withdrawn would be likely to have been refused had they not been withdrawn, is a pretty high rate of refusal, would you agree?

MR BARDEN: Yes.

DR McEVOY: Do you know how many of these sought internal review?

MR BARDEN: No, I don't.

DR McEVOY: And I suppose it would follow that you don't know to what extent there were proceedings in the AAT on any of these refusals?

MR BARDEN: No.

DR McEVOY: Do you consider that the department should be more proactive in seeking to deter certain applicants in the face of a 47 to 56 per cent effective refusal rate?

MR BARDEN: We have tried to – it's not so much to deter. You know, our aim is to – to encourage good applications that can be assessed. So we have taken steps to, where an application has come to us and, in our view, is deficient in terms of its content – hasn't provided the standard material that should be provided as outlined in the application form – then we return those directly to the applicant, and we don't undertake any assessment of them.

DR McEVOY: I suppose what I'm driving at, though, is whether deterrence from making application might be approached in a different way to the way that it's presently being approached. For example, whether there might be some sort of initial meeting with the approved provider so that some sort of assessment could be made at an early stage and information conveyed to a would-be provider about their prospects of success. Is that something that would be worth exploring?

MR BARDEN: Yes, I think it would be.

DR McEVOY: Operator, if you go to paragraph 5 of the document we're in. It's there at the top of the second page. So if you just read that paragraph, Mr Barden. So it's dealing with the issue of guidance documents.

MR BARDEN: Yes.

DR McEVOY: One of the criticisms that has been made is that there isn't appropriate guidance, and paragraph 5 refers to the document the department has prepared providing guidance, which is attachment C, and then there's also a form for an existing approved provider that wants another care type, attachment D, and then there's also attachment E for government authorities. It looks as though there's, at least, three different types of documents. Are you aware of the terms of these documents?

MR BARDEN: You mean their content, the way they're put together?

DR McEVOY: Yes, the content of them. Yes.

MR BARDEN: In – yes, in general. I couldn't go to each point of the detail.

DR McEVOY: All right. In paragraph 10, you note that once a provider is approved, they can commence delivering services, and they can remain an approved provider unless their status is revoked. Do you keep records or does the team or does the section or whatever you want to call it, keep records of how many of the providers which have been approved are actively continuing to provide services?

MR BARDEN: The Approved Provider Section doesn't, no.

DR McEVOY: Is that something that is done elsewhere in the department?

MR BARDEN: Yes, the department collects information on the service provision of approved providers, but I – it's an area – it's a function that happens in another part of the organisation, and I don't have detailed knowledge of that.

DR McEVOY: Can I just take you, then, to paragraph 12 which is at the bottom of page 3 of that document where you observe that the department provides a report of newly approved providers to the Commission each month. Have you ever seen one of those reports?

MR BARDEN: I feel that I have.

DR McEVOY: Yes. Is there dialogue that accompanies the report between, presumably, the Approved Provider Section and the Commission, as far as you're aware?

MR BARDEN: The report is actually prepared by another of the sections within my branch, the Aged Care Reporting Section. So it is run, and then just provided routinely to the Commission.

DR McEVOY: Do you know whether the Approved Provider Section or, for that matter, any other section gives anything in the nature of support to newly approved providers, that is to say, information about the way the regulations work, what expectations the department has?

MR BARDEN: The approval provider section does not, and I don't know in respect to other parts of the department.

DR McEVOY: One of the criticisms that was made by the witness for the Approved Provider Section was that some of the forms have meant that it's not really possible any longer for there to be a second vetting. In other words, if a provider slips through the process, that is to say, a provider who perhaps oughtn't to have got through the process, does manage to get through the process, then, in the end, it's up to the Quality Commission to deal with whatever problems come from that. Do you accept that as a criticism?

MR BARDEN: Yes, that is a potential.

DR McEVOY: And you would accept, would you, that that would be another area in which this process might be improved?

MR BARDEN: Yes, I do.

DR McEVOY: I think you've observed in your statement that there have been ongoing reforms. Certainly, the department has given evidence pretty consistently to the Commission, as is evidently the case, that in this area of government activity, there are ongoing reforms. Do you have a view about whether particular functions of

your section, including the approved provider part of the department, might be transferred to the Quality and Safety Commission from January of next year?

MR BARDEN: I – it has been put to me that the approved provider function could transfer to the Quality and Safety Commission, and I agree with the – with that view.

DR McEVOY: Who has put that view to you, Mr Barden, can you say?

MR BARDEN: Are you after a particular name or - - -

DR McEVOY: Well, is this a view within - - -

MR BARDEN: So is it - - -

DR McEVOY: - - - the department or are you referring to - - -

MR BARDEN: Sorry.

DR McEVOY: - - - the Commission's view or - - -

MR BARDEN: No, it's come up in discussions amongst my senior executive colleagues in aged care.

DR McEVOY: And so is that to be regarded as being on the cards, that that is what will happen with the Approved Provider Section?

MR BARDEN: My understanding is that that is part of the active considerations that are being made.

DR McEVOY: Commissioners, I don't have any further questions of Mr Barden.

COMMISSIONER TRACEY: Thank you. Mr Barden, I want to explore with you the assessment process as it currently operates. An application comes in and is allocated to an assessor; is that right?

MR BARDEN: It's – no, it is first considered. We have an administrative consideration first, so what we call a pre-assessment. So we have an administrative officer who first considers whether the application contains all of the material that is required – in effect, is it complete or not – and undertakes certain actions in accordance with that which may be to return the application or issue a request for information.

COMMISSIONER TRACEY: And are you able to say, roughly, what percentage of applications are rejected or returned at that point?

MR BARDEN: I – I can't give you a percentage figure, no.

COMMISSIONER TRACEY: It's a, sort of, triage application.

MR BARDEN: It is.

COMMISSIONER TRACEY: Yes. All right. And if the judgment is made, well, this is fit for assessment, it's then allocated to an assessor; is that right?

MR BARDEN: Correct. Correct, yes.

COMMISSIONER TRACEY: All right. Now, the assessor examines the application and tests it against the criteria that we've been told about. Does the assessor then prepare a report and a recommendation that goes to the delegate?

MR BARDEN: They do.

COMMISSIONER TRACEY: Does it go to anybody else before it goes to the delegate?

MR BARDEN: So it can go to the supervising team leader.

COMMISSIONER TRACEY: And, presumably, there is some time discipline which ensures that the final recommendation goes to the delegate in good time for the delegate to make a decision inside the 90 days.

MR BARDEN: That's what we're after.

COMMISSIONER TRACEY: If that hasn't happened, and we've heard examples where it hasn't, is the applicant advised that the 90 days hasn't been met and given an explanation?

MR BARDEN: Yes, my – my understanding is that they – a notice is provided to the applicant indicating that the 90 days has been exceeded, and the applicant is advised that the – the department will continue to assess the application on – on motion review.

COMMISSIONER TRACEY: Yes. And the delegate then makes a decision. If that is an adverse decision, is there a process of internal review?

MR BARDEN: No, not immediately, no.

COMMISSIONER TRACEY: So what recourse has the applicant got at that point, if any? Is there a right of appeal, for example, to the Administrative Appeals Tribunal?

MR BARDEN: Yes, there is.

COMMISSIONER TRACEY: Yes. Now, have you read the transcript of the evidence given by BE to the Commission?

MR BARDEN: I have.

COMMISSIONER TRACEY: And you would have seen there that what she told us was that, typically, an application that comes to an assessor takes about two weeks to complete before the assessor passes it up the line, and that, she said, applied to the majority of the people in the section; although, she said there was one lady who was a bit faster and got through these applications in about one and a half weeks. Now, I notice you don't gainsay any of that evidence in your statement. Are we to proceed on the basis that that is the fact?

MR BARDEN: My subsequent inquiries suggest to me that two weeks is not a typical period for – for the average assessor; that it is a shorter period.

COMMISSIONER TRACEY: Have you taken this up with BE?

MR BARDEN: No, I haven't spoken to BE.

COMMISSIONER TRACEY: And the other disturbing piece of evidence that she gave us was that, typically, the assessors, at any one time, have about 13 cases in their docket, and that that means that the 13th case that that's waiting is well past the 90 days. Have you – again, you don't gainsay any of that evidence in your statement. Are we to take it that that is accurate?

MR BARDEN: My understanding at the moment, and as I indicated in my witness statement, that we – we currently have in the order of around 60 applications on hand, and that with the number of staff that we have current, that the number that each assessor would have in their portfolio would be fewer than that.

COMMISSIONER TRACEY: And is that a matter that you have checked in the course of this week?

MR BARDEN: No, it's not.

COMMISSIONER BRIGGS: If you were to go back six months where there were, on average, 40 or twice the number than it would take you, I think, to – on average, they would have 12 per person. So that might reconcile those numbers, but - - -

MR BARDEN: That could well - - -

COMMISSIONER BRIGGS: - - - that's not what I want to ask you. For the benefit of the Royal Commission, there's a Commonwealth term called average staffing levels or ASL, and then there's a cap that the government imposes on the level of average staffing level. What's the cap for the Approved Provider Section?

MR BARDEN: So the cap doesn't operate at the level of a section.

COMMISSIONER BRIGGS: Okay. Do you have a feeling for what that is, and my question is, really, is that driving the employment of consultants?

MR BARDEN: It is – yes, it is easier to employ consultants when you – when you've reached your cap, you can employ consultants.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising from that, Dr McEvoy?

DR McEVOY: Well, just, I think, in relation to that last question and answer, you say that when you reach the cap, you can employ consultants, but, with respect, I think the Commissioner's question to you was, really, is that what's driving the appointment of consultants in this team, and are we to take your answer to that question as being yes?

MR BARDEN: Can I first clarify, if I first said consultants, I meant contracted staff. Just – it's – that has a difference for us in public service.

DR McEVOY: I think you did actually say consultants, yes.

MR BARDEN: Okay. So I did.

DR McEVOY: But you meant contractors?

MR BARDEN: I meant contract staff, yes. And, now, having done that clarification, I would have to ask you if you could repeat your question to me.

DR McEVOY: Well, really, the question is whether this issue of the cap to which Commissioner Briggs adverts - - -

MR BARDEN: Yes.

DR McEVOY: - - - is driving the appointment of contractors in the team, rather, perhaps, than a more organised and permanent workforce in the team.

MR BARDEN: No, I think it's – for me, it's the combination of the two different types of resource. And so - - -

DR McEVOY: The two different types of - - -

MR BARDEN: Resource.

DR McEVOY: Resource.

MR BARDEN: So permanent departmental staff or contracted staff. The – so the – the way that I look at it is, as provided in my witness statement, the work on hand is reducing quite significantly. So we've gone past that peak period, and so what I continue to do is –is look at the – the nature of the staffing profile. The continuing allocation of contracting of staff is consistent with monitoring a downward trend and looking to see where that plateaus, but I have – the circumstances aren't that I cannot put on departmental staff. And it was Friday of last week – and to be clear, this is before that I knew that I would be appearing before the Royal Commission. On Friday of last week, authorised actions to bring about the permanent transfer of a departmental officer into the Approved Provider Section to undertake assessments of applications to become an approved provider.

DR McEVOY: So, sorry, your point is that you decided to do this anyway before you even knew you were coming along here to give evidence about this?

MR BARDEN: Yes.

DR McEVOY: I don't think I have anything further, Commissioners.

COMMISSIONER TRACEY: Yes. Thank you very much for your evidence, Dr Barden. It has been most helpful.

MR BARDEN: Thank you.

<THE WITNESS WITHDREW [12.10 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 12.25.

ADJOURNED [12.10 pm]

RESUMED [12.42 pm]

COMMISSIONER TRACEY: Mr Free.

MR S. FREE: It was remiss for me not to mention it earlier, but I re-announce my appearance with MR ARNOTT for the Commonwealth.

COMMISSIONER TRACEY: Thank you. Yes, Dr McEvoy.

DR McEVOY: Commissioners, I would seek to call Mr Anthony Speed and Dr Lisa Studdert, who are both seated in the witness box.

COMMISSIONER TRACEY: Thank you.

<LISA JANE STUDDERT, AFFIRMED [12.42 pm]

<ANTHONY DAVID SPEED, AFFIRMED [12.42 pm]

DR McEVOY: Dr Studdert, could you please give the Commission your full name.

DR STUDDERT: Lisa Jane Studdert.

DR McEVOY: And could you indicate your role within the Department of Health.

DR STUDDERT: At the present I am the deputy secretary, Ageing and Aged Care Group.

DR McEVOY: How long have you been in that role?

DR STUDDERT: I've been in this role just for a few weeks. Due to some unforeseen circumstances we've had to do a rearrangement of deputies in the departmental executive.

DR McEVOY: And what was your role in the department prior to this change?

DR STUDDERT: I was the deputy secretary for Population Health, Sport and Aged Care Quality, and that incorporates the area responsible for aged care quality and compliance. And I should add that I acted in the role of deputy secretary for the Ageing and Aged Care division for six months in the last year.

DR McEVOY: And I think you've been in the Department of Health or in that portfolio at least since about 2011.

DR STUDDERT: That's correct.

DR McEVOY: Are you able to provide the Commission with an overview of what you have been doing in the department within that period.

DR STUDDERT: In that period I spent some time working in a portfolio agency, a national community health agency. I worked at the Therapeutic Goods Administration for two years. I worked in the Population Health and Sport Division, and I've spent some time in the Minister's office.

DR McEVOY: Which Ministers were they?

DR STUDDERT: I was chief of staff to Minister Sussan Ley, and a principal adviser to Minister Greg Hunt.

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

MR SPEED: Anthony David Speed.

DR McEVOY: And what role do you hold within the department?

MR SPEED: I'm currently the acting assistant secretary for the Aged Care Compliance Branch.

DR McEVOY: And you've been in that role for how long?

MR SPEED: I've been in that role since November 2018.

DR McEVOY: And what does that role involve?

MR SPEED: That role is the senior leader for the branch, responsible for administering the National Aged Care Compliance Program.

DR McEVOY: And I understand you've been in the department for quite a number of years.

MR SPEED: I have.

DR McEVOY: How long is that?

MR SPEED: I've been in the department for 25 years.

DR McEVOY: And are you able to give an indication of what you have been doing over the last few years?

MR SPEED: Certainly. Prior to this role, I was in the role National Aged Care domain manager in the health grants network, and prior to that I was a state manager in the Tasmanian office, and for a brief period the Victorian State office.

DR McEVOY: I think Mr Free and I are both having a bit of trouble hearing you.

MR SPEED: Okay.

DR McEVOY: Both of you, in fact, and so it would be of great assistance if you could speak up a little. Mr Speed, I want to ask you a few questions, first, about the nature and extent of non-compliance with the relevant standards in home care. So that's the context in which I want to ask you some questions. Can you tell the Commission whether, as far as you're aware, there has been an increase in non-compliance with the Home Care Standards by home care providers in recent years?

MR SPEED: There has been a slight increase in non-compliance by home care providers, evidenced by the numbers of sanctions that we've seen over the last three years.

DR McEVOY: Yes, and those sanctions notices have been increasing in number, have they?

MR SPEED: Slightly. The sanctions that delivered in '18/19 are slightly higher than the previous year, by year.

DR McEVOY: Do you know how many notices of non-compliance were sent to home care providers in the '18/19 year?

MR SPEED: I do not have that figure for '18/19, no.

DR McEVOY: Do you have it for '17/18?

MR SPEED: I believe it was 10.

DR McEVOY: 10, and do you have a '16/17?

MR SPEED: I believe it was eight.

DR McEVOY: So there's an increase but not a particularly significant increase.

MR SPEED: Not at this stage, no.

DR McEVOY: Yes. And what sort of non-compliance is being detected in the home care area?

MR SPEED: In home care, the unmet outcomes that the Commission is finding and reporting to the department find significant numbers in relation to regulatory compliance, governance requirements, planning and assessment, and care planning for care recipients; those are the key common unmet outcomes.

DR McEVOY: Quality of care, or is that not such a significant cause of sanction?

MR SPEED: Quality of care is measured through the unmet outcomes in relation to, for example, care planning.

DR McEVOY: Does a number of eight or 10 strike you as a low-ish sort of a number?

MR SPEED: It is a low number, if taken as a single figure.

DR McEVOY: Well, what do you mean if taken as a single figure?

MR SPEED: There are a number of levels below a notice of non-compliance for example, such as an administrative pathway that may be followed in which a provider is found to have unmet, have unmet outcomes by the commission, and then returns to compliance. Or the department works with that provider and the provider returns to compliance through a plan for continuous improvement period.

DR McEVOY: And are you aware of what the numbers are over the two periods we're looking at in relation to matters of that kind?

MR SPEED: No, I don't have those figures with me.

DR McEVOY: Do you have any idea?

MR SPEED: I'm sorry, I couldn't give you that figure.

DR McEVOY: Do you know whether those figures are on the increase or the decrease?

MR SPEED: I wouldn't – I wouldn't want to hesitate a guess.

DR McEVOY: Could I ask you to make arrangements to provide the Commission with a comprehensive answer to that question by reference, say, to the last three year periods?

MR SPEED: Yes.

DR McEVOY: It might be convenient to bring up, Operator, the Quality of Care Principles in the Home Care Standards. Commissioners, this is exhibit 1-23 and, Operator, that's CTH.0001.1000.4676. So you're obviously both familiar with these principles.

MR SPEED: Yes.

DR McEVOY: So perhaps if we could go, Operator, to part 1, dealing with effective management. Just go a little further. Perhaps if I can direct you, Operator, to page 4708. So the standards talk in terms of a continuous improvement approach. Are you familiar with that?

MR SPEED: Yes, I am.

DR McEVOY: And what does that actually mean?

MR SPEED: So the standards are measured by the Aged Care Quality and Safety Commission, and when the Aged Care Quality and Safety Commission undertakes a visit with an approved provider, they will look at who is providing home care services. They will look at their standards. In relation to 1.5, they will look at what systems and processes that approved provider has in place to ensure continuous

improvement practices are occurring. So that might be, for example, through their response to complaints and feedback provided by care recipients.

DR McEVOY: So continuous improvement seems to be both a standard as well as an outcome because it's also part of effective management; is that right?

MR SPEED: The – the standard is effective management.

DR McEVOY: Yes.

MR SPEED: The outcome is continuous improvement.

DR McEVOY: And is there a relevant distinction?

DR STUDDERT: I would say one is a mechanism by which you achieve effective management, and the other is, as you said, an outcome.

DR McEVOY: Does risk management – at 1.6, is that a reference to clinical or administrative issues, or both?

MR SPEED: It's a – can be a reference to both.

DR McEVOY: And where you refer to physical resources or where there is reference to physical resources in item 1.8, what is that to be taken to mean?

MR SPEED: That could be perhaps by way of example, a situation where a service provider is using the equipment that they have available to them to provide care, effectively and safely.

DR McEVOY: Can we go over the page to 2.2. I might return to that, Operator. Insofar as the standards refer to fitness for purpose, can I ask you, Dr Studdert, whether you know how soon after a home care provider is approved is there an assessment of that provider's capacity to meet the home care standards?

DR STUDDERT: The – well that's a process that the quality aged – that the Commission undertakes, and that will vary according to the circumstances and – and information they have available to them. The – the standard is within three years of a provider becoming active with clients, but that can vary enormously, depending on the sorts of information that becomes available to them, and that's through the complaints mechanism, through referrals from the department if we become aware of a situation, or any other information that they receive that would suggest it would be appropriate to engage with a provider sooner, rather than later.

DR McEVOY: So does that – so am I to take that answer to mean that it's not possible to give any clear indication of how long after there's an approval that there will, in fact, be an assessment, that it's going to depend on lots of different factors.

DR STUDDERT: Yes, that's correct.

DR McEVOY: And how does that compare to the position in relation to residential care services?

DR STUDDERT: Well, my understanding is – and, actually, Anthony might be able to assist here, that there is a step in residential where there's an accreditation process that is done soon, as an operator becomes active, and that reflects the risk and complexity of residential care, which is, of course, different, fortunately, than home care.

DR McEVOY: So do you have a view – and perhaps I will put this to you, Dr Studdert, first – about whether the home care standards place enough emphasis on the quality of care being provided to the care recipient?

DR STUDDERT: My view is that it does, through the emphasis on the care plan, and the attention that's paid to the capacity and undertake – and – and operations of the provider in terms of delivering to that care plan. That's a pretty central part of their operation, and that is the crux of what is being provided to the client.

DR McEVOY: Do you regard the home care standards as being sufficient for their purpose?

DR STUDDERT: I think that they have served us very well, but as you would be aware, we are transitioning to a new set of standards that have been developed in a pretty extensive consultation process based on new – on the evidence base we have and which will be a more contemporary and appropriate approach to the regulation moving forward.

DR McEVOY: Can I ask you some questions about the relationship between the department and the Commission in relation to regulation.

DR STUDDERT: Yes.

DR McEVOY: Obviously, the Commission is responsible for monitoring providers of home care. We've traversed that. How does a particular home care provider find its way onto the agenda, as it were, for the Commission, on the one hand, and the department, on the other?

DR STUDDERT: So, as I mentioned in my last – earlier answer, there's a range of ways that that happens, but it's important to remember that the Commission – a part – and a large part of the Commission's operations is a complaints system, and that that transition from the previous complaints Commissioner, and there are a large number of staff whose daily work is to field complaints from anyone in – a care recipient, a – a representative of the care recipient, another provider that may be giving us information about another provider. There's lots of that that happens. And – or anyone.

So that's a very important point, entry point, to the quality and regulatory system, in that – in ways we get intelligence. A lot of those complaints are resolved in the early stages of handling, and that's a good outcome in terms of giving the complainant resolution, but others will point to a system – to a process that needs to be initiated in terms of the quality regulatory processes, and that would start a process where assessors would go and visit the service, service provider. And often, at that point, they are in consultation with the department, further seeking out information that would expand the picture we have of what the risks or issues might be for a particular provider.

DR McEVOY: Well, that aspect of it, you would agree, I think, is reactive in the sense that there's a complaint made, and so the Commission will respond to that complaint, and I understand that and accept that, but going back to my question about how particular home care providers might come to be on the radar, as it were, I think your answer was to say that there are a range of ways.

DR STUDDERT: Yes.

DR McEVOY: And complaints is one of them, obviously enough, and you've just - - -

DR STUDDERT: I – I use the term "complaints" in its broadest possible form. It could also be, "Are you aware of; do you know; I think we should look at; I'm concerned about," and, of course, that is on top of - - -

DR McEVOY: Who would be saying that?

DR STUDDERT: People that would choose to provide information to the Commission - - -

DR McEVOY: Yes.

DR STUDDERT: - - - about services or situations that they're concerned about.

DR McEVOY: Yes, so is there any organic process, as it were, within the Commission for - - -

DR STUDDERT: Well, they do have a program of regular contact with providers, and that is to ensure that every provider is in contact and visited on a – on a recurring basis.

DR McEVOY: And does the department discuss that with the Commission at their meetings?

DR STUDDERT: Yes. Yes.

DR McEVOY: For that specific purpose?

DR STUDDERT: Well, there's a range of interactions that occur, but yes, I mean Anthony and his team have regular contact with the Commission on, either, broad issues of trends, policy implementation, to actual engagements on services of concern.

DR McEVOY: So it might be that, in the context of meetings of that kind, might it, that the department would say to the Commission, "Well, we are concerned about X or we're concerned about Y. You might want to think about looking at into that," is that the sort of thing?

MR SPEED: Yes, that is the sort of thing, or the department will undertake to provide a formal referral to the Commission either for information or requesting a review of that service as a type 2 or a type 3, or - - -

DR McEVOY: Now, the part of the department that participates in meetings of that kind, that's not the approval section that we were hearing evidence about before the break, is it?

MR SPEED: That's correct.

DR McEVOY: It's not the approval section.

DR STUDDERT: It's not the approval section.

MR SPEED: It's not the approved.

DR McEVOY: So does the approval section have any input into these regular meetings between the department and the Commission?

DR STUDDERT: Not as a matter of course, at this stage, no.

DR McEVOY: And do you know whether all or some of these regular meetings are minuted?

MR SPEED: Not all of them. Some of them, a risk list, if you like, is considered.

DR McEVOY: I'm sorry, a - - -

MR SPEED: A risk list of – of – of providers is – is considered.

DR McEVOY: So, what, are you saying the department or the Commission or both operate a risk list?

MR SPEED: At the, one of those meetings, one of the points of interaction with the Commission is a service providers of concern meeting, in which we have a list of – of providers that may be either under sanction, under a notice of non-compliance, which provides a basis for conversation regarding where those cases may be at.

DR McEVOY: So you've referred to a service provider of concern meeting. Is that the name of a regular program of meetings, is it?

MR SPEED: That's correct.

DR McEVOY: And that's between officers of the department and officers of the commission?

MR SPEED: It involves representatives from the commission but it's primarily a departmental group.

DR McEVOY: And how often does that sort of meeting occur?

MR SPEED: At the moment, fortnightly.

DR McEVOY: So once a fortnight there's such a meeting. And is that meeting minuted?

MR SPEED: No.

DR McEVOY: How many people would attend that meeting?

MR SPEED: It will vary depending on the case that may be considered as a particular concern. But generally it would be around a dozen staff, involving staff from the national office and from the state office network of the department.

DR McEVOY: So these dozen people who meet as a part of this specific program of meetings once a fortnight, it's not minuted. Do people take informal notes?

MR SPEED: They may take informal notes but as I mentioned, the key issue – the key format for discussion is the register of risk.

DR McEVOY: Well, what do you regard as a serious risk?

MR SPEED: Serious risk is a term that's identified in the Act. Serious risk is a term that's used by the commission in terms of their findings. And it's a term that – that relates to where there's a potential adverse impact on the care and safety of a care recipient.

DR McEVOY: And what's a serious risk report?

MR SPEED: A serious risk report is a report that the commission provides to the department where they become concerned about care and safety of a resident or a care recipient.

DR McEVOY: So would these serious risk reports be routinely discussed at the service provider of concern meetings?

MR SPEED: They can be. Where there's a particular case in relation to a particular provider, there may be a more targeted conversation about that particular case.

DR McEVOY: So you've said that the serious risk reports are provided to the department by the commission. Are they provided to the department prior to their finalisation by the commission?

MR SPEED: It will vary depending on the circumstances.

DR McEVOY: Are you aware of whether there are any current home care providers who have a serious risk finding but haven't been sanctioned or issued with any notice of non-compliance?

MR SPEED: No, I'm not aware of that.

DR McEVOY: Am I to take that answer to mean that you simply don't know or you think there are none?

MR SPEED: I'm not aware of – of those cases, no.

DR McEVOY: That's something that you could relatively easily find out, I would imagine.

MR SPEED: That's correct.

DR McEVOY: I might ask you to endeavour to provide that information to the Commission, perhaps over the last three months. Now, what about the proportion of serious risk findings that don't turn themselves into a sanction or into some sort of notice of non-compliance. Are you aware of that?

MR SPEED: I'm not quite clear what you're asking me.

DR McEVOY: So there will be, presumably, some serious risk findings that don't turn into sanctions or notices of non-compliance; would I be right in surmising that?

MR SPEED: It would be unlikely that a serious risk finding would not turn into a notice of non-compliance or a sanction.

DR McEVOY: So you think it would be unlikely – would you be able to say that it's always the case that a serious risk finding would turn into a sanction or a notice of non-compliance?

MR SPEED: There would be variation on a case-by-case basis but generally I would say that, yes.

DR McEVOY: Well, just so that we are dealing in the territory of certainty, could I ask you to consider that question, say over the last six months, and provide to the Commission the results of that consideration?

MR SPEED: Yes.

DR McEVOY: So if the department is going to decide to take regulatory action in relation to a home care provider, can you walk me through the information that it might typically have regard to?

MR SPEED: Typically, the department will have regard to – the delegate will have regard to the information that's provided by the commission.

DR McEVOY: And would that be all?

MR SPEED: The delegate can consider all reasonable evidence including history of non-compliance by a particular provider.

DR McEVOY: Well, that would also be material, wouldn't it, that would be referred to the delegate by the commission?

MR SPEED: That is also – that would be – that's correct, yes.

DR McEVOY: So would there be anything else other than material coming from the commission? I'm really trying to understand whether, in a functional sense, the department's only source of information is what it hears one way or another from the commission or whether there are other sources of information.

MR SPEED: The delegate can consider any information that's relevant to a case.

DR McEVOY: Sure.

DR STUDDERT: Can I just add to that; I think it's important to note in cases where – particular where there's serious and immediate risk identified and there's an early referral to the department, the process moves very quickly then to notices of non-compliance and sanctions because of the risk that is identified, and so I think the delegate would be not pausing too long to consider other information when that has been the case.

DR McEVOY: So would it be the position that the department doesn't really conduct any sort of independent assessment of the material that's provided to it by the commission?

DR STUDDERT: No, because that's the system is that we rely on and act on the information and advice of the commission.

DR McEVOY: Are you aware of whether the department ever disagrees with the views or the assessments of the former agency or the present commission?

DR STUDDERT: I'm certainly not aware of any case and I think that would be highly – highly unusual.

MR SPEED: That's correct.

DR McEVOY: But if you've been following the evidence, you would be aware that it would not be highly unusual for the agency and the department to come to quite a different position in relation to sanctions.

DR STUDDERT: I wouldn't agree to that proposal, no.

DR McEVOY: You would not agree that that might occur?

DR STUDDERT: I can't think of an example.

DR McEVOY: So the department might issue a notice of decision to impose sanctions where there's an immediate and severe risk to the safety, health or wellbeing of care recipients. What would you regard as an immediate and severe risk?

DR STUDDERT: Well, the situation where care recipients are not – we are not confident that they are getting care that is appropriate and necessary as – as a care plan would have indicated. And so in some cases the absence of a care plan alone would give us great cause for concern because there is no documentation by which you could verify that a recipient – a client was getting appropriate care.

DR McEVOY: So you would say that simply if there isn't a care plan that might provide an appropriate basis to conclude that there is an immediate and severe risk to the safety, health or wellbeing of a care recipient; that would be your view, would it?

DR STUDDERT: I think in the absence of anything else to indicate otherwise, yes.

DR McEVOY: Who makes the decision about whether there's an immediate and severe risk?

MR SPEED: It would be made by the delegate of the secretary in the department.

DR McEVOY: Operator, could you bring up CTH.1000.1015.0227. So this is a document that you have provided to us as a summary of the sanction process. Which of you is more familiar with this document; which of you has got better vision?

DR STUDDERT: Yes, I think Anthony is, although I am familiar with it also but Anthony uses it as a daily tool.

DR McEVOY: I wonder if, Mr Speed, you might walk us through how this actually works as a practical matter.

MR SPEED: So thank you, I will using the example of the box on the left which is the information referred to the department from what, in the production of this document, was then the Aged Care Quality Agency. The Quality Agency may provide advice to us in relation to unmet outcomes, in this case, in your context in relation to home care. So the department will assess that information and whether it is non-compliant under the framework of the Aged Care Act. A delegate may determine whether further information is provided – is required, or under the regulatory framework may determine that non-compliance is confirmed, and an initial risk assessment in relation to the service provided to the care recipient will be conducted, followed by a more detailed risk assessment where non-compliance has been confirmed.

The delegate may then choose to conduct an administrative response or a more detailed analysis based on the determination they've made about the severity of the risk to the care recipient. So, subject to their decision, an administrative response may be conducted through engagement with the approved provider to monitor their returning to compliance or a more detailed risk analysis and the determination around immediate and severe risk may lead them to make a decision about issuing a notice of non-compliance or, indeed, a notice of imposition of sanctions. The notice of imposition of sanctions will be determined by their assessment of the immediacy and the severity of the risk.

Where a notice of non-compliance has been issued, the notice of non-compliance will be provided to the approved provider who has an opportunity to respond to that. Their response will be analysed through their submission. A determination of whether their response is satisfactory or not will then determine the decision around issuing either a notice of intention to impose a sanction where their response has not been satisfactory or, indeed, a notice to remedy or an undertaking to remedy provided by the approved provider where the submission proves to be satisfactory. And, indeed, in some cases, a submission may lead to a no further action where there's evidence provided that there was no non-compliance currently. So they are the key pathways that that document details.

DR McEVOY: Commissioners, that may be a convenient time.

COMMISSIONER TRACEY: Very well. The Commission will adjourn until 2.15.

<THE WITNESSES WITHDREW [1.19 pm]

ADJOURNED [1.19 pm]

RESUMED **[2.28 pm]**

COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: If the Commission pleases, I call Ms Kersnovske. Ms Kersnovske appears by video link, Commissioners.

COMMISSIONER TRACEY: Yes.

<RITA MAY KERSNOVSKE, AFFIRMED **[2.28 pm]**

<EXAMINATION-IN-CHIEF BY MS HILL

MS HILL: Mrs Kersnovske, can you see and hear us okay?

MS KERSNOVSKE: Pardon?

MS HILL: Can you see and hear us okay?

MS KERSNOVSKE: Yes, yes.

MS HILL: Mrs Kersnovske, could I ask you to state your full name.

MS KERSNOVSKE: My full name is Rita May Kersnovske.

MS HILL: What age are you, Mrs Kersnovske?

MS KERSNOVSKE: I will be 81 in May.

MS HILL: You are currently at the courthouse in Gympie in Queensland?

MS KERSNOVSKE: That's true.

MS HILL: How far is Gympie from Brisbane?

MS KERSNOVSKE: It's about 160 kilometres.

MS HILL: And does that make - - -

MS KERSNOVSKE: And about – pardon?

MS HILL: You go.

MS KERSNOVSKE: And it's about an hour's drive from the Sunshine Coast, further north.

MS HILL: Have you prepared a statement dated 13 March 2019?

MS KERSNOVSKE: Yes, I have.

MS HILL: And have you got a copy of that statement in front of you?

MS KERSNOVSKE: Yes, I have.

MS HILL: If I could ask you to take that statement that's in front of you and turn it over, and I will ask the operator - - -

MS KERSNOVSKE: Okay.

MS HILL: You've got that statement there, Mrs Kersnovske?

MS KERSNOVSKE: Yes I have.

MS HILL: Operator, could you please display the document ID WIT.0088.0001.0001. Mrs Kersnovske, we've now got a copy of your statement in front of us in the hearing room in Adelaide.

MS KERSNOVSKE: Yes.

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

MS KERSNOVSKE: No, not at all.

MS HILL: And to the best of your knowledge and belief, are the contents of your statement true and correct?

MS KERSNOVSKE: Yes, they are.

MS HILL: I tender that, Commissioners.

COMMISSIONER TRACEY: The statement of Rita May Kersnovske dated 13 March 2019 will be Exhibit 2-80.

EXHIBIT #2-80 STATEMENT OF RITA MAY KERSNOVSKE DATED 13/03/2019 (WIT.0088.0001.0001)

MS HILL: As the Commission pleases. Mrs Kersnovske, your son Lester attended the Gympie courthouse with you today; is that right?

MS KERSNOVSKE: Yes, he has.

MS HILL: And he's just outside the room that you're in at the moment.

MS KERSNOVSKE: Yes, yes.

MS HILL: Your son, Lester; is he in his 30s?

MS KERSNOVSKE: He's in his 50s.

MS HILL: In his 50s.

MS KERSNOVSKE: He's 57.

MS HILL: And do you think he is out the front there watching you on the web stream at the moment?

MS KERSNOVSKE: I'm not real sure.

MS HILL: And you've got two other sons, don't you, Mrs Kersnovske?

MS KERSNOVSKE: Yes, I do. One in Brisbane, and one in Townsville. And I expect they will be watching.

MS HILL: How long have you been living in Gympie for, Mrs Kersnovske?

MS KERSNOVSKE: Since 1980, about 40 years.

MS HILL: And Gympie was where your husband, Col, was born and raised, wasn't it?

MS KERSNOVSKE: Yes, that's right.

MS HILL: Could I ask you to please tell the Commissioners a bit about your husband?

MS KERSNOVSKE: My husband – we were married back in 1961 and he was a happy-go-lucky, sports-playing person. And in his late 50s, his personality changed a lot, and that was eventually diagnosed, probably in his late 60s, that he had dementia, vascular dementia, and aggressive Alzheimer's. And I looked after him. He has been gone now for four years but I looked after him from then until he went into care about 20 months before he died.

MS HILL: And what did that mean in terms of the sort of care that you were providing for your husband?

MS KERSNOVSKE: Well, it meant I had to be very patient and – and tolerant, because his – his personality had completely changed and his moods had completely changed. And it was – yes, it was – the doctor virtually advised me to have a sense of humour about things that he – he did and not to let them bother me a real lot.

MS HILL: And did you ultimately make a decision to put Col into residential care?

MS KERSNOVSKE: Yes.

MS HILL: And how did you make that decision, Mrs Kersnovske?

MS KERSNOVSKE: He – he had become very be verbally abusive, and one day he – he was – he was going to bring a bucket of dirt into the lounge room, and I tried to stop him, and he just shook his fist at me, which was completely out of character. He had never struck me; he had never done anything like that. And the doctor just said, "Time he was in care." So he was obviously aware that his aggressiveness might get a little bit more physical than – and that's the reason why he went into care.

MS HILL: You're currently retired?

MS KERSNOVSKE: Yes.

MS HILL: Could I ask - - -

MS KERSNOVSKE: And have been for about – about 20 years.

MS HILL: And what did you do for work before you retired, Mrs Kersnovske?

MS KERSNOVSKE: I had various occupations. I worked for about 20 years in bakeries. My dad was a baker, and that seems to be how I got first started there, when I was about 13. And then I worked in a fabric store for a time, and also had friends who owned a commercial laundry and I worked there, helping them out for a time, just before I retired.

MS HILL: When your husband, Col, went into residential care, did you stay living at the same house that you and Col had had together?

MS KERSNOVSKE: Yes. Yes.

MS HILL: And then did you - - -

MS KERSNOVSKE: Yes, I did.

MS HILL: Did you ultimately move from that house?

MS KERSNOVSKE: When – I – I moved from the house – my house here in Gympie, to a smaller house just before he went into care. And it has just been good

for me. It was a big – a big job to do at the time but it has been good for me now because I'm in a smaller house and closer to my son.

MS HILL: Your son in fact lives next door with his family; is that right?

MS KERSNOVSKE: Yes.

MS HILL: I want to ask you some questions about My Aged Care.

MS KERSNOVSKE: Yes.

MS HILL: In 2018, you accessed My Aged Care, didn't you?

MS KERSNOVSKE: Yes.

MS HILL: Why did you access My Aged Care?

MS KERSNOVSKE: Because I – at the time I asked for an ACAT assessment and was told that they would decide whether I needed an ACAT assessment or not. And then I had a fall. That has given me a lot of trouble from September last year to now, and even my doctor has asked them to do a reassessment but it's – they have just done another RAS assessment which is what ACAT does before they send you on to have an ACAT assessment. So I really haven't got a lot of satisfaction out of My Aged Care, and I still don't have any help.

MS HILL: Is it correct to say that in September 2018 that's when you had your first ACAT assessment?

MS KERSNOVSKE: Yes.

MS HILL: And what was the outcome of that assessment?

MS KERSNOVSKE: They gave me – they gave me numbers to say that I could have domestic help, gardening help and help with maintenance. But I haven't been able to get – I've had to pay someone to do my garden because I can't weed or bend so well any more. And – and as far as maintenance is concerned, I've just got to call on Lester to do all – if the other boys are home, I call on them. And I'm supposed to be getting some help in the house but that was probably a month ago, if not longer, and I still don't have it.

MS HILL: And you told the Commissioners that you had a fall and since - - -

MS KERSNOVSKE: Yes.

MS HILL: - - - you've had that fall you've had further difficulties.

MS KERSNOVSKE: Yes.

MS HILL: Did you contact My Aged Care after that fall?

MS KERSNOVSKE: Yes. Yes.

MS HILL: And what happened when you called up?

MS KERSNOVSKE: And they just quoted me numbers. They – they said, "You've been assessed" and quoted me numbers and – and I got – I couldn't even walk to Lester and – over to his place to get a meal because it was just so painful. And, you know, I got really upset on the phone call, and just – I actually ended the phone call by saying, "I will just sit here and starve to death." And I just got no help – no help whatever from My Aged Care.

MS HILL: And you told the Commissioners that you spoke to your GP about My Aged Care.

MS KERSNOVSKE: Yes.

MS HILL: What did you talk to your GP about?

MS KERSNOVSKE: Well, he – he – I said to him that I needed care. He said, "Yes, we need to get you some help." And he sent My Aged Care an email asking for me to be reassessed, and they virtually rung me back and said, "No, he didn't give enough information." I would have thought if the doctor asked for me to be reassessed, that that should be enough. But it just didn't – it didn't happen that way.

MS HILL: And do you say, Ms Kersnovske that the type of help you need at the moment is in fact different to when you were first assessed in September of last year?

MS KERSNOVSKE: Yes. Yes. Definitely.

MS HILL: Have you received a further assessment?

MS KERSNOVSKE: The first day that I heard from Jodi on that same day they came to the house but there was really not an assessment, it was just the lady who came rung a few care providers, and she – she got on to All Aged Care which was one of the providers but I really haven't heard from them since. They said they could provide assistance for me but I haven't heard from them since.

MS HILL: And when you referred to Jodi, you are referring to one of the solicitors who works for the Royal Commission?

MS KERSNOVSKE: Jodi Moore, yes.

MS HILL: And that was about two weeks ago, was it?

MS KERSNOVSKE: Probably a little bit longer than that, I think. Maybe three.

MS HILL: Could I ask you to turn to your statement, Mrs Kersnovske, and turn to paragraph 31 of your statement.

MS KERSNOVSKE: Yes.

MS HILL: Now, at that paragraph of your statement, you give evidence that you learnt to use an iPad and an iPhone.

MS KERSNOVSKE: Yes.

MS HILL: Could I ask you to tell the Commissioners how that came to be?

MS KERSNOVSKE: It really started off, our youngest son had a phone that he wasn't using, and he offered it to us because this was in the early stages of Col having been diagnosed with dementia. And Col sort of said – we don't want one of those things, but Malcolm insisted that we have it because of travelling, you know, Col had given up driving. I was the one that did the driving. And we used to travel to visit our boys. And Malcolm decided that we needed, for safety's sake, more or less to – when we were in the car. And strangely enough, it was Col who wanted to use it first. We were driving and – and the car was acting up a bit. It was only a new car, and he blamed me for not driving properly, or something, and I said, "It's not me it's the car." And so we pulled over the side of the road and he said "Have you got that thing Malcolm gave you?" And so we used it right there and then.

MS HILL: Did Malcolm help you with how to use the phone?

MS KERSNOVSKE: Yes. I sort of thought I've got to learn a bit about this. So I laid on the bed one day and I texted him and my first texts were, you know, just a whole lot of words. And – and he wrote back and said to me, "Where's your capital letters?" And I said "I will find them, got to find the capital letters." And then he started about my punctuation, and I sort of had to find that so as that I wasn't getting a bit more, you know, teasing from him. And in the finish, I got quite confident with doing emails and sending messages. And then later on one of the boys said, "You need to join Facebook, mum." And because everybody was so scattered, the grandkids have grown up a little bit and he – he said, "You know, you will be able to keep in touch with everybody." And so, yes, I learnt how to do much more on my iPad. So I feel pretty confident about it now.

MS HILL: Do you enjoy using the iPhone and the iPad?

MS KERSNOVSKE: Yes. It keeps me in touch.

MS HILL: Is your experience with your phone and your iPad something that you've shared with other people as well?

MS KERSNOVSKE: Yes. I – for some reason some people think I'm a whiz on my iPad and iPhone, and I got asked at a – our local Probus meeting to speak about

my experience on learning my iPad and iPhone and so I just – I – I sort of was a bit bewildered because I'm not the best at public speaking, and I just sort of thought, well, I can only tell it as it is. So I started off with how I started and how the interest kind of got me, you know, all the way through, and I just finished the conversation with virtually saying "If this old lady can do it, so can any of you", because most of the Probus people are retired people my age and maybe some younger, some older. So it was pretty easy to just speak about, you know, what I – how I had done it because it was just how I did it.

MS HILL: Have you ever accessed My Aged Care online?

MS KERSNOVSKE: I've tried. It's almost hopeless. It's – some days they will – you will get a message to say they're not online at the moment, and some days you will get so far and then you can't get any further. And it's – it's just hopeless. So I hang on the phone for, sometimes, you know, an hour waiting for someone to answer.

MS HILL: Do you still use the online service of My Aged Care?

MS KERSNOVSKE: No.

MS HILL: Would you go back to using the online service of My Aged Care?

MS KERSNOVSKE: It would have to be improved a lot.

MS HILL: What would you need - - -

MS KERSNOVSKE: To make it – it's – it's – it needs to be improved a lot to allow older people to be able to access it. It's – My Aged Care is there for older people and a lot of older people don't have the – you know, there's such a lot of them, they might have an iPhone but they don't use it for anything but making calls or they might have, you know, a really efficient phone and – and they only use it for making calls because that's what they need it for. So My Aged Care needs to be – I don't know, something done about making it easier for elderly people to access it.

MS HILL: Do you then prefer to use the telephone when you are contacting My Aged Care?

MS KERSNOVSKE: Yes, I do.

MS HILL: Could you tell the Commissioners about your experience of contacting My Aged Care by the telephone?

MS KERSNOVSKE: Well, usually to contact My Aged Care on the telephone, you're put on hold because everybody's busy, nobody to answer you. And you're just put on hold, be it for 10 minutes, 20 minutes, an hour. It just depends. And you almost get, you know, sick of waiting. And there again, I can understand a lot of

older people not understanding why they can't – why they have to wait so long. Some get confused to say that – they must have disconnected me, you know. It's not just easy.

MS HILL: Have you ever taken this up with My Aged Care when you've been speaking to them?

MS KERSNOVSKE: No.

MS HILL: Are your children eligible for support in their support of you, Mrs Kersnovske?

MS KERSNOVSKE: No, unless my – my children are all boys and unless they're dressing me and showering me and all of that sort of personal stuff, they aren't eligible. As much as the boys do for me, the two that are away, when they're home, they do so much for me, and Lester does such a lot for me as well. But they – he's not – he's not eligible to be my carer because he doesn't live with me, and he needs to be there so many hours a week to make sure, like, he has got to put me to bed and all this sort of thing, that what he – what he does is a great help. But they don't – they don't think that that's worthy of any kind of, you know, him being classed as a carer.

MS HILL: What kind of supports do you think there should be for people like your son who is caring for you?

MS KERSNOVSKE: I just think that he should be, you know, anybody not just him but anybody who's – there's lots of families who are – who are doing lots of stuff for their families, and probably saving a lot of time and money for other people that – that they should be classed as some kind of help and receive some kind of remuneration for it.

MS HILL: You've told the Commissioners about your experience of caring for your late husband. In paragraphs 18 to 27 of your statement, you give evidence that Col was assessed for ACAT when you were in your late 60s.

MS KERSNOVSKE: Yes.

MS HILL: Were you asked at that time whether you would like to be assessed also?

MS KERSNOVSKE: Yes.

MS HILL: And what did you say?

MS KERSNOVSKE: I said "No, no, I'm all right" because I was only in my late 60s and have always led a fairly active life and been able to do everything I wanted.

MS HILL: How do you feel about that decision now, Mrs Kersnovske?

MS KERSNOVSKE: No, it's probably a little bit of regret there because back then, if I had have had some kind of assessment at the time, I could have – I would have been, you know, on the – on the list. I would have had a, you know, an early step in there to – it has just become harder now because back when Col had his assessment, the doctor just gave me the number to ACAT and I rang them, made an appointment. And they came when they could. Sure we probably had to wait a little while but they came. And he was – he was assessed straightaway, you know. And now, because you've got to go through My Aged Care, it seems to me as if there's a lot of personal – like, personal opinions come into whether you should be assessed or not.

I've always had people say to me, "You're much younger than your years", and have always been fairly fit for my age. And, you know, I think when they come in, into my house and sort of see me, I can walk around okay. I can't bend to pick anything up. I have difficulty hanging washing on the line. If I sneeze my back goes into a spasm and, you know, it's okay if I'm standing on my two feet but I shouldn't be assessed on that. I should be more assessed on what the doctor has proved is – is severe aggravation or degeneration in my spine.

MS HILL: When you were caring for your husband to live at home with his dementia, were there supports in place that allowed you to continue to care for Col whilst he was at home?

MS KERSNOVSKE: I probably chose – we had all the care that I felt that we needed at the time. It just became more difficult later on, not, you know, in the years, couple of years before he went into care. He was – he was still able to dress himself and shower and things like that. It was just his general mood and anger that was sometimes a bit hard to – to tolerate.

MS HILL: If I could ask you to turn to paragraph 45 of your statement, Mrs Kersnovske, at paragraph 45 you tell the Commissioners that your husband was allowed to receive about 62 days a year of respite.

MS KERSNOVSKE: Yes.

MS HILL: Was that something that was important to you as a carer of your husband?

MS KERSNOVSKE: Yes, it was.

MS HILL: And why was that?

MS KERSNOVSKE: It was – it was a time where he was being cared for. The doctor had said to me the reason why he was – he wanted him to be in respite, that someone else would be looking after him but he was – the doctor was more concerned in how I was travelling. And he said when Col goes into respite, not to be there every day. Just to visit, you know, when I needed to, and so I used to probably only go maybe two or three times a week. And the rest of the time mostly I would

try and get away to the boys so that I was sort of getting a real break away and didn't have to be sitting thinking about when Col came home again.

MS HILL: Mrs Kersnovske, if I can return to your current situation, how long do you estimate you've been waiting to receive a package now?

MS KERSNOVSKE: Well, since I had the fall back in September.

MS HILL: Have you been given any advice as to when you can expect to receive a package?

MS KERSNOVSKE: Not really. The only – well, no. I have to – I have to have an ACAT assessment before I can have a package. So even though there's All Aged Care – All Aged Care, yes, has said that they can help me domestically in the house, I still haven't had – I still – I'm still not receiving any kind of help in the house.

MS HILL: What do you want, Mrs Kersnovske, from Aged Care Services at home?

MS KERSNOVSKE: Well, I think once you get to a particular age – and this isn't just because of my age – I really think it should be mandatory that an ACAT assessment or an ACAT aged care assessment should be – should be given to, you know, like – at the moment, you can, the doctor will ring up and say, you know, you can have a pneumonia injection and things like that. I think there should be an age where you – it becomes compulsory for people to have an ACAT assessment. They've got in place at the moment, like from when I was 75, a lady came to the house to just make sure that things were going along nicely but that was only once a year.

And – and, sure, that's great, but I think there should be more done in that there should be a greater assessment done of any elderly person when they get to a particular age, be it 75, be it 80; I don't think you should leave it much after that, because I think that's when you start going downhill.

MS HILL: And do you think your experience is different, Mrs Kersnovske, because you live in a regional area?

MS KERSNOVSKE: Yes. It seems to be an area that misses out on lots of stuff. We are so close to the Sunshine Coast, but we are not at the Sunshine Coast. Sorry, and yet – then they talk about the Rockhampton/Bundaberg area, even Maryborough, there's more things. I had to go away from Gympie to have cataracts removed from my eyes because it couldn't be done here in Gympie. So it's – it's Gympie just seems to be a little area that gets missed out. Even the storms; we've been missing out on storms lately.

MS HILL: Is it important to you, Mrs Kersnovske to be able to stay at your own home, to be able to stay at Gympie?

MS KERSNOVSKE: Yes, very important. I have lots of friends there, and it's pretty much, you know, central to – I can – I can get to – well, I haven't tried since my back has been acting up, but I can get to Townsville. My husband was in the railway for 39 years, and I have free travel on the railway in Queensland. And that's where once it used to take, you know, 21 hours to get to Townsville, now they do it in about 14 and a half. So – and that's mostly overnight. So it's not a – a hard job for me to get to Townsville, and I can still drive to Brisbane.

MS HILL: What kind of support do you need, Mrs Kersnovske to be able to stay at home, to be able to stay at Gympie?

MS KERSNOVSKE: At the moment, I need that – that help, just general help around, domestic help, someone to do a bit of gardening, and maintenance would be another thing. But at the moment, Lester is able to do a fair bit of maintenance for me.

MS HILL: So you've been keeping him busy.

MS KERSNOVSKE: Yes.

MS HILL: Have you spoken to Lester about his experience supporting you?

MS KERSNOVSKE: He doesn't – he doesn't mind. He – he's, you know, he's pretty easy going and if he can't do it right now, he will eventually do it. And if he forgets to do it, I remind him. So he can't get out of it.

MS HILL: Mrs Kersnovske, what do you ask the Royal Commission to take away from both your and your husband's experience?

MS KERSNOVSKE: Just – just the realisation – I don't – I'm not the worst off. There are lots of people worse than me but there seems to be an awareness that there's such a lot of people who are struggling to stay in their own homes. You know, it's really difficult to be – to be expecting neighbours and friends – you know, it's – if you're an independent person, it's really hard to accept help from other people who are just friends and relatives, where there could be a better – a better set-up that helps people with – with more help in the home. People – friends and rellies can only do so much. Whereas there has got to be a better set-up that helps people with all their jobs to be able to stay in their homes. And it's a much nicer atmosphere to be in your own home. It must be very devastating for – I know it was for Col, to have to go into care. He didn't understand why he was there. He didn't understand his disease. And there has got to be a lot of other people just like him who need the help to stay in their own homes.

MS HILL: Mrs Kersnovske, that concludes the questions that I have for you. Commissioners.

COMMISSIONER TRACEY: You wish to stay in your own home and you wish to obtain assistance to do that. As I understand your evidence, you've applied for an assessment that, if it is, as you expect the outcome to be, render you eligible for some form of package that will furnish you with that assistance. Is that right?

MS KERSNOVSKE: Yes.

COMMISSIONER TRACEY: And you've made application for the assessment but you haven't been assessed. Is that right?

MS KERSNOVSKE: That's right. I haven't been assessed as an ACAT assessment. I've had a RAS assessment, and I'm not real sure.

COMMISSIONER TRACEY: Has anyone explained to you, in writing or otherwise, why you are not being assessed in the way that is necessary to allow you to access the assistance?

MS KERSNOVSKE: No. No, not at all.

COMMISSIONER TRACEY: When was the last time you had contact with My Aged Care?

MS KERSNOVSKE: Probably about a month ago. They – no. Probably a little bit longer than that, that I had contact directly with My Aged Care when they phoned me to say that the doctor hadn't given them enough information by just asking for a reassessment.

COMMISSIONER TRACEY: And did they say to you that they were going to contact your doctor to explain to him what additional information they needed?

MS KERSNOVSKE: No. No, because I rung my doctor the next day – I spoke to his nurse, and I said that I had been refused an ACAT assessment, and the nurse was going to pass it on to the doctor.

COMMISSIONER TRACEY: Yes, thank you. Ms Kersnovske, we are enormously grateful to you for taking the trouble to leave your home and come into the courthouse and participate in this hearing at long distance. It's very important for us to understand the way the system works in practice in the community and, in your case, in particularly a rural community. And we're most grateful for the insights that you have provided us with. Thank you very much.

MS KERSNOVSKE: That has not been a bother. Just – I've been helped so much by all the girls involved, and they've made me feel very comfortable. Thank you.

COMMISSIONER TRACEY: Well, let's hope we can do something for you.

MS KERSNOVSKE: Thank you.

<THE WITNESS WITHDREW [3.11 pm]

COMMISSIONER TRACEY: The Commission will adjourn temporarily.

ADJOURNED [3.11 pm]

RESUMED [3.20 pm]

<LISA JANE STUDDERT, ON FORMER AFFIRMATION [3.20 pm]

<ANTHONY DAVID SPEED, ON FORMER AFFIRMATION [3.20 pm]

DR McEVOY: Commissioner, just before lunch, Mr Speed had walked the Commission through the document which has just appeared on the screen, CTH.1000.1015.0227. That document is called the National Aged Care Compliance Program Decision-Making Procedure. I will tender that document.

COMMISSIONER TRACEY: Yes. The National Aged Care Compliance Program Decision-Making Procedure will be Exhibit 2-81.

EXHIBIT #2-81 NATIONAL AGED CARE COMPLIANCE PROGRAM DECISION-MAKING PROCEDURE (CTH.1000.1015.0227)

DR McEVOY: Operator, could you please bring up CTH.1000.1019.3267. Now, Mr Speed, this is a document that you've provided the Commission. You are familiar with that document.

MR SPEED: Yes, I am.

DR McEVOY: I think in the interests of time, I won't ask you to walk us through it. We will navigate that for ourselves but Commissioner, I seek to tender that document also.

COMMISSIONER TRACEY: Yes, the National Aged Care Compliance Program Procedure for Imposition of Sanctions, Immediate and Severe Risk will be Exhibit 2-82.

EXHIBIT #2-82 NATIONAL AGED CARE COMPLIANCE PROGRAM PROCEDURE FOR IMPOSITION OF SANCTIONS, IMMEDIATE AND SEVERE RISK (CTH.1000.1019.3267)

DR McEVOY: I think, Mr Speed, before you gave us the benefit of the description of the decision-making procedure chart, we were talking about what constituted an immediate and severe risk – this may have been a question I put to you, Dr Studdert – and who made that decision. Of course, the department can take other actions as well. How does the department distinguish between a provider being given time to improve on the one hand, as against taking immediate regulatory action?

DR STUDDERT: Well, that goes primarily to the determination is made around the risk to clients and their daily needs as would be expected to be provided by that provider. As you know, there are a range of outcomes are expected and some of those goes to business processes and administration of the home care package, and the services that we would suggest – or we would expect are necessary to deliver that in an efficient way with appropriate transparency to the client and to the Commonwealth, for that matter. And others around rights and responsibility of both the provider and the client. But in the centre of all of that is the service delivery to the client which goes to, in many cases, clinical care and assurance that the client is safe and well cared for in their home. And where that is not something that the Department can be confident of, then we would determine there is quite likely an immediate and severe risk.

COMMISSIONER TRACEY: Dr Studdert, can you explain this to me. We have heard lots of evidence of people who have been assessed and found in need of a certain level of care, and for 12 months they don't get anything. Then they get a lower level of care. We've heard from carers who say, "We need to give these people a lot more care than we are accredited to give them. We want to spend more time with them but they're on level 2. They've been assessed at level 4. They are not getting level 4. We can't give them the care that they require." Now, on your analysis, the person concerned is not getting adequate care. How can that be visited on the provider?

DR STUDDERT: Well, I guess at the point where the client has been assigned a package, the system is now in place to assure that they are getting care based on an expert care.

COMMISSIONER TRACEY: But not adequate care, and not what they're assessed to receive.

DR STUDDERT: There are other additional services through the Commonwealth Home Support Program that there are processes in place to also deliver to the client.

COMMISSIONER TRACEY: But not by the same care provider. We're talking about assessment of care provided by an individual provider. And they're not giving

them care to the people that they're supposed to be caring for to an adequate level, through no fault of theirs.

DR STUDDERT: I would have to accept that premise, yes.

COMMISSIONER TRACEY: That's the real world, isn't it?

DR STUDDERT: It is.

DR McEVOY: Dr Studdert, you've heard, I assume, the evidence of Ms Rita Kersnovske who has just given evidence to the Commission.

DR STUDDERT: Yes.

DR McEVOY: Were you aware of her particular situation?

DR STUDDERT: No, I wasn't until today.

DR McEVOY: And I don't imagine that in the last 15 minutes you've caused to have anything done about that.

DR STUDDERT: No, but I have indicated to my staff that I would like to do that following - - -

DR McEVOY: Yes, I was going to ask you whether you had an intention to do that.

DR STUDDERT: Yes.

DR McEVOY: Well, just going back to my earlier question and – well, my earlier question which was how you distinguish between a provider being given time to improve versus taking regulatory action in the nature of sanctions, and I think the essence of your answer was, really, that you would look carefully at whether the recipient was actually at risk and, if that was the position, then that would tend to suggest that you would move to sanctions.

DR STUDDERT: Correct.

DR McEVOY: Yes, okay.

DR STUDDERT: Because if I can just explain - - -

DR McEVOY: Yes, of course.

DR STUDDERT: - - - the sanctions give us two mechanisms. They give us the ability to work with the – well, to ask the provider to engage an adviser that will assist them in delivering that care which has been found to be lacking, or we're not assured of. And, secondly, it enables us to determine that the provider should not

take on any more clients until we are assured that they're in a position to provide appropriate care.

DR McEVOY: Well, just on the subject, then, of advisers and administrators, as you say, you are able to require the appointment of advisers or administrators. What's the difference between an adviser on the one hand, and an administrator on the other?

DR STUDDERT: Well, it goes to the management of the business, and then the clinical care that is – that is – and quality of care in the – in the home that is expected. Now, sometimes that can be one and the same person. In other cases, it would be two people and that would depend on the business offering from the adviser.

DR McEVOY: So which is which?

DR STUDDERT: Sorry, if I can just say, we don't require it; it's asked of the provider if they want to avoid the revocation of their provider status whilst – and work towards improving.

DR McEVOY: So would it be right to say that an adviser is in the nature of a clinical adviser and an administrator is in the nature of a regulatory business compliance - - -

DR STUDDERT: Correct, yes.

DR McEVOY: - - - administrator.

DR STUDDERT: Yes.

DR McEVOY: Now, who pays for the adviser or the administrator, if that's a regulatory road that - - -

DR STUDDERT: The provider.

DR McEVOY: Yes.

DR STUDDERT: It's a business relationship between the provider and the - - -

DR McEVOY: And is there any regulation on advisers or administrators?

DR STUDDERT: There is not.

DR McEVOY: Is that an area for consideration, would you say?

DR STUDDERT: I think that it could be argued that it is. But I think that it would be something that we would be inclined to take a broad range of opinions on from –

from a range of providers and business administrators and advocates. There has been more oversight of that in the past but the advice and feedback at the time was that the providers wanted more flexibility in how they engage with that – that sort of business service. And that has been – so that's where we sit today.

DR McEVOY: So my question was whether there's any regulation of advisers and whether that was an area for consideration, and I think what you said was it could be argued that that would be an area for consideration. What is it that makes you say that that could be argued?

DR STUDDERT: Well, I think that the Commission has heard examples of a wide-ranging set of circumstances that providers find themselves in when they're engaging with advisers, and that – you know, that's a marketplace that they enter into, I would suggest, often with advice from some of the peak organisations that have a broader view of – of the business and the marketplace in that space. And, you know, you would expect and hope that the market would work in that way and that reputation would lead providers to good advisers, and – and not to others. And – and that's – that's the way we've sort of assumed that it would operate, but I guess in any case where that proves to be not the case, there may be cause to look at it again.

DR McEVOY: So who chooses the adviser or the administer?

DR STUDDERT: The provider makes that - - -

DR McEVOY: With the suggestion from the Department?

DR STUDDERT: I – I couldn't speak to that; I don't know.

MR SPEED: I can speak to that. No, the Department doesn't engage on suggestions. The requirements for appointment of an adviser under the Act are specified in terms of the provider can't appoint someone who is a disqualified individual under the Act. There must be no conflict of interest with that individual. And they are the requirements that are specified in the Act.

DR STUDDERT: I think it's something the Department would be very cautious and averse to doing because it is a business relationship between the provider and that – that service.

DR McEVOY: So who does the adviser or the administer owe the duty to?

DR STUDDERT: The provider.

DR McEVOY: Have you seen, Dr Studdert, the evidence of BC that was given yesterday morning?

DR STUDDERT: Yes, I have.

DR McEVOY: Operator, can I ask you to bring up CTH.1002.1008.0729. Now, I think this is about three or four pages. Perhaps if we can go to the end – is it three pages? So you will have to bear with us, Dr Studdert. This is an exchange of emails between BC and her administrator. You might recall this from the evidence of BC. The administrator is there, you will see at about point 5 of the page on the left of the screen. So there's an exchange of emails between them in relation to an aspect of the administration. And operator, if you go back to the first page of the final email in the chain. So what has happened is that the exchange between the provider and the administrator, which was in relation to criminal checks, I think, that has simply been forwarded for the information of an officer of the Department. Does that sound to you to be consistent with the administrator owing a duty to the provider?

DR STUDDERT: So my understanding, having talked to the delegate involved in this process in the Department, is that this was a period of quite intense communication, three-way communication between BC, the adviser and the Department. And there were a range of conversations, meetings and emails in this period. So the circumstances under which that was forwarded, I couldn't comment on. It may have been done after a conversation involving all of them. It may – I just – I don't think it's appropriate to say – assume how that has come about and whether that indicates any questioning of that relationship.

DR McEVOY: Well, my earlier question to you was to whom does the adviser or the administrator owe the duty, and you said to the provider. And what we see here in this email is, effectively, unilaterally the administrator is providing details of communications between himself and the provider to the Department. Would you accept that?

DR STUDDERT: Well, I – I wouldn't accept unilaterally because I don't think that would necessarily – I mean, they could have had a conversation that day that agreed that that was going to be forwarded to the Department. I – I don't – I don't know the specifics of that set of interactions. Obviously, the Department was quite concerned, as you would expect, to ensure that staff had criminal history checks, which would have been an expectation from the outset. So there was obviously some intense effort under way to remedy that situation.

DR McEVOY: Do you recall, Dr Studdert, BC giving evidence yesterday that she did not authorise this email chain to be forwarded to the Department?

DR STUDDERT: So I wasn't in the room. I didn't see the documents as they were being reviewed in that proceeding. I do recall that exchange, as I heard it. So I wasn't aware that that was - - -

DR McEVOY: So her position is that she didn't authorise that email chain to be sent. In those circumstances, would you regard that as appropriate?

DR STUDDERT: I – I would have to – I guess it was – it was not but I think there are a lot of circumstances in that case that were concerning. And there was obviously an intense effort to get this provider back to compliance.

DR McEVOY: So when you say there were a lot of circumstances in that case that were concerning, you mean on the part of the provider; is that what you say when you say - - -

DR STUDDERT: Well, I think the large number of un-mets that we were dealing with. We – as a joined-up process with a large number of clients, relatively speaking, meant that there was a lot of effort underway to remedy that situation as quickly as possible.

DR McEVOY: That was a pretty serious situation.

DR STUDDERT: By our reckoning, absolutely. Yes.

DR McEVOY: Operator, could you bring up CTH.1002.1007.2482. This, Commissioners, is Exhibit 2-48. Now, you presumably, are not familiar with this document, Dr Studdert.

DR STUDDERT: No.

DR McEVOY: Perhaps I might ask you to just read that first page. So the position according to BC is that she was not copied into this confidential update that her administrator provided to the Department. Does that strike you as appropriate or inappropriate?

DR STUDDERT: Look, I think I can accept on the face of it it is inappropriate but I would return to the comments I made earlier, that this was a fairly extraordinary situation. As identified there, they were several weeks into this process and they still were struggling to determine who all the clients were and what their care needs were. And I guess judgments were made about the necessary steps that needed to be taken to – to continue to try to address the situation.

DR McEVOY: When you say it was "extraordinary", I take you to be saying, by the use of that word, that it was the Department's view that this was at the extreme end.

DR STUDDERT: Yes.

DR McEVOY: Are you aware of the fees that administrators and advisers charge?

DR STUDDERT: I wasn't aware until I read BCs statement, which did contain numbers.

DR McEVOY: And would it be the position that their fees are not regulated or monitored in any way by the Department?

DR STUDDERT: That's correct.

DR McEVOY: Do you know for how long a provider typically needs to engage an administrator or an adviser.

DR STUDDERT: The expectation is they are engaged until the sanctions is lifted, or alternatively, the provider exits the system.

DR McEVOY: What if the provider is not in a position to pay the fees charged by an administrator or an adviser?

DR STUDDERT: Well, again, that's a fairly extraordinary situation, and as – I'm only aware of one case where that has happened under extenuating circumstances.

DR McEVOY: And what happened in that case?

DR STUDDERT: In that case the Department did step in to pay the fees.

DR McEVOY: Do you know how much the department paid?

DR STUDDERT: I think someone mentioned a few thousand dollars.

MR SPEED: About $5600 or thereabouts.

DR STUDDERT: So what the department has been working on is more, I guess, more intelligent use – more intelligent use of data and available information to enable us and the Commission to – to more readily and efficiently identify risk where it exists in – in the home care provision space. With 800-plus providers now and that number expected to continue to grow, as in any regulated system, you look for more efficient and effective ways to monitor and enforce the regulatory framework. So, as you would be aware, this is – this is a relatively new part of, in terms of consumer directed care and home care packages of the aged care system, and so we are continuing to work with good evidence and wise counsel on how we can better regulate going forward.

DR McEVOY: But what is the nature of the pilot risk profiling and information analysis approach that was being trialled?

DR STUDDERT: Can Mr - - -

MR SPEED: I can talk to that. In addition to the measures outlined by Dr Studdert, there was a small pilot project that was run out of the Aged Care Compliance Branch where we voluntarily engaged with a very small sample of home care providers and we sought to identify through that engagement the issues that they experienced in managing compliance with the Home Care Standards.

DR McEVOY: So, what, you met with, or consultants met with a group of providers to talk to them about things?

MR SPEED: There was primarily a desk-based exercise with engagement with providers on a one-to-one basis.

DR McEVOY: I'm sorry, what does desk-based mean in this context?

MR SPEED: Assessment of information by officers of the department.

DR McEVOY: Without actually speaking to a provider?

MR SPEED: In addition to speaking to providers on a one-to-one basis.

DR McEVOY: So the department does have concerns, does it, that new entrants, new providers are not properly equipped to comply with the standards?

DR STUDDERT: I don't think it's a concern in terms of there's – there's anything particularly acute at the moment but I just – as in any regulated system, there will be problems. There will be providers that aren't either initially capable or – or – or fall over or have troubles along the way. As I said, there's 870-plus now and that's growing all the time, as it should, because we do need to grow the supply for the growth in this system over – over the future years. And I think it's just inevitable there will be problems, hopefully contained into a small number and readily and quickly detected.

DR McEVOY: We might go then, Dr Studdert, to what you've referred to as the extraordinary case of BC, the evidence of whom we heard yesterday. Now, you've provided us with a chronology of events in relation to each of the providers, the subject of NTP-0016. I won't have that chronology brought up, Commissioners, because I think there are still some redactions being made to it. But I would tender the document. It's CTH.1000.0002.6095, and it's the Department's chronology of events for each provider the subject of NTP-0016.

COMMISSIONER TRACEY: Yes, the chronology of relevant events relating to BC and BD Proprietary Limited will be Exhibit 2-83.

EXHIBIT #2-83 CHRONOLOGY OF RELEVANT EVENTS RELATING TO BC AND BD PROPRIETARY LIMITED (CTH.1000.0002.6095)

DR McEVOY: Now, the underlying facts here, Dr Studdert, are set out, you would be aware, in the chronology.

DR STUDDERT: Yes.

DR McEVOY: And I think you would also be familiar with them because we were informed of them yesterday by the person in question, and documents were tendered. But in broad terms, you might recall that on about 31 October last year the former regulator, the Australian Aged Care Quality Agency, the agency, I will call it, did an assessment conduct on BCs business. You accept that.

DR STUDDERT: Yes.

DR McEVOY: Now, about a week later, on 7 November, by email the agency provided an assessment contact report to the Department reporting that the company didn't meet about nine assessed outcomes of the Home Care Standards.

DR STUDDERT: Yes.

DR McEVOY: Now, that report was provided under cover of an email which is – and I will get you to bring this up operator, it's CTH.1002.1001.3860. This email, Commissioners, was not tendered yesterday but I would seek to tender it now, if that's convenient.

COMMISSIONER TRACEY: Yes. The email exchange between BD Proprietary Limited and the Quality Agency dated 7 November 2018 will be Exhibit 2-84.

EXHIBIT #2-84 EMAIL EXCHANGE BETWEEN THE QUALITY AGENCY AND THE DEPARTMENT OF HEALTH DATED 07/11/2018 (CTH.1002.1001.3860)

DR McEVOY: I'm sorry, Commissioner, the emails are between the Quality Agency and the Health Department.

COMMISSIONER TRACEY: Why is it headed BD – it concerns BD?

DR McEVOY: Yes.

COMMISSIONER TRACEY: Yes, I see.

DR McEVOY: Yes, in relation to BD.

COMMISSIONER TRACEY: Who are the parties to this, the Quality Agency and?

DR McEVOY: The Quality Agency and the Department.

COMMISSIONER TRACEY: Very well. Well, I will recast the description of the exhibit in those terms.

DR McEVOY: Thank you, Commissioner. Now, Dr Studdert, can I ask you to look at the date of the email. You will see it's Wednesday, 7 November at 3.34. Do you see that?

DR STUDDERT: Yes. Sorry.

DR McEVOY: So what the email is saying is that we conducted an assessment and an early release of the assessment contact report is attached. Now, operator, could

you please bring up a document CTH.1002.1001.3863. Commissioners, this has been tendered. Are you familiar with this document, Dr Studdert?

DR STUDDERT: Yes.

DR McEVOY: Yes. So this is the document that you – or perhaps one of the documents, is it, that you had in mind when you referred to the extraordinary nature - - -

DR STUDDERT: Yes.

DR McEVOY: - - - of this provider.

DR STUDDERT: Yes.

DR McEVOY: Now, you are aware that the relevant standards with which there was not compliance, were 1.2, 1.3, 1.5, 1.8, 2.1, 2.2, 2.3, 2.4 and 2.5?

DR STUDDERT: Yes.

DR McEVOY: Now, they might fairly be described as governance issues; would that – would you agree with that?

DR STUDDERT: Yes, correct.

DR McEVOY: Now - - -

DR STUDDERT: Sorry, 2.2 and 2.3 do relate to care.

DR McEVOY: Yes, do you want to just tell me what you mean by that?

DR STUDDERT: So the three groupings, as you mentioned are 1. – the ones relate to the administration and management of the business. The 2s are generally around care outcomes, and 3s are the rights and responsibilities.

DR McEVOY: What were the particular care outcomes in issue here?

DR STUDDERT: I would have to go to the report where they would be itemised, 2.1, 2.2, 2.3.

DR McEVOY: Yes, I'm happy. I'm content for you to do that.

DR STUDDERT: Okay. They would have them in separately described and – so 2.1:

Service access not met.

DR McEVOY: And what's the care issue that is the subject of that difficulty?

DR STUDDERT: Well, it relates to systems that document and support the premise that the care that is necessary for the clients is being delivered.

DR McEVOY: So it's a systems issue on its terms?

DR STUDDERT: Well, in the absence of that, one could not be assured that the care is being delivered.

DR McEVOY: Are you aware of whether there was any contact with particular care recipients in this case?

DR STUDDERT: I would go to page 3 of that report where it documents that there were five care recipients with whom contact was made.

DR McEVOY: And concerns expressed about the nature of the care being received?

DR STUDDERT: Well, I – I mean, I'm taking the report as it presents.

DR McEVOY: Yes.

DR STUDDERT: And I would assume that the data that were collected through the assessment contact, through that – those interviews and document sampling are what the assessor to determine that that outcome was not met; which particular bit of data, I'm not familiar with.

DR McEVOY: Okay. Operator, could you bring up CTH.1002.1007.1974. Are you familiar with this email, Dr Studdert?

DR STUDDERT: I am.

DR McEVOY: I believe, Commissioner, that this was not tendered, so I would seek - - -

COMMISSIONER TRACEY: I think that's right.

DR McEVOY: So I would seek to tender that document.

COMMISSIONER TRACEY: Well, there appear to be a series of emails in the chain, not a single one; is that right?

DR McEVOY: I think two, Commissioner.

COMMISSIONER TRACEY: Well, I've only got one page in front of me but even on that page there seemed to be two and there seems to be one at the bottom of the page - - -

DR McEVOY: Perhaps there are three. I'm sorry, Commissioner.

COMMISSIONER TRACEY: Anyway, these are exchanges between whom; an officer of the Department and an officer of the compliance organisation?

DR McEVOY: That's so, Commissioner. Yes.

COMMISSIONER TRACEY: Yes. All right. Well, the email exchange dated 7 November 2018 between an officer of the Department and an officer of the compliance organisation will be Exhibit 2-85.

EXHIBIT #2-85 THE EMAIL EXCHANGE BETWEEN AN OFFICER OF THE DEPARTMENT AND AN OFFICER OF THE COMPLIANCE ORGANISATION DATED 07/11/2018 (CTH.1002.1007.1974)

DR McEVOY: Thank you, Commissioner. My learned friend, Mr Free, points out that there are perhaps still some redactions that could be made. It may be necessary, in those circumstances, to issue a non-publication direction in relation to that email until that is done.

COMMISSIONER TRACEY: Well, I don't think it's appropriate to redact the whole email.

DR McEVOY: That was the view, I should say, Commissioners, that we took insofar as there were names in there of senior departmental officers - - -

COMMISSIONER TRACEY: All right. Well, insofar as individual names appear in those emails, there will be an non-publication order, and the documents will, in due course, be subject to redaction to remove those names.

DR McEVOY: Thank you, Commissioner. Operator, could you bring that document back up again.

So you will see there at the bottom of the page, Dr Studdert, on 7 November at 4.30, so in other words that's less than an hour after the earlier email I took you to, has been received, an officer of the Department indicates to, I think, a more senior officer of the Department, that they've just had an early release of the report in relation to BD Proprietary Limited, nine outcomes assessed in standards 1 and 2 were non-compliant; likely sanctioning. So within less than an hour, there's a view been taken that there's likely to be a sanction that has been sent up, and then in the top email, that's an indication that a heads-up is being given. That's the first line. And as you go down to paragraph 4:

> *The Quality Agency has since also visited BD Proprietary Limited and conducted an assessment contact assessing nine outcomes of the 18 and found them non-compliant with all nine.*

And then it says there in the next paragraph:

Intend to issue a sanction tomorrow.

It might reasonably be inferred, might it not, that there has been, in the space of that hour or so, a decision to impose the sanction without reading the report. Would that be fair?

DR STUDDERT: Well, I – I couldn't – couldn't suggest – and Anthony may be able to add to it – but I think nine out of nine un-mets, as I said earlier, is a fairly extraordinary situation, particularly when a good number of those relate to clinical care. So I think that headline alone would lead us to – would readily lead the Department to be very concerned about the situation.

DR McEVOY: So, operator, request you could bring up Exhibit 2-45, which is CTH.4000.1003.2096 – I'm sorry, I've given you the wrong number. If you could bring up CTH.1002.1002.0055.

So this, Dr Studdert, you would be – would I be right to say you are familiar with this document?

DR STUDDERT: Yes.

DR McEVOY: So this is the sanctions decision. It's dated 8 November, in which the Department notifies the provider that sanctions are imposed. So this is one of those straight to sanctions decisions - - -

DR STUDDERT: Yes.

DR McEVOY: - - - on the basis of an immediate and severe risk to the health – to the safety, health and wellbeing of care recipients.

DR STUDDERT: Yes, that's correct.

DR McEVOY: And if you go, operator, to page 0056, the sanctions are there set out:

(1) restrict payment;
(2) revoke approval.

Over the page:

(3) revoke approval, appoint administrator;
(4) revoke approval as an approved provider training.

If you could then go over to part B which is at 0059 in – I'm sorry, part C, rather, in the second half of the page, immediate and severe risk.

DR STUDDERT: Yes.

DR McEVOY:

There's an immediate and severe risk to the safety, health or wellbeing of care recipients, satisfied that there's an immediate and severe risk.

And then you go down to the last paragraph:

...extensive failures against the Home Care Standards are interrelated. Failure to meet individual outcomes. Apparent complete lack of understanding of your responsibilities as an approved provider under the Act, seriously undermines your ability to properly provide for care, recipients' health, safety and wellbeing, consequently recipients are placed at immediate and severe risk.

DR STUDDERT: Yes.

DR McEVOY: And then you go over the page, the next page, 0060, and you see there those dot points. Let's just go through all of those dot points:

You don't have a system in place to ensure compliance with aged care funded program guidelines.

So there's some problem there with ensuring compliance with the guidelines. Second dot point:

You don't have an understanding of the responsibilities of approved providers of home care under the Act.

Third dot point:

You can't demonstrate that each service user participates in assessment appropriate to the complexity of their needs.

So it's not being said that you don't do it; you just can't demonstrate that you don't do it.

You are not able to demonstrate that each service user and their representative has a care service plan. Not able to demonstrate that each service user's needs are monitored and regularly reassessed. Not able to demonstrate that you refer service users to other providers as appropriate. Five care recipients interviewed are not aware of the services they should be receiving.

Now, there's nothing in there that in terms deals with problems with clinical care, is there?

DR STUDDERT: Well, not directly but, as I said earlier, I think our view is that the care plan and the assessment of care needs is a – is a necessary document and

process that would lead the assessor to determine appropriate care – to assure themselves that appropriate care was being provided. And short of going to each care recipient, on an ongoing and regular basis, that is the documentation we expect providers to have available to provide that assurance. And to – to – indicate that they are running an orderly system by which they can manage a range of individuals in a range of settings with presumably a range of different care needs.

DR McEVOY: But this is – these concerns to use your language; to use your language, are concerns about whether an orderly system is being run, aren't they?

DR STUDDERT: A well-documented evidence-based system, yes.

DR McEVOY: And because there isn't a well-documented evidence-based system, you embrace the finding at the bottom of page 0059 that care recipients are placed at immediate and severe risk. Is that the position?

DR STUDDERT: Well, I would – yes, because in the absence of anything to suggest otherwise, we would err on the side of caution to put in place a process that would lead us to be in a better position to assure ourselves of that.

COMMISSIONER TRACEY: But that's not what it says, Dr Studdert.

Consequently, care recipients are placed at immediate and severe risk.

That's a non sequitur.

DR STUDDERT: I can agree with you on the grammar. I think it would be more appropriate that it said "are determined to be at immediate and serious risk", and that is how that is.

COMMISSIONER TRACEY: All it's based on is the proposition that the deficiencies that are identified seriously undermine the provider's ability to properly provide care, not that it isn't providing the care.

DR STUDDERT: Well, that may be the case but - - -

COMMISSIONER TRACEY: And if that's right - - -

DR STUDDERT: - - - we don't have a way of determining that.

COMMISSIONER TRACEY: If that's right, the final sentence simply is not supported.

DR STUDDERT: Well, I – I think that, as I said, in the absence of anything to advise us otherwise, the default position is to put in place a process that would lead us to determine that that was not the case.

COMMISSIONER TRACEY: Well, that may all be right but it doesn't justify the final sentence upon which all else hangs.

DR STUDDERT: Well, I think the system is there to provide the assurance that care recipients are getting the care they need, and that the documentation and the systems that the provider has in place assure that both to themselves as a provider, and to us as the regulator.

COMMISSIONER TRACEY: All that may well be right but it doesn't answer the point that I put to you; that there is no evidence in this report or any findings made in this report that support that final sentence.

DR STUDDERT: Well, I think there's a range of documentation here around care recipients' files that don't contain the specifics of service delivery, that the provider wasn't able to demonstrate that assisted care recipients have a care plan, and I guess our position, and this would – I would suggest be based on many years of experience in – in – in assessing risk around aged care, that the absence of that would give great cause for concern.

COMMISSIONER TRACEY: It may well, but it doesn't warrant that final sentence. Yes, Dr McEvoy.

DR McEVOY: Just on the subject then, Dr Studdert, of many years of experience being deployed in the assessment of this situation, you might recall before lunch I asked you about whether it was ever the case that the former Agency, now the Commission, and the Department are likely to be in disagreement or apart in relation to particular matters. And I think your answer in substance was that you thought that was quite unlikely.

DR STUDDERT: Yes.

DR McEVOY: You agree with that?

DR STUDDERT: Yes.

DR McEVOY: Yes. Operator, can you bring up CTH.4000.1003.2096.

Now, are you familiar with this document, Dr Studdert? I imagine you are.

DR STUDDERT: Yes.

DR McEVOY: This is the assessment contact advice provided by the former Aged Care Quality Agency in relation to BD Proprietary Limited, and it lists there, you will see on the first page, the various problems that we've already traversed. And if you go to page 2, operator, you will see there that heading 'Improvements'. This is what the agency thinks needs to happen:

There needs to be a revised plan for continuous improvement submitted by 30 November showing how the Home Care Standards will be met. They're improvements which must be made in order to meet the Home Care Standards. The timetable to do that ends on 31 January this year. If at the end of the timetable the service doesn't meet the home care standards, we will advise the Department of Health.

So there's no serious risk report issued or required to be issued, it would seem, if you ask the agency. Am I wrong about that?

DR STUDDERT: Well, this report was referred to the Department in short order, and I believe that was done with an accompanying severe risk report but I'm just reviewing the – just to note the system is such that these improvements are what is – the tools that are available to – were available to the Agency, now the Commission, in terms of their engagement with the provider. And then their obligation is to refer it to the Department, for the Department in its role and its assessment of what the information tell us as to what this – what this means and the more fulsome report has a lot more detail, of course, around the un-met – what underlies each of those un-mets and that that is where the determination around serious and immediate risk is made. So this is completely consistent with what the levers are that the Commission has versus those that the Department has.

DR McEVOY: But the reaction of the Agency, you would accept, is rather different to the reaction of the Department, wouldn't you?

DR STUDDERT: Well, this isn't the only reaction of the Agency, though. The other action that they took was to refer that in a short timespan to the Department, reflecting their level of concern.

DR McEVOY: They did, yes, and the department did what it did, and I've taken you to that, and you've fully embraced that. But isn't it the case that the agency has taken a rather less extreme view?

DR STUDDERT: Well, as I said, these are the levers that the agency has in terms of how it engages with the provider. And it's a two-part system.

DR McEVOY: I don't really understand, Dr Studdert, why you won't embrace the proposition that there is a clear and obvious difference between the Agency's approach and the Department's approach.

DR STUDDERT: Well, I guess I'm not sure what you're suggesting the Agency would have done had - - -

DR McEVOY: I'm not suggesting anything. I'm just suggesting – I'm not suggesting anything in that respect, I'm simply observing that the Agency says one thing and the Department says another. Isn't that a fair reading of - - -

DR STUDDERT: But the Agency has said that you've not met eight out of eight outcomes and our engagement will be to tell you how our expectations of what your program to improvement is – timetable for improvement is. And, at the same time, whilst not documented here, they will be referring that to the Department where there is – it is the Department's role to make that assessment as to what that means around risk to the care recipients.

DR McEVOY: But the Agency hasn't found that there's a serious risk.

DR STUDDERT: That's not their role to do so.

DR McEVOY: They haven't said anything that would indicate that there is anything like that order of concern.

DR STUDDERT: Well, I guess our – it may not be there in the words but eight out of eight un-mets is a serious issue.

DR McEVOY: Why do you say it's not their role to say anything on the subject of whether there's a serious risk?

DR STUDDERT: That's the role of the – in the system, that is the role of the Department, to make that determination.

DR McEVOY: I'm getting the sense that Mr Speed is wanting to say something.

MR SPEED: The delegate within the Department will consider the advice that comes to them to make a decision about non-compliance including a sanction decision. The delegate will use the initial risk assessment and the detailed risk assessment template that we viewed earlier to arrive at their decision, and in arriving at their decision they will consider the information that is provided to them by the Quality Agency, and a range of factors.

DR McEVOY: So it's the position of both of you, is it, that there's no asymmetry between what the Agency has had to say and what the Department has had to say?

DR STUDDERT: No.

MR SPEED: No.

DR McEVOY: There is no asymmetry.

DR STUDDERT: No.

MR SPEED: No.

DR STUDDERT: Inasmuch as each part of the system is playing its role and doing it – it was in the prescribed processes and guidelines that they are there to play.

DR McEVOY: And you remain of the view that this is an extraordinary case?

DR STUDDERT: That is correct, yes, because if I may, these clients were already – had already been, for the most part, been with one provider that had been sanctioned. They transitioned to another provider and now we found ourselves in the same position without – still without documented care plans that gave us, as the Department, any confidence that they were getting the care they received. So it was an extraordinary circumstance.

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

COMMISSIONER TRACEY: Could we leave that document on the screen, please. I think this is probably one for you, Mr Speed, but you've read this document?

MR SPEED: Yes, I have.

COMMISSIONER TRACEY: Do you regard that as an adequate notice to somebody who was found to be non-compliant?

MR SPEED: It is an advice to the Department, and it was provided in relation to a range of information that was released to the Department by the Commission.

COMMISSIONER TRACEY: You didn't answer my question.

MR SPEED: Could you repeat your question, sorry.

COMMISSIONER TRACEY: Do you regard this as an adequate notice to somebody who has found to be non-compliant?

MR SPEED: I regard it as an early release piece of information, adequate notice yes.

COMMISSIONER TRACEY: That is the second time you haven't answered my question.

MR SPEED: On the face of it, on the information that is contained in it, it would seem to be no.

COMMISSIONER TRACEY: Well, you see, improvements are required as a result of deficiencies. None of the deficiencies are particularised. All that has happened is a series of quotes from the manual. There is no indication to the provider as to how the company has fallen short of those standards. And yet their replacement - - -

DR STUDDERT: If I could - - -

COMMISSIONER TRACEY: I beg your pardon, rectification is being required of them.

DR STUDDERT: If I could, Commissioner, as Mr Speed just said, this is just one of the documents that is provided.

COMMISSIONER TRACEY: Well, what else did the provider get?

DR STUDDERT: And this - - -

COMMISSIONER TRACEY: At this time?

DR STUDDERT: So this document was actually provided to the Department. It was not - - -

COMMISSIONER TRACEY: Not to – well, I'm sorry, I don't understand how – why would a document that talks about improvements addressed to BD Proprietary Limited be a document that was sent instead to the Department?

DR McEVOY: Commissioner, before the witness answers that question, can I just indicate to you for your information that that was – that document we're talking about was sent to BC on 19 November 2018.

DR STUDDERT: But earlier to the Department.

DR McEVOY: Yes.

DR STUDDERT: And it was accompanied by, if I could, the home care assessment contact report which is the 19-page document which has the more fulsome description of how each of those un-mets were determined.

COMMISSIONER TRACEY: What 19-page document are you referring to?

DR McEVOY: Are you referring to the assessment contact report, Dr Studdert?

DR STUDDERT: Yes.

DR McEVOY: Operator, that's CTH.1002.1001.3863. That is the document you want, Dr Studdert?

DR STUDDERT: Yes.

COMMISSIONER TRACEY: Yes, and that document was sent together with the other one; is that right? To BD Proprietary Limited?

MR SPEED: If I may, the advice is sent to the Department and the contact report would have been sent to the – BD, as well as the Department.

COMMISSIONER TRACEY: So I'm just trying to put myself in the position of the provider who is dealing with the Agency and the Department at the same time. And there are allegations being made that the relevant standards have not been met in

particular ways. And that they must, according to the Agency, be rectified and there's a time limit for that rectification process that has been given. And in order for that to occur, the person must understand precisely what deficiencies there have been that have led to this position so that the rectification can take place. Now, the opening words of the previous document that we were looking at say "The assessment contact report" which is this other document:

> *...provides details of the assessment team's assessment during the assessment contact.*

So we then go to this other document which I assume is then also sent to the provider; is that right?

MR SPEED: I believe so, yes.

COMMISSIONER TRACEY: Yes. Is there anything in this contact report that suggests in any way, any deficiency in the provision of clinical services to any of the people for whom services are being provided?

DR STUDDERT: Commissioner, there is a lot of detail in this report and I – I think as a – I would say to answer your question, I would say yes.

COMMISSIONER TRACEY: You would say yes. Well, I've read it and I can't see anything. So I would be grateful if you would point out to me, please, anything in it that directly suggests that there are any deficiencies in it. Clinical services, I can see there's a complaint about a light bulb that hasn't been removed or replaced. That's not what I'm talking about.

DR STUDDERT: Well, Commissioner, I mean, as I've said earlier, I think the itemisation of the care recipients with blank care plans, and these were recipients that had been, in some cases, are quite high needs, level 4, and had been in care with either the previous provider and this provider for some months, was, as I've said, a cause for concern.

COMMISSIONER TRACEY: Well, it may well be, but would you agree with me that it is perfectly consistent with a failure to do the paperwork for high level care to be actually being provided?

DR STUDDERT: If there's no paperwork that actually says what care each care – each individual needs - - -

COMMISSIONER TRACEY: You're not answering my question.

DR STUDDERT: I accept that there's nothing here that says care is not being provided.

COMMISSIONER TRACEY: Well, no. The question was, conceptually there is nothing inconsistent with a failure to document a care plan and the actual provision of high quality care.

DR STUDDERT: I – I – I guess – I – I find it hard to accept that you could be – that there could be care being provided consistent with the client's needs and assessed needs to the level that would be expected if there's no documentation.

COMMISSIONER TRACEY: Well, that's just an assumption. That's not an answer to my question.

DR STUDDERT: Okay, I accept that's an assumption. I think in the case of the assessors, that would be one that's made on some basis of experience and engagement with a range of providers and clients over some, many years.

COMMISSIONER BRIGGS: If I might pick up on that, Dr Studdert. I think the issue about if you've got governance problems you may well have care problems is something that I think we probably appreciate. I think what we have heard in evidence and submissions and so on to this Royal Commission is that there's a lot of process in this system to assess quality of care but there's not much eyeballing or review of the quality of care itself. And so the care plan being in the written form providing a process, has become a substitute for an actual review of the quality of care being provided. And that's the challenge we're facing here, because in the evidence we heard yesterday, we couldn't see, or hear, that there wasn't very good quality care being provided by a very caring workforce. So where I'm going with this is to try and understand whether you believe that the care plan is sufficient to assess that there's quality of care.

DR STUDDERT: So I would accept it's not sufficient in and of itself. But I would contend, as I guess I've been trying to, that it's a necessary first step.

COMMISSIONER BRIGGS: Right. I hear that. Can I ask another question about the sanctions more generally. In a case where another provider was sanctioned and their beds or their care users of packages or whatever were then taken over by another provider, what's the sort of expectation and the timeframe for taking those services to a higher level that actually meets the standard? Does it vary according to size or is there a general expectation that within a period of months you will have complied with the sanctions, complied with the rules?

MR SPEED: If I may, the general period for a sanction is around six months.

DR McEVOY: Right.

MR SPEED: It can vary. It can be up to nine months. And there's the expectation that, within that period, the provider, be it residential or home care, will have returned to compliance.

DR STUDDERT: But I think your question was to the – this situation where we have transitioned clients from one provider to another, and I think these are fairly unique – or not – not unique, but unusual circumstances in our experience to date, and that that would be, I think, fair to say, done on a case-by-case basis, but with a lot of attention from the quality – from the Commission and the Department in that time, and that would essentially aim to do that as soon as possible.

COMMISSIONER BRIGGS: Right. Is the Department doing any work at the moment to assess, more effectively, the actual quality of care being delivered?

DR STUDDERT: Yes, it – it is and I think it goes to some of the earlier questions and comments that we provided that there – this is, by its nature, a very dispersed business and the capacity of the system to, as you said, eyeball every client is – is going to be limited, and so the ways to do that in an efficient, but effective way, but one that also takes into account the particular circumstances of the clients in their home setting, and the necessary privacy access issues that come with that, are ones that we have to continue to develop because that is not something that is – I don't think it's fully developed in the context of the growing system that we have, and that is something we are working on, yes.

COMMISSIONER BRIGGS: It might be useful if you provide us the information about how you are seeking to develop that system of quality clinical care, yes.

DR STUDDERT: Yes, and we would do that in conjunction with the Commission because that's also, of course, a very big part of their work.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising from that, Dr McEvoy?

DR McEVOY: Perhaps just one thing, Commissioner. Of course, Dr Studdert, just in relation to BC and BD Proprietary Limited, the imposition of these sanctions was in early November last year, a couple of weeks after the calling of this Royal Commission. There wouldn't be a sense, would there, in which the Department was wanting to make an example of particular providers?

DR STUDDERT: I would absolutely reject that premise.

DR McEVOY: Nothing further, Commissioner.

COMMISSIONER TRACEY: We thank you both for your evidence. We would be grateful if, as soon as possible, you could provide us with the matters that have been taken on notice, and we would also be most interested to know what the results of your researches relating to the treatment of Ms Kersnovske have been.

DR STUDDERT: Certainly.

COMMISSIONER TRACEY: Thank you both very much.

<THE WITNESSES WITHDREW [4.34 pm]

DR McEVOY: Now, Commissioners, we now have Professor Swerissen. I'm very conscious of the time. However, if the Commissioners are disposed to sit for a little longer - - -

COMMISSIONER TRACEY: Yes, we are happy to sit on to take this positional evidence.

DR McEVOY: Thank you, if Professor Swerissen could be called.

MR FREE: If we might be excused, Commissioners. Thank you.

<HAL SWERISSEN, AFFIRMED [4.35 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Operator, could you bring up WIT.0085.0001.0001 yes, thank you. Professor Swerissen, you've provided a statement to the Royal Commission which, I think, is there on the screen; is that correct?

PROF SWERISSEN: Yes, it is.

DR McEVOY: And is that statement true and correct to the best of your knowledge and belief.

PROF SWERISSEN: Apart from the odd typo, yes.

DR McEVOY: We will give you the typos. Commissioner, could I tender that statement and the annexures to it.

COMMISSIONER TRACEY: Yes, the statement of Professor Swerissen and the annexures to it will collectively constitute Exhibit 2-86.

EXHIBIT #2-86 THE STATEMENT OF PROFESSOR SWERISSEN AND THE ANNEXURES TO IT

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

PROF SWERISSEN: Yes, Hal Swerissen.

DR McEVOY: And what are your professional qualifications?

PROF SWERISSEN: I have professional qualifications in psychology, business management and organisational theory.

DR McEVOY: And what's your present professional role?

PROF SWERISSEN: I am Emeritus Professor of Public Health at La Trobe University and I'm a visiting fellow at the Grattan Institute.

DR McEVOY: And what's the Grattan Institute.

PROF SWERISSEN: It's a – I think what people would colloquially call a think tank and – its – its principal purpose is to assist in providing good public policy in the national interest or in public interest.

DR McEVOY: And does it receive ongoing funding from government?

PROF SWERISSEN: No, the Grattan Institute is funded by a bequest which was made – an endowment which was made some time ago, and it receives no public funding, and it also receives no – no funding for the research work that it does on a contract basis.

DR McEVOY: And what's the Institute's research interest in aged care?

PROF SWERISSEN: We have a health program which has done a number of reports, some of which I have listed in the statement, and the Institute is exploring long-term care, at the moment, as a research area, and that includes aged care, disability and probably mental health. We haven't decided on the exact parameters of it, but we are certainly interested in aged care at the moment.

DR McEVOY: So from about paragraph 8 of your statement, you set out major areas of concern in the delivery of aged care, particularly in the context of home care. How would you say Australia is travelling in its development of aged care policy?

PROF SWERISSEN: I think Australia is probably best described as being in a period of transition. The – the directions have been there for a while since the recent reforms, and so we're moving from a system which is – which was heavily dominated by, essentially, provider-based funding to one which is much more focused on consumer-directed funding. But it hasn't quite moved to a fully operational set of arrangements for consumer directed funding, and it still has a set of issues which are to do with the split between residential and community care, which I think I've outlined in the statement later. The other thing I would say is that the – as a result of doing – as a result of the transitional arrangements, the Commonwealth has increasingly taken over responsibility for aged care, and that's left some gaps operationally and in a systems management sense.

It has probably created some difficulty for consumers accessing services, as we've centralised the arrangements with the Commonwealth. There are significant set of issues with the transition that there are now different funding mechanisms for different parts of the system, and they're not – they are not well aligned, and so they will need to be addressed if we are going to see more portability of care. I think there are some anomalies now between, for example, the disability legislation and the aged care legislation in terms of the framework and the arrangements which – which have been put in place. So that long-term care is being seen differently in different parts of – for – for different populations. And I think that those issues are there because it's a very large-scale set of changes which are required and so, inevitably, there is a period where – where it needs to settle.

DR McEVOY: How does Australia compare to similarly placed countries in the OECD in relation to its aged care spend?

PROF SWERISSEN: Well, Australia – the short answer is we probably are a little less than the average on the OECD. We spend about one per cent of GDP. So GDP is roughly 1.8 trillion. The Commonwealth spends about 1.8 billion. So that's roughly one per cent of GDP. The OECD probably spends roughly 1.4 per cent of GDP on average. There are some issues about comparability of data, but that's the sort of general picture that you would see. The – the – the situation in Australia is that we probably see slightly more residential care being provided to older people and slightly less community-based care than you would see in – in the OECD. If you look at the, sort of, leading countries in the OECD in terms of spending, you would be looking at the Netherlands or Sweden, and they spend probably, in GDP terms, three times as much as Australia does.

DR McEVOY: One of the observations you have made in paragraph 8 is that we overemphasise spending control to the detriment of service access and quality of outcomes. Do you want to enlarge a bit upon that complaint?

PROF SWERISSEN: Yes, I – I can. The – inevitably, the government is faced with the problem of – of fiscal constraints. So with a large spend like aged care which is in the order of $820 billion, the government seeks to manage that, and the – the – the choice you have is, really, as government do make that universal system with relatively open access and then really manage the overall budget, or do you cap the budget, and the aged care budget is capped. The Medicare budget is not capped, PBS budget is not capped, and they manage their soft caps, which means that you try and manage it, but you don't – you don't absolutely constrain it. The disability legislation has moved towards, essentially, a soft capping type of approach which is – which is a much more open-ended. Meet the – the – what are called the 'reasonable and necessary' needs of people with disabilities.

The aged care legislation is much more concerned about actually putting in place systems of assessment, classification, and the mechanisms for controlling the overall spend in the aged care system. So if you look at the two pieces of legislation side by side, you will see that there's an enormous amount of effort in the – in the aged care

legislation focused on assessment, eligibility, the management of the money, and you look at the disability legislation, you will see there's an enormous amount of effort put into how do you do the plan for people with disability so that they get the services that they actually need. Now, that's quite a difference in philosophy for the two systems, and that's an indication that there's some transitional issues going on in our thinking about long-term care.

DR McEVOY: Another of the observations you make in paragraph 8 is that, over time, the planning organisation management of aged care has become overly centralised. Now, that's a criticism that has been made by others that we've heard. What do you have in mind, particularly when you say that, and what would you regard as the alternative?

PROF SWERISSEN: So the – what I have in mind when I say that is that the Commonwealth, quite understandably, has brought in a national approach, national funding arrangements, national waiting lists and waiting times that follow from that, which are national. It's set up a system with My Aged Care which is essentially a portal which is a national portal with a telephone line that goes with it. The alternative is to have a system where you have national functions and responsibilities but you also then set up an integrated – a sensible set of regional or area-based arrangements which are responsible for managing the system, which provide clean access for people, where people within reason localise the arrangements to suit circumstances which actually apply and they are quite different in North Queensland than they are in metropolitan Melbourne.

In that sense you have to have an approach which says, well, let's sort out what the – what the relevant functions are locally, and what are the relevant functions at the national level. And there are some which should be done nationally, and there are some which should be done much more locally. And because the Commonwealth has taken over these responsibilities, local government has dropped away and so have the states. And the states typically have been the systems managers in the past, always a bit fractious but nevertheless that was partly their role. They have moved out of that space, so has the – local government has increasingly become a service provider rather than a co-designer of a system, and the result is that we have got a bit of a vacuum emerging in the local management of service systems and there are basically two – internationally there are two models for dealing with that.

One is you organise things on an area basis. You take a population within a given catchment and you say this organisational entity is responsible for ensuring planning, governance of the service system, making sure that things actually work locally. Or you have a population enrolment approach where you can have – you are not so worried about the area, as the – organising the region or the geographic area, and you can organise things on the basis that people enrol with a particular insurer or a particular agency, which is more like the United States in terms of its health care system of enrolling with particular health insurers.

Now, Australia has traditionally used area-based models for organising services. They have regionalised and so – and the most obvious one is states. But the

Commonwealth has moved into that space and it hasn't sorted out an arrangement at the local level for how this is to be done.

DR McEVOY: And you would say that an arrangement at a local level is of very great importance.

PROF SWERISSEN: Yes, I do. I think two things that matter: one is you need some – a place where the consumers, you know, people have talked about having a gateway or a portal, and so on and that needs to be localised and it needs to be consistent in the sense of bringing things together. You need to bring assessment, planning, coordination, the management of the actual person's needs, and they can still be consumer directed, people can make choices, but somebody needs to be there that they can go to at the local level. And the other part of it is that an individual consumer can't manage a service system. If there is a gap somewhere in Gympie or Boort the reality is the individual consumer can't actually fix that. So there needs to be somebody who is accountable for saying okay, we have got a planning, we have got a gap in the service system, how shall we fix that at that local level.

And that then becomes a matter of managing that service system so that there are services for people to choose from. And that's called – well, usually people see that as managing the market or actually doing service system planning and nudging the service system in particular directions. You don't have to do that in a Stalinist way, you can do that in a facilitating and nudging way, to get what you need. So I'm not arguing for going back to, you know, some sort of Soviet approach to these sort of things but I do think there needs to be some – some agency in the system that deals with these issues, otherwise you're trying to deal with it all from Canberra, basically, and that is very difficult because you are a long way away and you don't have relationships.

The experience in other places trying to do this as having these highly bureaucratic administrative arrangements lose the sense of the relationships between the players at the local level, and the management of that system in a more sophisticated way. You end up doing it all by basically administrative fiat or trying to deal with it in a very transactional way. And if you look at the literature on that, those transactional approaches tend to have difficulties particular in systems in transition and where the arrangements are fuzzy, where you've got – you know, where not everything is yet sorted out.

DR McEVOY: This is a classic subsidiarity model.

PROF SWERISSEN: It is a classic subsidiarity model. And you can choose various options for the subsidiarity. The problem in Australia at the moment is that we have moved the states out of it, and the states have said it's the Commonwealth's responsibility and the Commonwealth needs to make some choices about what subsidiarity model it wants to develop. I have suggested that there are some options for that. And so the important point is that unless that gap is filled there will continue to be difficulties.

DR McEVOY: Well, why don't you walk us through the options that you've identified.

PROF SWERISSEN: So one of the main, one of the things that the Commonwealth has done and I have to declare a conflict, is to set up primary health networks and I actually sit on the board of one of those. There are 31 of those nationally. The reason the Commonwealth has done that is - - -

DR McEVOY: Do you want to just explain for the benefit of the Royal Commission precisely what a primary - - -

PROF SWERISSEN: Yes, I will. So a primary health network is a – there are 31 primary health networks and their job is to bring together the general practice system with other allied health and the acute hospital system and, increasingly, they have also had a role in long-term care so they have been asked to do mental health more recently. The Commonwealth now funds mental health through that. The primary care networks are independent of service provision. They don't offer any service providing. They only commission services, and they do the planning for a region. So there are 31 of them so they tend to have populations of about a million people, roughly 600,000 to a million. They have probably a billion dollars a year being spent. I haven't looked at the numbers recently but it's a significant organisational infrastructure and it does this management of the relationships between agencies and the planning. It provides information to the community and so on.

And there is an opportunity to leverage those arrangements to start to see some of this happening in terms of the subsidiarity model. The other option would be local government but local government is very different in different states, and it has the problem that this provides services. So it's difficult for it to be separated out. You could go back to a Commonwealth/State negotiation and let the states do it but we have been down that path and the states have moved out of aged care so that would be difficult to do. You would need to, whatever model is brought in, you need to bring into that subsidiarity model the Commonwealth role, the State role and local government role back in but with a broker, so that you start to sort these quite difficult service delivery issues out.

The other thing that I would do is I would bring things like the consumer and respite care function, which is currently being done by the Commonwealth into that kind of model so that information and access was there. I would bring the aged care assessment services into that sort of a model so they have got a coherent home that they live with, and I would start to integrate these functions at the local level. I would leave My Aged Care in place for those people that want to use it but it would be supported by a coherent structure at the local level so that in fact you would be able to see these things happening. Now, the Commonwealth is thinking about these sort of things but inevitably the Commonwealth always runs these little trials so it has got a navigator trial out there at the moment and – so we will see how that goes.

It needs to think a bit more systemically about these issues than simply let's have yet another grafted on function. It needs to say, okay, we the Commonwealth need to

recognise we have functions that we should do and there are some things that should be done more locally and we need to sort out how we are going to do that.

DR McEVOY: You will be aware that since the start of the Royal Commission the government has announced an additional 20,000 home care packages.

PROF SWERISSEN: Yes.

DR McEVOY: What do you think is likely to happen as a result of this? Do you regard this as being a sufficient injection into the system?

PROF SWERISSEN: It's welcome but it's not enough. Well, you well know, I think, that there are 130,000-odd people on the waiting list at the moment, and there are significant waiting times for that. There are two priority queues running; one really allocating people as quickly as possible to a lower level of package, and then another one which is running more slowly beside it. I think the reality is that putting more packages in is a good thing, and I would support that, but really there needs to be some reforms to bring that funding system into a more organised space. One of the things that's a problem is that we've bundled funding around accommodation approaches.

So we have bundled funding around home and around residential care, and it would be better if we separated those funding streams and said we need a funding stream for care regardless of the accommodation setting, and that could then include all the things that you would normally think of as care services. And a funding stream which is more focused on supporting accommodation needs; that's facility charges, you know, what people sometimes called board and lodging, and the capital costs associated with care. Then, if you do that then it becomes easier to move people – for people to take their care funding to an accommodation setting that's sensible rather than being limited to either home or residential care so that they can move to supported accommodation. So, for example, the Swiss have a model where you have supported accommodation which is more like what we would call villages, and you can move care into that village because it – and you have portable arrangements. If you have things which are only sort of linked to a home care package or a residential care arrangement, then they're the choices you have got.

Whereas if you have got a more flexible care package, you can move that around. You then have to sort out what is in the accommodation side of it and there are some choices about that. So I think the fundamental issue will be that – the other side of that is that we have got this split between, basically, home support, which is entry level care and then more complex care and that creates a set of disjunctures as well in terms of moving from one to the other, and then what happens if your needs change up and so on. So it would be better to bring care funding into one stream and accommodation-type funding into another and then start to flex that up, so that you allow basically, not to cap that, but to allow it to flex up and manage it in other ways. Manage the overall quantum of money if that's what the Commonwealth is worried about in a more sophisticated way than simply saying, well, there are only this many packages.

DR McEVOY: Can I ask you to turn to the issue of increasing user contributions.

PROF SWERISSEN: Yes.

DR McEVOY: What do you say about that?

PROF SWERISSEN: Increasing user contributions; well, we need to make a decision, really, I think about what is the reasonable balance between user contributions and other forms of funding, either insurance-based funding or taxation-based funding, and what are the principles that we are using for the use of those. So at the moment the principles are largely equity-based so that you essentially say people on low incomes will be protected in the scheme. And there is a set of arrangements which say, well, we should essentially have a board and lodgings charge. And that may well be reasonable but we have some discontinuities in that at the moment which, for example, on low-level packages care, if your means are a bit too high, then the package becomes essentially – well, you are basically paying for it yourself.

So we need to make choices about that. So that needs to be streamlined. I think probably that the sensible approach is to say board and lodging is your responsibility. It would be your responsibility if you were living independently of any services so why would it be not your responsibility in some form or other. And then protect very low income people in terms of accommodation charges so that they don't end up – particularly people, for example, who are homeless or who have insecure housing and so on. And then the care, we can have a different kind of user contribution arrangement for that; the care services. And that – we need to make a decision as to what we do. So some places like France have very steep means tested arrangements for that. Japan started off with a 10 per cent charge on care, then moved it up to 30 per cent as it got more expensive.

We need to have a discussion as to what we think the principles are for dealing with that. It has become a bit messy in terms of the various contribution schemes that are there at the moment.

DR McEVOY: What I was actually going to ask you about Japan, which you discuss in paragraph 44 of your statement, as being perhaps a place where they've got it reasonably well set up. Mandatory insurance schemes, how they do it, as I understand the position from your statement, in Japan - - -

PROF SWERISSEN: Yes.

DR McEVOY: How is that done?

PROF SWERISSEN: It's essentially – so the Japanese experience was, up until about 2000 there was virtually no – essentially, people were responsible for their own long-term care, and so it was – there were – there were very many people clogging up the hospital system because there was not – not many other places to go. So they had very long stays in hospital as a result of people not having a long-term

care system. So long-term care system was legislated in '79 and introduced in 2000. The initial approach was, essentially, to say about half the system would be funded through general taxation, and the other half would be funded through social insurance, basically.

And there were two parts to the social insurance scheme. One is that people over the age of 40 paid social insurance in anticipation of their potential aged care needs, so it pooled the risk, and people – and there – there two parts to that: one was how you were paid before you retired, and there was one part after you – when you were over 65, what would happen. That was brought in, and then there was a 10 per cent user charge. Just – if you got services, there was a 10 per cent user charge. The Japanese then built a system which was very heavily based on the idea of local coordination centres. They put 4000 local coordination centres in place with the sorts of things that I was talking about earlier, and they then ran it and they've had a series of modifications to tweak it since then, but that's probably the most – well, it's one of the systems which has had the biggest change over the last 20 years, going from a very different system to something new. So there's a whole lot that can be learnt from what happened in the Japanese experience.

DR McEVOY: Why has it been so popular in Japan?

PROF SWERISSEN: I think because people didn't have access to services before that. It's – they worked very hard on getting community support for it. So if you go out into Australia and say, "Well, I think we should have significant increase in general taxation," people would go, "That's not such a great idea." If you go out and say, "I think we should have a dedicated taxation arrangements or insurance arrangement – social insurance arrangement for long-term care or for aged care, let's – you know, then people are much more likely to say, "Well, that sounds reasonable, given the sorts of things we've been hearing about aged care. So we would be prepared to see additional funding go into that."

The way that that was done for the disability scheme, of course, was to increase the Medicare levy to – to see additional funds come into the system. My view is that unless you have additional money, we will – we will have – we will be here again at some point in time having a discussion about, you know, quality of care, lack of a workforce, the sorts of issues there. That will always happen. The other part of the thing, which isn't so much the money, is if we don't reorganise the local arrangements, we will be here again because you can't run everything from Canberra. You have to have something at the local level. So those are the two major systemic issues that have to be addressed if you're going to start to address these, you know, the concerns that we're hearing about quality and access and fragmentation and so on.

DR McEVOY: But there's got to be a way to control the spend, doesn't there?

PROF SWERISSEN: Yes.

DR McEVOY: If you are going to have a plan-based funding model, what do you do about controlling the spend?

PROF SWERISSEN: Well, essentially, there are two ways of – two main ways of controlling spending: one is price and the other is volume. And we've got a lot of emphasis on volume at the moment about who can get access to a package. The other thing you can do, of course, is have a much more managed schedule of costs so that you – you effectively say, in the plan, there's a successful of costs and you can only charge those costs. You set them as maximum so that people can compete going down on those costs, but you then have a schedule. So what we've got at the moment is an assessment arrangement where you get assessed for eligibility, you get allocated to a funding category, and then you are off trying to figure out what services you need yourself, and then you sign a service agreement and all the things that happen, happen.

What probably needs to happen is a more organised approach to that service agreement being done by an independent broker as part of the arrangements which the – which the consumer, the person, the older person themselves or their carers negotiate. And then there's a schedule of fees, so you would say an hour of personal care in the morning is worth this, and you can't charge more than that, so and so forth, and you manage the costs by actually managing the – the – the – the cost schedule. And then the other thing that's really important in that is what is happened in the disability scheme is the concept of necessary and reasonable, and that needs to be a negotiated arrangement. So that, you know – I can't – I shouldn't just be able to go out and say, "Well, I've got a set of needs, and I think I need these things without having some sort of negotiation about that being necessary and reasonable with a sensible planner."

That's – that's a reasonable set of arrangements which is adopted in other places. So I think that that's how you manage costs. Instead of it being these hard barriers, you do it on a more nuanced basis. What's happening at the moment with these costs that we've got, we've got a series of difficulties with the ACFI in the nursing home world which we're not – which – which I'm sure you will get to, at some point, and there's a series of difficulties with the four level arrangement that we've got with the community care arrangement where we've got $350 million of unspent money, at the moment, because we allocate the money and then the services aren't properly planned around an individual. If you plan them around the individual, then they would get what they needed for their plan. There wouldn't be any unspent money.

DR McEVOY: So are you – when you talk about this, are you really talking about the imposition of price caps for services?

PROF SWERISSEN: I'm talking about having – having a negotiated set of prices for different types of care. So hours of nursing, hours of personal care, what Allied Health gets and so on, and then the hours negotiated in the plan, and they have to be reasonable and necessary, and so that's a managed system so that you don't end up with just Rafferty's rules, but that requires a rethink on how things are done at the

moment. At the moment, the capping is done by just allocating an amount of money per person and saying, "Now, it's over to you to spend it," and that's a different model of how you manage those costs.

DR McEVOY: For present purposes, Commissioner, I don't have further questions of Professor Swerissen. His statement is very comprehensive. It may be that we need to hear from him again in relation to particular aspects of what he proposes.

COMMISSIONER TRACEY: Professor, thank you very much for your introduction to many of the issues that we're going to have to grapple with as the year goes on. As senior counsel has just indicated, I think it more likely than not that as our ideas become more formulated, we may be calling on you again. Perhaps not in a formal setting like this, but at a round table just to air options with you and see, at a policy level, what is the best scheme for this country in an area of enormous concern to more and more people as they get older, but thank you for introducing us to your research and suggestion, and we are very grateful to you also for agreeing to stay on late today and give your evidence at a time where you might rather be elsewhere. Thank you very much.

PROF SWERISSEN: Thank you very much.

COMMISSIONER TRACEY: Dr McEvoy, 10 o'clock in the morning.

DR McEVOY: Thank you, Commissioner, yes.

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

<THE WITNESS WITHDREW

MATTER ADJOURNED at 5.08 pm UNTIL FRIDAY, 22 MARCH 2019

Index of Witness Events

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EXHIBIT #2-86 THE STATEMENT OF PROFESSOR SWERISSEN AND THE ANNEXURES TO IT (WIT.0085.0001.0001) P-1036