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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

BRISBANE

9.33 AM, FRIDAY, 9 AUGUST 2019

Continued from 8.8.19

DAY 46

MR P. GRAY QC, counsel assisting, appears with MR R. KNOWLES, MR P. BOLSTER and MS B. HUTCHINS
MR G. KENNETT SC appears with MR J. ARNOTT for the Commonwealth of Australia

COMMISSIONER TRACEY: Please open the Commission. Yes, Ms Hutchins.

MS HUTCHINS: Commissioners, I call Ms Debra Ann Barnes.

<DEBRA ANN BARNES, AFFIRMED [9.34 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Operator, please bring up WIT.0328.0001.0001. Ms Barnes, is this a copy of the statement that you've prepared for the Commission?

MS BARNES: Yes.

MS HUTCHINS: Do you have a copy in front of you?

MS BARNES: I do, thank you.

MS HUTCHINS: Do you wish to make any amendments to the statement?

MS BARNES: No. Thank you.

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

MS BARNES: They are.

MS HUTCHINS: Thank you. Commissioners, I tender the statement of Ms Debra Ann Barnes dated 24 July 2019.

COMMISSIONER TRACEY: Yes. The witness statement of Debra Ann Barnes dated 24 July 2019 will be exhibit 8-43.

MS HUTCHINS: Ms Barnes, in your own time, could you please read from your statement commencing at paragraph 4.

MS BARNES: Thank you:

My full name is Debra Ann Barnes. I am 65 years old. I have previously worked in IT and HR and I am now retired. My mum was born in Coburg, Victoria. Mum and Dad had four children: two sons and two daughters. Mum was a physical education teacher and lecturer in her early teaching days and later an infants' teacher and head mistress. Mum was one of five, so we grew up with lots of aunts, uncles and cousins. Mum and Dad had eight

grandchildren and 11 great-grandchildren. For her 90th birthday, Mum celebrated with 38 family members. Mum enjoyed her retirement and she and Dad travelled throughout Australia and overseas. Mum researched family history, learned to quilt and played cards regularly.

In 2002, Mum and Dad moved to an independent villa within a complex, a retirement complex. In 2002, when Mum was moved into the villa, she was generally in good health. She was managing maturity onset type 2 diabetes well with diet and daily medication. Mum and Dad lived independently and were able to cook and clean for themselves. They received some housekeeping assistance from DVA for a couple of years prior to 2017. On 20 December 2015, Mum fell in the villa and broke her hip. After her fall, her mobility and cognitive ability declined. It was no longer possible for her to live at home with Dad.

In January 2016, Mum had an ACAT assessment in hospital and we prepared to move her into full-time care. The ACAT assessment identified that Mum was experiencing cognitive decline. On 4 February 2016, Mum moved into the facility. Mum was still very much a part of the facility community while she was in that area. Mum's friends from independent living would come and visit her. Sometimes, my family or I would take Mum in a wheelchair back to the villa for family gatherings, lunch or morning tea with Dad and for Mum to check how Dad was going.

When it was time for Mum to enter high care, the main factor we considered, as a family, was the accessibility for Dad. The facility was within walking distance for Dad to visit, which was the key reason we were happy to have Mum at the facility. At that stage, I didn't really know what to look for in terms of quality of care in the aged care setting. My sister and I became Mum's enduring power of attorney after her ACAT assessment. My sister had a full plate with her own health concerns, so I handled most of Mum's needs. I made the time to be involved in the day-to-day running of Mum's care.

I would say I was the most annoying brilliant advocate daughter that I could be. I didn't mind coming across as a busybody if it meant I could ask all of the questions that needed to be asked on Mum's behalf. During Mum's stay in the facility, I texted or emailed my siblings to keep them updated. I shared everything from hairdressing appointments to changes in Mum's health. As I was present several times a week, I was able to observe the way the facility staff handled Mum's needs and I often provided formal and informal feedback. The facility had a paper-based feedback system. There was a folder of feedback slips available at the front entrance near the visitor sign-in book, which you could complete and put in the feedback box.

I also used the online web inquiries platform on a couple of occasions. However, I never received a response from that medium. As far as I was aware, these were the only options for providing feedback in writing unless you

had a staff member's email address. I regularly provided feedback via the feedback slips, both positive and areas for improvement. I estimate that I provided feedback on 50 to 60 occasions. In my experience, I only received acknowledgement of my feedback about 25 per cent of the time and then mainly informal. I often had to find staff in the corridors if I wanted a response. I didn't like doing this as I was aware the staff were busy.

However, after being patient for a couple of weeks, I would then try and catch someone when I saw them. On several occasions, the facility ran out of feedback slips. I took to keeping a couple of feedback slips in my bag to get around the lack of slips. On 19 January 2018, I contacted the facility through the online inquiries form. We had experienced a recent bout of extreme heat in the area. When I was visiting Mum during this period, I could feel that the facility was unreasonably hot and I could see that Mum and other residents looked uncomfortable. I was uncomfortable. The staff appeared uncomfortable.

In my email to the facility, I noted that there had been an absence of feedback forms for the past week. I asked whether any of the senior leadership team had visited the facility during the extreme heat period, whether they would be satisfied for their family members to live in those conditions and what plans they had in place to bring the facility up to a reasonable level of comfort. My query was never acknowledged by the facility and I never received a response. From January 2018, I noticed that Mum was sleeping more and talking less. On 5 March 2018, I spoke to Mum's GP and we discussed the fact that medication changes had not improved Mum's recent drowsiness.

I told the doctor I did not want to rely on other sources of information on how we best support and look after Mum. I also said that I want to understand better where Mum is at so we know what to expect from the staff at the facility and so we can all do the best for her. After this discussion with the doctor, I requested a meeting with the key care staff to talk through Mum's care plan. The meeting was scheduled for 21 March 2018. In early March, I had several conversations with staff members about Mum's care plan being updated. The conversations were always in passing and I felt like I wasn't getting a clear answer.

The clinical nurse educator told me there was a note in Mum's file that I was consulted on 6 February 2018 and that Mum's care plan had been updated. I explained that I had never seen a care plan let alone been consulted about updating it. The clinical nurse educator told me, "The problem is because you're here so often, we don't get as formal". On 19 March 2018, I emailed the clinical manager, a senior staff member and the CEO of the facility and advised that I thought that there had been a communication breakdown. I wrote that I knew what information I had shared with the staff at the facility but that I was not clear on what information I should receive back, through which medium and how regularly.

I told them that I needed information to be formally shared with me and not just conversations in passing in the corridors. I asked, "What else is being done or should be done to ensure that we all look out for Mum as best as possible?". In response to my email, the clinical manager advised that she would join the 21 March 2018 meeting to discuss my concerns. On 21 March I attended a meeting with the clinical manager and another RN. I felt it was bumpy in spots but overall a productive meeting. My goal for the interaction was to focus on the message on providing the best possible care and support for Mum.

I was hopeful that communication was going to flow better between the facility, Mum and myself. In and around mid-April 2018, I realised that Mum had missed another of her regular hairdressing appointments. Mum had always taken pride in her appearance and having her hair washed and styled at the hairdresser was an important factor in maintaining her quality of life. By this stage, I had seen a draft of Mum's care plan at the meeting on 21 March. Mum had standing twice weekly hairdressing appointments recorded in her care plan. I asked the RN responsible why Mum had not been taken to her appointment. The RN said that she didn't realise that this was in Mum's care plan and wasn't share what had happened. After a short time, the RN came back to see me. She told me that the care worker who was scheduled to take Mum to her appointment was called away to another area and wasn't able to come back.

After learning this, I called the hairdresser directly. The hairdresser told me that when she realised that Mum had not arrived for her appointment, she called the facility and nobody answered the phone. The hairdresser said she also called again in two hours' time and, again, nobody answered the phone. These appointments were important to my Mum and were recorded in her care plan. I felt really let down that the facility staff were not communicating with each other to ensure that Mum was cared for in accordance with her plan. Also, I witnessed the difference it made when Mum had had her hair done. People would stop and comment on how lovely Mum looked and Mum would respond or smile.

I submitted a feedback slip to share my concerns. The clinical nurse educator called me later that night. We had an awkward conversation in which she aggressively asked me why I had put in written feedback when I could have spoken to her directly. I had been told time and time again that the facility welcomed feedback so I was overwhelmed by the clinical nurse educator's response. I asked that we end the phone call because I felt extremely uncomfortable and I could not believe what I was hearing. After the phone conversation, I emailed the clinical manager and a senior staff member and requested that any future discussion about feedback or Mum's care not involve the clinical nurse educator.

Disappointingly, no one even acknowledged that email or issue. I saw the clinical manager two weeks later in the corridor and asked her about it. She

said to me, "It's all in hand. You don't need to worry about it." I felt dismissed and disappointed. I felt that the communication continued to be an issue with the facility as time continued. On 23 May 2018, I received a call from the facility to inform me that Mum may need to go to hospital because she had perspired so heavily that her sheets were wet. I was shocked because I had been there that day and I had told staff that, if Mum was sick, then of course they should send her to hospital. I waited with Mum before the ambulance took her to hospital.

I consulted with the emergency doctor and the RN, who told me that Mum had a UTI and high blood sugar reading. The RN explained to me that Mum's blood sugar would rise with an infection. From about January 2018, Mum had been speaking very little. When she was diagnosed with a UTI, it became clear to me that Mum had not been able to tell staff that she was uncomfortable, which meant that they did not realise she had a UTI. My key focus after the emergency room visit was to ensure the facility had measures in place to prevent and identify any future infections. I sent several emails and spoke to different staff members about strategies that could be put in place to monitor and prevent further infections.

The clinical manager offered an option of monitoring Mum's fluid intake to make sure Mum was drinking plenty of fluids. I told her that Mum needed prompting to drink at times. On 2 June 2018, I visited Mum for the afternoon. I found that there was no cup of water available for her to drink and I had to get one myself. That happened regularly. If there was a water cup and a water jug on the bedside table, it was often out of Mum's reach when she was in bed. Mum's fluids were to be monitored over two days. The RN on duty on the Saturday after the monitoring period finished assured me that Mum had healthy numbers on her fluid intake sheet.

When I followed up and questioned that further, the clinical nurse educator told me that the fluid intake sheet only records what drinks Mum had been offered and that it didn't capture whether or not she drank them. I challenged the numbers as I had been with Mum from 10.30 am to 3.30 pm on the Wednesday and no one asked me about what Mum had drunk or been offered. On 4 June 2018, I spoke to the clinical nurse educator in the afternoon about why nobody was making sure Mum was getting the fluid she needed. The clinical nurse educator told me they did not provide acute care and it was up to Mum as to what she did or did not drink.

I was feeling incredibly confused and frustrated because I simply couldn't understand how that would not be a part of the care that they would offer Mum. At that point, the clinical nurse educator told me that I could be intimidating and that perhaps staff didn't feel comfortable approaching me with problems or information. By that stage I had serious concerns about the facility's ability to care for Mum. I made inquiries at a new residential aged care facility closer to my home and arranged to have a tour. I found a geriatrician who was

prepared to visit Mum at the facility. The geriatrician advised that, unless there was a major concern, we should keep Mum at the existing facility because she was familiar with her surroundings.

In or around July 2018, the clinical manager informed me that they needed to swab a pressure injury on Mum's buttocks to test whether there was an infection that required antibiotics. On July 2018, I wrote to the clinical manager and asked for a meeting to discuss how long Mum had had the pressure injury, what had been done and how could I track the treatment progress. At our meeting, I was told that the injury had been identified in January 2018 and was being monitored. I had been aware of the pressure sore for a little while but not from the beginning of 2018. It felt like I was not being told or given updates unless I proactively asked for them.

On about 20 July 2018, my elder brother and I requested the facility undertake an internal investigation into Mum's care. The facility provided a report to us on 24 July 2018. The report recorded that staff were relying on word of mouth rather than utilising the communication book. It also noted that there were annual care planning education sessions for nursing staff. The facility advised that they planned to make these sessions mandatory every six months. On 2 August 2018, my sister visited Mum and found her asleep at about 9 am. Mum couldn't be roused and was taken to the emergency department. The doctors tried to assess Mum's blood sugar levels with a BGL machine. Her levels were too high for the machine to read.

Doctors also found that Mum's stomach was distended due to urinary retention and a urinary tract infection. Mum passed away in the palliative care unit at the hospital on 9 August 2018. I was saddened and frustrated with the communication I had with the facility in Mum's last six months of life. At several different stages, I felt like my voice was not being heard and that I was powerless. I did not know who else I could talk to about my concerns. The facility did not tell me about any external complaint services that I could access. As Mum's power of attorney and loving daughter, I felt responsible for ensuring that she was receiving the best possible care. I wanted to be kept informed and involved with decisions and any developments about Mum's care.

After Mum passed, I was left with an overwhelming and absolutely certain feeling that she didn't get the care that she should have received. I spoke to a lawyer who had helped with Dad's estate and asked who I could turn to for help. The lawyer recommended contacting the Office of the Health Ombudsman. In mid-September 2018, I contacted the Health Ombudsman to raise my concerns about Mum's care and subsequent death. Within a week or so, I was informed that they had referred my complaint to the Aged Care Complaints Commission, now known as the Aged Care Quality and Safety Commission. I was assigned a case officer at the commission who helped me understand the complaint review process.

I was told that my complaint was being triaged and they would return to me with an update as soon as possible. My case officer was very clear about the commission having processes that they need to go through to investigate complaints. She emphasised that there was no guarantee of an outcome. I provided all of the documents I had available, including files I had obtained through a freedom of information request from the hospital. I contacted my case officer in September and October 2018. By November 2018, I had not received an update, so I sent an email to my previous contact at the commission asking if she would send on to the correct person as I did not have their email address.

The commission told me by phone that my complaint was still in the queue. The person that I spoke to acknowledged they had said they were going to provide regular updates and apologised for the lack of communication. I contacted the commission again in mid-January 2019 because I had still not received any updates. A case officer responded and said that my emails may have been lost in the system as they were having technical issues since moving to the new Aged Care Quality and Safety Commission. My complaint was then sent to the clinical assessment team at the commission to evaluate Mum's care.

I subsequently received a draft report from the commission and I was given an opportunity to provide feedback on that draft, which I did. On 12 April 2019, the commission advised me by letter that a decision had been made to end the resolution process on the basis that the facility had addressed the issues to the satisfaction of the commissioner. The commission found that the facility did not meet an expected level of clinical care when assessing and transferring Mum to hospital on 2 August 2018. The commission also found the assessments conducted by the facility were not comprehensive in that they did not adequately identify Mum's changed care needs.

The commission found that the facility had implemented a range of quality improvements, including a dedicated assessment tool for acute change of status, a review of policies and procedures and provision of training to staff. These actions were found to have satisfactorily addressed the facility's failure to provide clinical care of a required standard to my Mum. I do not understand how the complaint could have been resolved without there being an acknowledgement of what actually happened to Mum and who was accountable for it. The commission report also did not identify that the facility standard review and continuous improvement practices had failed to identify a number of areas for improvement.

My complaint was a non-standard input to a review and continuous cycle. In my opinion, there should be standard inputs to the aged care providers' reviews and continuous improvement cycle, such as frequent reviews and education sessions with staff. The facility noted in their response to the commission that they had implemented a range of new education and policy measures. I am concerned that if I had not complained, these improvements

would not have been made. It felt like the facility was reactive rather than proactive and the commission was satisfied with that approach. I was not satisfied when I received the commission final report. I felt that the commission had simply been through the steps of a process, rather than critically assessing the outcome to see if it was reasonable and fair.

On 14 May 2019, I sent an email to the commission requesting an internal review of the decision. In my request for a review, I wrote that I thought some of the information provided the facility should be clarified because I felt the commission review and the facility's response did not address all of the matters that I had raised in my complaint. On 11 June 2019, the commission advised by letter that they had reviewed the findings that were the subject of my review and had decided not to investigate further.

COMMISSIONER TRACEY: Were you told why?

MS BARNES: They were satisfied with the information that they had received.

COMMISSIONER TRACEY: Do you know what that information was?

MS BARNES: No.

MS HUTCHINS: No further questions, Commissioners.

COMMISSIONER TRACEY: Thank you very much, Ms Barnes. It's been a very enlightening opening to the morning's proceedings and we're very grateful to you for having shared your shocking experiences with us. Thank you.

MS BARNES: Thank you for the opportunity.

COMMISSIONER TRACEY: You are excused from further attendance.

<THE WITNESS WITHDREW [10.05 am]

MS HUTCHINS: Richard Knowles will call the next witness.

MR KNOWLES: Thank you, Commissioners. I now call Ms Shona Reid from the Aged Care Quality and Safety Commission.

<SHONA LIANNE REID, SWORN [10.06 am]

<EXAMINATION BY MR KNOWLES

MR KNOWLES: Ms Reid, can you tell the Royal Commission your full name?

MS REID: Shona Lianne Reid.

MR KNOWLES: Yes. And do you have before you both a statement and a subsequent annexure to that statement that you have prepared for the Royal Commission?

MS REID: Yes, I have.

MR KNOWLES: Is the statement dated 26 July 2019?

MS REID: Yes, it is.

MR KNOWLES: That is document WIT.0307.0001.0001. The annexure is, so far as I can see, not dated but that is the document that, I take it you have before you which has a document number in the top right-hand corner of WIT.0307.0002.0001.

MS REID: Yes.

MR KNOWLES: Thank you. Now, have you read, firstly, the statement lately?

MS REID: Yes.

MR KNOWLES: Have you read the annexure as well lately?

MS REID: Yes.

MR KNOWLES: Are there any changes that you wish to make to either of those documents?

MS REID: Yes. At number 12, I need to change the number.

MR KNOWLES: Paragraph 12 of your statement, is it?

MS REID: Yes. There's a number that's incorrect. The number of issues.

MR KNOWLES: Thank you. What do you wish to change that to?

MS REID: It should be 18,000.

MR KNOWLES: 190 issues?

MS REID: Yes. Thank you.

MR KNOWLES: Are there any other changes that you wish to make to the documents?

MS REID: No.

MR KNOWLES: In respect of your statement, subject to that one change to paragraph 12, are the contents of your statement true and correct to the best of your knowledge and belief?

MS REID: Yes.

MR KNOWLES: Yes. I seek to tender the statement, Commissioners.

COMMISSIONER TRACEY: The witness statement of Shona Lianne Reid dated 26 July 2019, as amended, and the annexure thereto will be exhibit 8-44.

MR KNOWLES: Thank you, Commissioners. I don't believe that I directly asked Ms Reid about the contents of the annexure. I might just do that now just to confirm. You've read the annexure lately. I take it you don't wish to make any changes to that document?

MS REID: No.

MR KNOWLES: The contents of that, too, are true and correct to the best of your knowledge and belief?

MS REID: Yes.

MR KNOWLES: Yes. Thank you. Now, Ms Reid, can you tell the Royal Commission what your present position is?

MS REID: Yes. My position is executive director of the complaints resolution group and my role is – my title is performance, education and policy.

MR KNOWLES: Right. So are you heading up the complaints area within the Quality and Safety Commission, are you?

MS REID: No. I share that role with another executive director who is the national complaints manager.

MR KNOWLES: Right. I see. So you have joint responsibility for that particular role; is that correct?

MS REID: No. The national operations manager has responsibility for all of the operational complaints functions and processes, and I have responsibility for some operational areas such as the clinical unit, the review function and a complex case area and then I have support functions reporting to me which are the legal area and training and policy and procedures and support for complaints officers. So the executive director and I work very closely together. I'm also responsible for the case management system and reporting and analytics.

MR KNOWLES: Yes. Thank you. And you, previously to occupying this position with the commission - - -

MS REID: Yes.

MR KNOWLES: - - - occupied a position with what was the Aged Care Complaints Commission?

MS REID: That's correct.

MR KNOWLES: Can you just describe when you occupied that position and what it was?

MS REID: Okay. I moved into that – previous to moving into the role in 2016, I worked for the Department of Health transitioning the previous aged care complaints scheme to the new independent Aged Care Complaints Commissioner and started in that role as assistant commissioner on 1 January 2016.

MR KNOWLES: Yes. And what was the role that you started in 2016 and that continued up until the transition across from the complaints commission to the Quality and Safety Commission?

MS REID: Broadly the same role that I have now, with the addition of FOI that I now have for the whole organisation.

MR KNOWLES: Yes. Thank you. I take it, therefore, from what you've just said, you're quite familiar with the two ways in which previously complaints were handled by the complaints commission and presently the complaints are handled by the Quality and Safety Commission?

MS REID: Yes.

MR KNOWLES: And you've referred to that in your statement at paragraph 17 and following, haven't you?

MS REID: Yes.

MR KNOWLES: And at the end of paragraph 17, you say that there are no substantive differences in the acts and rules setting out the complaints handling processes adopted by the Quality and Safety Commission and the complaints commissioner respectively?

MS REID: That's correct.

MR KNOWLES: You then say there are, however, differences in the approaches to the complaints handling processes as between the Quality and Safety Commission and the complaints commission?

MS REID: Yes.

MR KNOWLES: Yes. Now, before I come to that, you've then set out at paragraphs 19 the rules as they presently stand and, at 20, you say that those rules broadly reflect what the contents of the rules were previously?

MS REID: Yes.

MR KNOWLES: Then at 21 you say the differences in the approaches to the complaints handling processes, as between now and previously include – and you set out various matters?

MS REID: Yes.

MR KNOWLES: Now, the first relates to intake of complaints. And you say in the third line of that subparagraph (a) that the Quality and Safety Commission is in the process of considering recommendations to redesign its intake process?

MS REID: Yes.

MR KNOWLES: So that hasn't actually changed as yet; is that correct?

MS REID: Yes, that's correct.

MR KNOWLES: Then you refer, over the page, at the top of the page, still in subparagraph (a) to:

...plans to implement an organisation-wide web form –

but I take it, again, that actually is not implemented as yet?

MS REID: That's correct. We have a web form, but it doesn't pre-populate or automatically populate our case management system.

MR KNOWLES: Right. Is that the same as the web form that existed previously?

MS REID: Yes.

MR KNOWLES: Yes. Thank you. Otherwise, in terms of the actual process for complaints handling, you don't refer to any specific differences in paragraph 21, do you?

MS REID: No.

MR KNOWLES: Am I right in thinking that, at present, there's no real difference in the complaints handling procedure now to what went before under the complaints commission?

MS REID: That's right.

MR KNOWLES: Thanks.

MS REID: If you are talking about process?

MR KNOWLES: Yes.

MS REID: Yes.

MR KNOWLES: I am. I mean - - -

MS REID: Sorry.

MR KNOWLES: I take your point, that you've said, well, now there's a re-organisation formally of the entity that deals with complaints, that it's now brought into the Quality and Safety Commission, and you make that point there.

MS REID: Yes.

MR KNOWLES: But the actual process itself, you accept, is substantially the same as went before at the present time.

MS REID: Yes. The legislation's the same, yes – which drives our processes.

MR KNOWLES: The legislation's the same, and in terms of how it's administered – that's still substantially the same.

MS REID: Yes.

MR KNOWLES: Thank you. You have, as I say, observed that, in a formal organisational sense, the complaints Commission's functions are now performed by the complaints-resolution group within the Aged Care Quality and Safety Commission?

MS REID: Yes.

MR KNOWLES: And are you aware of the evidence that was given earlier this week by Ms Tracey Rees of the Quality and Safety Commission that, at least in Queensland – and this was given in the context of the People Care case study – the quality-assessment-and-monitoring group is separate from the complaints-resolution group in terms of physical location?

MS REID: Yes. That's correct.

MR KNOWLES: And those physical locations reflect where the two bodies were prior to the complaints-resolution group coming into the fold so speak. That is into the fold of the Quality and Safety Commission?

MS REID: Yes. Yes.

MR KNOWLES: Yes. And did you hear the evidence that was given by Ms Rees also, that each of those groups within the Quality and Safety Commission still has a different IT system?

MS REID: Yes. That's correct.

MR KNOWLES: Yes. So is it fair, to say that in a practical sense there remains some legacy of the former separation of these two areas, at least in Queensland?

MS REID: It, probably, is a national - - -

MR KNOWLES: It's a national - - -

MS REID: Yes. The computer systems are separate nationally.

MR KNOWLES: Yes. And does offices – do they remain separate nationally as well?

MS REID: In most offices except for the ACT and, I think, Tasmania currently.

MR KNOWLES: Yes. But otherwise they still remain in separate physical locations.

MS REID: Yes. Yes.

MR KNOWLES: Yes. Now, in your statement, at paragraph 21, subparagraph A(i) – you've indicated at the bottom of that passage that, in the first three quarters of 2018, 19, approximately 30 per cent of contacts with CRG were not within the scope of the Aged Care Quality and Safety Commission's remit.

MS REID: Yes.

MR KNOWLES: What were those kinds of complaints that were found not to be within the remit of the Quality and Safety Commission?

MS REID: Well, when people phone us, we try and help them as much as we can; so they're types of questions about retirement homes – they might be questions about issues to do with access that My Aged Care could deal with better. Sometimes people want to know how to get to the doctors and which busses to get, and we try and help as much as we can, and we spend time – we get a lot of Telstra complaints, because people – and those kinds of things that are not within our remit. And what

we do is – we try to refer them to the appropriate body, and we have a great long list of appropriate bodies in our offices, to try and help people. But they take quite a lot of time and discussion with helping complainants who ring us.

MR KNOWLES: Yes. Do you think that might reflect some lack awareness on the part of those that ring you about the function of the Quality and Safety Commission's complaints-resolution group and what it can do and what it can't do?

MS REID: Yes. Particularly retirement homes, because they're not government funded – so, therefore, we don't – they're not within our remit. They're the state bodies, that need to help them. And the state bodies do advertise that they take complaints as well. So - - -

MR KNOWLES: Yes. And have you given any consideration as to how you might – in terms of an organisation – perhaps inform people better about what the function of the complaints-resolution group is?

MS REID: Yes. Well, that's been an ongoing piece of work, even from when I first started working for the previous commissioner, and the commissioner will present and go to presentations. We offer education on site. We offer education at senior groups and other consumer-type bodies, where we take along information and explain to people what we do. Whenever we're invited, we never say "no"; we do go, and we have had education sessions with the My Aged Care staff to help them understand what we do. We've had education sessions in the past with – we've sent letters to the visitors' scheme to help them understand what we do. We have shared-education sessions in the past with the advocacy groups so they understand what we do and we understand what they do – all those kinds of areas. Promotion of what we do – we provide free external information to the public, and that's a huge take-up. Haven't got the numbers with me today, but they're in the thousands. And – yes. We are promoting, and I guess our complaints have increased, and that's also media. When there's media about us, more people know about us.

MR KNOWLES: Yes. Yes. Well, that brings me – yes. Yes. Well, that was my next topic that I wanted to turn to. You refer to that in subparagraph A of paragraph 21, that there's been an increase in the volume, and if I can bring up, as well, beside your statement on the screen, tab 125 of the general tender bundle – and do you see that there, Ms Reid, the complaints-data document supplied by the Commonwealth shows that complaints have increased in the last four years from 3744 complaints in the 2014, 15 year to 7828 complaints in the 2018, 19 year?

MS REID: Yes.

MR KNOWLES: Has any consideration been given – as to why that increase has occurred to that extent?

MS REID: We think it's predominantly, as I said, more interaction over the past three years and continuing on with the general public and promoting who we are and

what we do. In addition to that, I believe, it's been media, it's been announcement of the Royal Commission, and that way more people have found out who we are, which is good.

MR KNOWLES: Has any consideration been given to the possibility that it might reflect increasing levels of substandard care?

MS REID: Well, you would have to think that more complaints mean more problems and more issues in services. There's a million people receiving care, and there's 7828 complaints and over 18,000 issues that we deal with every year. I would think there, probably, is a lot more complaints and a lot more people that don't know about us.

MR KNOWLES: Now, in terms of that increase in complaints – what's been done within the Quality and Safety Commission and its predecessor, the ACCC – the Aged Care Complaints Commission – in terms of resourcing and staffing levels to deal with that? Have there been commensurate increases in staffing levels?

MS REID: Well, we – since the beginning of January, we have eight more complaints officers. So we've employed eight more operational-complaints officers than we had from the 1st of January. We're also looking at those areas, that 30 per cent you were talking about that's not within our remit, and we are currently trialling some set of more-direct questions to try and see if we can reduce the time-frames that we are dealing with those out-of-scope or – calls that aren't within our remit to free more time up to spend on complaints. There is constant – as I said to you, I look after the analytics. So we do see trends. We do see areas where the complaints are increasing and issues are increasing, and that's communicated with the – to the commissioner currently by the national-operations manager, and they're having – they meet fortnightly, and monthly their discussion is about the statistics and how things are going. I have confidence, and I know that the commissioner has discussions with the Department of Health about resourcing and appropriate resourcing for the organisation.

MR KNOWLES: You said before that you've had eight more staff members appointed. Do they – eight more staff members dealing directly with complaints. Is that right?

MS REID: Yes. That's right.

MR KNOWLES: And since when was that?

MS REID: Since the 1st of January this year.

MR KNOWLES: And what does that bring the total number of staff members across the country dealing with the complaints that are brought to the Commission's attention?

MS REID: It's 181 FTE for the whole group and about 123 FTE of complaints officers.

MR KNOWLES: So 123 full time-equivalent workers in terms of the complaints function across the country. And that's to deal with some 18,000 issues raised per year.

MS REID: Yes.

MR KNOWLES: Now, I take it, you'd agree that a proper complaints-handling process is absolutely vital to good regulation of aged care.

MS REID: Absolutely.

MR KNOWLES: And you would've heard the evidence, I take it, given earlier by a colleague of yours, Ms Catherine Rosenbrock, that but for the complaint made by Ms Johanna Aalberts-Henderson about her mother's treatment at Avondrust, it was unlikely, sanctions would've been imposed on MiCare when they were.

MS REID: That's correct.

MR KNOWLES: And she made it clear, that external sources by way of complaints were the most valuable source of information available to the Quality and Safety Commission; do you recall that?

MS REID: Yes, I do.

MR KNOWLES: Yes. Now can I take you – bearing that in mind, can I take you to the document at tab 71 of the general-tender bundle. This is a document produced by the Quality and Safety Commission, dealing with how complaints might be dealt with through early resolution. Can I ask you to explain to the Royal Commission the various ways in which complaints might be dealt with? And I know you've set this out in your statement, but perhaps if you could, just go over that now before we go to this document.

MS REID: Okay. So we offer a free service, and we offer a service where people can phone in, and the majority of our complaints are by telephone. People can use the web form, and that's emailed to us, and we will call people back to then discuss their issues that they would like to raise. So it's a free service. People can make that – complaints anonymously or confidentially. Once we receive the initial complaint at intake, we will then have several discussions with the complainant, sometimes – or it might be at the first discussion – that discusses what their issues are and also what outcome they're seeking. Many complainants come to us, and the outcome that they're seeking is an apology from the service and also improvements in care for everybody else in the service, including their loved one, if they're still in the service. So that's sort of the main outcome that they're looking for.

We then risk-assess very quickly and determine what escalation time-frame the complaints officer needs to escalate that to their complaints-manager. It might be a moderate, which would be within 48 hours a discussion with their complaints-manager. It might be major, which would be 24 hours they need to escalate that to their complaints-manager, or immediate, and then it needs to be escalated to their complaints-manager immediately, and often that would mean a discussion with their complaints-manager about undertaking one of those type 3s that you were talking about. And then, if it was determined, that there would be a type 3, that would – a copy of that would be given to the department of health and our quality-and-monitoring group, and the national complaints-manager would discuss what happens next.

MR KNOWLES: So in terms of - - -

MS REID: Then – sorry.

MR KNOWLES: I understand that process but, in terms of making a decision about whether or not something is dealt with through early resolution or otherwise, can you explain when that decision is made and what the difference is between dealing with a complaint through early resolution - - -

MS REID: Yes.

MR KNOWLES: - - - and through referral to the resolution team, I think it's referred to?

MS REID: That's right. There's two parts. So after that escalation discussion, the complaint will be dealt with in early resolution and – or it may be determined, after another risk assessment, that the complaint is more complex or needs to – and needs to use a different tool such as investigation or conciliation, mediation or provider resolution and then it will move to the resolution phase. The resolution phase does take longer.

MR KNOWLES: And is more detailed - - -

MS REID: Yes.

MR KNOWLES: - - - in terms of the scrutiny that is given to the particular complaint and the issues raised by it?

MS REID: Yes.

MR KNOWLES: So in terms of what we see on this first page of the document:

How do I handle a complaint through early resolution?

MS REID: Yes.

MR KNOWLES: Do you see the heading:

What types of issue are suitable for early resolution?

It says underneath that heading:

We finalise a very large proportion of complaints at early resolution, therefore, all issues are potentially suitable for early resolution unless there is an immediate risk to care recipients.

And then there's some circumstances of the exceptions where one might not find a case to be suitable for early resolution.

MS REID: Yes.

MR KNOWLES: Do you agree that what this document would tend to suggest is that early resolution is encouraged wherever it is regarded as possible?

MS REID: Yes.

MR KNOWLES: Do you agree also that, in the ordinary course, it's usually regarded as possible?

MS REID: Yes.

MR KNOWLES: Going back to the document that I took you to earlier about complaints data at tab 125 of the general tender bundle, if we go to the second page of that document, this is just in relation to statistics since 1 January this year up until 30 June. You see that there are 3545 complaints finalised in the second line there?

MS REID: Yes.

MR KNOWLES: Then there's a reference to number of complaints finalised at early resolution during this period and it's 3496.

MR KNOWLES: Can I just clarify: I think that's issues.

MR KNOWLES: I see.

MS REID: Yes. When a complainant makes complaints, on average there's three issues per complaint.

MR KNOWLES: So why do you say that's issues and not complaints?

MS REID: Because each issue may have a different resolution process depending on what the issue is, so the issue could be the service has lost my laundry, or it might be the medication wasn't delivered on time to my mother, so they're separate issues

and they would be treated as separate issues. But I'm just looking at the footnote to see – is the footnote on that page?

MR KNOWLES: Yes, perhaps if we can zoom out from the page. The footnote - - -

MS REID: It talks about issues.

MR KNOWLES: In footnote 5, but – I mean, you've already seen the evidence that there were some 7800 complaints last year.

MS REID: Yes.

MR KNOWLES: Given that we're talking about half a year, this would tend to suggest that this is referring to complaints as distinct from issues for a six-month period, wouldn't it?

MS REID: Yes, it would be, yes. I could be wrong. It could be complaints.

MR KNOWLES: So if we go back to those figures that are on the screen, would you agree that what that does is bears out what you've already acknowledged, that the vast majority of complaints are finalised at early resolution?

MS REID: That's correct.

MR KNOWLES: Yes. Now, can I take you back to your statement and paragraph 55. There you refer to how the Quality and Safety Commission assesses effectiveness of its complaints handling function. You refer to several measures that it looks at in order to assess the effectiveness of the complaints handling function.

MS REID: Yes.

MR KNOWLES: Save for subparagraph (e), they are all matters that go to the timeliness within which complaints – pardon me, the first three go to matters relating to timeliness within which complaints are finalised. Do you agree?

MS REID: Yes.

MR KNOWLES: The fourth goes to how the complaint was resolved, so that's not particularly pertinent here but - - -

MS REID: Yes.

MR KNOWLES: But then the fifth refers to "number of complaints about our service". So is that – the only one of those things that you've referred to that might possibly concern any feedback, is the fifth one; is that right?

MS REID: There are complaints about our service but we also provide a survey to complainants and receive an indicator of satisfaction rating.

MR KNOWLES: Yes. I was going to ask about that. You've referred to that survey in your statement at paragraph 58.

MS REID: Yes.

MR KNOWLES: You haven't – you've just referred to – if we perhaps keep both pages up, the former page as well containing paragraph 55. Thank you for that. You haven't referred to survey feedback there in 55, have you?

MS REID: No.

MR KNOWLES: Do you now say that that is something that is used to assess the effectiveness of complaints handling functions?

MS REID: Yes, it is but it doesn't go to timeliness.

MR KNOWLES: I understand.

MS REID: As you pointed out with those - - -

MR KNOWLES: But it is one of the matters that you take into account to assess how effective the Quality and Safety Commission has been; is that right?

MS REID: It's an indicator, yes.

MR KNOWLES: Okay. All right. Do you agree that that survey and those results should be, really, the critical matter that ought to be taken into account to assess the effectiveness of a complaints handling scheme, given that it is there, after all, for the complainants?

MS REID: Yes.

MR KNOWLES: In that regard, you say at paragraphs 58 through to 62 of your statement – if we could bring up those two pages now – that what those surveys have shown is that the overall satisfaction of survey respondents – you've described how that is measured in paragraph 59 – the overall satisfaction for the last year of survey respondents was a little under 75 per cent?

MS REID: Yes.

MR KNOWLES: From that, do I take it that, one in four people who completed the survey were not satisfied overall with the complaints handling function by the Quality and Safety Commission or its predecessor?

MS REID: If that's how the maths work out, yes. I can't work it out.

MR KNOWLES: Well, 25 per cent is equivalent to a quarter so would you agree with that?

MS REID: Yes.

MR KNOWLES: Does that strike you as a good outcome?

MS REID: It's not ideal. I mean, we would strive for 100 per cent and some complainants are not happy with our outcomes.

MR KNOWLES: Well, this survey, I take it, goes to not the outcome but the process and how it is handled; is that fair?

MS REID: It is but it also – it also, in the mind of complainants, I think, is the outcome that they've received from us or the decision that we've made.

MR KNOWLES: Does that go to, perhaps, explaining to complainants what the process is better? Or not doing it effectively enough?

MS REID: Can you repeat that question, please.

MR KNOWLES: Sorry. I'm not very clear. So does that go to a lack of effectively explaining to complainants what they can expect to obtain from the process?

MS REID: I think it's – so it's about 52 per cent of the early resolution complaints are resolved to the satisfaction of the complainant. So that leaves another percentage where we make the decision that the commission is satisfied with the outcome, or the changes or the work that the service has offered up or put into place to improve care into the future. Complainants are not always happy with that outcome. Some complainants are seeking more punitive action and our aim is to get the service to improve, fix care and have a much better improved care for care recipients.

MR KNOWLES: Now, the level of overall satisfaction of 75 per cent, that fell short of the Quality and Safety Commission's aspirational target of 85 per cent?

MS REID: Yes.

MR KNOWLES: So that aspirational target of 85 per cent is one in which the, I take it, Quality and Safety Commission considers that, provided that only one in six people are dissatisfied with the service, that's okay?

MS REID: It's not okay. I would prefer all complainants were happy with our service and happy with our outcomes. So we need to constantly be talking about where we can learn, where we can improve to meet their expectations.

MR KNOWLES: Now, in your statement at paragraph 58, you say in the first sentence that the Quality and Safety Commission issues a survey to those complainants who are not within particular categories, so those who are anonymous, those who withdraw the complaint before the point at which the survey is issued or for those who choose not to participate. So there are certain people who do not get a survey?

MS REID: That's right.

MR KNOWLES: Why wouldn't you give a survey to people who withdraw from the process, given that they may do that precisely because they're dissatisfied with it?

MS REID: I don't know but I think that's something I should look at. I agree.

MR KNOWLES: Now, in paragraph 67 of your statement, you have referred to – paragraph 64, pardon me, you've referred to key performance indicators for staff who handle complaints. You say that those KPIs are informed by timeframes with respect to the triaging, resolution or referral of complaints and the six-monthly operational plan. Am I right in thinking that that places some considerable significance on timeliness of resolution of complaints?

MS REID: Yes. That's referring to the 30 days, 60 days and 90 days KPI.

MR KNOWLES: Yes. So they are actual stated key performance indicators set out for workers in terms of how they ought to resolve complaints as promptly as they can?

MS REID: Yes.

MR KNOWLES: And is there a stated KPI in relation to complainant satisfaction with the process?

MS REID: Do you mean – what do you mean? Is there an indicator that we're – is there a - - -

MR KNOWLES: Yes.

MS REID: Yes. There is, yes. I can tell you what they are now, if you like?

MR KNOWLES: Yes, what is that?

MS REID: So, currently, we're at – 59 per cent of our complaints are completed within 30 days and 82 per cent in 60 days and 92 per cent in 90 days.

MR KNOWLES: I see. So that's in terms of timeliness, but I'm asking you about whether or not there's a key performance indicator that goes to how someone deals

with complaints being to the satisfaction of complainants. Is there any measurement of that for the purposes of - - -

MS REID: There's not a measurement, but we do know that 90 per cent of our complaints are dealt with at early resolution.

MR KNOWLES: Again, I'm asking you as to whether or not - - -

MS REID: Sorry. I'm not understanding.

MR KNOWLES: I'm sure it's – I'm just not being clear, Ms Reid.

MS REID: It could be me. Yes.

MR KNOWLES: But what I'm asking you is to whether or not there's any key performance indicator for staff that is measured by way of complainants' satisfaction about the process, not timeliness issues, not how speedy things are resolved – speedily things are resolved but, rather, the qualitative satisfaction that complainants might have. Is that at all used?

MS REID: There is – we do look at the number of complaints carried over each month, and we do look at that by state, and the national manager of operations gets monthly reports, where she will get information about how we're tracking in the workloads, and she will have discussions with the commissioner about that and other executives in the organisation.

MR KNOWLES: What do you mean by "carried over each month"? You just mean that they haven't been finalised?

MS REID: Yes. Yes.

MR KNOWLES: So that's again going to timeliness, is it?

MS REID: Yes.

MR KNOWLES: All right. Well, perhaps I'll move on to your annexure. Now, in that you have dealt with or provided the description of the then complaints Commission's response to two specific cases.

MS REID: Yes.

MR KNOWLES: The first one is the complaint that was made by Ms Sarah Holland-Batt. And that was about her father's treatment in aged care. And the second was the complaint made by Ms Lisa Backhouse on behalf of her mother. Yes.

MS REID: Yes.

MR KNOWLES: Now, in doing that, you've consulted the Commission's records? They're referred to in your annexure?

MS REID: Yes.

MR KNOWLES: Did you also read the statements of Ms Holland-Batt and Ms Backhouse that had been given to the Royal Commission?

MS REID: Yes.

MR KNOWLES: Yes? Thank you. And have you had an opportunity to see their testimony that they've given to the Royal Commission orally?

MS REID: I was able to listen to Ms Holland-Batt. Ms Backhouse – I heard parts of it.

MR KNOWLES: And so I take it from that, you're fully aware of the issues in each of those complaints.

MS REID: Yes.

MR KNOWLES: Yes. And in the case of Ms Holland-Batt, as you'll be aware, then, she raised concerns about her father being a victim of abuse at the hands of a staff member and otherwise raised concerns about the clinical care that had been given to her father?

MS REID: Yes. Yes.

MR KNOWLES: And Ms Backhouse raised concerns about her mother's continence-care, falls-management, pain-management and nutrition and hydration?

MS REID: Yes. That sounds right.

MR KNOWLES: Now, in both those cases, the complainants were advocates for the aged care recipients. What proportion of complaints are made directly by care recipients themselves?

MS REID: I haven't got that with me today, but I can get that. We do statistically break that down.

MR KNOWLES: That would be something that – if you could provide that to the Royal Commission, it would be appreciated.

MS REID: Yes. Yes.

MR KNOWLES: Firstly, would that be capable of being broken down by care recipients directly making the complaint?

MS REID: Yes.

MR KNOWLES: Care recipients' relatives or other informal advocates who make complaints?

MS REID: We call them representatives, family members and representatives. Yes.

MR KNOWLES: Yes. Yes. And staff – do you break it down by reference to staff who make complaints?

MS REID: I think it's other, but when you get the data, I'll see what I can get for you.

MR KNOWLES: What about advocacy groups and community visitors: are they identified as a separate category in terms of the source of a complaint?

MS REID: I'm sorry. I can't visualise the data. I can only visualise the representatives, which is the majority. The majority is family and representatives.

MR KNOWLES: Yes. Yes. Now, that – when you say "the majority" – is it a sizeable majority of complaints, that are made by representatives, being family members or informal advocates?

MS REID: Yes. I'm visualising a pie chart that I'll give you, but, yes, it is.

MR KNOWLES: Yes. Yes. Is it well over a half in that visualisation of a pie chart in your mind? I'm not going to hold you to it, given - - -

MS REID: No, that's okay. I think it is.

MR KNOWLES: Yes. We'll receive that information from you in due course.

MS REID: Yes. Yes. Definitely.

MR KNOWLES: But given what you've just said about it being a fairly high number or high proportion of complainants being relatives or informal advocates – do those proportions point to a need for the Quality and Safety Commission to provide support for complainants who might not have supportive relatives or advocates?

MS REID: Yes. Yes. When people call us – a lot of people who call us are grieving, angry, emotional, and it's really hard, to make a complaint in aged care; it's not easy. And I think you've heard, over the course of people giving that information, it's really difficult. So we do recommend that people go to the advocacy groups, go to OPAN. They're a critical stake-holder for us. We can also support people by letting them make their complaint confidential or anonymous. We also coach and give enormous support to complainants, if they would like to raise it

with their service-provider in the first instance, which is our preference. If the service-provider can resolve the issues, be open and transparent and have good complaints-management practices in place, the relationships are much better. The previous – Ms Barnes talked about the relationship breakdown. So being – with services being able to do that, the relationships are preserved as well.

MR KNOWLES: These are people who've already come to you, I take it, where you provide that support.

MS REID: Yes.

MR KNOWLES: How do you support people in coming to you in the first place?

MS REID: In that way, with the - - -

MR KNOWLES: Do you understand my question?

MS REID: No. I thought I just answered it; sorry.

MR KNOWLES: Well, pardon me. How does the Quality and Safety Commission support people to make complaints when they don't have an advocate for them or when they, perhaps even more so, don't have an advocate and may have difficulties in communicating a complaint due to cognitive-decline, communication difficulties, very limited mobility and the like?

MS REID: So there's a lot of options. One is to refer to the advocates. There's an option for complaints officers to invite the complainant into our offices to have a face-to-face conversation; there's an option where a complaints officer can go out on site. If a complaint is raised by somebody who's not a legal representative, we will go out and talk to the care recipient and check whether they do want to raise the complaint often.

MR KNOWLES: Yes, but what is done to actually support people to make the complaint in the first place, when they might have obstacles to doing so, to even taking that first step?

MS REID: We will go out on site, if we need to, and we will sit with the care recipient and talk to them about their complaint to try and define what those issues are.

MR KNOWLES: You mentioned advocacy groups a moment ago.

MS REID: Yes.

MR KNOWLES: Did you hear the evidence of Ms Natalie Siegel-Brown yesterday, that, in this regard, there's a need for a professional and fully funded community-visitor program?

MS REID: Yes.

MR KNOWLES: Do you agree with that?

MS REID: Yes. There currently is a federally funded community-visitors scheme, and a year ago, the previous commissioner wrote to all of those people in that scheme, inviting them to have an education session with us, and we did do several – and in the letter, it gave information to them, that they could raise complaints with us.

MR KNOWLES: Do you regard – withdraw that. Now, in both these cases, the complaints were dealt with by way of communications, by telephone or email. Is that your understanding from the records?

MS REID: Definitely Ms Holland-Batt's. Yes.

MR KNOWLES: There was no face-to-face meeting?

MS REID: No.

MR KNOWLES: Do officers meet people face-to-face in the majority of cases?

MS REID: No.

MR KNOWLES: Why not?

MS REID: They try to, and they do successfully discuss over the phone what the issues are – that the complainant wants to raise – and what the outcomes are. We call it defining the issues, and they spend a lot of time, making sure that they get that right over the telephone, and most of the time they do. As I said, if there is problems and they're having a hard time or it's not working, being able to define the issues or understand what the complainant would like to happen, we can offer to come out and meet them, or as I said, we can offer for them to come and meet us, and we would.

MR KNOWLES: Well, you've given evidence about the number of staff, 123 fulltime-equivalent staff.

MS REID: Yes.

MR KNOWLES: And they're situated all in capital cities across Australia?

MS REID: Yes.

MR KNOWLES: And they're divided into regions; is that right?

MS REID: Yes.

MR KNOWLES: So one region which is staffed by personnel in Adelaide covers the whole of South Australia, Northern Territory and Western Australia?

MS REID: Yes. There are people in our Perth office as well. Yes.

MR KNOWLES: So there's – I see. I see. But there are difficulties, perhaps – I put it to you – in terms of just getting to people in regional and remote areas?

MS REID: Yes.

MR KNOWLES: Yes. Now, you've identified in your annexure various ways in which you perceive there to have been some short comings in the complaints-handling processes for each of Ms Holland-Batt and Ms Backhouse?

MS REID: Yes.

MR KNOWLES: And for Ms Holland-Batt – that's referred to in paragraph 18 of your annexure? Now, you've firstly acknowledged that the response – and this is at the top of the page – to the allegations, given their seriousness, involving, among other things, allegations of abuse by a staff member, was too slow? Did you look at why that occurred in this case?

MS REID: It was given a major rating, and I talked before about the escalation process. So that should've gone to the complaints-manager within 24 hours. The discussion was held, but the decision, in my view, is that – the service-provider should've been called earlier than within two days to discuss those issues.

MR KNOWLES: This is also going to the response time. They were given a week to respond to the allegations, weren't they?

MS REID: Yes.

MR KNOWLES: So this goes to allowing them that time while there were allegations on foot that there was, potentially, a staff member at the premises who was engaging in abuse of at least one resident.

MS REID: Yes, and when we did ring the service-provider, they informed us that they were undertaking investigation into the behaviour of the carer. They said that they had suspended the carer and that they were continuing the investigation. And it's their responsibility, to do that.

MR KNOWLES: Yes. Well, is there any responsibility – and I take this to be something that's acknowledged in paragraph C. Is there any responsibility for the Quality and Safety Commission to investigate that as well?

MS REID: Yes. What I'm referring to there was when we did get the report, the investigations report, there was a mention of another care recipient who we then

went back to the service and asked about and their answer was that they had no – they had no – they didn't know who that person was, they didn't know the name of that person. So what I'm referring to there is we took that on face value. We didn't check whether there was a person – another care recipient by that name.

MR KNOWLES: Is it right to say, also, that the complaints commission took on face value that the allegations were unsubstantiated? The allegations of abuse, that is?

MS REID: No. We did get the report. We got the report to say that they did find that the carer had – had not behaved in the manner that they should have and it was abuse and that that carer was terminated.

MR KNOWLES: But prior to that – you've read Ms Holland-Batt's statement. She says that that basically occurred as a result of her going back and approaching the whistleblower and urging the whistleblower to come forward.

MS REID: Yes.

MR KNOWLES: But there was no action undertaken by the complaints commission in that regard to go and investigate the matter; it was thrown back on Ms Holland-Batt to undertake those measures, wasn't it?

MS REID: My understanding is that Ms Holland-Batt had already raised the concerns about that carer with the service before she contacted us. And so their investigation was underway. That information about the whistleblower came later and that was where Ms Holland-Batt successfully encouraged that whistleblower to come forward and give information to the service, is my understanding from her statement to us.

MR KNOWLES: Now, is it fair to say that, in paragraph (c), what you're acknowledging is that there needed to be a greater degree of scepticism, or at least testing, of what you'd been told by approved providers?

MS REID: Yes. In the case of that care recipient, when we got the report.

MR KNOWLES: Now, in terms of Ms Backhouse, you've said at paragraph 45 of the annexure that it appeared that her complaint took some time to resolve. It took, didn't it, over six months, or about – over six months?

MS REID: Yes.

MR KNOWLES: Do you agree that that was an unduly slow resolution of the investigation into her complaint?

MS REID: Yes.

MR KNOWLES: It was only in March of 2019, and that was some three and a half months after she'd made the complaint, that it was given higher priority?

MS REID: Yes, it went to the clinical unit for clinical advice.

MR KNOWLES: That also occurred in March of 2019?

MS REID: I just have to check.

MR KNOWLES: I think on the 13th.

MS REID: Yes, and it took that timeframe before the advice was provided to the complaints officer.

MR KNOWLES: They provided their advice by 26 March, so they, in the scheme of things – so if you look at paragraph 36 of your annexure - - -

MS REID: Sorry. I've got to find it.

MR KNOWLES: - - - you see there you say on 13 March her complaint, as it was considered a higher priority, it was re-prioritised and allocated to a clinical adviser. Is that the point at which it went to a clinical adviser?

MS REID: Yes.

MR KNOWLES: You see at paragraph 37 across the page, there's a reference to clinical advice being provided dated 25 March 2019. So it was only a two-week period in which there was the advice given – sorry, that it took to get the advice from the clinical adviser. That doesn't explain the six-month period, does it?

MS REID: No. There were also delays in changing complaints officers. I thought there was a longer delay in the clinical advice coming back, so - - -

MR KNOWLES: And the clinical advice, you agree, went to there being problems in terms of clinical care, do you agree with that?

MS REID: Yes.

MR KNOWLES: Do you see, if we now leave that paragraph and move to paragraph 46, you say there, in terms of the six-month or so delay:

> *There were some initial factors that gave assurance that any immediate risks were being managed.*

And you say that one of them was that Ms Backhouse's mother had moved to a new service.

MS REID: Yes.

MR KNOWLES: That doesn't account for problems with clinical care insofar as they might affect other residents at the facility that she was at, does it?

MS REID: It's hard for me to answer that because the complaints officer managing the case would have made that decision and the clinical unit would have had discussions – the clinician would have had several discussions with the complaints officer, which is our process, to understand what's happening in the service.

MR KNOWLES: Can I take you, in that regard, to the document that is now tab 158 of the general tender bundle.

MS REID: Sorry. I'm having trouble finding things.

MR KNOWLES: It's on the screen. Can you see that?

MS REID: Yes. Thank you.

MR KNOWLES: That's a letter from the complaints commissioner to what was then the Australian Aged Care Quality Agency?

MS REID: Yes.

MR KNOWLES: That relates to the complaint raised by Ms Backhouse about her mother's care. It's a type 2 referral. It raises significant issues or concerns?

MS REID: Yes.

MR KNOWLES: So it was serious enough for the complaints commission to regard it as raising significant issues; do you agree with that?

MS REID: Yes.

MR KNOWLES: If we go to the second page of the letter, do you see, under the first group of dot points, the paragraph that begins with the words:

> *The complainant has since removed her mother from the service, due to concerns about retribution and care delivery.*

MS REID: Yes.

MR KNOWLES: It then says:

> *While concerns raised are about an individual, our review of Ms Backhouse's mother's care records indicates there may be potential to affect other residents.*

MS REID: Yes, that's why we made the referral.

MR KNOWLES: Yes. And towards the bottom of the page, under the dot points, you see it says:

> *Since 1 January 2018, we have received three complaints in relation to the service, one with similar issues of continence care and falls management.*

MS REID: Yes.

MR KNOWLES: These were issues that went well beyond Ms Backhouse's mother, weren't they?

MS REID: Yes.

MR KNOWLES: So going back to what you say in paragraph 46 of your annexure, and subparagraph (b), it's neither here nor there, is it, that Ms Backhouse's mother had moved to a new service. That wouldn't affect the immediacy of the need to deal with the complaint in respect of deficiencies in care at the facility?

MS REID: No.

MR KNOWLES: You see at paragraph (c):

> *A type 2 referral was made to the Quality Agency on 19 December.*

MS REID: Yes.

MR KNOWLES: That's the letter that we just went to, isn't it?

MS REID: Yes.

MR KNOWLES: And that was the letter – that letter was sent on 19 December. But you have said yourself, in paragraph 49, that there was a divergence between the quality agency's assessment of the adequacy of care and the complaints commission's assessment of the adequacy of care.

MS REID: Yes.

MR KNOWLES: They didn't regard it as warranting further attention but clearly the complaints commission did?

MS REID: That's right. The complaints officer in the clinical unit had a lot more information. The information they had were individual clinical records in relation to Mrs Weightman. They had hospital records. They had a lot more information that the quality assessors didn't have when they did that first assessment and so that's

why we did the type 2, so that they then understood that we had found out this information via our clinical assessment.

MR KNOWLES: But they, even after that type 2 referral, didn't assess the risk in the same way that the complaints commission did, did they? For instance, at paragraph 32 of your statement – the annexure, you actually say:

> *In response to receiving the referral, the quality agency assessors conducted an unannounced site visit.*

And there are two things that they observed: staff reported they had sufficient time to care for consumers, care recipients interviewed were satisfied.

MS REID: Yes. I'd just like to check. I think they did two visits.

MR KNOWLES: Pardon me. Are you referring to the later referral?

MS REID: Yes.

MR KNOWLES: Sorry. Pardon me, Ms Reid. So at paragraph 48, you refer to a supplementary referral that was made?

MS REID: Yes. Yes.

MR KNOWLES: Is it fair, though, to say that, between what is now the quality assessment and monitoring group and the complaints resolution group, there is a difference of opinion about the seriousness of the departure from good quality care at this facility?

MS REID: By the time the supplementary referral was made, the service had already reported all of the changes and what they were doing to mitigate what we'd found and fix up what we'd found and we did find the service lacking in a number of areas, as you know, and the service had described an action plan and a whole lot of other areas that they agreed to make sure that their care had improved, particularly clinical care, and that was – that was quality-assured by the clinical unit.

MR KNOWLES: Can I just, seeing as you raised the clinical unit, I mentioned earlier that there was an allocation to a clinical adviser on 13 March 2019 in Ms Backhouse's complaint and that the clinical adviser gave advice dated 25 March 2019. Do you recall that?

MS REID: Yes.

MR KNOWLES: It was brought to my attention that you've also referred to the fact of the complaints officer seeking advice from the clinical unit in December the previous year. You say that at paragraph 29 of your statement. But in terms of the

advice that was received from the clinical adviser, I take it that took two weeks from when it was referred to the clinical adviser; is that right – in that six-month period?

MS REID: Yes.

MR KNOWLES: Okay. Now, in terms of the process, you've no doubt seen what Ms Holland-Batt has said about how her case was referred to early resolution. You've referred to that referral taking place the day after she made the phone call to make her complaint? Perhaps if you have a look in the annexure at paragraph 4.

MS REID: Thank you.

MR KNOWLES: Do you see there, on 4 April 2017, it was determined that this complaint was a suitable case for early resolution.

MS REID: Yes.

MR KNOWLES: Within one day of making the complaint, it's determined that this case ought to be dealt with more summarily; do you agree?

MS REID: Well, it was determined that it could be dealt with at early resolution, yes.

MR KNOWLES: Ms Holland-Batt wasn't consulted about that determination, was she?

MS REID: No.

MR KNOWLES: Do you agree that she ought to have had some input into how the complaint might be resolved?

MS REID: There is a file note that the complaints officer did verbally discuss with – have several discussions with Ms Holland-Batt about her issues that she wanted us to resolve and the outcome she was looking for and part of that file note was that we would be going back to the service and discussing her outcomes with them and that we would be – so I guess what I'm saying is that Ms Holland-Batt knew that what we were going to be doing was going and phoning the service, which is our early resolution approach.

MR KNOWLES: She didn't know, though, that there were other options for how you might deal with it; that there was an early resolution approach and then there was another approach involving referral to the resolution team, did she?

MS REID: Not to my knowledge, no.

MR KNOWLES: Do you think that people should be told that there are those different methodologies for resolution of their complaints at the outset?

MS REID: Yes, I do.

MR KNOWLES: Do you think they should have an opportunity to make some sort of submission as to which of those approaches they would prefer?

MS REID: No.

MR KNOWLES: You don't think they should have some - - -

MS REID: No.

MR KNOWLES: - - - an opportunity even just to make a submission to that end.

MS REID: They could say but it really is – the decision is – is up to the delegate and the complaints officer based on how the case is going, what the factors are, what the risk factors are, the complexity of the case. The complaints officer and the complaints manager determine the process that's needed. If it goes to resolution, there is a – and there is a discussion with the complainant about some of the tools that we use and one might be conciliation. In that case, we would discuss with the complainant, "We would like to conciliate on site; would you be open to that?" And describe the process. So depending on what stage of the process we're at, there is information provided to the complainant.

MR KNOWLES: But you wouldn't be telling somebody that their complaint has been referred to early resolution?

MS REID: Not early resolution but we do advise them if it goes to resolution.

MR KNOWLES: And so when a complaint goes to early resolution, you agree that that document that I took you to earlier about how matters are to be resolved by early resolution states, "Our intent is to resolve a case quickly" if it's been referred to early resolution. Do you think somebody should know about that, that the intent of the decision-maker is to resolve the matter quickly if it's referred to early resolution?

MS REID: I think the complaints officer would have said, because that's our process, that we will try to resolve this as quickly as we can, we'll try to get the outcomes for you as quickly as we can. I mean, that would be the language that we would use because we believe that if we can resolve it quickly with the service and with – it's better for relationships, it's better for outcomes at the end of the day.

MR KNOWLES: In relation to the process that then followed, you will have seen that Ms Holland-Batt indicated that she was never shown any written response from the approved provider?

MS REID: Yes.

MR KNOWLES: Now, she has an interest in the process, obviously, the key interest is the complainant, do you agree with that?

MS REID: Yes.

MR KNOWLES: Do you agree that due process, in those circumstances, ought to include provision of a written response from the approved provider to her for her comment?

MS REID: What happens at early resolution is that, if the complainant says they're really satisfied and they're happy, our process is to ask the complainant, "Would you like a feedback letter or would you like more information?". Depending on what they say, we will pursue that for them.

MR KNOWLES: My question was do you think that the appropriate course was to give her the approved provider's response?

MS REID: Listening to Ms Holland-Batt's evidence, yes, I think the communication needed clarifying. Not verbally but in writing.

MR KNOWLES: Provision of that document, certainly in this case at the very least, would promote transparency of the process, wouldn't it?

MS REID: Yes.

MR KNOWLES: And it would give her proper and fair process to deal with anything that was put by the approved provider with which she disagreed?

MS REID: Yes. And I think it would have given her a greater understanding of the outcomes we had achieved with the service for her.

MR KNOWLES: And possibly greater satisfaction with the process?

MS REID: Yes, yes.

MR KNOWLES: Now, you referred – I took you earlier to the question of testing information provided by an approved provider. Do you remember how that was one of the short comings that you identified in paragraph 18 of the annexure?

MS REID: For Ms Holland-Batt?

MR KNOWLES: Yes.

MS REID: Yes.

MR KNOWLES: Other than speaking with management, what inquiries were made to test the assertions in the approved provider's response?

MS REID: The only – the only evidence that we collected, to my knowledge, was a copy of the report.

MR KNOWLES: A copy of which report?

MS REID: The investigation report that the provider undertook into the investigation of the carer.

MR KNOWLES: That's the document that was provided by management of the approved provider?

MS REID: Yes. And then the responses from management which you're talking about, the provider response.

MR KNOWLES: Yes. So nothing else?

MS REID: No. It was all verbal and discussions over the phone.

MR KNOWLES: But there were no interviews with staff or residents or anyone else other than Ms Holland-Batt?

MS REID: No, because the provider did that with their investigation. They interviewed 11 people.

MR KNOWLES: So you relied on the provider's conduct of the investigation yourself?

MS REID: Yes.

MR KNOWLES: When I say "yourself" - - -

MS REID: Yes, the complaints officer did.

MR KNOWLES: - - - I mean the Complaints Commission relied the provider to conduct the investigation?

MS REID: The complaints officer did, yes, and the complaints manager.

MR KNOWLES: Do you regard that as satisfactory?

MS REID: We rely on – whether it might be seen as unsatisfactory, we rely – we don't – we don't follow up. We do rely on the complainant coming back to us and letting us know if the changes have actually been put in place. Our other reliance is the strengthening joined-up now, of ourselves and the quality and monitoring group where we make many more type 1 referrals at the end of our processes so that they are able to monitor and check that what the services say they have put in place has actually been put in place.

MR KNOWLES: Well, that was my next question, actually. How was that done in the case of this service – Ms Holland-Batt's – that was the subject of Ms Holland-Batt's complaint? Do you know if there was any follow-up on the purported improvements that had been put in place by the approved provider?

MS REID: No. The complaints officer didn't make a type 1 referral at the end of the process.

MR KNOWLES: So there was no follow-up to see that what had satisfied, at least in words, the complaints officer, had actually been put into effect and was sustainable down the track?

MS REID: No. Unless the complainant came back, and, to my knowledge, she wouldn't.

MR KNOWLES: Well, she wouldn't because her mother had moved to another facility?

MS REID: That's right, yes.

MR KNOWLES: So was it the same in the case of Ms Backhouse's complaint? Was there an absence of a type 1 referral after that?

MS REID: No, we made the referral that you showed me, the supplementary referral at the end.

MR KNOWLES: Pardon me. I'm sorry, Ms Reid.

MS REID: That's okay.

MR KNOWLES: I've just been informed, I think I've got the two cases conflated in the sense that Ms Holland-Batt's father didn't move to another residence so I apologise, Commissioners, for that.

MS REID: It's Mrs Weightman.

MR KNOWLES: Yes. So in the case of Ms Backhouse's complaint about her mother - - -

MS REID: Yes.

MR KNOWLES: - - - was there a type 1 referral that followed on from that?

MS REID: In the case of Ms Backhouse's mother, there was a referral made at the end of – a supplementary referral made at the end of the process, yes, to provide the quality and monitoring group with the outcomes that we'd found, where we found

that care was lacking but we also informed them of the remediation and improvements and actions the service had taken in the form of the action plan.

MR KNOWLES: But no such referral in respect of Ms Holland-Batt's complaint?

MS REID: Correct.

MR KNOWLES: Yes. That was cast back on her, if there was a need for a further complaint, it had to come from her or some other resident or their representative?

MS REID: In that instance, yes. We could have received further complaints as well.

MR KNOWLES: Yes. In terms of Ms Holland-Batt, can I take you to what is now tab 157 of the general tender bundle. It's document number CTH.4009.9998.0003. While that's being brought up, perhaps – this complaint was resolved on the basis that all issues had been resolved to the satisfaction of the complainant.

MS REID: Yes.

MR KNOWLES: Yes. And you've heard Ms Holland-Batt's evidence about that?

MS REID: Yes.

MR KNOWLES: Do you think that she was satisfied as to how the issues were resolved, in truth?

MS REID: No.

MR KNOWLES: In terms of this document that's been brought up, if we can go to the second-last page, do you see at the bottom of the page there's a passage that begins with:

> *COM remains sceptical of improvements and is concerned that the procedures discussed were in place at the time but didn't prevent her dad from being victimised.*

MS REID: Yes.

MR KNOWLES:

> *However, she has agreed to finalise the complaint.*

Do you agree that doesn't suggest that she was satisfied with the process, even to the complaints officer's knowledge?

MS REID: Well, Ms Holland-Batt asked us to go back to the service and find out from the service what procedures they had in place and what whistleblowing procedures and other processes they had in place, which we did communicate to Ms Holland-Batt – or the complaints officer did communicate to Ms Holland-Batt. There's kind of a piece there that's missing where – which is elsewhere, where the complainant – where the file note would have said that she verbally explained the outcomes and what the service provider had said and agreed.

MR KNOWLES: Yes. But accepting all of that, do you agree that, even after that explanation has been given, there's an ongoing level of concern on the part of the complainant at that point?

MS REID: I'm sorry, I don't know, because the complaints officer had other file notes and she – in my view, she 100 per cent thought that Ms Holland-Batt was satisfied. I know – I know now, listening to Ms Holland-Batt's evidence, that she wasn't.

MR KNOWLES: Do you think, in cases such as these, there is an impetus to deal with the complaint quickly at the expense of a proper due process for the complainants?

MS REID: No.

MR KNOWLES: No further questions for Ms Reid. Thank you, Commissioners.

COMMISSIONER TRACEY: Ms Reid, I just want to confirm with you my understanding of the way in which the early resolution of complaints is achieved. Your organisation gets a written complaint or a telephone complaint, which is reduced to writing so that there's a record of that complaint.

MS REID: Yes.

COMMISSIONER TRACEY: And what's the next step? Is it that the terms of – the complaint is then sent to the provider?

MS REID: Yes. The next step is to put those allegations or put those concerns to the provider and then to immediately start to talk to the provider about what, they think, they could do to meet the outcomes. We also explain to the provider the outcomes that the complainant is looking for.

COMMISSIONER TRACEY: Yes. And so there is both written communications and telephone communications between your office and the provider.

MS REID: Yes.

COMMISSIONER TRACEY: That right?

MS REID: Yes.

COMMISSIONER TRACEY: What's the next step? The provider responds in writing?

MS REID: Yes, to our questions. Yes.

COMMISSIONER TRACEY: At that point, does the case officer make a judgment about whether the complaint has been satisfactorily resolved or not?

MS REID: The complaints officer, yes, makes a judgment. Yes.

COMMISSIONER TRACEY: And once the case officer has formed that judgment – if it is favourable to the provider, that's an end of the matter; is that right?

MS REID: No. Once the complaints officer has thought about that, they then call the complainant back and discuss what the provider has proposed to do to improve care or to meet the outcomes that the complainant is looking for, sometimes an apology, sometimes both that and what they're going to do to remediate or fix up these areas of concern.

COMMISSIONER TRACEY: And that's done over the telephone.

MS REID: Yes.

COMMISSIONER TRACEY: And if the complainant says, "Well, I'm satisfied with that explanation", that's an end to the matter?

MS REID: Yes.

COMMISSIONER TRACEY: If the complainant says, "I'm not satisfied because of A, B and C," what happens then?

MS REID: What happens then is we take the A, B and C back to the provider as well and discuss again A, B and C and keep going back until we – the complainant is satisfied that the provider has improved. If we get to a point that we think that the provider has – and the complaints officer can make that judgment – has put all the necessary steps in place to mitigate risk, to improve care, then it's to the satisfaction of the commissioner, and it's closed to the satisfaction of the commissioner. The complainant then has review rights.

COMMISSIONER TRACEY: Yes. What exactly are those review rights?

MS REID: They're able to come back to us within a certain number of days and ask for a reconsideration of their decision.

COMMISSIONER TRACEY: And who conducts that review?

MS REID: There's a review team. So it's a – separate officers that report to me, not the national complaints-manager.

COMMISSIONER TRACEY: Were you here this morning, when Ms Barnes gave her evidence?

MS REID: Yes.

COMMISSIONER TRACEY: And you heard her saying that she was, simply, advised by letter at the end of the review process that it had been decided, not to investigate the matter further, but given no reasons beyond that or other explanation. Now, I'm conscious that that's, probably, the first time you heard that.

MS REID: Yes. It - - -

COMMISSIONER TRACEY: But is that a normal response, and, if so, do you regard it as satisfactory?

MS REID: It's not a normal response. The response would have a bit more information in it, and it would also say that you're able to go to the ombudsman, if you're not happy with – and we give the details, phone numbers of the Commonwealth ombudsman – to be able to take that further, if they didn't agree. Sometimes we would also do another whole resolution process. It's not always the case.

COMMISSIONER TRACEY: In the normal course of an investigation, would the case officer provide a copy of any written response from the provider to the complainant?

MS REID: If the case goes to resolution, which is where we are able to use investigation, conciliation, mediation or another, more-intense service-provider resolution, the complainant always gets a written response, and, yes, they do get a lot more information. We will always ask the provider "Can we give that response to the complainant?". It's a lot more intensive, and they do get a lot more information.

COMMISSIONER TRACEY: How can a complainant make an informed judgment as to whether or not the matters under complaint have been satisfactorily resolved, if they don't have access to the precise response of the provider?

MS REID: So if you're referring to the early resolution, where – it is our process, to verbally provide that information, and most of the time, people are satisfied, and they talk through the issues, and they say "I'm satisfied" - - -

COMMISSIONER TRACEY: It depends on what they're told. Doesn't it.

MS REID: Yes.

COMMISSIONER TRACEY: The case officer might be paraphrasing or shortcutting. Why not just put the response on the photocopier, scan it and send it?

MS REID: Okay. So we can ask the service provider; the service-provider can say "no" - - -

COMMISSIONER TRACEY: Why? The complainant's written complaint is given to the provider. Why not reciprocity?

MS REID: Yes. In aged care – I would have to say that it's not an open and transparent complaints-management kind of best practice if you like, within services generally. They are a bit defensive and feel threatened by doing that sometimes, and that's about open disclosure. With the new standards – we believe that's going to go a long way to trying to help to change that culture within aged care services, that they are open about their complaints, they do talk about their complaints, such as Professor Paterson talked about in his evidence. So under the Aged Care Act, we are unable to give that document to a complainant, if the provider doesn't agree, due to those provisions.

COMMISSIONER TRACEY: On a different topic: I'm just trying to get a clear understanding of how there are internal communications and notifications from one section of your operation to another about the existence of problems.

MS REID: Yes.

COMMISSIONER TRACEY: Are you familiar with the Earle Haven matter?

MS REID: Generally, yes.

COMMISSIONER TRACEY: Well, you would know that in June the assessors had gone in and amongst the things they were told was that 71 per cent of the residents of the establishment were under some form of psychotropic medication and 50 per cent were subject on a regular basis to physical restraint. Now, that was information gleaned from the provider so that there was no question of needing to put that information to the provider to get it confirmed. That's what the assessors had been told.

MS REID: Yes.

COMMISSIONER TRACEY: Now, as we were told yesterday, that should have raised alarm bells. Do you know what happened internally within the Agency or the Commission, as it now is, about whether that information was conveyed to those elements that could do something about it? I would've thought there should've been a clinical team down there the next day.

MS REID: Yes. We – Professor Paterson talked about the canary in the coalmine and that complaints have that power and that information and that intelligence, and,

unfortunately, as you saw through some of the evidence given, that information – the complaints officer should've joined the dots and the complaints manager joined the dots and passed that information on to the quality-and-monitoring group a lot quicker than they did. I would agree.

COMMISSIONER TRACEY: Well, they hadn't done it by the 11th of July.

MS REID: I know.

COMMISSIONER TRACEY: And as far as we know, it's not been done since.

MS REID: They have it now. Yes. Yes. But you're right; it wasn't - - -

COMMISSIONER TRACEY: Well, beyond any point at which they can do anything practical about it.

MS REID: Yes. Yes. They didn't do their curiosity - - -

COMMISSIONER BRIGGS: ..... one question, please. In the new procedures, is it a requirement, when an individual makes a complaint to a provider – so before it comes to you – that the provider now makes the response in writing?

MS REID: There's no requirement for them to manage their – previously manage their complaints except to have good complaints-management processes in place. Now with standard 6, there are some really – more-effective requirements, in my view, that service-providers are going to have to meet, and they're going to have to show evidence that they have open disclosure in place, that they have better-practice complaints management processes in place, that they are recording those and that they are showing that their complaints make improvements. So they're going to need to show the assessors that, when they're assessed now under standard 6 and also with clinical open disclosure in the clinical standard. That's a good thing.

COMMISSIONER TRACEY: Anything arising out of that, Mr Knowles?

MR KNOWLES: Just one question. And that is this, Ms Reid: in terms of what, you say, prevents the approved providers from providing – pardon me – prevents the Quality and Safety Commission from providing the approved provider's submission to complainants – what provision – what statutory provision is that?

MS REID: I can't – I don't have the Act with me now, but it's words to the effect of "not sharing information about the provider's business". It's under the Aged Care Act. If I had it, I could look it up and find it. But – yes. That's if they say "no". There are occasions where they say "yes" as well.

MR KNOWLES: Are they asked routinely as to whether or not any written submission that they've put in can be shared with a complainant?

MS REID: I believe so; yes. But not in the case of Ms Holland-Batt unfortunately.

MR KNOWLES: No. Nothing further. Thank you, Commissioners.

COMMISSIONER TRACEY: Ms Reid, you might be kind enough to add the answer to that matter to the other item which you volunteered very kindly earlier to provide the Commission with information about, but, subject to that, you're excused from further attendance. Thank you very much for your attendance.

MS REID: Thank you very much. Thank you very much.

COMMISSIONER TRACEY: The Commission will adjourn until 12 noon.

ADJOURNED [11.44 am]

RESUMED [12.06 pm]

COMMISSIONER TRACEY: Before you start, Mr Bolster, I've just got to amend the exhibit list. The last two exhibits in order should have been marked as 8-39 and 8-40.

EXHIBIT #8-39 WITNESS STATEMENT OF DEBRA ANN BARNES DATED 24/07/2019 (WIT.0328.0001.0001)

EXHIBIT #8-40 WITNESS STATEMENT OF SHONA LIANNE REID DATED 26/07/2019, AS AMENDED, AND THE ANNEXURE THERETO (WIT.0307.0001.0001 & WIT.0307.0002.0001)

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioners. The next witness is Professor Debora Margaret Picone who I call, and who is on the audiovisual link from Sydney.

<DEBORA MARGARET PICONE, SWORN [12.07 pm]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: If the following document could be brought up, WIT.0290.0001.0001. Professor Picone, you have in front of you a hard copy of a document that bears those numbers at the top right-hand corner? Is that correct?

PROF PICONE: I'm just trying to check now. Mr Bolster, I have my statement in front of me, my witness statement.

MR BOLSTER: Yes. Does it have some numbers at the top right-hand corner?

PROF PICONE: No, it – this particular one does not.

MR BOLSTER: All right. It's the statement dated 19 July this year?

PROF PICONE: Yes.

MR BOLSTER: It comprises some 39 pages?

PROF PICONE: Yes, that's correct.

MR BOLSTER: Is that statement true and correct to the best of your knowledge and belief?

PROF PICONE: Yes, it is.

MR BOLSTER: I tender Professor Picone's statement, Commissioners.

COMMISSIONER TRACEY: Yes. The witness statement of Debora Margaret Picone dated 19 July 2019 will be exhibit 8-41.

EXHIBIT #8-41 WITNESS STATEMENT OF DEBORA MARGARET PICONE DATED 19/07/2019 (WIT.0290.0001.0001)

MR BOLSTER: Professor Picone, you are the chief executive officer of the Australian Commission on Safety and Quality in Healthcare; correct?

PROF PICONE: Yes.

MR BOLSTER: You've held that position since 2012?

PROF PICONE: Yes, that's correct.

MR BOLSTER: So far this Royal Commission has heard evidence from various officers in the Safety and Quality Commission in relation to aged care and the safeguarding and quality commission in relation to the NDIS. What's the distinguishing feature of your commission?

PROF PICONE: Our commission is a statutory health corporation established under the health reform legislation to oversee – this is a precis – to oversee the safety and quality of the acute healthcare system. It's different to the other agencies in that it's a shareholder model between the Commonwealth, the states and the territories actually constitute the group that we report to.

MR BOLSTER: Where does direction in relation to the development of standards come from? Does it come from COAG or does it come from the organisation itself?

PROF PICONE: It comes generally from the organisation. From time to time, COAG will make referrals back to us to investigate matters and provide advice to them.

MR BOLSTER: You say in paragraph 15, if we could perhaps turn to that, you list there the purposes of the organisation. Could you speak briefly to what it is that you're principally focused on in your activities?

PROF PICONE: The commission has been established to lead and coordinate national improvements in safety and quality in healthcare. We focus most heavily on the formulation of standards, guidelines and other matters relating to safety and also to the operation of an accreditation system for hospitals, day procedure centres and dentistry.

MR BOLSTER: You accredit all public hospitals and private hospitals?

PROF PICONE: We oversee that accreditation system, yes.

MR BOLSTER: All right. And the assessors who are involved in that accreditation system, do they respond to a training framework that you develop and you control?

PROF PICONE: They're required to respond, yes.

MR BOLSTER: What about assessment against the standards – which we'll come to in due course? Who carries out the assessment process?

PROF PICONE: There are eight independent accreditation agencies that have been accredited by the commission for the purposes of conducting accreditation of both the public and private healthcare system and so it will depend on who's been appointed by that health service to conduct the accreditation. Generally, it's done on a tender process.

MR BOLSTER: Is the approach that the accreditation procedures and the people who do it operate to a national framework and national principles?

PROF PICONE: Yes. They must operate to our framework and principles.

MR BOLSTER: All right. We'll come back to that a little bit later. But can we talk, firstly, about transparency and public disclosure of performance information. It's one of the issues you deal with fairly early in your statement. Why is the measurement of clinical data fundamental to advancing safety and quality?

PROF PICONE: Because it actually shines a light on what is actually happening. There's very strong evidence that promoting that transparency will also inform the choice of the consumer by providing them with direct information. It certainly stimulates improvements in quality and safety and it also holds the provider accountable for the delivery of health services.

MR BOLSTER: Could you speak briefly to some of the best practice models in that area around the world?

PROF PICONE: I would have to say that Australia is lagging behind some international examples. So, for example, in the United Kingdom, there's a national adult cardiac surgery audit that's publicly reported annually and actually gives you the results and outcomes of cardiac surgery. So that means that I as a consumer can look that up and decide which hospital is going to give me better outcomes. We're currently working through a process with the Australian Health Ministers' Advisory Council, and the council itself, on improving measures and to develop a set of measures that are relevant to the consumer rather than a set of performance measures.

MR BOLSTER: We'll address that in some detail later. How broad, though, is the system of mandatory reporting in Australia?

PROF PICONE: The system of mandatory reporting of adverse events is very broad and, in my view, one of the best developed internationally. So every hospital, public and private, is required to report on a set of what are called sentinel events, which are events that should never happen, very serious adverse events, and then a series of other clinical adverse events and then, more recently, a series of what are called hospital-acquired complications. So we have a very detailed reporting-system on adverse events.

MR BOLSTER: All right. Well, what does your Commission do with the information that it receives at all three levels?

PROF PICONE: The sentinel events are reported annually through the Minister's council. There's not a large number. There's about 67, but they're very serious. For example: wrong-sided surgery, mismatched blood transfusion. These are things that should never happen, and they're publicly – they are publicly reported by each state and territory. The other data is reported by each jurisdiction. So – the number of clinical events and incidents by hospital, and then, more recently, the hospital-acquired complications are moving into a reporting-regime where they'll be reported on a hospital basis.

MR BOLSTER: Well, if we can, look at the hospital-acquired events or HACs, as they're called. You list them in paragraph 36. If we could, perhaps bring that up onto the screen here at the Commission. A through P are the hospital-acquired complications. Is that – you have a copy of that in front of you, don't you, Professor Picone?

PROF PICONE: Yes, I do.

MR BOLSTER: That – you say they include – how many HACs are there in total?

PROF PICONE: There are 10.

MR BOLSTER: Why do we see A through P, if there are 10?

PROF PICONE: Because some of them break into subcategories, and there's been a recent addition. So we've given you the most recent list; there are 16.

MR BOLSTER: Right. And so what's the process for the reporting of those on a hospital-by-hospital basis? How do – how does that information come to you?

PROF PICONE: The information is required to be reported, and this requirement was made by the health Minister's council. The information is sourced from the patient's medical record. So we know, and we have a lot of confidence in the actual accuracy. The information is then fed up through that hospital, through the state department of health and then in to us at the Commission.

MR BOLSTER: If you wanted to know if there was a trend in relation to pressure injuries in a particular region of NSW for example, you could analyse the data from the previous year; is that a fair summary?

PROF PICONE: Yes, it is.

MR BOLSTER: And if you were able to identify an increase in a particular clinical indicator such as that, what would be the response of the Commission?

PROF PICONE: It's now actually subjected to a funding-arrangement. So if the health service has a higher-than-accepted rate, say, of pressure injuries – they will actually lose funding based on that.

MR BOLSTER: When you look at that list – a good number of those indicators could transport or be applicable directly to a funding-situation in aged care, couldn't they?

PROF PICONE: Absolutely.

MR BOLSTER: I'm thinking for example of delirium, malnutrition, infections and, of course, pressure injuries themselves.

PROF PICONE: Absolutely. And I would add falls resulting in fractures as well.

MR BOLSTER: What about UTIs?

PROF PICONE: They'll get picked up in the healthcare-associated infections. Urinary-tract infection is the most – one of the most common infections in residential aged care.

MR BOLSTER: Right. So that – and what's the – what are the barriers for a hospital to implement a system that records these sorts of complications?

PROF PICONE: There's no barrier.

MR BOLSTER: Would there be a barrier for an aged care facility to collect and report on information about a select group directly applicable to aged care?

PROF PICONE: In my view, no barrier.

MR BOLSTER: The tying of these events or performance measured against these events, at all three levels: how significant has that been in achieving a clinical performance?

PROF PICONE: The – if we go to the actual performance-reporting data, which has been reported for a long time – and you may be familiar with things such as hospital waiting-lists, waiting-times in emergency departments. They have been very significant in the way the actual health system is measured, because the community doesn't find it acceptable, that a person waits too long for a surgery, particularly if a surgery's – for a cancer surgery and the doctor has said they need it within the month and they're waiting three months; this is not acceptable.

So those performance measures that have led to very significant changes in the system. These more-recent measures, which we've had out now for just under 18 months, getting on to two years – it's early days yet, but we're already starting to show some reductions in some of those areas, but in international jurisdictions that've used them, some of those complications have dropped by up to 40 per cent.

MR BOLSTER: At the moment we're talking about disclosure reporting and analysis within the healthcare system. So this would be information known to the hospitals, to practitioners, to the state departments of health. What about if we go outside that bubble to the consumer, the patient or the relative of the patient – to what extent is there public disclosure and reporting of similar data?

PROF PICONE: So, in our view, very little. Yet we have very, very rich sources of clinical-outcome data that would be of great interest to the public, but they're not aware that these data exist, and some of the medical profession aren't keen for it to be published. So there are clinical-registry data going back over 10 years that show you the outcomes, either good or bad, from different interventions. But we do know

that people are not so much interested in performance, though they're very concerned, if their local hospital has ambulances queuing out the front, but they tend to be more interested in what's happening, for obvious reasons, to them.

So they'll be interested in things like what is the cost of care including out-of-pocket expenses, how long are they expected to wait for an elective procedure, how long will I be in hospital for. "Will someone give me decision aids to help me make a decision about the treatment options? What's the likely success of treatment outcomes?" People are increasingly interested in the hospital-infection rate because of the emergence of antimicrobial-resistance, and they're very interested in the opinion of other patients about their outcomes and experiences of care.

MR BOLSTER: Is there any reporting at all in the aged care system that you're aware of about the infection issue that you were just talking about?

PROF PICONE: There is no reporting, and, in fact, the Commission has worked with other Agencies in the last two years to do reporting on infection rates in aged care facilities.

MR BOLSTER: Should that be a priority matter that's - - -

PROF PICONE: Yes, it should.

MR BOLSTER: Why?

PROF PICONE: It's a major public-safety risk, and it's a major risk to the actual individuals within the residential-aged care facility and, even more so, because of antimicrobial-resistance.

MR BOLSTER: For example: where there's a gastric outbreak in a nursing-home, fundamental, critical incident that requires some serious response – are we in the same ballpark in terms of reporting? If there was reporting about infection control in that facility – would that not assist in stopping those sorts of outbreaks?

PROF PICONE: Yes, it would, though I do believe that we are better at public-health responses to things like, for example listeria, gastro outbreaks and other things, than we are to a urinary-tract infection, major skin infections and other areas.

MR BOLSTER: All right. The – you mention that only seven indicators are currently reported, out of, I think, an intended list of 17, which is the ultimate aim. What progress is under way to get to 17, and when is the health system likely to get there?

PROF PICONE: We actually report all of these now. Starting July 1, every one of these hospital-acquired complications is reported by every public hospital and day-procedure centre in Australia.

MR BOLSTER: Right. You mentioned one of the problems in getting to that point has been the fact that different jurisdictions collect different data in different ways; is that correct?

PROF PICONE: That is absolutely correct. So one of the roles of the Commission is to harmonise those data collections and to remove some of that controversy. So for argument's sake: one jurisdiction held us up for nearly four years over a denominator. Sad but true.

MR BOLSTER: Yes. Well, in aged care, where there's one funder, one regulator and one person to collect the data, those barriers wouldn't be there.

PROF PICONE: Absolutely. It's a much easier data-collection exercise because of that.

MR BOLSTER: All right. Can we go back, then, to the patient-centred reporting measures. They're called PROMs and PREMs. A PROM is a patient-reported outcome measure. And a PREM is patient-reported experience measure. What's the difference between the two?

PROF PICONE: The PROM is geared more into the actual procedure. So it might be a person undergoing treatment for cancer. They might've had a hip replacement. The PROM's reporting tends to go into some detail. So for example: if I decide to have a knee replacement, it will tell me all the things I need to know, how long will I be in hospital, what day should I be up walking around, the average person's going to be up walking around, what will my pain be like, but most importantly to the individual, what will my exercise tolerance and pain be like two months post-surgery. So the PROMs tends to focus in on clinical groups, whereas the PREMs, which were developed by the Commission, focus in on the person's experience in the healthcare system.

MR BOLSTER: I want to then turn to the issue of standard-setting, and one of the roles of your organisation is the development of the eight standards in the national health-standards. What is the philosophy behind the standards for the health sector?

PROF PICONE: The standards are designed to protect the public from harm – so they're a risk-mitigation strategy – and to improve the quality of the healthcare system.

MR BOLSTER: And how closely are they aligned to the aged care-quality standards?

PROF PICONE: While I am familiar with the aged care-quality standards, I don't know them in depth, but I do know that there are some – and I'm taking this very much from memory – that there are some crossovers such as clinical governance, which we have been involved with, partnering with consumers, the – they have an infection standard, and I don't recall if they have a medication-safety standard.

MR BOLSTER: You talk about an aged care module. Is that a – what is that? Is that a part of the standards or is that a clinical-governance – a clinical-guidance standard that operates outside of the rest of the standards?

PROF PICONE: This arose because there are health centres called multipurpose centres. They're, generally, in rural and remote settings. They have a mixture of long-term residential care, which is the majority of the care that goes on there, some acute care given via – generally general practitioner or nurse practitioner and then allied healthcare. Those services approached us and wanted to be accredited under the national safety standards. So we have to date accredited 147 multi-purpose centres under the national safety standards.

MR BOLSTER: Do they report to you on the aged care side of their performance?

PROF PICONE: Yes, they do. And the purpose of developing that aged care module was we do this with the standards. If we've got specialised services, we take the core standards but write it in such a way that it's relevant to that particular service. So it becomes more real for them and also for the consumer.

MR BOLSTER: So, for example, the HACs, going back to the list in paragraph 36, that are applicable to aged care, you receive data from the MPS about how they perform in that regard?

PROF PICONE: No, we don't, because they're residential – they're listed as residential aged care beds, but we have actually studied it. And we're giving this some consideration at the moment because there are, in some places, quite high rates of pressure injuries, infection and other areas, surprisingly high rates, and more than we see in some acute care hospitals. But the answer to your question is they can – we could turn that on tomorrow if we wanted to.

MR BOLSTER: Right. Okay. Thank you. What aspects of the health standards would you like to see as a priority in the aged care standards? Have you thought about what's missing, what essential features in the health standards could be transported into aged care?

PROF PICONE: Yes. Our view is there should be one set of core standards because it doesn't matter where an older person is, whether they're in doctors' rooms, they're at their general practice community health, residential aged care or an acute care setting, it's the same person with the same set of care needs. So we've argued, fairly strongly, in our submission to the Royal Commission that there should be a set of core standards and I'm just trying to take myself to where we actually put this in our submission. Yes.

So we felt for governance, including clinical governance, patient-centred care, preventing and controlling healthcare-associated infection, comprehensive care – so pressure injury, falls, poor nutrition and malnutrition – cognitive impairment particularly in relation to unpredictable behaviour and restrictive practice, the actual

accreditation scheme itself and then risks of harm for older people at times of transition. Then medication safety, end-of-life care and having a series of safety and quality measures. And we believe they should be harmonised. They should be exactly the same whether it's an acute care setting or in a longer-term care setting.

MR BOLSTER: I just want to explore with you one of those standards. If we could bring up in the Commission hearing room, tab 8 which is the health standard and we'll go to page 138 of that of that document to standard 1.11 and 1.12.

PROF PICONE: This is incident management systems and open disclosure?

MR BOLSTER: Yes. If we could have brought up side-by-side with that the relevant aged care standard and the aged care standards are at – perhaps I will just read them out. In the aged care standard 8, it's in these terms:

> *Where clinical care is provided, a clinical governance framework, including open disclosure, is a requirement –*

but it's expressed in those very simple terms. At standard 6, there is a requirement that:

> *Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

May I suggest, Professor Picone, that there is far more detail in your standards 1.11 and 1.12. Can I ask why you go into such detail in those standards?

PROF PICONE: Yes. So the open disclosure system has been in place in Australia for over 10 years. And, in fact, Australia was the first country to adopt this as a national standard. So we now have a lot of experience with the actual operation of it in the field and it's, over the years, been quite variable. So given that, when we revised these standards just recently, we made the elements of it much clearer in this second standard but it's also the standard that I often refer to as the Sergeant Schultz defence, which is, when something goes wrong, suddenly everybody knows nothing or can't remember anything or didn't see anything, and I do a lot of reviews of, you know, lapses in safety or failures in safety and there are always two elements in those reviews.

One is a failure to do open disclosure with the people involved and the second one is the failure to give informed consent. It's a feature in every single one of them.

MR BOLSTER: So how long has open disclosure been a requirement under the national health standards?

PROF PICONE: 10 years.

MR BOLSTER: How difficult is it to entrench it in a health organisation, such as a public hospital?

PROF PICONE: Initially, in the earlier days of it, I thought it was quite difficult. It was a major change in culture. Let me say this, though, that the best clinician will always tell the patient and the family when something goes wrong. It's just an automatic response. But there are a number of people who, for whatever reason, have chosen not to do that. My observation is, over the last couple of years, that this system of open disclosure is now just operating automatically but there are times when it doesn't operate automatically and that is generally times when you are having a major failure in the safety of the system.

MR BOLSTER: How do you measure that someone is implementing open disclosure? Is there a reporting of events and some form of tracking of how the process is implemented on a case-by-case basis?

PROF PICONE: Yes, there is. So usually the event has to be reasonably significant, resulting in harm to a person and so, as a part of that procedure of investigating that incident, open disclosure is compulsory. So then it's recorded at that time that a conversation was held with the person, an explanation was given that something had gone wrong, that had resulted in harm, an apology is given and we often also try to explain to people how we're planning to prevent that from happening in the future.

MR BOLSTER: All right. The other health standard that I wanted to draw to your attention was standards 1.8 and 1.9 regarding measurement and quality improvement. You have a copy of those in front of you, don't you?

PROF PICONE: These are the national safety standards?

MR BOLSTER: Yes. If we could go to those standards, it should be in the same document as we were looking at before. It should be page 138 in tab 8.

PROF PICONE: Yes. So these are patient safety and quality systems. Yes.

MR BOLSTER: I won't take you to the aged care standards but what's the reason for going into that degree of detail for those standards in health?

PROF PICONE: For exactly the same reason: Australia has led internationally in having incident reporting systems that are mandated, that are required. When something goes wrong, we – people are required to report that and so we wanted to provide the actual detail in the standard to make that clearer. The reason we need this incident information is frequently it provides an early warning sign that something is going wrong. If the same problem occurs again and again, the same sort of medication error, or suddenly the pressure injury – not suddenly, but over time the pressure injury rate is increasing, or our infection rates are increasing, this

provides early warning signs to step in and to remediate the problem. So it's the most detailed intelligence that we get into the system about patient safety.

MR BOLSTER: All right. Thank you. In paragraphs 133 through to about 137, you deal with the way in which you identify issues in accreditation and assessment processes. Could you speak very briefly as to what it is that any organisation that deals with those two tasks, accreditation and assessment, needs to focus on.

PROF PICONE: We have this very tightly detailed. So if a hospital is going through a survey, the purpose of the survey is to ensure the community that they have implemented the national safety standards and that they are operational in that hospital. So a team of experts ranging from medical clinicians, nurses, senior management people and increasingly consumer representatives are put together and then they go into the health facility and examine it in detail for those matters. We have - - -

MR BOLSTER: How important is it that you have a community representative in that process?

PROF PICONE: It's very important because that person brings that patient-centred perspective, which is critical.

MR BOLSTER: All right. Sorry if I interrupted. If you could just continue.

PROF PICONE: No, no. That was – that was - - -

MR BOLSTER: Okay.

PROF PICONE: I think I've lost it.

MR BOLSTER: No. Well, let's get back on track. Where does the assessment process fall down? What errors do you see creeping into the assessment process that you have to constantly look for and you constantly have to address?

PROF PICONE: Yes, so there are – there were major significant issues with the actual survey process. So this was raised with the commission by state health departments, chief executive officers and other people that the actual reliability of our survey process needed some significant improvement. It came to our attention most when a hospital that had a series of unavoidable deaths of neonates received a three-year accreditation. It happened at that time I was assisting in the investigation into those matters and I couldn't see how they possibly could have passed the governance standard. So at that time, and for some time, we'd had a view that we needed to improve the veracity of the system so we implemented a series of improvements that commenced from January this year to improve the reliability and veracity of the survey process.

MR BOLSTER: That leads me to one of the last things I want to deal with, and that is the governance issue and clinical attestation. To what extent do the standards require the people with decision-making control in the hospital or in the health system to attest to the services that the facility aims to provide under the standards?

PROF PICONE: This is mandated. It is compulsory. It has been one of our observations, that often in – when there have been failures, the boards will tell you they had no idea these problems were going on, which quite frankly I don't accept on any of the times I've been told that. So we wanted to make safety and quality as important as finance and as general performance. So we now require each member of the governing body to sign an attestation statement to say that they're satisfied that a whole range of issues are in place for safety and quality.

MR BOLSTER: And how accountable are they for that attestation?

PROF PICONE: If they were to give or – mislead in any way in that attestation statement, which is very detailed, there would be significant response from the regulator.

MR BOLSTER: Such as?

PROF PICONE: My view would be they would be removed from their position, and, depending on the seriousness of it, there'd be further investigations.

MR BOLSTER: Unfortunately, Professor Picone, we are coming close to the end of the time available, but can I ask you this. Transparency has been a theme of the hearing this week, transparency of regulation, transparency of responses to complaints. What's the most significant thing that the Commission needs to understand about achieving or attempting to achieve or aiming to achieve transparency in this field?

PROF PICONE: That transparency is absolutely critical to the operation of the system and to the accountability that we give to members of the community, that these care facilities are doing what they're meant to be doing. We have to have it. You will come against a lot of pushback. People will tell you that it's impossible, that it's adding another regulatory burden; "Why are you doing this?" They will give you every reason not to publicly report. This is all abject nonsense. It is in the public interest, that these matters are reported on a regular basis, that they're located somewhere that I, as a citizen, can go to, and I can look it up.

MR BOLSTER: These are my questions. Thank you, Commissioners.

COMMISSIONER TRACEY: Professor Picone, thank you very much for your evidence. We are grappling with the concept of disclosure and proper regulation of facilities for the elderly in this country and going back to first principles; it's very hard, to discriminate, as a matter of principle, between what's going on in the hospital system and what's going on in the aged care system. So your evidence is

invaluable, and we're very grateful to you for taking the time to come and give it to us. Thank you very much.

PROF PICONE: Thank you, Commissioner.

UNIDENTIFIED MALE: Nothing for this witness.

COMMISSIONER TRACEY: I'm sorry. Unknown to you, counsel rose behind the screen.

MR BOLSTER: Might the witness be excused?

COMMISSIONER TRACEY: We break the link?

MR BOLSTER: Yes. Thank you, Professor Picone.

PROF PICONE: Thank you, Mr Bolster.

<THE WITNESS WITHDREW [12.49 pm]

MR BOLSTER: There was one other thing I wanted to deal with arising from that evidence, commissioners. There is an open-disclosure frame-work and guidance published by the Aged care-quality-and-safety Commission that's so far not in evidence, seems to have been published in advance of the standards coming into effect on 1 July. If it can be brought up – RCD.9999.0173.0001. And I tender it.

COMMISSIONER TRACEY: I'm happy for that to occur as soon as I see it.

MR BOLSTER: Yes. I want to see it too. It's only just been added to the – that's it.

COMMISSIONER TRACEY: Does the document bear a date?

MR BOLSTER: No, it doesn't.

COMMISSIONER TRACEY: All right. The document entitled "Open-disclosure frame-work and guidance" produced by the Aged care-quality-and-safety Commission will be exhibit 8–42.

EXHIBIT #8–42 THE DOCUMENT ENTITLED "OPEN-DISCLOSURE FRAME-WORK AND GUIDANCE" PRODUCED BY THE AGED CARE-QUALITY-AND-SAFETY COMMISSION

MR BOLSTER: Thank you, commissioners.

COMMISSIONER TRACEY: Now, Mr Arnott, were you desirous of raising a matter?

MR ARNOTT: I was. I was, commissioner. Commissioner, you asked Ms Barnes some questions about the letter she received from the Commission on the 11th of June. We seek to – we've obtained that document since you asked that question, and we seek to tender it.

COMMISSIONER TRACEY: Well, I think it should become an exhibit, and if you would, provide my associate with a copy. I assume counsel assisting has seen the document.

MR KNOWLES: Yes, and we have no objection to that course.

COMMISSIONER TRACEY: Very good. The letter from the delegate of the Commissioner of the Aged care-quality-and-safety Commission to Ms Debra Barnes dated the 11th of June 2019 will be exhibit 843.

EXHIBIT #8–43 THE LETTER FROM THE DELEGATE OF THE COMMISSIONER OF THE AGED CARE-QUALITY-AND-SAFETY COMMISSION TO MS DEBRA BARNES DATED 11/06/2019

COMMISSIONER TRACEY: Will you arrange for multiple copies of that document to be produced?

MR KNOWLES: Yes, indeed, commissioner.

COMMISSIONER TRACEY: Yes. Thank you, Mr Knowles. Yes.

MR KNOWLES: Commissioners, I now seek to call the final witnesses for this week of hearing, and they are professors John and Valerie Braithwaite. If they could, come to the witness box now.

<VALERIE BRAITHWAITE, AFFIRMED [12.53 pm]

<JOHN BRAITHWAITE, AFFIRMED [12.54 pm]

MR KNOWLES: Commissioners, before proceeding further I should note Professor Toni Makkai was to give evidence today with professors John and Valerie

Braithwaite but cannot do so for personal reasons. May I formally request that she be excused from her summons today?

COMMISSIONER TRACEY: Yes. Professor Makkai is excused from attendance at the Commission today on her summons.

MR KNOWLES: Thank you, commissioners. Now can I ask you, Professors Braithwaite, to tell the Commission your full name first off?

PROF V. BRAITHWAITE: Professor Valerie Braithwaite.

PROF J. BRAITHWAITE: John Braithwaite.

MR KNOWLES: Now, you have prepared a statement with Professor Makkai; is that correct?

PROF J. BRAITHWAITE: Correct.

MR KNOWLES: And you have a copy of your statement there with you before you?

PROF V. BRAITHWAITE: Yes; we do.

PROF J. BRAITHWAITE: Yes.

MR KNOWLES: Yes. And have you had an opportunity to read your statement in recent times?

PROF V. BRAITHWAITE: We have.

MR KNOWLES: Yes. And the statement is undated, but did you provide that to the Royal Commission on the 3rd of August this year?

PROF J. BRAITHWAITE: Correct.

MR KNOWLES: And that is the document, I should say, commissioners, RCD.9999.0149.0001. Now, are the contents of that paper that you have prepared true and correct to the best of your knowledge and belief?

PROF V. BRAITHWAITE: It is.

MR KNOWLES: Thank you. I seek to tender the paper prepared by the Braithwaites and Professor Makkai.

COMMISSIONER TRACEY: Yes. The document entitled "Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai" will be exhibit 8–44.

EXHIBIT #8–44 THE DOCUMENT ENTITLED "ANSWERS TO QUESTIONS POSED BY THE COMMISSION TO JOHN BRAITHWAITE, VALERIE BRAITHWAITE AND TONI MAKKAI"

MR KNOWLES: Now, if I can start with you, Professor John Braithwaite – could you please tell the Royal Commission what your present position is?

PROF J. BRAITHWAITE: I'm a professor at the Australian National university in the regulatory-institutions network, these days known as the school of regulation and global governance, which – Valerie and I were the cofounders. Do you want us to say some more about - - -

MR KNOWLES: That's your present position at the moment?

PROF J. BRAITHWAITE: Yes. Yes.

MR KNOWLES: Yes. And, Professor Valerie Braithwaite, can you tell the Royal Commission your position?

PROF V. BRAITHWAITE: My position is the same in the regulations-institution network, now known as the school of regulation and global governance, at the ANU.

MR KNOWLES: Yes. And you both founded that body.

PROF V. BRAITHWAITE: Yes.

MR KNOWLES: Yes. And can I ask you, Professor John Braithwaite, to indicate to the Royal Commission some of your past experience and expertise?

PROF J. BRAITHWAITE: Well, Val and I, together with Toni Makkai and Diane Gibson, were consultants to the Commonwealth department of – health and human services, I think it was initially called – in the late 1980s through to 1993 and produced a number of reports for the Government on the quality of aged care. We're both regulatory generalists, I guess, have not stayed actively involved with aged care all the way through. There was a long period of our lives where regulation of aged care was our main research topic, but, in recent years, Valerie's done an inquiry for the Minister for education on regulation of universities, on regulation of vocational education and training for Minister Birmingham as well, and I've been involved in other areas such as environmental regulation. So we have broad experience of regulation. I was a commissioner, part-time commissioner with the Australian Competition and Consumer Commission for 10 years.

MR KNOWLES: It's fair, to say that you have both taken up various esteemed academic and consultancy positions in Australia and overseas for decades.

PROF V. BRAITHWAITE: Yes.

MR KNOWLES: Yes. You're being unduly modest, I think, Professor Braithwaite. But it's fair, to say that you are leaders, nationally and internationally, in the field of regulatory theory.

PROF J. BRAITHWAITE: Well, Valerie is.

PROF V. BRAITHWAITE: I think that is fair enough, to say that. Yes.

MR KNOWLES: You have published numerous articles and books of great renown in that field for a considerable period of time. Haven't you.

PROF J. BRAITHWAITE: Yes.

MR KNOWLES: Yes. As you've indicated already, you both studied aged care and its regulation intensively for about a decade prior to 1997 and perhaps somewhat less intensively for the decade after that, you say in your statement.

PROF J. BRAITHWAITE: That's right, yes.

MR KNOWLES: Yes. And that culminated in you, together with Professor Toni Makkai, producing and writing and publishing the book Regulating Aged Care: Ritualism and the New Pyramid in 2007?

PROF V. BRAITHWAITE: Yes.

MR KNOWLES: Yes. Now, before I proceed any further, I understand that you wish to say something in respect of Professor Makkai at the outset of giving evidence today?

PROF J. BRAITHWAITE: Yes. I'd like to say something introductory on behalf of Val and I. Toni Makkai was such a major contributor to our program of research across the decades on the regulation of aged care and it was so important to her to be here today, partly in light of her mother's recent struggles with issues of – of aged care quality but she's sitting beside her mother at the moment in the Ainslie Goodwin Aged Care Home where she's at the latter stages of palliative care. And I said to Toni, "Was there anything that you would have wanted us to say today?" One thing that Val and I want to say, that we know Toni wanted to dedicate her testimony here today to the memory of her mother, Veronica Makkai, and we hereby do that.

And Toni said in reply to our question, well, you know, my mum is the beneficiary of some significant improvements in quality of palliative care in Canberra where she is having her palliative care in place, in her aged care facility, where the palliative care nurses are coming into the home from the Clare Holland Hospice, and that really is such a valuable thing. We've said in our submission that regulation of pain management is not one of the greatest strengths of the Australian aged care regulatory system.

But here, we have an area of improvement that has been happening in Canberra in recent years. But Toni wanted to say that, sadly, this is not the case and our own quick research indicates that this is not the case for most Australians. So we would like to say that what is – has been a right for Veronica Makkai, to get that end-of-life palliative care coming into the aged care facility, supporting those nurses to provide it in her aged care facility, should be a right of all Australians even in the most remote rural areas.

MR KNOWLES: Thank you. Now, returning to the book, Regulating Aged Care, what were the key aspects of aged care regulation that you explored in that book?

PROF V. BRAITHWAITE: The work that was published in 2007 in the book was an accumulation of the 10 years of research in the nineties, papers published mainly by John and Toni together and it made the point that relational regulation was what made the difference for aged care facilities and improving compliance and improving the quality of care. By relational regulation, I mean it was what was happening in that particular aged care facility. It was the interactions that were occurring between inspectors who were behaving like detectives and working out exactly what was going on, joining the dots, and the management, the provider, and the staff. So it was – the improvements came when they all came together and the regulator assumed the role, not just of calling out inappropriate behaviour or breaches to the standards, but also motivating everyone in the home to get on and improve the situation in a sustainable and continuous way. That was really the special contribution, I think, of that particular volume.

MR KNOWLES: Did the book compare the situation in Australia with other jurisdictions?

PROF V. BRAITHWAITE: Yes, it did involve field work in the United States and field work in Britain and that was compared with Australia, and John did supplementary work closer to the publication date to make sure that our findings were still relevant when that book was published in 2007.

MR KNOWLES: What conclusions did you and Professor Makkai reach in the book about the efficacy of aged care regulation in Australia?

PROF J. BRAITHWAITE: We found a result that has been considerably replicated in other areas of regulatory practice. People are often cynical about the effectiveness of regulation, but we found that regulation did contribute to the quality of care and it contributed in a great variety of ways. What the current literature that's built on that and replicated a lot of our quantitative results, which were mainly based on an analysis of following up over a period of years of 410 Australian aged care facilities, is that deterrence is important in achieving regulatory compliance, but it doesn't work on its own.

A strategy that's based on achieving compliance through deterrence threats is ineffective in the recent University of Maryland meta-analysis, but it is effective in

combination with the regulatory mix. It's when you have a mix of regulatory strategies, we found, in our work evaluating Australian regulation of quality of care, it works very much at the street level. Most of the effective work is done in a very informal, relational way by the assessors who go out and engage with that conversational regulation on site and then send appropriate cases up for more serious enforcement engagement.

MR KNOWLES: In terms of that relational regulation that you described, does that mean in cases where there might be a team of assessors that go to a particular facility to assess compliance, it might be more desirable to have at least one assessor who has actually been to that facility previously and dealt with staff and management previously? Is that what you're getting at in terms of the relational regulation as such?

PROF J. BRAITHWAITE: Very much. Very much. You can't logistically have the same team going back to the same facility every time but if you have at least one member of the team who provides that continuity, then the relational aspect of the regulatory conversation can be continuously advanced, and the kind of agility and wisdom that Professor Paterson spoke of in his testimony can be delivered. You can also have that when you have a team that hard cop and soft cop thing that you sometimes need.

You know, you need regulation to be firm and fair and sometimes very firm indeed but when you've got someone giving that very tough message and someone else saying – giving encouraging relational messages, "You can improve". And, indeed, our research shows that when the team does come back later on and sees improvements, one of the cheapest ways of achieving improvement in quality of care is when the assessment team offers informal praise.

It costs the government nothing for that team to say, "You've still got some problems but, gee, you really got on top of this problem and these two nurses who took the lead in that improvement initiative, they deserve really serious praise." That works. We showed, when that happened, with inspection teams, quality of care improved two years later.

MR KNOWLES: That actually brings me to the next matter that I wanted to ask you about. The book that you authored with Professor Makkai refers to the new pyramid. By that I take it to refer to the concept of a regulatory pyramid in which you are fundamental to. The pyramid, as such, has typically, in the past, been a pyramid of sanctions but what you're referring to also is a pyramid of supports; is that right?

PROF J. BRAITHWAITE: Yes.

MR KNOWLES: Yes. And before I go any further, can I ask for the document which is added to the general tender bundle at tab 155 to be brought up on the screen. Do you see that there? That's a document I think that you have prepared yourselves.

Can you just explain that document in terms of what it represents by way of regulatory pyramid?

PROF J. BRAITHWAITE: Well, the idea of the regulatory pyramid is you have a presumption in starting at the base of the pyramid. You can override that presumption if there's an imminent risk, for example, you might want to move immediately to a higher level of the pyramid but the presumption means that you always ask yourself the question: could we deal with this problem at the base of the pyramid with nothing more than providing capacity development for our service providers, and by assuming that they will want to learn how to do it better, how to do it right.

And if they are doing it worse and doing it wrong, we might be able to convene a restorative conversation about what we've learnt from the mistake, the complaint, as came up earlier this morning with your intervention, Commissioner, in asking the question about sharing information so if you have a complaint, it could go back to a regular care planning committee meeting, which would – is something that can occur in the form of a restorative justice circle where there can be sharing of all of the information, as it were, as an alternative to – I'm stealing your thunder here, Valerie, because you made that point as the Commissioner was asking that question.

So then if that's not working, you can move up to deterrence and tougher and tougher deterrence, if you're not getting compliance up to incapacitation, which in criminal law, we put people in jail so they no longer pose a threat to the community. Here, it's more about taking out of the system directors of nursing or administrators who are not capable of providing a safe and effective environment, and a caring environment, for our elders or removing accreditation.

MR KNOWLES: Can I take you to the next page of this - - -

PROF J. BRAITHWAITE: Did you want to add something?

MR KNOWLES: - - - of the tender bundle, and perhaps then I'll ask you, Professor Braithwaite, to add anything as you see fit. We will come back to this tab in a moment.

PROF V. BRAITHWAITE: I think it is very important to recognise that the capacity building at the bottom is not done with ignorance on the part of the inspectors. In fact, there could be a death in the nursing home or in the aged care facility, but – and there could be formal legal proceedings that will continue. But you can still have a capacity-building exercise at the bottom of the pyramid if your provider and management are willing to be learning citizens and come to you and say, "We don't want this happening again, let's do what we can to fix this up, even though we know there's going to be a court case or whatever legal action is going to happen further down the track." So I just want to make that point that it isn't an easy opt-out, "We'll do capacity-building because we haven't done our detective work

well"; you've always got to do that detective work very well to be using these pyramids.

MR KNOWLES: Yes, and in terms of a pyramid that was developed, I understand, by yourselves some considerable time ago but in respect of aged care, is that an example of such a pyramid there on the screen now?

PROF V. BRAITHWAITE: Yes.

PROF J. BRAITHWAITE: This is a very old PowerPoint, obviously, but this is what we were sending to the various ministers that we were answering to in the – providing our reports to in the early 1990s, and these things have been put in the pyramids in different ways. It took a long time before suspension of benefits for new residents was actually being used and we still don't know how much it's being used, or we don't, but I'm sure the department does. But so, yes, these were not in place at the time of our work but now they are.

MR KNOWLES: Yes. And you mentioned earlier praise and the place that that holds. If I could move to the next page of the particular tab; this is a diagram which incorporates both a pyramid of sanctions and a pyramid of supports, I take it?

PROF J. BRAITHWAITE: Yes. It's actually – we kind of like this but, more importantly, practical regulators tend to like this diagram better than the one we produced in our book, which was actually two pyramids side-by-side, a pyramid of sanctions, a regulatory pyramid and a pyramid of support, so you would escalate supports to encourage excellence, and this particular diagram has been picked up by a number of regulatory agencies around the world these days. This one was taken from South Australian environmental protection agencies and you see the nice green supports where we have "champions" on the far right side. So the idea is that you improve quality of care not only by doing something about the bad guys, if I can put it that way, but also encouraging the good guys to take quality of care up through new levels of excellence.

And the idea is that, if champions, on the right side of this diagram, are taking quality of care up through new ceilings of excellence, they actually drag up the bottom-dwellers with them; they raise the average standard. So it's important at both ends to have an integrated strategy of this kind. But with tough stuff, of course, in the regulatory regime under discussion with the Commonwealth at least, there is not access to criminal sanctions. We think there should be but there's not.

MR KNOWLES: Are you aware of that recognition and rewarding of champions in aged care regulation as such now?

PROF J. BRAITHWAITE: Yes, yes. I served for a number of years on an awards committee that the accreditation body had in place. In some ways they could have made better use of that to convey strategic lessons by explaining with more precision what it is that is excellent, that others in the industry should be following. So

excellence in regulation is – you know, risk management is the bread and butter of good regulation but seizing opportunities, such as the opportunity to develop capacity across the industry, "Here's a form of excellence, the rest of you seize the opportunity to follow it and become better in the way they have become better", that's important, too.

PROF V. BRAITHWAITE: It's also the way to breathe life into continuous improvement. When you find something that's been done that's quite outstanding, then that can be the model others follow and they can – if they are wanting to pursue that as part of their continuous improvement plan, they can. It is not a ritual of continuous improvement; it is a genuine commitment to continuous improvement.

MR KNOWLES: You raised the concept of ritualism as such. Can I perhaps move to that. What do you mean by ritualism, not just in continuous improvement as such but in regulation more broadly?

PROF J. BRAITHWAITE: Ritualism means a process that's focusing on the means for achieving an outcome while losing sight of the outcome itself. So the feeling that you're doing something terrific by following some protocols, for example, when, in the particular context, the following of the protocols does not deliver safety and quality.

MR KNOWLES: How do you think that concept of regulatory ritualism applies in the context of aged care regulation?

PROF J. BRAITHWAITE: Consultants that come in and use tick-box instruments to create evidence, constructing something that's a pretty routine kind of thing as evidence of continuous improvement. You know, the gardener leaves and – this is probably a very unfair example but to clearly explain the concept, the gardener leaves and they have to be replaced and the new gardener, there's this narrative about the great landscape qualifications this new gardener has to improve the quality of the experience of residents walking around, so all of these things can be seized upon as an opportunity to demonstrate continuous improvement when it's really just a routine replacement of staff.

MR KNOWLES: Do you see that concept of regulatory ritualism in aged care even beyond the area of continuous improvement?

PROF V. BRAITHWAITE: I would say so. I would say using categories to describe what's wrong in a nursing home is a form of ritualism. With ritualism, we are wedded to – sometimes it's collecting particular bits of data, filling out forms and we don't have time to sit there and think about what we're seeing and connecting the dots.

So for an investigator of any kind, the important thing is to sit down afterwards and look at their notes and think about what all of this means, to try to create a narrative about what they've seen and what they've written down. Somehow a ritualistic

filling out of forms, writing reports in a certain format, collecting certain pieces of data interferes with that thinking process of a regulator taking agency to say, "I want to know what the narrative is, I want to know what's going on". I think we see that in a lot of areas of regulation.

MR KNOWLES: Are you aware of the evidence that has come before the Royal Commission earlier this week that referred to computer-generated template rationales for findings in audit reports and the like?

PROF V. BRAITHWAITE: Yes. It must numb the minds of regulators. It must mean that they simply are not thinking about what they've seen, the information in front of them and getting that narrative together.

PROF J. BRAITHWAITE: We were pleased to see that that was abandoned but it's also an example of a misplaced emphasis on consistency because it's justified in terms of consistency but it's a very ritualistic form of consistency, the kind of consistency you don't want to have in a responsive regulatory regime, because you really want people to be thinking in time – I guess the most troubling and recurrent form of ritualism is just the signing of a care plan without reading it and without participating in a care planning meeting as residents and relatives and all of the carers involved in that particular individual's future.

PROF V. BRAITHWAITE: I think another form of ritualism that we saw in the transcripts was the assumption about – there was this decision about met – a standard being met or an outcome being met or not met. They didn't – it was quite clear that if there was no indication that a standard – sorry, there was no indication that a standard was met, the goal was simply to find examples of it not being met. So if there was an example of the standard being not met, then it automatically became a "met". There wasn't active evidence to show that the standard was being met. Did I get that straight or did I get that muddled up?

PROF J. BRAITHWAITE: As Theresa May would put it, to me, it means met. It doesn't mean there's not evidence of it not being met, you know? That's a real problem.

PROF V. BRAITHWAITE: I think that's an example of ritualism. Because if you think about it, you come back and say, "That standard was met. I didn't see evidence that it was met but then there was no evidence that it was not met so it must be met". So that logic, if you think about it, is not a very sound logic at all. So I would put that down to ritualism coming into the system and it not being questioned because no one is thinking about what the outcome is, which is to assure everyone that the quality of care is high in that particular aged care facility.

MR KNOWLES: There was also evidence earlier in the week about a difference of approach taken by assessors attending on site at facilities depending upon the particular type of visit that was being conducted. So if it was a review audit and there were some concerns that had been raised that led to the review audit, there was

a more vigorous level of scrutiny but if it was a re-accreditation audit, that might not be the case. Do you see that as having implications in terms of the ritualism features that you describe?

PROF J. BRAITHWAITE: Well, I mean, it's a good thing that there is a certain amount of triage for more serious cases of concern, having more individuals going out on the visit to the facility, having longer at the facility; that's a good aspect of the review audit but it's very important that that not give the message that, when you have a standard accreditation, that what's expected in terms of, "Met means met", it doesn't mean, if we don't happen to see anything bad on our quicker look around, that we feel that we're able to use a bit of standard language and communicate, falsely I would say, the message to consumers that there has been an assessment and the assessment is that the place – I mean, it would be like our university.

You're hiring someone who is a graduate of our university and they send you the transcript and it says that they got 100 out of 100 on all of their assessments at our university, and we would hope that you would be impressed by that but if our practice was to give them 100 per cent on every assignment if we couldn't see anything particularly negative there, I think employers wouldn't be very satisfied with that.

MR KNOWLES: Yes. Well, that brings me to another point. You may have heard the evidence during the week that was, I think, mentioned in the opening address by senior counsel assisting, that in recent years, there have been around 98 per cent of all facilities, or services, being assessed as meeting 44 out of 44 expected outcomes across the accreditation standards. What does that say to you about regulation of the aged care industry?

PROF J. BRAITHWAITE: A risk of ritualism. We noticed also that there was some testimony that came to you that said, in the self-assessments by the facilities, they always gave themselves 44 out of 44. So that's a self-assessment that's not working. If you can't find anything that you really need to do important things to improve on, it's not a genuine form of self-assessment. It is very worrying in being a false form of transparency. I mean, when we were looking in aged care facilities in Canberra, we'd go to the website and it looks like all of the facilities that we could send our parents to looked perfect.

So it's giving no information to consumers, it's giving no feedback to facilities as to when they're doing better and when they're doing not so well. It makes the praise less meaningful when they are having this view of themselves that, "We've got a perfect score. We've got – you know - - -

MR KNOWLES: Do you think those figures suggest that the regulator is afraid to give negative feedback or reports to approved providers?

PROF J. BRAITHWAITE: It's hard to make sense of it in other ways. I mean, we can make some sense of it in terms of the research that we did a long time ago. Way

back then, in our work on capture, we found that capture was not as big a problem in this arena as it is in some others, at least in the sense of a revolving door. That is to say that assessors who came, standards-monitors who came from the industry were not a lot less tough than those who had not come from the industry.

So that revolving-door part of the capture problem was not as serious as in some areas, but the other interesting result there on the – those hoping to go into a job in the industry were a bit softer and gentler in their assessments – but not a massive effect, I would say, compared to other regulatory regimes. But those who were tougher and more demanding and were wanting to have more standards rated "not met" were more likely to leave. So they got – they would get discouraged and leave. And that's a dynamic that you have in regulatory agency, all regulatory Agencies, I would say, but we, certainly, see that in the aged care-regulation arena in Australia, that those who are more demanding get disappointed and leave.

MR KNOWLES: And does that have flow-on effects? Would you say?

PROF V. BRAITHWAITE: Yes, because it means the culture then of the regulators is not one of calling out inappropriate behaviour. There's also some suggestion in the literature that social services in general don't like to see themselves as being regulated or having regulators. It's a helping profession, and so the notion of – "regulation" is a bit of a dirty word, but that, clearly, should be resisted, and – particularly our view of regulation, which is not just saying this is inappropriate but making sure people have pathways to pursue and correct the inappropriate actions and also the support to do so. So that could be part of the explanation, but then that doesn't gel with the banking Royal Commission, of course, because they don't see themselves as social-service providers.

MR KNOWLES: And in terms of industry capture, though, putting to one side the people working at the coalface who are in the position of assessors – are there other areas where you have perceived industry capture in the aged care regulatory frame-work?

PROF J. BRAITHWAITE: Well, we're a bit out of touch with that aspect of it, but, certainly, back in our day, when we were working intensively in this area, it was, certainly, the case, that people in the department were afraid of certain dominant providers in the industry and worried about their political clout. There's – there is evidence out there – of political donations by providers, and that's a recurrent theme in all regulatory regimes. It may not be as big a problem in this area as it is in regulation of gambling or all sorts of other areas, but, in our view, at that time, up to 2007, there was clear evidence of that.

What we didn't see evidence of – on the positive side is we did not see evidence of corruption in Australian aged care regulation, and, usually, we do, when we're working in regulatory areas in Australia and elsewhere, and we, certainly, saw it in aged care regulation in the United States. I mean there were cases of convictions, of operators of nursing-homes providing a packet of – plain envelope of a hundred

dollar bills to nursing-home inspectors and being convicted of that and lots of rumours around – of other examples of that happening and that being believable, facilities owned by the mafia and so on, the story of an exit conference where the owner put a gun on the table during the exit conference.

Well, we haven't had those sort of – that level of corruption problem, to our knowledge, up to the time when we were working, but we think there are more – there were quite worrying other levels of capture and concern about the political influence of the industry. And, indeed, in retrospect, we kind of think that the whole idea of setting up an accreditation agency that was separate from government regulation was a wish that the industry was lobbying for for a long time.

And that was the politics of delivering to an industry something they wanted to get regulators off their backs, if – they weren't totally happy with and – I mean we're pleased that the present Government is moving in an opposite direction and accomplishing some re-integration of the accreditation function and the enforcement function, which, in our view, has to be better government.

PROF V. BRAITHWAITE: Just for clarification: the exit conference is not about terminating anyone. It's about debriefing the nursing-home on the findings of the inspectors.

MR KNOWLES: Yes. Thank you for that. On a related issue: you, in your 2007 book, referred to enfeeblement of enforcement in the Australian aged care regulatory system. How do you see that manifested in Australia as distinct from perhaps other jurisdictions like the US and the UK?

PROF J. BRAITHWAITE: Obviously we don't have criminal penalties. We don't have enforceable undertakings. I mean, I have some background in the ACCC. I hope this doesn't indicate my capture by the ACCC, but I think a lot of regulatory thinkers would have the view of the Australian Competition and Consumer Commission as the most – having the record of the highest enforcement competence of any regulator. The Hayne Royal Commission said as much in its report, and so, I think, we learn from cases. I've lost track of your question now.

MR KNOWLES: No, no. I was just asking about enfeeblement of enforcement. Do you think that is actually manifested in the aged care regulatory system in any way? In particular, do you think that – you've mentioned the absence of certain measures? Do you think that the regulatory toolbox has enough in it for people to successfully regulate the industry?

PROF V. BRAITHWAITE: The kinds of measures that John has mentioned means that the expectation of improvement is taken more seriously. If you think you're going to have an enforceable undertaking or something worse, then you listen and you act more readily. So – and that's the idea of the enforcement pyramid, that you know that, if you delay and you don't do what you're supposed to do, there are consequences that will hurt you down the track.

So it pushes more resolution of problems to that level of dialogue and discussion and residents' committees et cetera. It's in the interests of the provider and the Management, to actually solve problems at that level. You don't get that effect, if a provider or a regulator – sorry – a provider or the Management feel that they can cover up the problem and keep batting the problem back to Government or to the regulators.

PROF J. BRAITHWAITE: You might say, "What's the difference between an ACCC enforceable undertaking and the aged care regulator requiring a continuous-improvement plan, which is ratified by the regulator?" And then the regulator assesses whether it's implemented. Well, one reason why the enforceable undertaking is a step up the regulatory pyramid is, if it is, that it's court-sanctioned so that, if the provider doesn't comply with the enforceable undertaking, it's contempt of court – and that's a criminal offence as well.

So you track back to the power, including the symbolic power, of the criminal sanction having a useful role in aged care regulation. That's not to say that you want criminal prosecutions all over the place. We would like to have more criminal prosecutions, particularly for matters like sexual assault, of course, without fully individualising it; we want the facilities that allow the sexual assault to occur to be also held to account at the same time the individual criminal offender is, but the symbolic power of the criminal sanction is, we think, useful, and of course, that's not available under the current legal regime.

MR KNOWLES: Can I just ask some final questions of you in relation to one of the matters that you raised, Professor Valerie Braithwaite, you raised in relation to resident councils or resident-representative bodies. How useful do you see them as being – in terms of complementing a regulatory frame-work?

PROF V. BRAITHWAITE: I think they're absolutely essential for holding the facility to account. There's been discussion of transparency. I think that's very important too. It's not that transparency in and of itself produces change, but transparency, combined with voices of how change can occur, as well as muscle to make that change occur, is a very effective strategy. I can understand the concern about reputational damage, but the reality is that, if you are an open and transparent provider, your residents, relatives, friends, advocates will know that. So even though you might have a moment of great embarrassment and humiliation, because of your past history of being an open and transparent provider, they will rally behind you and you will overcome your problems sooner than you would otherwise by keeping them secret.

So I'm a great believer in strengthening that capacity, and I do think at the moment it sounds as if a lot of people who are interested and are willing to hold the system to account are being denied information or they're being silenced by just wearing them down with the enormous lengths of time that it takes. I don't think it's reasonable, to put the onus on residents' families, to always have to keep complaining for instance. They're in a – they're trying to provide the best quality of life for their resident in

difficult situations often; so to be expecting them to be making the phone calls, to keep making the complaints, to have that persistence, I think, is unreasonable, and I'm sure many of them get worn down or decide that the priority is to just spend their time with their relative and try to protect them as best they can.

MR KNOWLES: Yes. Thank you. One last question of you, and that is in relation to complaints and what you've just mentioned about the need for people to make complaints to get things done. Do you think that there is too much reliance in the aged care regulatory frame-work on complaints in order to uncover deficiencies in care?

PROF V. BRAITHWAITE: Absolutely. Yes.

MR KNOWLES: And how would you remove that undue reliance on complaint-making otherwise?

PROF V. BRAITHWAITE: Spending more time in the nursing-homes, using the eyes and the ears of residents, to be meeting for their care-planning meetings. I think care-planning meetings have – are under-utilised. They can be used to sort out all sorts of problems that a provider might be quite willing to sort out, if the – when the problem is new for – if they can do it there and then, anxieties, tensions, different views aren't allowed to cause disruption to the relationship. As we were hearing, the relationship is better, if problems are solved in these care-planning meetings for example, at the time that they occur. I think if that was working more efficiently, then the number of complaints that would actually be made to government would be fewer. It's the fact that they're not being resolved at the time locally that I think is part of the problem here.

PROF J. BRAITHWAITE: Yes. We think there is particularly heavy reliance on complaints with home care because it's so difficult to have an inspection process for home care where you arrive unannounced and, you know, you're not going to find the home care provider in the home, so that standard kind of inspection approach doesn't work, but nor does it work to encourage people to send in complaints with a bit of a ginger-up of encouragement to do that just before there is an audit process for the home care provider. Complaints are important but, again, I go back to Professor Paterson's testimony, the need for pulling complaints together in an agile way with other sources of information, quality of care indicator information and we think that at all levels, in a relational approach to quality of care, it's important to empower the street-level assessors more than we do, to move away a bit from the culture of, "My job is just to see what I see. If I see any problem, to report it", albeit to report it in an excessively templated way.

And then someone in central office, as it were, takes care of it and decides what to do. What we want is – what we're advocating in our submission is a more detective-oriented approach on the street, as it were, that they are taking the initiative to seek out evidence from complainants, to seek out evidence from advocacy organisations, from community visitors, looking diagnostically at the quality indicators, coming to a

view holistically about whether this is a high risk facility or not and having those conversations. And in terms of ritualism in continuous improvement, what Val is talking about is kind of a big part of the solution there.

So if you have, from the most micro level of care planning meetings where relatives – you know, under the US regulations, the relative has a right – gets a letter of invitation to a care planning meeting for their relative. And so this, in effect, mandates that the care planning meetings have to happen on a regular basis, which is not the case in Australian aged care facilities but also the residents' council and in these forums. So if there's a form of continuous improvement ritualism going on, where some phoney documentation has been created to demonstrate continuous improvement on some outcome, an advocacy organisation can come along and have sought advice from a competing consultancy provider.

And so these can be the fora where there can be openness and critique of shoddy continuous improvement work with support from other consultants who have a different view and say, "This is not the best way to demonstrate this kind of continuous improvement. This is not something the regulator should be accepting. This is not something the facility should be accepting. This is not something the home care provider should be accepting". So, in particular with home care, we think that it's necessary to actually have more conversations with those who use home care services rather than send them a letter to say, "If you've got any complaints, write in now". That's not going to work.

MR KNOWLES: I have no further questions, Commissioners.

COMMISSIONER TRACEY: Only one from me and it's this: as you work your way up the second of the pyramids and map out how to deal with recalcitrant providers, you come up against the possibility of imposing short-term sanctions whereby they can't take on any more residents until they've corrected the problems that have been identified. The next step, however, is that they can't take new residents on for a protracted period. And when you get there, I see some incongruity because what you're doing is saying, "Well, the ones they've got, they can stay, despite the terrible situation that has led to the imposition of the sanction whereby we're not going to allow anybody else in for a protracted period". How do you resolve that conceptual problem?

PROF J. BRAITHWAITE: You're making a good point there, Commissioner, but there are two, on the other hand, points. One is that when you're not – it's very resource-intensive to bring new residents into the facility. So when you're not taking new residents – you are concentrating such resources as you have on the people that you have who are already there. So that mitigates your point somewhat. The other one is, as tempted as we might be a lot of the time to close a facility to protect those residents who remain behind, there is quite a bit of evidence that moving people even to a better facility can result in worse outcomes in terms of mortality and morbidity.

So it would normally be better regulatory practice, on the balance of all of those considerations, to prefer the lower step down the pyramid of pressuring, in some way, using some appropriate regulatory lever, the replacement of the management team. So you get better management in solving those problems, or better training of lower-level staff in solving those problems to protect those who remain.

PROF V. BRAITHWAITE: I think more generally the point is that the regulators will engage in other strategies to find that pathway forward while that sanction is there. It's never going to be one sanction that works. It's really a matter of using many sanctions, and also carrots, actually, to try to get things back on track. But as I think you're suggesting, it doesn't always work.

COMMISSIONER TRACEY: Thank you both very much. We have learned a great deal in the last hour and the good part of it is that it comes from people with a depth of experience of the industry but from people who are not captive by any of the competing interests in the industry, and we're very grateful for the independence of your well-thought-through views. We would extend our felicitations, through you, to Professor Makkai and thank her for her courteous explanation of her absence and her contribution to the information that we've received this afternoon.

PROF V. BRAITHWAITE: Thank you, Commissioner.

COMMISSIONER TRACEY: Thank you both very much.

MR KNOWLES: Commissioners, apologies, I've been asked by counsel for the Commonwealth to raise a couple of matters very quickly with the Braithwaites.

COMMISSIONER TRACEY: Yes, certainly.

MR KNOWLES: They're just questions requiring a yes or no answer. Can I ask each of you, have you accompanied any assessors from the Aged Care Quality and Safety Commission in their conduct of assessment contacts or audits?

PROF J. BRAITHWAITE: As we explained in our commission, our on-the-ground research ended in 2007 and predates the existence of the commission.

MR KNOWLES: Thank you. Yes. And I take it, therefore, that you haven't reviewed audit methodology documents in recent times?

PROF V. BRAITHWAITE: No.

MR KNOWLES: Produced by the aged care regulator?

PROF J. BRAITHWAITE: I have a little, but we would not claim to be – you know, our reflections, as we want to emphasise at every point of your question, is reflecting back on the data that we had from our empirical research.

PROF V. BRAITHWAITE: And I think we are reflecting on the testimonies that we've heard while we've been here.

PROF J. BRAITHWAITE: We've listened to the testimony. We certainly learnt things from that that we didn't know before about things that have changed, such as this negative – giving a met rating on the basis of there not being negatives that came into your testimony. That was our source, you were – the Commission hearing was our source for that view.

MR KNOWLES: Yes. And did you read any of the documents, like the actual decisions that were the subject of that oral testimony yourselves? No?

PROF J. BRAITHWAITE: I don't understand the question.

MR KNOWLES: You've referred to viewing oral testimony in the Royal Commission.

PROF V. BRAITHWAITE: Yes.

MR KNOWLES: Have you read any of the documents that were the subject of that oral testimony, insofar as they were decisions or reports produced by regulators?

PROF J. BRAITHWAITE: I don't think we made any comments on particular decisions.

MR KNOWLES: Thank you, Commissioners. I appreciate that.

COMMISSIONER TRACEY: Second time lucky, you're excused.

PROF V. BRAITHWAITE: Thank you.

MR GRAY: Commissioner, if the Braithwaites may be excused, I'll just proceed straight into the closing address.

COMMISSIONER TRACEY: Please do.

<THE WITNESSES WITHDREW [1.56 pm]

MR GRAY: Thank you. The evidence this week has exposed serious defects in the regulation of quality and safety of aged care at both the operational level and the design level. Equally concerning, these defects are old news. Government has been tardy in implementing previously recommended forms. There's been no sense of urgency. Government is yet even to reach a decision on aspects of the actions that have previously been recommended by Carnell-Paterson. Government has been unable to deal with the challenge posed by the need for reform or at least to do so

promptly. Critical urgent reform tasks have been outsourced to consultants and appear to be mired in protracted and multi-staged industry consultation processes.

Inside the department, officials are focused on policies and procedures being in place, standards being met, timing and formal processes. On the evidence this week, a spirit of inquisitiveness and curiosity appears to be sadly lacking. The evidence indicates that some, but perhaps not all regulatory functions, will be transferred to the new Aged Care Quality and Safety Commission, which I will be calling the Quality Commission, with effect in January 2020, subject to necessary legislation being passed. The secretary of the department, Ms Beauchamp, told you in February that the concentration of regulatory functions in the commission's hands, in January 2020, is likely to involve the transfer of the departmental workforce who currently exercise those functions.

That being so, Commissioners, there is no guarantee of cultural change without a transcending intervention of some kind. In any event, a similar focus on process over the spirit of inquiry also seems to pervade the Quality Commission, in relation to those functions it has already assumed. For example, you heard the extraordinary evidence that, until recently, assessors of residential aged care facilities prepared their reports with computer-generated templates which contained a large number of template rationales for findings or assessments. In our submission, much of the evidence this week points to a process-driven approach to accreditation, the very approach critiqued in Carnell-Paterson which was published almost two years ago.

The failures of the regulators – I'm referring to both the department and the Quality Commission – to respond to clear and present risks in the Earle Haven matter are failures in responsive regulation of the kind identified by Carnell-Paterson. In the MiCare case study also, the Commission heard evidence about what appears to be inconsistent quality assessments undertaken by the Quality Commission which seems to have been adhering to the kind of monitoring process critiqued by Carnell-Paterson. Returning to the Earle Haven case study, you heard evidence about the numerous risk factors that People Care, the approved provider, had presented over a number of years. As Mr Speed conceded, if all the information had been put together, this might have indicated to the department that a more immediate response was warranted.

Now is not the occasion for a detailed closing address as to the proposed factual findings in the case studies. Commissioners, we'll be doing that in a written submission after the hearing in accordance with the directions you've made. However, the point I make about failure to appreciate risks raised in the course of different functions being exercised by different officials can be demonstrated from the following facts in the weeks preceding 11 July 2019 in the Earle Haven case study, even without considering the long history which preceded that time.

The first fact. The complaint section in the commission had received a number of complaints. One dated 5 April 2019 referred to attempts to address inadequacies and failings at Orchid House since June 2017:

Despite this, we have been unable to progress any meaningful and lasting changes to care. The situation under the current lessees, HelpStreet, has become untenable. HelpStreet is about to sign another five-year lease contract with Miller Enterprises and this concerns us greatly.

It appears that the complaints section in the Quality Commission was provided by this complainant with minutes of the recent relatives meetings at which a number of complaints about service and staffing levels had been aired. The second fact, the complaints officers of the Quality Commission attended a meeting with Arthur Miller of People Care and Karen Parsons of HelpStreet on 30 May 2019 from which it was obvious that the two companies were not communicating about the issues raised by the complaints. This meant there was a breakdown between the entity that was subject to statutory obligations, the approved provider, People Care, and the entity with the practical ability to do something about those issues, HelpStreet.

The third fact. In the meantime, the prudential compliance section of the department had been attempting to obtain missing information about prudential compliance from People Street for months after a notice of non-compliance had been served in January 2019 which resulted in only partial compliance. After months of attempting to obtain the omitted information on 13 June 2019, a prudential compliance delegate decided to take no further action. The fourth fact. On 25 June 2019, an assessment contact was conducted by the quality monitoring personnel inside the Quality Commission and that area of the commission is separate from the complaints area.

Those personnel were to follow up certain issues raised by complaints and incidents, and that's a positive, however, there were, by now, broader issues of concern about the functioning of the facility. One of the things the personnel from the quality monitoring area discovered during the assessment contact was an alarming use of chemical and physical restraints with the level of the use of psychotropics at 71 per cent and the use of physical restraints at 50 per cent. The assessors did not broaden the scope of their assessment contact to respond to this information.

It appears that these four facts were not considered holistically by the Commonwealth regulators at any time before the abrupt cessation of services on 11 July 2019 and that they had no contingency plan to secure the welfare of care recipients at Earle Haven and, in the end, it was left to state emergency services to deal with that event. This morning, Ms Reid of the Quality Commission, rightly acknowledged that the complaints area of the Quality Commission failed to show requisite curiosity and failed to communicate with the quality monitoring section within the commission. It appears that the quality monitoring section itself failed to raise the alarm based on its assessment contact.

We submit that the evidence establishes disconnections within the commission, disconnections within the department and a disconnection between the commission and the department. And we submit that the aged care regulatory system does not have the broad, agile and integrated approach to risk analysis that is required. On the direct accounts and case studies this week, the regulatory system has failed

adequately to consider and act on the views of care recipients and their families in relation to the care that they've received. Ms Laffan pointed to the recent replacement of the accreditation and home care standards with a single quality standards framework and the use of consumer experience reports, CERs. On their own, these measures will not achieve the required change.

The Royal Commission has heard evidence in previous hearings raising concerns about the new standards. Further, only a small proportion of residential aged care recipients are engaged through the CER process and then only as part of the accreditation audit process. Accreditation is a rare event, usually occur only every three years. The imperative to listen to the voice of the care recipient must start in the facility or the service. Ms Beverley Johnson told the Commission about the difficulties she has experienced in having her voice heard and respected in the aged care facility where she lives. When asked about representation of residents in aged care facilities, she said:

> *Well, I would say what representation? There seems to be very little of it and, like anyone in the community, residents should have a right as to how you're treated and residents, it would appear, once they pass through the front door of the facility, give up that right.*

That voice must also be heard as part of the regulatory process. The consumer experience report mechanism is still in its infancy in residential care settings. There is no statutory obligation to consult with recipients of home care as part of the quality review process at all. The requirements around consulting with care recipients in both residential and home care should be advanced, broadened and the results should be published. The Commission heard from a number of witnesses they did not feel that the complaints processes responded to the underlying circumstances that led to their complaint or provide any satisfactory resolutions to their concerns.

Ms Gwenda Darling, a recipient of home care services, said in that interaction with the ACCC – that's the Complaints Commission, of course:

> *I didn't feel like there was any compassion for me or concern about my experience. It felt like the woman I spoke to had a script to read and there was no personalisation.*

Ms Darling told the Commission that after trying multiple avenues to raise complaints:

> *I felt it was useless to keep trying to complain so I didn't pursue it. As a home care client, I feel like no one cares.*

Associate Professor Sarah Holland-Batt, who gave evidence about her father's experience in residential aged care said:

I got the impression that the ACCC was inclined to work with the facility and accept its assurances and did not really intervene in the process and make suggestions about what measures might be appropriate.

Ms Holland-Batt also said:

I would like to see greater transparency regarding provider responses to complainants.

We'll be outlining in further detail the evidence that was heard in relation to complainants. Ms Debra Barnes also gave relevant evidence. Mr Geoff Rowe, the CEO of Aged and Disability Advocacy Australia, also gave relevant evidence concerning his impression that the Act reads like an overarching funding mechanism and we submit that Mr Rowe's impression is the correct one. There's a legislative focus on providers' funding entitlements to the detriment of the rights of people receiving care. Commissioners, you should be guided by the evidence of Professor Ron Paterson ONZM. He told you:

Consumers and their families must be confident that there is a strong independent complaints handling function within the Aged Care Quality and Safety Commission. The complaints commissioner must be highly visible in the aged care sector and more broadly in the community. It must be and be seen to be rigorously independent from regulatory functions. Its complaint handling must be skilled, timely and effective and the lessons and trends from complaints must be well publicised, promptly and in user-friendly formats for consumers, providers and the community.

Commissioners, you also heard evidence about the incident reporting scheme and you heard a case study as to the assessment that occurs and the limited degree to which there's follow-up with providers. We'll be addressing that in written submissions. There's also the policy issue regarding the very major exemption to the compulsory reporting regime, which we addressed in the opening and we'll address again in written submissions. The current regulatory model of aged care in Australia falls well short of best practice standards and is insufficiently responsive to risk in the range of the interventions that it deploys.

The Earle Haven case study shows that quality regulators and the officials with power to impose sanctions have been preoccupied with the question of compliance with minimum quality standards, the procedural steps that apply in cases of detected non-compliance and with an apparent objective of managing approved providers back to compliance at virtually all costs. People Care's status as an approved provider was not revoked despite repeated failures and a relapse after temporary improvements achieved under sanction in 2016 proved unsustainable. This led to further sanctions in 2017 but not to a revocation.

And after this, of course, from about April 2018, the management and provision of care was outsourced to HelpStreet under arrangements that proved to be uncertain and led to commercial disputation this year and ultimately the events of 11 July.

Professors John and Valerie Braithwaite have described the enforcement function as enfeebled. Numerous witnesses have identified the narrow range of sanctions currently available and the regulator's apparent unwillingness to use them. Witnesses have agreed that the regulatory model would be strengthened by having access to a wider range of sanctions including, potentially, powers to hold directors personally to account. Evidence from direct-experience witnesses also suggests that the available suite of sanctions do not provide for effective accountability. Ms Holland-Batt said:

> *The solutions I wanted, consequences for the abusive carer and assurances she would never be able to victimise vulnerable patients in the sector again, apparently, could not be provided. What I wanted was some kind of penalty for the people responsible for what had happened to my dad.*

That's the end of the quote. At the same time as regulators have been unwilling to move to the top of the regulatory pyramid, there are also failings at the lower tier of the pyramid. The design of regulatory frame-work has provided no incentives to excellence. Well-performing or excellent providers are not rewarded by a graduated scale of performance or by publication of that performance. Professor Paterson said regulation is not just about setting minimum standards, it can be used to promote quality improvement. Professor Paterson agreed with a suggestion I made, that an accreditation system relying on cyclical reviews, simply providing a met or not met outcome in which 98 per cent of the relevant services meet the relevant standard, simply, does not provide transparency or any incentive for providers to improve.

Wish to turn to home care. The regulation of quality and safety of care delivered in the home is even less developed than the regime for residential care. You heard from Ms Laffan about gaps and weaknesses in the regulation of home care. She referred to the absence of any requirement for accreditation against the standards before the commencement of service provision, no statutory obligation to engage with care recipients when undertaking a quality review, the absence of visibility on actual delivery of home care, reporting requirements which do not require home care providers to advise the department of changes to key personnel and less transparency than in residential care. And I might add the absence of compulsory reporting of incidents at present.

The evidence from Ms Laffan suggests the department has in the past had the view that differences in the home-care setting justified a weaker approach but that view is no longer held. Commissioners, it appears, that the department considered that, under the consumer-directed care model for home care, market forces would act as a safe guard at least to some degree. But you've heard in other areas that consumer-directed care in home care is problematic in areas where information's not available to the care recipient, where services are thin, such as in rural, regional and remote

areas, and where the care system is confusing and difficult to navigate. Quality reviews of home care services need not occur until a significant time after a provider begins operations, leaving a window of significant risk before the Quality Commission first scrutinises the service in question.

Ms Gwenda Darling's opinion is that the home-care system is broken and seems totally unregulated. She offered a practical suggestion for the regulation of home care, namely, that home-care users should be surveyed for their views on the quality of service as part of the quality-review process. In terms of home care, we submit regulation is deficient. And it's unclear, whether various foreshadowed improvements will end up protecting care recipients and address their overarching concerns and priorities.

Commissioners, I want to turn to the issue of interactions with the system across a range of topics, complaints, advocacy and the like. You've heard about the difficulties that people experience in seeking to access and navigate the complaints system. Ms Holland-Batt and Ms Barnes have said they feel as though providers pay lip service to their complaints, they feel as though the complaints system does not extend empathy or concern and they feel like the priority is to resolve cases and do that quickly rather than really address concerns. You also heard about the difficulties that people face – accessing advocacy and support services.

Professor Paterson noted that, when he undertook the review of national aged care-quality regulatory processes with Ms Carnell, he thought that there was scope to strengthen advocacy services in Australia. He described it as a weakness in the Australian system. Professor Paterson gave evidence to you that the absence of a strong consumer voice in the aged care system is a notable feature of aged care in Australia. The voices of providers are predominant in the Australian system and appear to be highly influential in policy debates with Ministers, departments, Agencies and officials, but the voices of consumers, families and consumer advocates are relatively weak.

Mr Rowe gave evidence that, despite best efforts, we are only supporting less than one per cent of aged care users. To me that's extraordinarily frustrating, and what we're seeing is a real growth in demands for advocacy services. Ms Holland-Batt, who provided evidence to the Royal Commission about her experience supporting and advocating for her father, said:

> *So it would have been really helpful as someone who was new to this process, to perhaps have someone, a disinterested party helping me to navigate it or giving me advice or information, because my feeling was that the complaints officer was taking the facility at their word, and so I didn't have anyone to help me push back against that. So, yes, someone perhaps, some function where people could be given some disinterested advice and support would've been helpful as well.*

Ms Gwenda Darling, who shared with the Royal Commission her experience with a number of home-care providers, suggested that – and I quote:

> *It would be good, to have people in a role like a guardian, when someone commences with home care, as a contact and advocate for them, if they experience problems with their care.*

End quote. No regulatory frame-work is a guarantee against some bad outcomes. But the current regulatory frame-work has too often failed to listen to the person receiving care or their family and has too often failed to detect risks and to detect and deter substandard care and other threats to the wellbeing of people receiving care. Our contention is that the current regulatory system, which is focussed on processes rather than actual outcomes and is based on minimum standards, is unlikely to provide an adequate basis for improving the quality of care and welfare of care recipients. The regulatory model for aged care and the culture of the regulators needs to change.

You've heard evidence about other approaches to the regulation of quality and safety in different but related sectors. Mr Graeme Head's evidence with respect to the National Disability Insurance Scheme Quality and Safeguards Commission framework revealed significant contrasts between regulatory approaches in disability services as compared with aged care. The NDIS Commission's regulatory philosophy arises out of the objects and general principles set out in legislation, including the objective of giving effect to Australia's obligations under the United Nations convention of the rights of persons with disabilities. By comparison, it seems, the aged care framework and regulatory philosophy doesn't meaningfully protect or enhance the human rights of service users.

Professor Debora Picone, AO, chief executive of the Australian Commission on Safety and Quality in Healthcare, gave evidence regarding steps taken within the health sector to promote transparency and engagement of service users within the governance of healthcare services with the intent of enabling service-users to drive quality in the delivery of care. Professor Picone gave evidence about the use of clinical indicators by the Australian Commission on Safety and Quality in Healthcare and the importance of that data in measuring quality as well as giving early warning signs about something going wrong. She agreed that there would be no barrier to the collection and reporting on this information in the aged care context.

Professor Picone observed disparities between standards applied to clinical care in the health and aged care settings and suggested there may be opportunities for greater harmonisation of healthcare standards across settings. She told the Royal Commission:

> *Our view is there should be one set of core standards.*

The Queensland public guardian, Ms Natalie Siegel-Brown, observed that other systems such as disability, mental health and children's services are more advanced

when it comes to promoting the voice of persons who interact with their systems and receive care, support or other services. She considers the aged care system is decades behind these other sectors. She said – and I quote.

> *It would appear to me, that the aged care sector is where we were 20, 30 years ago with disability, when we had for example, in Queensland, the Carter inquiry that gave rise to this need for regular eyes and ears, monitoring the rights of people who very often may not have the cognitive capacity or self-efficacy to advocate on their own behalf.*

End quote. Fundamental change to the regulatory system for aged care is needed. We submit that piecemeal adjustments and improvements are unlikely to achieve what is required. A philosophical shift is required, placing the people receiving care at the centre of quality and safety regulation. This means a new system, empowering them and respecting their rights. It should involve a different and enhanced approach to complaints and other avenues for the voice of the care recipient to be heard and for the regulators to respond to it. The Royal Commission has received a good deal of evidence about the importance of placing the person receiving care and their relationship with the care provider at the centre of decision-making to ensure a good quality of life as well as appropriate personal and clinical care. The same philosophy should also permeate all aspects of quality and safety regulation. A person-centred approach to regulation would place the needs and aspirations of care recipients at its centre. It would have regard not only to the older person but their family and the important people in their life. It would recognise the importance of the relationship between the older person and their care workers.

We will be addressing further issues related to quality of care in future hearings and expect to hear further from the Quality Commission, from the secretary of the department and other senior officials to assist in our inquiries into aged care regulation. Commissioners, as in earlier hearings, you've made directions for the preparation of written submissions on the case studies or other matters arising in the hearing. Those directions have been published on the Royal Commission's website. Counsel assisting submissions are to be provided by Monday, 19 August, responding submissions within seven business days of the provision of counsel assisting's submissions and any reply submissions within five further business days.

COMMISSIONER TRACEY: Thank you, Mr Gray. There will be directions to that effect on the website this evening. We thank counsel for their assistance. We thank those who've been responsible for setting up this week's hearing here in Brisbane, which has been no mean feat. We thank the Family Court of Australia for making this courtroom and other facilities available to the Commission for the purposes of its hearings. The Commission's further hearings will be adjourned to Melbourne on a date to be fixed.

MATTER ADJOURNED at 2.23 pm INDEFINITELY

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Index of Exhibits and MFIs