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TRANSCRIPT OF PROCEEDINGS

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

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

SYDNEY

10.04 AM, MONDAY, 31 AUGUST 2020

DAY 88

MR P. GRAY QC appears with MS E. HILL as counsel assisting
MR S. FREE SC with MS A. MUNRO appears for the Commonwealth of Australia
MR P. ENGLISH appears for Mable Technologies Pty Ltd
MS V. HOLT appears for the State of Victoria
MS E. HILTON appears for Hireup

COMMISSIONER PAGONE: We begin by acknowledging the traditional custodians of the land on which we meet, the Ngunnawal people and the Gadigal people of the Eora nation and we pay our respects to their elders, past, present and emerging. Mr Gray.

MR GRAY QC: Commissioners, in this hearing, I appear with Ms Erin Hill. The chair and I are located in Sydney. Commissioner Briggs is in Canberra and the hearing will be conducted by remote links with witnesses in various places, including some prerecorded evidence.

I wish to acknowledge the traditional custodians of the land on which we meet, the Gadigal people of the Eora nation, and for Commissioner Briggs, the Ngunnawal people, as well as the traditional custodians of the lands from which our witnesses appear over the next three days, and to pay my respects to their elders, past, present and emerging.

The subject of this hearing is aged care provided to people living at home and in other community settings outside residential aged care facilities. By comparison with other developed nations, Australia has a very high percentage of its aged care recipients in residential aged care. In most other developed countries, there is proportionally far greater take-up of community and home care, by comparison with residential care. Over 6% of people in Australia aged 65 or over live in residential aged care facilities, the second highest in the OECD after Lithuania; and an astonishing figure of nearly 19% of people in Australia aged 80 or over live in residential aged care facilities and that's the highest currently or recently reported percentage in the OECD, although Belgium may be higher. That percentage in Canada and the Scandinavian countries is between 12% and 13% --- 12% and 13% compared with our 19% --- and in New Zealand, it's about 14%.

Some countries that are more densely populated manage to sustain far lower rates of institutionalisation in residential aged care facilities, such as Japan at 7% and South Korea at 9%. This is likely to be unrealistic for us, but the figures in Canada and New Zealand do suggest that our system is distorted towards institutional care and away from community and home care.

There should be far more urgent efforts to prioritise home care over residential care. This is not to disparage residential care. There will always be a place for high-quality residential care, but as the research indicates, and I will come to that in a minute, it's not generally the setting a person would choose.

The current COVID-19 pandemic is likely to reinforce people's general preference to age in place at their home and do all they can to avoid admission to residential aged care. As at 30 August, yesterday, the most recent day's data reported by the Department when I checked this morning, there had been seven deaths amongst the nearly 1 million people receiving Commonwealth subsidised in-home and community care, compared with 412 deaths amongst about 200,000 people in residential aged care facilities in this country.

The Royal Commission first examined home care in a hearing in March 2019, very early in its inquiry. In their interim report, Commissioners Tracey and Briggs called for urgent action on the long waiting list for Home Care Packages. The Government recently announced that since the 2018/19 budget, there has been investment in an additional 50,000 Home Care Packages. Nearly 18 months after the Royal Commission's home care hearing in March 2019 and 10 months after the interim report, people who need more complex or intense care at home are, however, still waiting more than 12 months for their assessed needs to be met; that is, they're waiting more than 12 months after the assessment until they get the help they need.

As at the end of the last financial year, there were more than 100,000 people awaiting assignment of a package at the level they had been assessed as needing. Now, many of those people had been offered lower level supports, but they're waiting for the support that they'd been assessed as needing.

Well-designed arrangements for home care will be crucial for the future of aged care in Australia; its responsiveness to the needs of older people, its quality and safety and its sustainability. On the currently available evidence, changes in approach and greater focus and urgency are going to be needed.

During the hearing this week, we will be testing a suite of proposals for how best to provide support and care for older people in the home and community. Those proposals are set out in 10 propositions which we have provided to the witnesses in advance of this hearing.

Operator, please display the index to the general tender bundle for this hearing?

Commissioners, I tender the general tender bundle for the hearing comprising the documents in this index.

COMMISSIONER PAGONE: Exhibit 20-1.

EXHIBIT #20-1 - GENERAL TENDER BUNDLE COMPRISING DOCUMENTS IN INDEX

MR GRAY QC: On the page currently displayed viewers can see proposition H1, and the next page HC2 and so forth.

We will be testing the 10 propositions, HC1 through to 10, from a number of different angles. I will briefly now outline five key themes of this hearing, each of which reflects guiding objectives or principles which the arrangements for home care should promote.

Firstly, when older people consider inviting the provision of care into their own

homes, they must be confident that they will be able to exert a lot of influence over who delivers that care and how it is delivered. So the first theme is how best to respect the preferences and the choices and to boost control and enable independence for the people seeking support and care in their homes for the long haul.

The second theme is how best to transition from the current situation to arrangements that are easy to use, efficient, and can deliver care that meets assessed needs and is guided by the principles of autonomy that I've just mentioned. This will involve eliminating fragmentation and duplication in the way services are currently arranged and lifting current restrictions in supply of necessary services, particularly to people who have more complex needs which are currently waiting a long time for assignment of a rationed package.

The third theme is how best to ensure the providers and the workforce have the capabilities to provide the services that are needed. The fourth theme is closely related to the question of provider and workforce capability and it also involves regulatory oversight and other regulatory functions. This theme is how best to ensure that the services will be provided safely and that they will be of high quality.

The final theme is how best to ensure that all of this is achievable in the long term, in a sustainable manner.

I'll now say something in a little more detail about each of these themes in turn, introducing the proposals or propositions we wish to raise for consideration and to have tested during the hearing, and also mentioning, in broad outline form, the evidence we intend to call over the next three days.

So that first theme of preferences, choice, control and independence. The main purpose, we submit, of home care must be to sustain the health, wellbeing and the quality of life of older people, enabling them to maintain their independence for as long as possible, to live independently at home for as long as possible, always provided that this can be done safely and that high standards of quality are met.

Arrangements for home care should therefore respect the preferences, choice, control and independence of the people seeking help. The importance of this is reinforced by the fact that the care takes place within their own home and a design respecting these principles will act as an encouragement to people to obtain the services they need in a timely and early manner, when they can best have the beneficial effect. That effect must be to prevent or delay deterioration in functioning to sustain independence and maintain wellbeing and quality of life.

We hope that this will mean that in most cases older people can remain in independent accommodation, their own homes, to the end of their days.

A report of a 2015 Australian study, tendered but not published at tender bundle tab 5, suggests that for each hour of additional home care per week, there's an association with an appreciable 6% lowering of the chance that that person will ever

have to enter residential care. Home care should, in this manner, act as a stitch in time, preventing or at least delaying much more weighty problems for the individual and much more costly forms of care.

These purposes are reflected in our proposition 10 which sets out measures to ensure an enablement approach is taken to home care from assessment onwards.

The preference to remain at home has been a constant theme in both the direct evidence and the expert evidence received by the Royal Commission. Operator, please play and stream the compilation of home care preference testimony that has been prepared.

VIDEO OF HOME CARE PREFERENCE TESTIMONY BEGINS

MS JOAN ROSENTHAL: Ian, more so than I, we're both accumulators and if we were to move out of our home, first of all we'd have to sell it and we'd have to buy something else and then we would have to deal with all our belongings and that's something we just haven't wanted to face and we would lose our garden, which we love, we both love. And so as long as Ian can manage those 25 steps that's not --- there's no reason that we would want to move out.

MS PATRICIA SPARROW: They want to stay at home, they want to be supported at home.

DR DAVID PANTER: Older people themselves were voting with their feet and wanting to stay at home.

DR ANTONY BARTONE: We know older patients and older Australians prefer to remain at home.

MS ANGELA RAGUZ: We know that older people want to stay at home. I think that's the other thing that we're hearing, people do not want to live in hospitals for the last three years of their life if that's the average length of stay. People would prefer to stay in their own home surrounded by people who they love and who they trust.

MS RUTH HAMILTON: She wanted to stay at home and I tried to keep her at home for at least, I think, five months.

MS CATHERINE THOMSON: It's also a positive experience in terms of providing a loved one in providing the care that they need and knowing that you're providing the best sort of care that you can and you're allowing that person to remain independent and to remain at home, which is what they want to do.

VIDEO OF HOME CARE PREFERENCE TESTIMONY CONCLUDES

MR GRAY QC: Thank you. The available research evidence also supports this impression. This includes recent reports by Flinders University and IPSOS commissioned and published by the Office of the Royal Commission. Flinders University, in their report, state that the overwhelming preference, what they call the vast majority of Australians, is to remain independent and living at home, and a significant majority, of 72%, would be willing to pay a co-contribution fee to remain at home rather than move into residential aged care.

The IPSOS survey report confirms the wish of the vast majority to remain in their own home living independently for as long as possible, and there are many reasons for this. The predominant theme in the research seems to be that people want to live at home to maintain independence, control and choice as to how they live. Independence is frequently cited as the most significant quality of life indicator for older people. Some people may be afraid of going into nursing homes. This might be because they have witnessed poor and unsafe care of family members, or because residential care is seen as an end-of-life option, it means end of life is approaching.

Fear of institutional settings is particularly acute amongst certain groups. For example, people who have experienced trauma or discrimination. Home, and the surrounding community, may have other advantages over traditional institutional care by providing physical and mental wellbeing that's critical to meet basic human needs. Familiar surroundings confer feelings of safety, comfort and security. People want to stay close to known and familiar services; their GP, other healthcare options, shops, cafes, and the like. New surroundings are increasingly disorientating for older people.

The Flinders University and IPSOS findings are broadly consistent with the results of a survey conducted for the Royal Commission and published by Roy Morgan, although that survey returned a result that a significant minority of 29% of older Australians would opt for residential care in the event they need care on an almost daily basis in the nature of dressing, eating, going to the bathroom or nursing care, as opposed to simply needing some support in their daily activities.

Operator, please display the Royal Commission's research paper number 4, page 48, figure 32.

That's the Roy Morgan outcomes, including a paraphrase of questions that were asked and the questions in their entirety can be found at the back of the report.

Commissioners, the evidence you heard at the Sydney hearing 3 earlier this month demonstrated that there's a lack of suitable accommodation for ageing in place, which may impact people's ability to remain at home in the future. The IPSOS report survey responses also highlight the importance of accessibility features promoting independence and access to community to people planning for housing in their old age. Thank you operator, you can take that chart down now.

The principle of respecting preferences was central to the Government's purposes in establishing this Royal Commission. Commissioners, your terms of reference require you to inquire into challenges and opportunities in aged care raised by "changing demographics and preferences, in particular people's desire to remain living at home as they age." And "how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers in care-related matters."

There are, of course, circumstances in which supported decision-making will be required in order to interpret an individual's preferences. Ms Marie McCabe, Chief Executive Officer, Dementia Australia, has highlighted that: As dementia progresses, for example, there will come a time when people are unable to make choices about their care clear. Ms McCabe went on to explain that Dementia Australia absolutely supports consumer-directed care but that many people living with dementia cannot speak for themselves and do not have carers or advocates who can speak for them. She explained that the system needs to be flexible enough to take into account the unique challenges that many people are faced with.

One way in which choice is currently exercised in the direction of Home Care Package expenditure is via online applications through which package holders can arrange care services. Tomorrow afternoon, you will hear a recorded interview with Eileen Kramer who, with the support of others, used an online platform called Mabel to arrange home care services directly with workers who suited her needs. Via Mabel, there are thousands of care workers who make themselves available for engagement as independent contractors, that at least is the characterisation placed upon it by a witness who we'll hear from later today, and that engagement as independent contractors may be by people who had aged care Home Care Packages or NDIS support plans.

The witness later today is Mr Peter Scutt. You will hear from him later this afternoon. He will explain the benefits for those who prefer to manage their own care arrangements through Mabel and the ways in which Mabel interacts with home care recipients, home care providers and the workers who may be engaged by recipients or providers over the platform.

According to Mr Scutt, Mabel is not an employer but rather a facilitator of engagement of care workers. He will also speak about the safeguards that Mabel uses and the differences he perceives between aged care and disability services.

Commissioners, there are also critics of Mabel's model and of the brokerage of care services in certain circumstances. One of those critics is Mr Paul Versteege, of the Combined Pensioners and Superannuants Association who will be giving evidence at the next hearing of the Royal Commission in mid-September. We are tendering his statement now and it forms part of the general tender bundle. It's at tab 82.

Criticisms of such models are also identified by Dr Paula McDonald in a statement at tab 37. Some submissions received by the Royal Commission also express concerns about platforms of this kind such as the submission received from the Australian Nurses and Midwifery Federation. We will be asking Mr Scutt about these matters later today.

We will also call Jessica Timmins who represents another online platform called Hireup. Hireup employs the workers whose profile appear on it and they're available to provide services to NDIS participants who may select particular workers and arrange the particular services they will receive by using the Hireup platform. Hireup does not operate in aged care, but it provides an example that you might find instructive, Commissioners.

One of the witnesses you will hear from on Wednesday is Dr Carmel Laragy. Operator, please display tab 46. This trial was directed to increasing consumer self-management in home care. You will hear from Dr Laragy that the literature review she conducted for the trial, which is also available in the tender bundle at tab 30. That indicates that there's a range of better outcomes for older people who self-manage their care in certain circumstances. The outcomes depend, however, on the experience of the provider in facilitating self-management. This suggests that self-management is perhaps something of a misnomer and we'll explore this later in the hearing.

These challenging issues are reflected in propositions HC3 and 5.

The next theme is the simplification of the service arrangements and the integration of the current arrangements into one set of arrangements that will provide a much simpler experience for the person needing care. As the interim report related, the manner in which successive governments and the sector have attempted to meet the needs of people that need aged care and foster choice, control and independence, has been marked by reforms which can be described as marketisation and individualisation. There have been increasing efforts over time to open the supply of home care services to greater levels of competition through providing people with budgets that are known as Home Care Packages and these packages are supposed to be spent at the direction of the person seeking care on the needs for which they've been assessed.

There is, of course, a freestanding Home Care Package program for administering these packages. It has its own assessment processes and four levels of funding available depending on the outcome of the assessment. They are level 1 basic needs which runs to approximately $9,000 a year; level 2 low-care needs, about $15,750 a year; level 3 intermediate care needs, about $34,500 a year; and level 4 high-care needs, approximately $52,250 a year.

In the Home Care Package program there's a basic daily fee and a means-tested co-contribution fee, but the evidence suggests that providers don't always collect the fees and may be omitting to do so as a competitive measure, to attract package

holders to their businesses.

The interim report flagged the need to consider the current Government policy trajectory which has been towards increasing marketisation of aged care services. The interim report foreshadowed the need to explore measures to manage a fragmented market for the delivery of aged care, along with the consideration of alternatives, and that is what we assisting the Royal Commissioners have been doing.

As you've seen over the course of your inquiry, Commissioners, the Home Care Package program, I will be calling it the HCP program at times, sits alongside another program which provides overlapping services accessible through a different assessment process and funded in a different manner. That program is the Commonwealth Home Support Program, or CHSP.

CHSP has undoubted strengths that should be preserved to the extent compatible with the need to combine the two into an integrated set of arrangements. CHSP evolved from State-based arrangements and is admirable for its ability to ensure service coverage even in communities with dispersed populations, and its relative ease of administration compared with the HCP program. CHSP is the mainstay for providing high volume, low unit cost, home and community support services at, supposedly, the more basic end of the spectrum for the purposes of preventing people's conditions from deteriorating. It covers a broad range of community and in-home care services ranging from domestic assistance, social support, transport, meals, assistive technologies, home modifications, some forms of respite, through to time-limited personal nursing and allied healthcare. Importantly, it no longer --- it did once, but it no longer --- affords a means of funded care management or coordination.

By comparison with Home Care Packages, however, CHSP is weak on the principle of empowerment of individuals' ability to tailor their own supports and care. While the HCP program is at least, in theory, stronger on that matter of respecting choice and independence, it has various weaknesses of its own. Its effectiveness depends on the information that's available to individuals. The willingness and the capability of people to assess that information, informed consumer choice, in short, and also it depends on the presence of competitive market forces in all places and service categories including for diverse needs. There are uncertainties about all of those matters that I've just mentioned and there are distortions in the resourcing of the program. The numbers of the packages are capped, and as I said right at the outset, there are significant waiting lists at present. The packages are only meeting about half of the call for services to meet higher, more complex care needs that have been assessed.

Notwithstanding that people are not getting the packages they need in a timely fashion, people who do have packages are not spending all the money they're entitled to spend, leaving a large and accumulating pool of unspent Government funds in the hands of providers hosting the packages. Who are the Home Care Package providers? At the end of financial year 2018/19, there were 928 of them, 52% of

whom are not-for-profit organisations who enjoy a 72% market share by number of package holders. 36 of the home care providers are for-profit organisations enjoying a 22% market share and the remainder are Government owned.

The providers were funded about $2.5 billion to provide services in that financial year to about 106,000 people at a point in time, 30 June 2019. The number of people who had packages on that date was up 16% from the end of the previous financial year, and the numbers of people holding a package are generally on the increase. They've been increasing year on year for the last several years.

The average age of people holding a package was about 81 years old. The number of packages assigned to older people has risen since the end of financial year 2018/19, as I just mentioned. By December 2019 it's reported that 145,320 people had access to a package, and as at 30 March 2020, 151,958 people had access to a package.

There were more than 1,450 providers funded to provide CHSP services in the nature of home support in that financial year 2018/19. The cost of that program was similar to the cost of the Home Care Package program. About $2.5 billion was spent on care and another $100 million on support services such as assessments. The people receiving those services is far greater than the people receiving services under the HCP program. Under CHSP in 2018/19, about 840,000 people received services. The average age of those people was 80 years old. There were also, in that financial year, about 564 CHSP-funded respite providers.

There's broad consensus in the submissions to the Royal Commission that integration and simplification is needed but the optimal form the new arrangements should take is contested. Following a consultative process and a hearing on 4 March 2020, we made submissions to you, Commissioners, about the key elements that should guide the redesign of the program for aged care services including home and community services. Those submissions are published on the Royal Commission's website.

Further submissions in response have since been received from stakeholders, the public, the sector. Consistently with our submissions on 4 March, we've now formulated more detailed proposals for integrated arrangements in community settings and in the home. Operator, please display tender bundle tab 59, just the first page, which is our outline of proposed new arrangements.

The proposal for these new service arrangements is set out in some detail in this document and this document has been made available to witnesses in advance of the hearing and it's publicly available at tab 59 of the general tender bundle.

Operator, please go back and display the propositions at tender bundle tab 1, proposition H2. Commissioners, our proposition H2 is intended to meet the need for adequate provision of support and care in the home through integrated arrangements in a way that extracts benefits from the strengths of each of the two existing programs while correcting their respective weaknesses. Some categories of services should continue to be funded in the manner CHSP is currently funded. While the

HCP approach to funding is justified in some circumstances, there will others where it will not. It will be essential the full range of community and in-home care services are available to people in outer regional areas and beyond, and to people with diverse needs such as Aboriginal and Torres Strait Islander people, other people who are culturally and linguistically diverse, people affected by trauma, people who are or are at risk of being homeless, people who are socially isolated through disadvantage or through stigma such as former prisoners.

In many cases, a market-based model may be inadequate and the Government should commission providers through direct grant agreements to ensure services are available in these circumstances and for these people.

Operator, please display proposition HC1. That proposition in various detail proposals in propositions 4 and 6 are all designed to enable a transition to the new integrated home care arrangements. HC1 is a set of interim arrangements for a transitional period which should be no longer than three years, in our submission. The objective is a demand-driven, uncapped set of services where everyone is entitled to aged care and will be guaranteed access to the care they've been assessed as needing. This approach serves the principle of sustaining people in their preference to age, at place in their home wherever possible, and if that is to be achieved, the key issues of capability that are addressed in the later propositions, in particular HC6, must be prioritised with the assistance in HC4. I will address those propositions a little later in these remarks.

We will be testing our proposals for the structure and features of the new integrated services with a panel of providers this afternoon including a small provider with an innovative niche suite of services, Mr Ahilan St George of Vitality Club, and with a provider with a specialisation in care management of services for vulnerable people, Mr Brian Corley of Community Options and with Ms Sharyn Broer of Meals on Wheels, South Australia, and two witnesses from large scale home providers associated with Uniting Care Australia, Uniting New South Wales, ACT, and Uniting AgeWell.

As we foreshadowed in our March 2020 submissions, Commissioners, the new services should be uncapped and demand driven, not rationed. More than half the people who need packages for more complex needs are currently waiting more than 12 months, on average, and may miss out on ever receiving a package. Despite releases of additional packages earlier than originally forecast in the budget forward estimates model, with the result that the number of packages in the hands of people has climbed as I outlined earlier, it's still the case, as at March 2020, that a total of 103,599 people were waiting for a package at their assessed level, and that included 59,071 people waiting for a package at their approved level who had not yet been offered a package at a lower level as an interim measure. Now, many of those people might be receiving CHSP services. To some extent the resources of HCP are being diverted from CHSP's critical preventive role and being used as a stop gap to meet demand to those higher-level needs.

People typically under-spend their Home Care Package, saving for a rainy day, and as at March 2020 it is estimated that there were accumulated unspent funds of over $1 billion and Stuart Brown estimated then that by July this year, that figure would be $1.1 billion and that represents more than $8,000 per package holder on average. If this allocative inefficiency were remedied, funds of that kind could be deployed in releasing more packages to meet the needs of people who are waiting in the queue to receive one. Although package holders are generally under-spending their package, it seems that for some people even the highest value packages are inadequate to provide the level of care they need to remain at home in some circumstances where the community might expect that they can.

Evidence on this point will be led in the funding hearing in mid September from Dr David Panter and Mr Martin Warner and their statements are before you now. They've been tendered at tabs 68 and 69.

The delivery of services to holders of Home Care Packages depends on what is called "consumer-directed care". But as evidence in Adelaide Hearing 2, back in March 2019, and evidence in the Mildura Hearing has already shown, consumer-directed care does not work properly because of information deficits, difficulties in navigation of the system, and the widespread lack of sufficient depth of supply of necessary services, particularly in rural and remote areas.

The fact that the two programs are assessed and also administered separately, causing confusion, is a distortion that must be addressed. There are also arbitrage opportunities created whereby people choose not to take up a Home Care Package because they perceive that in their area it may be more advantageous to them to stay on CHSP, even though they're assessed as now needing a Home Care Package. It makes little sense for the two programs to continue side by side with the overlap and distortion that I've mentioned. The challenges of integrating them are going to be tested during this hearing with the witnesses, starting with the witnesses we're calling today from the providers I've mentioned.

The third theme, Commissioners, is provider and workforce capabilities. Increasing the supply of home care subsidies will require providers to scale up their operations. Further, increasing the availability of funding will be of little use and could even have harmful effects unless there's a sufficiently numerous and appropriately trained and supported workforce available to deliver the care to be purchased with those subsidies.

As propositions HC1 and 2 describe, our proposal is that the level of funding available in home care should increase to the maximum that that particular individual would receive if assessed for residential care. Operator, please display tender bundle tab 69, the statement of Dr Panter at page 5, paragraph 12. Dr Panter is a provider. His organisation is a large-scale South Australian home care provider, ECH. ECH conducted a trial of this same approach, that is, providing a home care budget equivalent to the budget the person would receive for the care component of residential care with a small number of its home care recipients and had good results.

The logic behind this proposal is that permitting the recipient to spend up to the level of the care component of what would be spent on them in residential care, enabling them to spend that care money in the setting of their choice, could serve to keep that person out of residential care, meeting their preference and sustaining their independence and, in theory, this should be cost-neutral to the Commonwealth and might in fact save the Commonwealth from paying accommodation-related subsidies that would occur for some people when they move into residential care.

On the other hand, it might be said that for complex and intense needs, it's more efficient to fund services in a congregate facility than to fund services at home. That issue will be tested at the hearing in mid-September.

However, increasing the number of packages and the level of packages, that is, the level of funds available to people with complex and intensive needs, means that people with complex needs who are currently compelled to enter residential aged care should be able to remain in their homes for longer and this entails the building of capability in the current providers of in-home and community care so that those people can be properly cared for. Proactive management by Government will be needed to ensure that there are providers who have the clinical capability to provide that care. We'll be asking a panel of experts on Wednesday, consisting of Susan Emerson, RN, of the Australian College of Nursing, Associate Professor Lee-Fay Low, and Dr Carmel Laragy to reflect on that issue, amongst others.

What are the current capabilities of home care providers? We don't know the answers because of a lack of data. Proposition HC6(f) proposes as a starting point an analysis to identify current levels of home care service capability across the country. A market analysis would be the first step in identifying where commissioning arrangements might be needed to fill gaps. It's surprising, and a matter of public concern, that little is known about the services on which Home Care Packages are spent. The Government does not systematically collect this information. In our submission, that must change.

There is proposed legislation which provides an opportunity to enable much better scrutiny to be given to the use of home care funds. If that legislation is enacted, home care payments will no longer be paid in advance but will be paid in arrears, and that should be an opportunity to collect data so that Government can understand the performance of the aged care system which is a necessary first step before necessary refinements can be made over time. In the interim, and in order to provide some basis for inferring what services are being purchased with Home Care Package funds, the Department of Health conducted a survey of a large sample of home care providers which has since been analysed by Stewart Brown.

Operator, please display tab 4, just the cover sheet. Now, for one financial year, there was a significant sample of almost half of home care providers surveyed for the purposes of this study. So the survey has a sound basis in evidence and it shows that there is extremely low utilisation of certain services, unexpectedly low utilisation of

nursing and allied health services, even for people on packages intended for --- even people on the packages intended for the most complex needs are, on average, receiving only about 15 minutes per fortnight of nursing care and about 15 minutes per fortnight of allied healthcare, amounts which Stewart Brown rightly describes as negligible. This does not seem, in any sense, to be sufficient for dealing with complex needs. We will be testing, in proposition HC9, whether a minimum contact period for people with clinical medical and personal needs is required.

There's much to be done by Government to support the training and supply of the necessary workforce and the development of career path opportunities for improving the skills of existing aged care workers and for encouraging entry into more advanced job classifications. Proposition HC4 proposes funding that would assist these measures.

As we previously submitted, Government should be implementing the 14 strategic actions recommended in September 2018 by the Aged Care Work Force Strategy Taskforce headed by Professor Pollaers. Those actions recommended two years ago are more urgent than ever now. Ironically, the effect of the COVID-19 pandemic on unemployment rates may present an opportunity to increase and improve the aged care workforce if Government moves quickly on this.

Increasing the supply of home care subsidies must not compromise safety and quality. Counsel assisting have already made a recommendation to you, Commissioners, in February this year, that all aged care workers providing hands-on personal care subsidised by the Commonwealth should be required to have a minimum qualification at certificate III level and to be registered.

In the home care setting we'll ask witnesses whether, if there is a likelihood of the personal care worker being unsupervised, the minimum qualification should be greater, perhaps at a certificate IV level.

Technological innovation has previously been addressed in a separate hearing and is not a particular focus of this hearing. That said, there will be a focus on the use of online applications and platforms to arrange care services. Technology affords opportunities for improving the reliability and efficacy of home care and improving consumer choice and engagement, but it also poses potential threats, including threats to privacy and threats to workforce stability that have flow-ons to quality and safety. Deployment of new technology needs to be monitored and managed by thoughtful and proactive system governance and not simply left to market forces, in our submission.

Propositions HC6(a) and (b) propose measures to improve the capability of the workforce and its stability by improving the arrangements under which the workforce are engaged and deployed by providers.

The recently released report of the inquiry into the Victorian online demand workforce reveals that between 2014 and 2018, the number of independent

contractors in health and social care increased by 29% compared with a 19% overall increase in that workforce. Online platforms are playing a role in the trend towards the increase of use of independent contracting.

In February 2020, we made submissions about the future challenge of attracting people to work in aged care, given future demographic predictions. We submitted that the 'Royal Commissioners have the opportunity to set the policy parameters to provide aged care workers with the training and support that they need to have a fulfilling career with opportunities for professional development and an attractive career trajectory'.

This week, Commissioners, you will hear from a panel of workforce experts, Dr Fiona McDonald of RMIT, Dr Jim Stanford, Director of the Centre for Future Work and Professor Andrew Stewart of Adelaide University about impacts for the aged care sector in personal care workers providing services as independent contractors. We will be asking those witnesses whether the emerging trend of engagement of independent contractors impacts on building the attractiveness of aged care as a career destination and we'll ask whether there are links between quality and safety of care and the employment and engagement arrangements for personal care workers.

We'll also ask whether there is a risk of compromising quality and safety in circumstances where personal care workers are not subject to direction and control of a clinically-qualified person within an aged care provider organisation. The fourth theme flows straight on from that point. It's ensuring quality and safety for services delivered in the home, and in considering this theme, we have to acknowledge that the regulation of quality and safety of services provided on private premises has been a regulatory weak spot for some time.

Now it's evident, in our submission, that strong care coordination or care management is needed if there's to be reliance on a marketised model to answer needs of people, including needs that may be very challenging and needs arising from diverse backgrounds.

Operator, please display general tender bundle tab 12, the statement of Danielle Dougherty of Mallee District Aboriginal Services. Ms Dougherty gives evidence in her statement about what amounts - these are my words - to the misuse of Home Care Packages. Ms Dougherty has said that many clients have received a generic service that's not tailored to their needs and doesn't offer changes to be made quickly and easily to accommodate evolving needs. And over the next page she uses examples of some providers sending care recipients vouchers for food or retail stores without having properly assessed their needs and in some cases people being unable to purchase necessary therapeutic equipment, with dire results.

Care management must be done appropriately and it will involve referral for reassessment when a person's needs change and it will involve well-resourced and nimble assessment services able to provide punctual reassessment; otherwise a marketised model will not be able to succeed. Care management, in spite of its

importance, is not uniformly well understood or practised. Margaret Harker's statement in last year's Home Care hearing gave an example of poor care management and problems that can arise when care management is separated from the workforce that provides that care. And, operator, we won't play the video of Margaret Harker's evidence but it will be made available for the public to view it as part of an addition to the tender bundle.

We will test with witnesses our propositions to clarify and strengthen care management which we say should be a mandatory function performed for all residents of care at the home under the new arrangements. The key issues will include how such a care manager is to ensure that care providers are integrated with all the other services that are available to older Australians from health and community sources; what qualifications or experience is required of a care manager; and how important is a clinical background for a care manager.

During Adelaide Workshop 1 in February this year, Professor Parker of the University of Technology, Sydney and of the Australian College of Nursing, stressed the importance of maintaining oversight for people receiving even supposedly basic services and of assisting people as their needs change. She outlined the basis of care management, "That we do want to make sure that people are getting the right assessment, the right care delivered by the right people at the right time."

Now, of course, it can't always be left to the person receiving care to ask for more. Ms McCabe of Dementia Australia has reinforced the point that the needs of people living with cognitive impairment caused by dementia need to be considered in that regard as well.

Current data drawn from the recent survey of home care providers I mentioned that's been analysed by Stewart Brown, as I said indicates that very little of a Home Care Package is currently used for nursing care services. Now, the picture presented by this data raise real concerns that inadequate clinical expertise is being brought to bear in the care management of people with complex needs who may need assistance in coordination of primary healthcare, allied healthcare and potentially subacute care, as well as personal care services and the data also shows that there may be a deficit in clinical care more generally.

Although the primary onus must be on the provider and its care management, there's also a role for official monitoring and quality and safety regulation. It's long been recognised that the regulation of quality and safety in home care on private premises is very challenging. Because it's delivered behind closed doors in private homes, and it's delivered to so many hundreds of thousands of people, this makes it very necessary to consider ways in which safety and quality can be indirectly measured, rather than directly monitored and observed. The challenge will become more acute as more people choose to age in place in their homes.

Officials of the Department of Health have acknowledged to the Royal Commission that the regulation of care in the home is less developed than the regime that applies

in residential care. The Government has a plan for improvement of quality and safety in home care, set out in a document generated last year called the Home Care Compliance Action Plan, and that's in the tender bundle, and the regulator has a project to achieve similar broad objectives. We'll be examining these plans in sessions with witnesses from the Department and from the Quality Regulator on Wednesday.

This afternoon and on Tuesday, we will be hearing about safeguarding arrangements for people provided with services in the home and community; we'll hear from Professor Jos Schols of Maastricht University on various aspects of home care including safety measures in the Netherlands, and tomorrow we'll hear from Commissioner Robert Fitzgerald and Ms Kathryn McKenzie from the New South Wales Ageing and Disability Commission on these topics.

In propositions HC6(c) we propose higher hurdles for suitability before a provider is licensed and certified or approved to provide care. New home services should receive a prompt quality review against the quality standards immediately upon commencement of services. At present, many months may pass before this occurs. This is unacceptable, at least in cases where the provider doesn't already have a proven track record of high quality and safe services.

In proposition HC7, we propose an overarching general duty on providers to ensure high quality and safe care. This will be an important element of the overall approach to quality and safety across all forms of aged care, including home care.

Measures for consumer feedback and engagement will be a key element of home care quality regulation. Measurement of quality indicators can play their part. On Tuesday, you will hear from Dr Gillian Caughey of ROSA, the Registry of Senior Australians, about research she has conducted and overseen for the Royal Commission into use of quality indicators in overseas aged care systems and we'll examine the categories of indicators that might be appropriate for monitoring in the home care context.

Amongst other propositions in HC6, we propose an extension of the Serious Incident Reporting Scheme that currently applies in residential care into aged care settings, at least where higher-level care needs are being met in the home. And we also propose to draw all these information sources about provider performance together and establish a transparent, public reporting regime to inform consumer choice.

All of these measures will place additional burdens on the regulator. The regulator must be properly funded, staffed and supported for these tasks. There's reason for concern that the current levels of resourcing of the regulator and its current capabilities may be inadequate.

I turn now to that critical issue. There appears to have been a steep fall in regulatory activity by the regulator since July 2019. The new quality standards were introduced at that time. It might have been expected that a regulator would seek to increase

activity to encourage adherence to the new standards. However, since that time, there's been a fall. To give you an illustration of the level to which regulatory activity has fallen since that time, Commissioners, I will give you an example of the quarter before July 2019.

In the quarter 1 April 2019 to 30 June 2019, there were 181 quality reviews conducted by the regulator on home care providers. In the next quarter, after July 2019, there was a huge drop, and in the three quarters since July 2019 for which we have a report, there's been an average of only 25 quality reviews in each of those quarters; 25 quality reviews compared to 181 in the quarter before.

The Aged Care Quality and Safety Commission has explained in response to a notice issued by the Royal Commissioners, that the level of home care service compliance activity has been impacted by high turnover of the assessor workforce, also the introduction of the quality standards which has increased the time taken for quality assessors to undertake assessments, and a higher number of non-compliances identified in residential aged care.

Commissioners, in the budget for 2019/20, the Government announced $5.6 million to commence implementation of an enhanced Home Care Compliance Framework. In addition to asking witnesses about the progress of that framework, we'll be asking witnesses about the capability issues and the staffing issues that I've just identified.

Finally, Commissioners, your terms of reference require you to enquire into how best to deliver aged care in a sustainable manner. Sustainability will be a key focus of your next hearing on funding, financing prudential arrangements in mid-September, but it's also an important principle to consider in relation to home care. If the system of aged care services could get home care right as well as meeting the preferences of older people, this will probably alleviate fiscal pressure on the system at least to some extent, and that pressure is severe.

Home care is cheaper than residential care on a per capita basis and is currently much cheaper on an aggregated basis, too. The average Commonwealth funding paid for someone in residential care in 2018/19 was about $191 per day, whereas the average daily expenditure by providers for a person on a Home Care Package was about $71 in that period. In aggregate terms, CHSP and HCP together cost the Government a little over $5 billion in 2018/19, and residential care cost the Government about $13 billion in that period.

I want to mention very briefly the importance of respite in meeting the needs of informal carers, in particular, and in sustaining the system of provision of home care services. The provision of home care services, to a large extent, depends on assistance by informal carers. The current system for provision of respite is badly flawed and is geared to providing inflexible chunks or blocks of time in residential respite when the evidence shows that informal carers would prefer to receive respite on a far more flexible basis, including short stay or overnight respite. There needs to be a dedicated set of arrangements for respite and you will see that in our

propositions, in particular proposition HC2.

Operator, please play the evidence of Ms Rosemary Cameron at the Mildura Hearing.

VIDEO OF MRS ROSEMARY CAMERON BEGINS

MRS CAMERON: I learnt you don't wait until you need respite, that you need to book ahead so you know you've got a set break in so you can pace yourself, virtually, because you won't get anything at the time. So sometimes I would book it in and it would be three months ahead and then I would get a few weeks just prior to going in and you're hanging on, thinking, well, if I just hang on a little longer I'd get that respite and they'd ring me to say "I'm sorry, that bed is not available now, we filled it with a permanent resident, so I'm sorry, you can't have that." So then you've got to ring again and wait longer again. So you are just put to the back of the list.

A lot of the facilities were closing down their respite beds and it was told to me by one facility that it really wasn't worth them doing all that paperwork every two weeks. If they did two-week slots for respite, then it was far too much paperwork. If they put a permanent resident into that bed it was easier. So they were stopping their respite beds.

VIDEO OF MRS ROSEMARY CAMERON CONCLUDES

MR GRAY QC: As well as having difficulties in obtaining respite and in spite of being assessed as needing a higher-level Home Care Package, that package was never assigned to Mrs Cameron's husband Don, and there were times when Mrs Cameron almost despaired.

In the future, aged care needs assessment must include a focus on the needs of informal carers and a tailored package of respite must be available to support them in the long term. And it should have a dual purpose; providing relief for the carer as well as improved enablement outcomes for the person receiving care.

We propose that the respite category of services should be grant-funded and commissioned regionally so that there are local solutions for local needs.

In addition, to sustain and incentivise these informal carers in their vital role, we propose, at HC8, a new measure to protect the workforce participation rights of informal carers. One of the issues highlighted in the Mildura Hearing was the difficulty for informal carers in continuing with employment for a period of time when caring for an older person. A panel tomorrow will consider the new employment rights we propose under proposition HC8 which concern extended leave

and flexible working arrangements for carers.

Commissioners, I will conclude by just saying this: the five lines of enquiry which I've just mentioned each provide insights into bringing about lasting improvement in home care, but of course they can't be considered in isolation from each other. I will be asking the witnesses to consider the ways in which these matters can best be combined to deliver lasting improvements and this will involve careful consideration of tensions which exist between them.

Commissioners, I understand there are now some appearances to be made or announced.

COMMISSIONER PAGONE: Yes. Thank you, Mr Gray. Do we have some appearances?

MR ENGLISH: May it please the Commission, can I be heard? My name is English.

COMMISSIONER PAGONE: Yes, Mr English, you can be heard.

MR ENGLISH: Thank you, Commissioner. I seek leave to appear for Mabel Technologies Pty Ltd.

COMMISSIONER PAGONE: Thank you, Mr English.

MR ENGLISH: Please the Commission.

MS HOLT: I appear for the State of Victoria. My name is Holt.

COMMISSIONER PAGONE: Thank you, Ms Holt, we can just barely hear you, but if I understand you correctly, you're appearing for Hireup in respect of the witness Jess Timmins, is that correct?

MS HOLT: No, Commissioner, I appear for the State of Victoria.

COMMISSIONER PAGONE: Sorry, I misheard you completely. Thank you.

MS HOLT: Thank you.

MR GRAY QC: As I mentioned earlier, Commissioners, during the hearing I will invite you to receive pre-recorded videos of evidence given by direct experience witnesses together with related documents. There are going to be three such recordings. The first of these is evidence of Rod and Rosalie Foreman. I tender the statement of Rodney Foreman, document ID RCD.9999.0479.0001. Commissioner, I could tender the entire set of documents relating to the recording of this evidence as one exhibit if ---

COMMISSIONER PAGONE: I think that would be preferable, wouldn't it, unless for some reason why it should not happen?

MR GRAY QC: I will recite the codes for the other two documents that make up the bundle. I tender also the recording of Rodney and Rosalie Foreman, document RCD.9999.0476.0001, and I also tender the transcript of that recording, document RCD.9999.0476.0002. So those three documents together, I tender that as one exhibit.

COMMISSIONER PAGONE: Those three documents will be exhibit 20-2.

EXHIBIT #20-2 - STATEMENT OF RODNEY FOREMAN; RECORDING OF RODNEY AND ROSALIE FOREMAN; TRANSCRIPT OF RECORDING

MR GRAY QC: Thank you, Commissioner. Operator, please play the recording of Rod and Rosalie Foreman's evidence.

VIDEO OF RODNEY AND ROSALIE FOREMAN BEGINS

MS HILL: This is an interview between Rodney and Rosalie Foreman and Erin Hill, Counsel Assisting. Today's date is 24 August 2020.

The interview today is being recorded. The recording of this interview will be tendered at a public hearing of the Royal Commission into Aged Care Quality and Safety, commencing on 31 August 2020 in Sydney. The recording will then be made publicly available.

Rosalie, do you consent for Rod to speak on your behalf today?

ROSALIE FOREMAN: Yes.

MS HILL: Thank you.

Rodney, do you agree to continue with the interview today on that basis?

RODNEY FOREMAN: Yes, indeed.

MS HILL: Thank you. Starting with you, Rod, could I ask you to tell us your full name.

RODNEY FOREMAN: Rodney Keith Foreman.

MS HILL: And how old are you?

RODNEY FOREMAN: 73 and a half. I had to think about that. Sorry.

MS HILL: Where do you live?

RODNEY FOREMAN: In Mannum, South Australia.

MS HILL: And that's on the west bank of the Murray; is that right?

RODNEY FOREMAN: Yes, correct.

MS HILL: And how far from Adelaide is Mannum?

RODNEY FOREMAN: Approximately 100 kilometres. Depends which part of Adelaide you're going to.

MS HILL: And seated with you today is Rosalie Foreman?

RODNEY FOREMAN: Correct.

MS HILL: And Rosalie is your wife?

RODNEY FOREMAN: Correct.

MS HILL: And you and Rosalie live together in a unit in Mannum?

RODNEY FOREMAN: Correct.

MS HILL: How long have you and Rosalie been married for?

RODNEY FOREMAN: Getting up 13 years in November.

MS HILL: And would you like to share the story of how the two of you met with the Royal Commission today?

RODNEY FOREMAN: Yes. We --- Rosalie had lost her late husband, I was very separated from my previous wife, my sister introduced us. We took a little bit of time to get to know each other but once we were together in our own time we just hit it off like a house on fire.

MS HILL: And after you were first married, you spent some time in Melbourne?

RODNEY FOREMAN: Not initially. We spent time in Melbourne and Victoria at the time of the stroke, around the time of the stroke, which was two and a quarter years ago.

MS HILL: But ultimately, after you were first married, you were living in South Australia?

RODNEY FOREMAN: Yes.

MS HILL: And you were working at that point, both of you?

RODNEY FOREMAN: I was, yes. Rosalie had two part time jobs, courtesy of a challenge from her late husband to go and work at McDonald's, and she impressed the proprietor in the nursery with her knowledge, answering other customers' questions that she was asked.

MS HILL: When you were both in your early 60s, what did you and Rosalie decide to do?

RODNEY FOREMAN: Rosalie was happy to spend time with me. We spent 12 months in Adelaide to see my son through year 12. We then spent more than two years in Port Lincoln, I was lucky enough to work from home on a computer. And when that went belly up, courtesy of working from home, being offshored, we went to live on a houseboat, which we did for about eight years.

MS HILL: That was your retirement plans, effectively?

RODNEY FOREMAN: Yes, yep.

MS HILL: Did you stay retired?

RODNEY FOREMAN: We did until we started motorhoming three years ago and we were coaxed out of long term retirement to run a caravan park in central Victoria, in Charlton.

MS HILL: And how was that experience?

RODNEY FOREMAN: We both loved it. Unfortunately, we only had seven weeks running it before Rosalie had her stroke.

MS HILL: And when Rosalie had her stroke, what happened? What did you do?

RODNEY FOREMAN: In the short term --- well, we were both helicoptered to Royal Melbourne. On the way down, the doctor said, "Next of kin are not normally accommodated in the chopper," but because Rosalie was so crook, he wanted me to be with her. Two weeks in the Royal Melbourne, 10 weeks in Bendigo, doing rehab at Bendigo Health, and then they wanted to move us on, so we --- Rosalie quite rightly said, "I want to go back to Mannum." We still had a very small base in Mannum, we had friends and family within cooee, being in Mannum; not so in Victoria.

MS HILL: Where did you go to live in Mannum?

RODNEY FOREMAN: Rosalie came back basically straight into the Aminya Nursing Home for the Aged. I moved into an independent unit as part of the Aminya complex, at the back of the Aminya, and so I was able to visit her as often as I wanted, every day, all day every day, to the point where she was spending so much time in the unit, towards the end, and then with the virus, it was easy to get her out of the aged care facility and into the unit.

MS HILL: When Rosalie first went into the nursing home there, what were you told about Rosalie's mobility and prospects of walking again?

RODNEY FOREMAN: The notes that accompanied Rosalie from Victoria said that she would never walk again and that her health was not really expected to improve particularly.

MS HILL: What did the two of you think about that?

RODNEY FOREMAN: We weren't very keen about it. We had really enjoyed each other's company all the time. We were fortunate to come across a physio who was contracted to work in the aged facility on a maintenance basis, 10 minutes per resident, up to four times a week. Fortunately, this young lady saw some potential in Rosalie. She asked what our short term goals were and we undertook to pay her for additional sessions each week and ticked off all but one of those short term goals over a number of months.

MS HILL: What were those short term goals?

RODNEY FOREMAN: One for her to be able to walk, which she can do with a quad stick and assistance on the other side, on her bad arm; to spend time with me; to live in the unit; to get into a car, in and out of a car, which she can do quite easily now. I don't remember the others. They were documented.

MS HILL: How did you arrange for Rosalie to receive those extra physiotherapy sessions?

RODNEY FOREMAN: Because the unit was basically within the perimeters of aged care, we could wheelchair Rosalie down to the unit, so that the physio wasn't seen to be doing something that she should not be doing or that Rosalie as a resident wasn't getting more treatment than someone else. So we contracted her for two sessions a week, Monday and Friday, and she was still continuing to get the 10 minutes up to four times a day when she was --- when we could coordinate that she was in the aged care.

MS HILL: Did those two additional sessions have a different focus to the physiotherapy that Rosalie received when she was in the nursing home?

RODNEY FOREMAN: Probably different, in that they were aimed at getting her mobility back on track. The first time she actually walked, basically with just a quad stick, I was behind her with my phone and I videoed it and showed the physio and I've shown several other people, including a couple of friends in Victoria, and obviously family. And it was just a great day.

MS HILL: How did it feel, Rosalie?

ROSALIE FOREMAN: Very good.

RODNEY FOREMAN: A miracle?

ROSALIE FOREMAN: Yes, very good.

MS HILL: Rod has described as part of your mobility improvement, Rosalie, that you started spending nights together at the unit?

ROSALIE FOREMAN: Yes.

MS HILL: How did you make those arrangements, Rod?

RODNEY FOREMAN: With difficulty in the early days. We were --- I was --- Rosalie had obviously some referrals through CHSP and we were trying to access some funding towards an electric bed and a mobile commode and a couple of other things
that I was hoping we could get some assistance with, given we had already parted with money for other things, like a Stedy Sara, which is a lifting device. But the --- Rosalie has to do some of the work to pull herself up on that, and you can wheel her around and put her down on different seats and things like that. But I finished up giving up and basically self funded, with a little bit of help, the electric bed, the commode. Because in the short term, early days, I was borrowing the commode from up in the aged care residence. Yes, just perseverance. And I think we're almost set, aren't we?

ROSALIE FOREMAN: Hm.

MS HILL: So you described Rosalie having access to CHSP. Was Rosalie eligible for aged care services or CHSP or a home care package when she was in the nursing home?

RODNEY FOREMAN: That was the dilemma. In theory she was eligible but because she was deemed to be in aged care, in a facility, it was very difficult to get --- we basically didn't get much access to that. I had myself assessed so that I could get some assistance as social support individual, which with a cooperative provider here we were able to do stuff on a minimal basis. We parted with a lot of money to get to where we've got to. But that's the nature of the beast, I guess.

MS HILL: As the time that Rosalie was spending at home with you increased, what did you two end up deciding to do?

RODNEY FOREMAN: Well, one of the goals that we had documented with the physio was always to get her home. When she was having --- when the frequency of the sleepovers, as I called them, increased, discussions with the aged care facility said we were only allowed to do that, I think it was 26 or 28 times a year, or she would be deemed to have left the aged care facility. So we were just starting to navigate our way round that and then the COVID hit. So we knew the aged care facility would go into almost total lockdown, or just with very restricted access, it was just easier to say, we'll bite the bullet and get her out.

MS HILL: How long has Rosalie been home now?

RODNEY FOREMAN: I think it's four and a half months. 23 March is when she came out.

MS HILL: And how does it feel to have Rosalie back at home with you?

RODNEY FOREMAN: Great.

ROSALIE FOREMAN: (Laughs)

MS HILL: How do you feel, Rosalie?

ROSALIE FOREMAN: Very happy.

MS HILL: Rod, you described that you got yourself assessed. What aged care services do you receive at home?

RODNEY FOREMAN: Some domestic assistance and social support individual. Also some driving assistance in the early days. But I've gone away from that, I basically drive us everywhere we go now. We were using the --- the local provider had a wheelchair friendly vehicle but I became --- I was eventually allowed to drive so I could put Rosalie in the back in the wheelchair and go to Adelaide for appointments. But she now --- we get her out of the wheelchair, sit her in the front seat to do most things.

MS HILL: And what aged care services is Rosalie receiving at home?

RODNEY FOREMAN: Level 4 home care package. And currently three physio sessions a week, shower and dressing three times a week and podiatry every six weeks. I think that's it. And some support while I play nine holes of golf once a week.

MS HILL: Could you describe to me what support you receive, which you have just

referred to in part, when you get those nine holes in, to support and care for Rosalie?

RODNEY FOREMAN: The carers that coordinate, whoever is showering and washing her, basically come and sit with her for those three or four hours while I go to golf. I am lucky to be part of a very friendly group of similarly aged guys; I call it friendly competitive. We all go in for one drink afterwards and so that's, if you were heading towards mental health, that certainly helps me to not be in Rosalie's hair 24/7.

MS HILL: Between the services that you require, Rod, and those which Rosalie needs, are you able to access all the services that you need where you are?

RODNEY FOREMAN: No. We're still waiting for some speech pathology, a geriatric assessment or some help with Rosalie's cognitive skills. And in the early days I struggled to get my own ear, nose and throat and arthritis specialist appointments. Almost anything in Mannum, despite the fact it's only 100 ks from Adelaide, it's difficult to come by, if you wanted it in, say, the next three months or six months.

MS HILL: Looking to the future, what do you need for the both of you to be able to stay at home?

RODNEY FOREMAN: A continuation of the current services. Hopefully I won't do anything silly to myself, physically and capability wise. But down the track we might want a little bit more assistance each day for the two of us. That's --- right now I think we're fairly comfortable, other than having been told that things like the geriatric assessment won't happen until next year, which is disappointing to hear that. But I went through that waiting for an ear, nose and throat specialist appointment and the arthritic appointment.

We have been told the speech pathologist --- I was given, just before Rosalie went on to the level 4 package, I was given the names and addresses of about seven speech pathologists, but five of them won't come past Mount Barker, which is halfway between here and Adelaide.

MS HILL: Why was it important for you and Rosalie to share your story with the Royal Commission?

RODNEY FOREMAN: I think because of the --- we did something which doesn't happen very often, we got Rosalie out of aged care. But I'm not convinced that there couldn't be more situations similar to ours. The fact that we have done it, but I struggled to find my way through what was available, what wasn't available, how to go about applying for it, those sorts of things, aged care has become a lot more of our focus, given our situation. Yeah. Happy to state our case, put our views across, for want of a better word.

MS HILL: Rod, yourself and Rosalie requested that you would be able to speak with us today and not later in the week. What have you and Rosalie got planned for rest of your week?

ROSALIE FOREMAN: You have to tell them.

RODNEY FOREMAN: We're planning to go to Port Lincoln tomorrow, for hopefully a week. It's the first time we will have been away since the stroke. We are taking a carer with us to help me and Rosalie to get through each day and particularly night. We are looking forward to doing it. And several people we have told, of necessity, "We are going away," have said, "Really great, hope you enjoy it." It's lovely to have other people supporting us.

MS HILL: What does it mean for the two of you to be able to get away together?

ROSALIE FOREMAN: For us, it's more about Rod. He's the one taking us.

RODNEY FOREMAN: Did you catch that? We're going with friends and we're taking a carer, who has met the friends that we're going with. We'll be staying in similar situations there. They've got a motorhome. We travelled with them in our motorhome and previous to that on our houseboats, so we've known them for 10 years. They're great people.

It's just nice to spend some time away, get out --- as the physio said, "It will be nice to get out of that unit for a while," because Rosalie is in it a lot of the time. I can get out three days a week while she's being showered to go for a walk and what I call drip shop, just buy a few things at a time as required. But it will be nice to go back to where we lived for a couple of years and just experience the Eyre Peninsula again.

MS HILL: Rod and Rosalie, that concludes our interview for today. Thank you for the time that you have been able to give the Royal Commission.

RODNEY FOREMAN: Thank you very much.

VIDEO OF RODNEY AND ROSALIE FOREMAN CONCLUDES

COMMISSIONER PAGONE: Thank you, Mr Gray. Just before you resume, it is appropriate, I think, just in case the Foremans may be listening to the video from here, and for all the others who are listening, that we publicly thank them for making themselves available in all this.

I'm getting messages that the audio at this end is not working.

COMMISSIONER BRIGGS: It's better.

COMMISSIONER PAGONE: Is it working now?

COMMISSIONER BRIGGS: It's better now, Commissioner.

COMMISSIONER PAGONE: Third time lucky. Let me repeat by saying that before you resume, Mr Gray, we should put on record for those who have heard that evidence and also more particularly for Mr and Mrs Foreman, to thank them for having made themselves available. It's a big task that each of those people do when they effectively share their private lives with the entire nation, if not the entire world. It's a big thing, not just time-consuming but a revealing of people's private lives is not something that's done lightly and we're very, very grateful for them in doing so. So thank you for that.

Mr Gray, I think you're now going to ask for a slight break.

MR GRAY QC: That's right, Commissioner. Would that be all right?

COMMISSIONER PAGONE: Yes, it is. We might make it 10 rather than 15 minutes, if that is convenient. So we will resume at quarter to.

ADJOURNED **[11.36 AM]**

RESUMED **[11.46 AM]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Commissioner, I call a panel of five witnesses. Firstly Mr Brian Corley, Chief Executive Officer of Community Options. Should he be affirmed separately or should I announce the entire panel?

COMMISSIONER PAGONE: You can announce the entire panel first and we'll do them one at a time.

MR GRAY QC: Mr Ahilan St George, Director and Co-Founder of Vitality Club, Ms Sharyn Broer, Chief Executive Officer of Meals on Wheels South Australia, Ms Jaclyn Attridge, Head of Operations of Uniting Care, Uniting AgeWell, and another Uniting witness, Mr Fonda Voukelatos. Mr Voukelatos is General Manager, Strategy and Business Development, Uniting AgeWell, and Uniting NSW/ACT.

BRIAN CORLEY, AFFIRMED

AHILAN ST GEORGE, SWORN

SHARYN BROER, AFFIRMED

JACLYN ATTRIDGE, SWORN

FONDA VOUKELATOS, SWORN

MR GRAY QC: There's another appearance, I believe there was a technical difficulty preventing this party announcing its appearance at the outset and I will allow that party an opportunity to be heard now.

COMMISSIONER PAGONE: Yes, thank you.

MS MUNRO: Commissioners, can you hear me? My name is Amy Munro and I appear on behalf of the Commonwealth and over the course of the next few days I will also appear with Mr Stephen Free, but he's not able to attend today.

COMMISSIONER PAGONE: Thank you, Ms Munro.

MS MUNRO: Thank you, Commissioners.

EXAMINATION BY MR GRAY QC

MR GRAY QC: Panellists, I'm going to ask you to give a brief introductory remark about your organisation and your perspective on the proposals for the improvement of home and community care with which you've been provided, and to start with you, Mr Corley. Mr Corley, you've made a statement that's at tender bundle tab 72 and in addition you've provided a submission and a set of six case studies accompanying that submission. We'll ask that the statement be brought up, you can identify it and I will ask you whether it's true and correct, and then I will ask you to make those introductory remarks. Operator, tab 72.

Mr Corley, is that the statement you've made for the Royal Commission?

MR CORLEY: That's correct.

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

MR CORLEY: Yes.

MR GRAY QC: Commissioner, that's already part of the tender bundle.

Mr Corley, your organisation, Community Options, is a CHSP provider, is that so?

MR CORLEY: And a Home Care Package provider, yes.

MR GRAY QC: And you're a specialist in care management, I understand. Is that right?

MR CORLEY: The Community Options model is about care management fund holding and purchasing services on behalf of our clients, yes.

MR GRAY QC: And in addition to care management, how would you describe the services your organisation provides to older Australians?

MR CORLEY: Well, under the Commonwealth Home Support Program, we provide basically the full menu of in-home support services, assistance in the home, home maintenance, housecleaning, social support services, and similarly in the Home Care Package area as well. Our model is that we work with our clients, develop a package of care around their support needs and then implement that with support staff and with our coordination services.

MR GRAY QC: Thank you. In the case studies that you've provided for the Royal Commission, they, in your submission, are at tabs 25 and 26, you identify a number of challenging cases in which intensive case management was necessary. You also note that case management is no longer funded under CHSP. Is that proving a challenge?

MR CORLEY: Well, Community Options was established under the old Home and Community Care Program as a case management service with the model of fund holding and the transition to the Commonwealth Home Support Program, our case management funding was removed and that's proved very challenging. We've tried to maintain --- traditionally, we work with clients who have complex needs and have difficulties accessing service and we've tried to continue that. But I guess we have always viewed the removal of case management at level of service as an error.

MR GRAY QC: What's the single most important reform issue in home and community aged care for your organisation, and what would you ask the Commissioners to do about it?

MR CORLEY: Well, I've addressed the case management issue. I think it's wrongly targeted at the moment. But I think, you know, the system needs to be made compatible with the wants and aspirations of older Australians and that is a primary focus of people to continue to live at home for as long as that is practical and appropriate for them. That should be the policy goal.

MR GRAY QC: Thank you. Mr St George, you've provided a submission that's

available in the tender bundle at tab 31. It describes the development of Vitality Club, from its origins as a walking group some five or six years ago, was it, and you've since developed Vitality Club into, if I may say so, it sounds like a dynamic provider of niche services of various kinds. Is it the case that you're primarily funded under CHSP?

MR ST GEORGE: Yes. So we have several contracts. One of them is to deliver CHSP for allied health across all five regions of Sydney, and recently we won a grant round to also deliver services in Melbourne and Central Coast. That would be about 70% of funding. We also deliver regional assessment service assessments for northern Sydney and south-east Sydney, as well as being a new Home Care Package provider as of 2019, May. We also run a few contracts for NSW Health in the provision of exercise classes across regional communities in Australia, in New South Wales.

MR GRAY QC: Now, you've made some cautionary remarks in your submission about the administrative difficulties of the HCP program. You've cautioned, in your submission, that there might be difficulties in integrating the program that is integrating CHSP and HCP if the expectation is that all of the CHSP services are going to be packaged and marketised in the manner of an HCP package. Is that right? Is that your view? And what are the reasons for these concerns?

MR ST GEORGE: Yes, I think that is a fair summary of my opinion. In my opinion, the Home Care Package system is an effective means of delivering long-term care, however it is currently struggling under the quantity and caseload provided. So there are about 120,000 people receiving a Home Care Package with about 100,000 people waiting for a Home Care Package for about 6 to 18 months. The CHSP program is grant funded by services about 800,000 to 900,000 people per year and I find it difficult to imagine a situation where the Home Care Package system can absorb those 900,000 people to deliver seamless care and immediate care for 1.2 million people when they struggle with the current 200,000 people.

MR GRAY QC: From your organisation's perspective, same question I asked Mr Corley, what's the single most important reform issue and what should the Royal Commissioners do about it, in your opinion?

MR ST GEORGE: In my opinion, I personally think that the single assessment workforce should be --- is probably the most important reform issue. Merger of ACAT and RAS could go a long way towards seamless delivery of aged care services and a more seamless consumer journey for people who are receiving subsidised care at home. In my opinion, it was politicised due to poor transparency and lack of inclusion of the public health system which gave it the optics of a privatisation bid. Again, just my opinion. But I think that we could go a significant way --- a significant increase in an assessment workforce and a more streamlined system through a single assessment workforce by, say, doubling the size of the workforce that delivers assessment and adopting a more preventative model where people get rapid assessment every three months, to more proactively manage people

declining and pick up people before they fall into critical incidents of decline. And it would be great if, when that comes on, Vitality Club can be considered as a prime contractor as all of those things are ironed out.

MR GRAY QC: Thank you, Mr St George. Ms Broer, Meals on Wheels is very famous and well known but for the record, I will ask you to just outline what are the services that Meals on Wheels provide, what are the incidental benefits, some of which you've noted in your submissions at tabs 50 and 51, and some of which also are mentioned in the course of your response to the proposals in this hearing at tab 76 of the tender bundle. An outline of the services and benefits Meals on Wheels provide.

MS BROER: So Meals on Wheels service model is internationally evidence-based and it comprises the food, the social support and the well-being check on the person that is being visited. In terms of the food, we're providing food to a standard, not a price. We're aiming to deliver about 40% of the daily nutrition requirements in the meals that are provided to people's doors. We're also providing speciality meals for people who have therapeutic dietary requirements or who have swallowing difficulties. So particularly tailored to people who are elderly. Good nutrition is a preventive health measure for older people. We make sure that we provide variety in the diet and food safety is absolutely essential.

The Meals on Wheels service deliverers usually go into the home, providing a meal that's hot and ready to eat, or could be chilled or frozen for people to heat later when it's convenient for them to do so, and food intake is monitored, usually visually, but also in discussion with the consumer.

The social connection that comes part and parcel with that service is critical to supporting the confidence of people to live independently and it's a light-touch way of reducing loneliness and isolation of people within the community. So the volunteers generally who deliver those meals have conversations with the people that they're visiting, form relationships and rapport with them over time, and that's become quite critical. Many consumers report that the volunteer and the conversation is as important to them as the food they receive.

Then the third part of the service model is the wellbeing model. We have volunteers providing peace of mind and follow-up to family members and others by monitoring how that person's going, asking them how they are and reporting back, and most importantly, following up when people are showing signs of medical distress or, indeed, may have had a fall and the volunteers are the first people to be on the scene and get the medical assistance coming in as well. So those are the key components of our service model.

MR GRAY QC: Thank you. One of your submissions notes that for people aged 85 and over in Australia, Meals on Wheels is providing at least some meals in a given year to about 14% of that cohort, is that right?

MS BROER: Yes, we do have --- the median age of the consumers that we support is around 85 years and data suggests that there's a high level of use of meal services, to older people who are living at home, particularly those who live alone.

MR GRAY QC: And those nutritional benefits you mentioned in the submission, there's reference to studies correlating those nutritional outcomes with improved health outcomes and avoidance of hospitalisations, is that right?

MS BROER: Indeed. So there's strong evidence to support that good nutrition and nutrition delivered through Meals on Wheels programs has been shown to be preventative of falls. It's also been shown that Meals on Wheels recipients are less likely to present at hospital emergency departments. If they do, they're less likely to be admitted. If they are admitted, their length of stay will be shorter and their recovery and subsequent outcomes will be better than people that are not well nourished on admission.

MR GRAY QC: How are Meals on Wheels funded in Australia? Relevantly, for present purposes, to the extent that there are aged care subsidies from the Commonwealth? What form of funding are Meals on Wheels services receiving?

MS BROER: Predominantly the funding comes from consumer contributions. There's secondary funding through the Commonwealth Home Support Program which is where most of the Meals on Wheels service delivery occurs in Australia, and then many of our members also provide services under contract to Home Care Package providers. So that's an indirect funding stream. We don't receive direct Home Care Package funding.

In Meals on Wheels SA, we receive 10% --- sorry, we deliver 10% of all of the services to the Commonwealth Home Support Program under meal services category and we receive 5% of the national CHSP funding for that service.

MR GRAY QC: You mentioned in the submission, I think you describe it as a need for that funding to be provided as block funding as opposed to some other form of funding. Would there be a difficulty in Meals on Wheels competing with, say, Uber Eats and so forth via a marketised, individualised package model?

MS BROER: There is a challenge in what consumers perceive is the value proposition of a delivered meal service. So while there is a proliferation of home delivery services in the community, they're not delivering the full level of care that a delivered meal service is able to, through the grant-funded activities. Grant funding is particularly suitable for Meals on Wheels services, given that we have high fixed and capital costs associated with the service, along with a reliance on volunteer labour, and also that Meals on Wheels is a service that the community expects to be available immediately. It's an essential human need to be able to access food and to be able to stand up services rapidly such as we recently were able to do during the pandemic is one of the benefits of grant funding.

MR GRAY QC: And, again, the same question that I've asked Mr St George and Mr Corley; what's the single most important reform issue in home and community aged care from the perspective of your organisation and what would you ask the Royal Commissioners to do about it?

MS BROER: Recognising that good nutrition is fundamental to healthy ageing at home. We need to make it as easy and quick as possible for the older people to access the meal and nutrition information support before they become undernourished. Ensure that people's contributions for meal services are affordable and improving the interface between primary health and aged care systems. And we believe that can be achieved by providing older Australians with an entitlement to appropriate food services to support their healthy ageing, direct rapid and simple service access, and equitable, adequate and sustained investment in evidence-based meal support services so that consumers pay only the cost of the ingredients, eliminating the financial barriers they're currently experiencing, and improving their health outcomes. And we're very encouraged to see that these matters are largely addressed in the draft propositions.

MR GRAY QC: Mr Voukelatos and Ms Attridge, if it's all right, I'll address you jointly and I understand you're going to have some sort of method of deciding who responds to a particular question I pose to the Uniting organisations that you represent. Could we have a brief outline? I know the operations of the Uniting entities are very extensive. Taken together, we're probably talking about certainly one of Australia's very largest providers of aged care in the home and community. Could we have a brief outline of the scale and scope of the operations in home and community care subsidised by the Commonwealth aged care system?

MS ATTRIDGE: Fonda?

MR VOUKELATOS: Good morning, Mr Gray, and good morning, Commissioners. My name is Fonda Voukelatos and I'm representing Uniting Care Australia and Uniting AgeWell. In terms of a size and scale of services for Uniting Care Australia, we're talking about having, in aged care, over $2 million worth of services funded through various means including residential aged care, Home Care Packages and CHSP.

From a Home Care Package perspective nationally, we're delivering over 15,000 Home Care Packages as a collective. My organisation, Uniting AgeWell that operates across Victoria and Tasmania, delivers approximately 1,800 Home Care Packages. In Jacki's situation, Uniting NSW/ACT delivers over 2,200 Home Care Packages per annum. So we are very, very large entity but we're also quite big within our own catchments as well, Mr Gray.

MR GRAY QC: In addition to the Home Care Packages are Uniting organisations providing services funded by CHSP?

MR VOUKELATOS: Certainly. So the Uniting entities all provide CHSP services,

services in the home, centre-based activities, allied therapy services. We also provide flexible care under the Aged Care Act. That includes initiatives like short-term restorative care and transition care programs in the community.

MR GRAY QC: And across all those different modes of care and support, would it be fair to say that there is a range of different modes of engagement of the people who provide the care directly so that you've got permanent employees, you've got casual employees, you have specialists whom you might subcontract? Is that a fair summary?

MR VOUKELATOS: It is a fair summary, yes. All of the above, Mr Gray, yes.

MR GRAY QC: And this might be difficult given the breadth of the organisation, but are you able to say, Mr Voukelatos, what is the most pressing reform issue of all in the home and community care sphere and what should the Royal Commissioners do about it?

MR VOUKELATOS: So probably the largest reform issue that we're facing is the suitability of the current home care system to deal with unmet needs, deliver high quality coordinated, safe and responsive services to each person at the right place at the right time. Simply put, how do we go about having the biggest and best impact we can in the health and wellness of people given the current fragmentation of a system, the supply issues and current funding arrangements?

MR GRAY QC: Thank you. That's a good entry point into a theme that I want to test with this panel now. The theme is the challenges of integration of CHSP and HCP, how best to transition the current arrangements into ones that are easy to use, efficient, and can deliver care that meets principles of autonomy while also balancing autonomy with safety and facilitating flexible but strong care management, particularly where people have complex needs and they need intensive care management.

Now, can we break this into separate propositions and I will ask the panel some questions about each. Involved in, as a sort of a background to the questions I'm asking, it should be understood that you've read the outline of new service arrangements that was furnished to you, as well as the propositions document. Both of those documents are in the tender bundle and available to the public.

Firstly, propositions HC1 and 2 which envisage a transition to reformed arrangements for demand-driven uncapped care in the community and in the home with the recipient able to choose to receive home care funding up to a level equal to the care component of the funding that they would have received in resicare. Could we just take that principle first. Could I ask you, Ms Attridge or Mr Voukelatos, to comment on whether you agree with that as an optimal approach to reform of the system?

MS ATTRIDGE: Yes, I think understanding what the unmet need is within home

care is critical in terms of it being successful and then having a system that has the capacity then to respond to that need regardless of where someone lives. So we would absolutely support that proposition.

MR GRAY QC: Are there any other panellists who wish to offer a different view or an additional view to that view of Ms Attridge on that element of these proposals?

MR CORLEY: No.

MR GRAY QC: Thank you. We'll move to one of the interim measures which is in HC1. Firstly, under the existing arrangements whereby we do have, still, separate programs, Home Care Package and CHSP, the first interim step is to clear the waiting list for assessed need for Home Care Packages and keep it clear. No doubt that will require additional funding. But also to rearrange services to this extent, to allow people on packages to access CHSP for certain categories of services corresponding to social support, respite and the like in accordance with the proposition we've provided to you.

Now, Ms Broer, can I ask you, what's your response to that element of these proposals?

MS BROER: I'm unclear as to whether the intent is for the packaged funds to pay for the services or the Commonwealth Home Support Program.

MR GRAY QC: Yes. The proposal is for the Commonwealth Home Support Program to make those services available.

MS BROER: Right. In that case, the concern that I would have is an avoidance of oversubscribing the Commonwealth Home Support Program. We need to ensure that people who don't currently have needs requiring a Home Care Package can also continue to have readily available access to those services. We would want to make sure also that some of the discrepancies in consumer contributions to the programs are made clear. So, currently, certainly for my service at Meals on Wheels SA, a consumer receiving a meals service through a Home Care Package pays only the cost of the ingredients in the food which is $4.75. They also make a contribution, a means-tested contribution, to their total package which I understand from the Aged Care Financing Authority report is around about 6%.

Within the Commonwealth Home Support Program, the level of Government investment is much lower and it's quite variable within the CHSP within and across jurisdictions. So, again, in South Australia, our Meals on Wheels service delivered to the CHSP requires a consumer contribution of $9.75. So it's the exact same service but the consumer's paying $5 more to get that service through the CHSP than through the Home Care Package. So for this proposition to be successful, there would need to be not only an increase in the capacity of the CHSP to respond to those 100,000 people who are on the waiting list, some of whom may, indeed, already be receiving meal services from the Home Support Program, but we also

need that evening out of the Government contribution so that it's completely transparent and understandable to the consumers about what they're accessing.

Having said that, I think there are some strengths in being able to access social support respite, transported meals as the Commonwealth Home Support Program services outside of the envelope of the funding of the Home Care Package budget. I think it would be administratively simpler and more straightforward for service users.

MR GRAY QC: Thank you. Mr Corley, broadening out the discussion to encompass not just meals but those other categories of services, transport and other social support services, respite, and the like which Ms Broer touched on at the end, do you consider that if those two conditions are met, which Ms Broer identified, upscaling the capacity of the grant agreements and the activity limits, no doubt, on the grant agreements under CHSP and equalising and creating uniformity as to co-contributions, if those two things are done, then this transitional mechanism is workable? What are your views, Mr Corley?

MR CORLEY: I think there are issues in the transition. I broadly support the transition to a more unified funding stream for aged care. I think there can be a variety of service models under that. As a CHSP provider we're already under increasing pressure from Home Care Package providers seeking our CHSP services to effectively top up their packages, and I think that needs to be carefully monitored because a significant proportion of the people currently waiting for a Home Care Package would be receiving CHSP services and if those services are no longer available, a significant portion of those people would find themselves in extreme difficulty. But as a transition arrangement, I think it could work if it was carefully managed and planned, yes.

MR GRAY QC: Carefully managed and planned by a very active system management function on the part of Government, keeping a very close eye on local developments, is that what you mean?

MR CORLEY: By Government, but also regionally. I still think regional variances will occur and I think that you would, in that transition process, would require a significant injection of funds probably at both levels, but to allow that smooth transition because what you don't want is people being falling --- or not being able to access CHSP during that transition because all those funds are being directed to supplementing Home Care Packages.

MR GRAY QC: In your opinion, does Government have its eyes on the ground to the sufficient level required on a regional basis?

MR CORLEY: No. I think I would strongly urge Government to relook at regional planning models for aged care services. I think a lot of the decision-making is centralised, even state offices aren't necessarily involved in making decisions, as we understand it, about funding or things like that. So I would strongly urge a regional

focus involving local health authorities, involving local providers, involving local communities as much as possible.

MR GRAY QC: Would that local level gaze or regional level gaze also be a necessary precondition of a successful transition, Mr Corley?

MR CORLEY: I think it would be an indicator or something that would enhance a transition, absolutely. I mean, I think regional differences should be allowed to grow and develop. I don't think we should aim for a homogenised system where everything's the same. I think regional development, regional initiatives, we can all learn from those.

MR GRAY QC: I want to move to another topic but just in case any of the other panellists had a brief contribution, particularly if you disagree with something that's been said, or you have a critical addition to make?

MS ATTRIDGE: I think it's worth noting that the original intent of the CHSP program was about entry level. What you're proposing now is looking at service types that would go across the need journey of the client. I think that, for some providers, would be a significant change in terms of what the intent of the original CHSP program was. So that would need to be worked in, in terms of how that would transition. I think Fonda wants to say something, too. But also, too, just acknowledging the fact that you'd need to have a coordinated approach to services as well. There's complexity when additional and multiple service providers are involved in the provision of care. So there could need to be clear ways about how those different providers could potentially coordinate as well, I would suggest.

MR GRAY QC: Mr Voukelatos, sorry, I think I better move to the next topic unless Mr St George, on behalf of his organisation, has a contribution to this point?

MR ST GEORGE: I will just try and be quick. Firstly with the transition, continuing CHSP funding for a narrower scope of organisations to deliver a service is fine. However, moving to a package set of funding for care at home, as you suggested, could be a difficult transition especially when it could be --- it could require a significant up-skilling of an assessment workforce to determine the package needs and the level of contribution that people should be able to get based on their level of, let's say, disability or frailty, and that could be a significant change.

I think underpinning it all would be --- it would be reasonable to implement a sort of single source of truth, a risk-stratified care plan for consumers that all people use as a coordination point before they deliver care and they update and modify this sort of situation. Yes, it would be difficult to transition, in my opinion, just based on the volume of people but I think that without a mix of grant funding and package funding, the system could still fall into the same gap of people, let's say, double dipping or not knowing where the bounds of scope to accessing their services lie.

MR GRAY QC: Thank you, Mr St George. Just for those viewing the evidence, Mr

St George's submission at tab 31 expands on the idea of the risk stratified care plan and that's intended to be a single tool which will be accessible to all people providing care, Mr St George, and be capable of being updated by all people contributing to the care of a particular individual over their entire journey and use of all of the services that are available; is that a correct summary?

MR ST GEORGE: Yes. I think it would be a good building block to be able to follow a person through their journey of receiving services and really assist all providers with managing multiple stakeholders in the delivery of care.

MR GRAY QC: I want to go back to the response Ms Attridge gave and use that to open the next topic. Ms Attridge, you correctly pointed out there is quite a fundamental restructuring involved in these proposals whereas the present arrangements are conceived of on the basis, it's supposed, of entry level services via CHSP and more advanced or complex services via HCP. In fact, that's led to, in our submission, confusion and fragmentation, different assessment processes, as Mr St George identified, RAS and ACAT for the two. Even though CHSP is used very substantially to help people who are assessed as needing an HCP and there is, in effect, the same categories of services available under CHSP as are available under HCP, it's just that under CHSP they're supposed to be time-limited.

This restructuring is on a service category basis in the hope that that will be clearer and that one assessment service can be used to give access to the whole suite of available service types. But important to that, our proposal is that the first three categories of services, which include social supports as we've defined them, assistive technologies and home modifications and also respite, will be grant funded or block an activity funded by direct agreements with providers. All care at home, where there's a sufficient market for a package to be used, will be funded via an individualised package. I want to now turn to that point. That is where these proposals lead, that is what we transition to on the submissions that we're advancing. What are your responses to that proposal? I'll start with Uniting. Does Uniting want to comment, either Ms Attridge or Mr Voukelatos?

MR VOUKELATOS: Thank you, Mr Gray. So Uniting's response to this proposition is that we need to move to a fully accessible, more simplified system that actually builds on the strengths of individuals. So the domains that have been proposed, we're in agreement with those and we believe that as people's needs change over time, that they should move to an individual program.

In addition, people who are entering the system for the first time may have complex care needs. So they, of course, need to move into that care management, individualised package component as well. We feel that every Australian, as per our submission, needs to have access to good care regardless of where they live in Australia.

MR GRAY QC: Mr Corley, can I turn to you and, in particular, could I ask you to comment on what you think of the proposal that is critical, that is a critical element to

this overall suggestion, that is that there be a budget for care management per se on the basis of an assessment of the complexity of the care management needs of the individual?

MR CORLEY: I'm broadly supportive of the establishment of a budget but one of the issues of concern is that care management sometimes is required as the person enters the system because of their complexity. And so a problem arises where they don't get care management until they get a budget assigned, but for some people it's navigating that process and it's the negotiation and solving some of the complexities around their support needs that has to happen upfront. So there needs to be some capacity to support people even entering and maintaining themselves within the support system because some highly vulnerable people drop out of support for a whole variety of reasons.

So care management/case management, whatever you want to call it, can happen at multiple points and I think the other element that needs to be considered is, often, care management is defined by providers as just managing what they do. And I think we need to look at care management or case management in a broader context of helping vulnerable older Australians to continue to live in their homes and interacting and interfacing with all the services that may be involved, both aged care services and other, that may support or put that at risk. So there's a broader context of care management that needs to be considered and there needs to be capacity for it to be, if you like, front-ended as people are trying to enter the system.

MR GRAY QC: Mr Corley, as you spoke, I was reminded of the second of the case studies that you have documented and lodged with the Royal Commission, which is available in the tender bundle. It ostensibly was a case of providing cleaning services for a person who actually had a whole suite of far more complex needs. It was a salutary reminder that you can't make any assumption just by reference to the fact that a service might be described in simple terms, that the case is at all simple.

MR CORLEY: This is one of the things that people often get, you know, confused about, that someone's just getting domestic assistance, or another low-level service or even an entry-level service. Sometimes for some of our clients those are the hardest services to sustain and daily services, people will accept, even though they may be assessed as needing a wider menu.

MR GRAY QC: Mr Corley, the proposal here is to have these service categories but none of them really should be described as an entry-level service. They're all flexible according to need. Would you agree that that is the right approach?

MR CORLEY: I absolutely agree. I have never subscribed to the conveyor belt model of aged care, that you enter at one point, move to another system and finish up in residential aged care. As you know, the data doesn't support that. That's not the experience for most Australians using the aged care system. So every service that a person receives at whatever point is crucial to their needs as at that time and should be adjusted as their needs change.

MR GRAY QC: I should make it clear to those listening that our proposals, as we've documented them, are that services from these categories might well be available at the same time to the same person. There is in no sense any mutual exclusivity between the service categories. Would you agree, Mr Corley, that that's the correct approach as well?

MR CORLEY: I do agree that it's the correct approach. The only comment I would make about in-home services is that I believe --- I don't fully support that it's all individualised. I think there needs to be a safety net and I think there needs to be a capacity for quick response while some of those assessments are taking place because, I mean, our experience in the National Disability Insurance Scheme is you're either in or you're out. If you're not in, there's nothing for you and that can be hugely problematic. So I would encourage the consideration of some quick response, safety net services that can provide support while some of these other things are taking place.

MR GRAY QC: So how would that look? Would that require local or regional commissioning by direct grant of a service provider of last resort, so-called?

MR CORLEY: Quite possibly. I think it would vary on a region to region and, you know, what we all know in some of the rural and remote areas there will be a scarcity of service providers. So there may be, you know, some individualised commissioning there. I just think the issue is that people's needs --- people sometimes enter the system quickly. Their health condition changes dramatically and they need services or, you know, we often get calls on a Friday afternoon for services to go in on Monday, or their primary carer had a fall or gets ill and they need services immediately. So I just think a system needs to have capacity to respond to those rapid changing circumstances.

MR GRAY QC: Thank you. Can I open this up to any other panellists who wish to either disagree or add to what's been said on this important topic? Yes, Ms Broer.

MS BROER: Thank you. We really support the notion that meals, community transport and social support are included in a discrete category and that category is grant-funded and it's because those services are often bundled together to create a social connection experience for older people. They can be high frequency, low intensity, relatively low-risk services and are sometimes required episodically. I'd like to reinforce the point that Mr Corley made about some services needing to be available very rapidly, even before a comprehensive assessment of somebody's needs are done, particularly to support hospital discharge or hospital avoidance and further to that, that if people do first come into contact with the formal aged care system at a point of crisis or instability, that the presenting issues that they have at that point need some support and case management and it may be that within a fairly short period of time, and some stability comes into play, that they may not need such an intensive set of services in an ongoing capacity.

MR GRAY QC: The proposals we've documented and provided to you include obviously a much bigger and more nimble assessment capability than currently exists, that's the first thing. And also a person who would act as an intermediary between the assessment service and the person who is seeking the services, whom we've described as a care finder, do you agree that those are sensible propositions? Do you think they're workable?

MS BROER: Yes, I do. And I think that the care finder may be able to access immediate services, whether it's from commissioned providers or some other mechanism. But that may be the mechanism that would support the proposition being successful.

MR GRAY QC: I want to go to the next topic now. It's a brief one. It's HC6(f) and it's the starting point to determining where it might be necessary to commission services or to take other steps to supplement supply of services, particularly in rural and remote areas, possibly also in metropolitan areas for diverse needs groups, if supply is thin or scarce in respect of the needs of particular people of diverse backgrounds. Do you, the panellists, agree that it would be sensible to obtain a much better understanding, and this must be done by or on behalf of the Government, of where the gaps are in the services that provide CHSP and HCP services at present and on which this future system is going to depend? Start with you, Mr St George. Do you agree that's a sensible step?

MR ST GEORGE: Yes. I think that in a primarily Government-funded industry, the ability to undertake market analysis and identify gaps is always paramount. I think that currently the Government utilises CHSP growth rounds to target areas of need where they oversee the sort of data that is put into the data exchange which is where CHSP providers report their outputs in order to target certain areas that might be under-serviced.

As far as I'm aware, home care providers don't need to report on output level data like that and that could make it more complicated for the Government to be able to do that type of market analysis. But ultimately, all of these things only really capture the known need and I would suggest that there is a far greater level of unknown need that exists in the community for people who have trouble accessing the system, who don't necessarily have, like, some kind of financial disadvantage, or being able to equitably access the system. That could require a more thorough needs analysis on a region-by-region basis.

MR GRAY QC: Thank you. Do any of the other panellists wish to add to what's been said? I'll move on to another topic if not. Thank you. There's the question about whether the funding that is provided in packaged form is actually sufficient to, or well calibrated to assess need. At present there are four, my words, arbitrary levels of Home Care Package. You will see that in the submissions that were made to the Royal Commissioners in March there's a proposal that there be independent price analysis --- I beg your pardon, independent cost analysis and the calibration of funding levels to actual cost data and in the forthcoming hearing in mid September

there will be greater development of this concept. Now, built into the funding provided to meet individually assessed needs, is it uncontroversial that the funding should cover the sorts of on-costs referred to in our proposition HC4; capacity building, training and other necessary overheads? I'll start with Uniting.

MS ATTRIDGE: Yes, absolutely, all of what you're talking about there are core parts and requirements of providing a safe quality service. So, yes.

MR GRAY QC: Do any other panellists wish to comment on this? Ms Broer?

MS BROER: Yes, there's been a lack of rigour and transparency about the efficient cost of care of people in the home. The Commonwealth Home Support Program process for price setting is a mystery to many of us. The future price-setting process must be transparent and fair. In addition to the oncosts that have been listed, capital and fixed costs also apply to many of the services that are delivered in people's homes, especially meals and transport and respite, but also to some other categories. And those services that have been reliant on our volunteer workforce have been somewhat disadvantaged over time with the way that the pricing has been set. Only the volunteer's time is free, every other cost of engaging volunteers is the same as if it were a paid worker.

MR GRAY QC: Thank you, Ms Broer. Does anybody --- yes, Mr St George?

MR ST GEORGE: Yes, look, I wholeheartedly agree with the fact that pricing should account for all sorts of administrative and case management activities and the things that you've listed are all core to --- core inputs to that pricing.

MR GRAY QC: Can I just stop you for a minute. We do propose that care management receives a separate budget, yes. I'm sorry, please go on.

MR ST GEORGE: Sorry. But, yes, just initial and ongoing education and improved management and governance, all of those things are very important to price into the cost of doing business.

I do, however, think that there should be a much greater increase in pricing transparency around these costs in order to really ascertain what the true value of these costs are to each organisation. For example, our organisation is much more lean and we're able to do things slightly cheaper than, say, Uniting, who cover, you know, the breadth of Australia. Those things have to form the matrix of adequate pricing, but it always seems to be a race to the bottom and when we price these things in, we have to understand that we're pricing quality and so we should account for the fact that if we improve the funding into these areas, organisations will have more breadth and more scope in order to really invest in these activities which can overall improve the quality of services offered throughout the industry.

And so we shouldn't really be around finding out what the lowest common denominator is, but really what the lowest common standard of care we're willing to

accept is and how all organisations need to work together in terms of resourcing and funding to achieve that standard.

MR GRAY QC: Thank you. Mr St George, were your remarks then directed specifically to one or other of the current forms of funding, that is, CHSP grant funding or HCP package funding? Or were they generally applicable to both?

MR ST GEORGE: I think they're generally applicable to both, however I was probably leaning more towards the Home Care Package funding arrangements as they stand. But there is very --- there is, like, significant lack of price transparency around CHSP services, but, yes, Home Care Package services are probably more of a problem area, especially with regards to consumer expectations and consumer knowledge about what the industry pricing regimes are.

MR GRAY QC: Do any other panellists want to comment, including on Mr St George's additional point there, that in any future transparent cost review and subsidy level determination process, it will be very important to, in effect, price in the quality that the system is seeking? Does anybody wish to respond or I'll move onto the next topic? Mr Corley.

MR CORLEY: Other than just to agree, you know. You have to price --- if you want high quality you've got to price that in. There's no other way around it.

MR GRAY QC: Can we go now to a topic I raised right at the outset with you, Mr Corley, so we might as well carry on with you. We've got two developed propositions about care management, HC5 and HC10. There's also HC3 which is a proposal to reposition self-management for people for whom it's appropriate and they wish to manage their own care and support arrangements, to reposition that or reorientate that as shared management of care. So these three propositions, HC3, 5 and 10, are all critical to proposals about how care management should operate and I'll just paraphrase briefly. HC5 is intended to impose a very strong care management responsibility on any home care provider who is hosting a person's Home Care Package and that when I say a Home Care Package, I mean a future package for care in the home under the fourth category for services. As I said a couple of times earlier in this session, there will be a separate budget, an estimate of hours, the assessment process will actually focus on the complexity of need of the individual who is seeking the help and there will be a good deal of attention given to what the care management requirements are, whether the person providing care management should be clinically qualified, who should be providing the care management. If the needs are complex and clinical, then the care management should be by a clinically-qualified person, and that there's a very close link here to assessment. Assessment in HC10 has to get this process right from the beginning and it must approach this issue with an enablement perspective from the outset.

Now, I'm sorry that was a very long lead-up, but, Mr Corley, starting with you, have we got it right on care management?

MR CORLEY: Well, you know, the implementation is always the issue. I will just make some observations. Care management or case management is an important service if it's directed correctly to people who need it. If it's not directed to people who need it, it's a waste of time. In our current system, many people in their Home Care Package will be paying for case management and not getting it. So the targeting of care management is fundamental and what that means is those people who are assessed or it's determined they need some sort of care management or case management support, then that needs to be adequately funded to do the task at hand and that could be short term or it could be long term, it just depends on the circumstances, or it could be periodic, if you know what I mean, people fall in and out of situations.

So the targeting of care management is important. It's a valid and vital service for those who need it. It should be appropriately supported and delivered by qualified and trained staff, and it should be done in partnership with the person, not in control. I like your notion of shared responsibility, but the care manager needs to be clearly working for the person. I know there's some criticism about the potential for care management to channel people into certain providers and things like that and that needs to be guarded against. The care manager needs to clearly work for the person, but care management should also be closely located with service because a care manager needs to exercise control over the services, be able to negotiate with different service providers to get the outcome that's required for the person. So it's a complex issue. Suffice to say I think it's a step in the right direction. It's important that it's recognised. How it's funded is important.

Our experience of the NDIS, it's badly targeted and underfunded and people who needs lots of support coordination in that world get not enough and some people who don't need it get a lot, and so there's balance that needs to be applied here. But it's fundamental that it's recognised as important and it's targeted appropriately. That would be my comment.

MR GRAY QC: Thank you. Mr Corley, perhaps you were thinking, when you referred to the NDIS experience just then, perhaps you were thinking of Mr David Tune's review, amongst other evidence, of problems in the NDIS sphere with support planning and support coordination because of resourcing and timing issues. Is that what you had in mind there?

MR CORLEY: Well, certainly on our experience, you know, being funded for, you know, 15 hours a year to provide support coordination to a person with complex support needs is woefully inadequate, and that causes real issues and it causes providers like ourselves to do vast amounts of effectively pro bono work for the National Disability Insurance Scheme. Yes.

MR GRAY QC: So there are some preconditions to this proposal being successful and they are ---

MR CORLEY: I think the precondition is that it's recognised as being fundamentally

important and it's appropriately targeted and then appropriately funded.

MR GRAY QC: It sounds like it also needs to be supported by a very well-resourced and nimble assessment function, is that right, because of the changing needs you just mentioned. A person might not need care management for a time, then they might need it temporarily or they might need a great deal of it or the amount they need might change. All of that needs nimble assessment ---

MR CORLEY: They're the variables as people move, you know, interact with the system and other issues occur. I like the concept of a nimble assessment. Again, some of the issues that all providers face, and again, if we're looking at the National Disability Insurance Scheme as an example of people waiting several months for reassessment where their needs change and that, again, causes huge problems. So nimble assessment is important but also the capacity of providers to respond quickly while waiting for that assessment or reassessment to occur is important. I guess that's going back to an earlier point I made.

MR GRAY QC: Can I open that up to the other panellists? Can I ask Uniting, either Ms Attridge or Mr Voukelatos, do you have any comments to make? Do you disagree with anything Mr Corley said? Do you want to add anything? I can't hear Ms Attridge?

MS ATTRIDGE: Can you hear me now?

MR GRAY QC: Yes.

MS ATTRIDGE: Apologies. Just listening to Mr Corley, I just wonder about the underlying issue of supply, whether it be about making sure that funding is available that is appropriate to people's needs so we're not foregoing one service type for another service type? I think we see that a lot. And responding to that underlying issue of supply, I think in the industry at the moment would be one that will help significantly.

MR GRAY QC: Thank you. Mr St George?

MR ST GEORGE: Yes, I would like to just say that in a proposed single assessment workforce where the assessment workforce would not need to be separated by RAS and ACAT, organisations that are selected to deliver this service would have the ability to sort of clinically triage complex cases and then deliver these plans. I think that it makes sense as an extension of this service. So they have, let's say, a mobile or a rapid response team to be able to deliver short-term case management or, you know, sort of like a program of reablement care in order to make sure that by the time that services are implemented by normal providers, that person hasn't deteriorated further.

I do accept that there is a significant problem in care coordination in the system and with people being lost in the system. So they go, they have an assessment, they wait,

they wait for services, they wait for an ACAT assessment, and it is my hope that with a single assessment workforce that can be alleviated to some degree. But it would be nice if there weren't additional links in that chain for people to have to go through in order to receive that continuum of care. If that was handled by the assessment workforce, which inevitably things will have to go backwards and forwards through anyway, I think that could be a more seamless journey for a client going through the aged care system and I think that in a single assessment workforce where organisations are required to have that capacity for clinical triage, if they could expand that team, that is a sort of service that they could offer.

MR GRAY QC: Thank you. I want to go now, finally, to a topic that Ms Attridge mentioned in her response a minute ago. The question of supply, and Ms Attridge, I will start with you. It's the theme of building the capability of providers and the workforce to meet the challenge posed by the set of arrangements that we are proposing. That set of arrangements, just to repeat myself perhaps, deals with a vast spectrum of need for a little over a million people, going on the current numbers of people in CHSP and HCP programs, and their needs vary from quite simple needs to the most complex imaginable needs for a person seeking to remain at home. We've explored some of the arrangements that might facilitate an ambitious, integrated program covering that spectrum of need but we haven't focused on the capabilities of the providers and the workforce and what will be needed to ensure that we can transition to a system of that ambitious scale and scope.

So, starting with you, Ms Attridge, what are the things that can be done? I'm not asking for hard data, I'm not asking for an estimate of how long it will take, but what are the things that can be done to ensure that providers and the workforce have the capability needed? We know that there's a set of strategic actions recommended by Professor Pollaers' group and it's the position of those assisting the Royal Commissioners that those actions should be taken to improve the workforce. Do you agree with that? Is that a reasonable starting point and what other measures should be taken?

MS ATTRIDGE: Firstly, I'm not over Pollaers' responses, so I can't talk to those. Just from my own personal experience, though, I think what we need to do is make home care and aged care more generally an attractive place to work so that we can attract and retain the types of people and the quality of the workforce that we need to respond to the underlying need that we know is there. We already have challenges in terms of recruitment now in competing with public health systems but things like conditions and pay and the like and supports more generally need to be there so that we can have the volume of people that we need to deliver the types of services we want to.

MR GRAY QC: The propositions that we've developed for consideration by the Royal Commissioners in effect seek to incentivise a direct employment model as the predominant model through which care would be provided and they also float the idea of a minimum certificate III qualification, at least for people who are performing unsupervised, personal hands-on care work in the home. There's also an element of a

minimum hours requirement, or a minimum contact time requirement so we don't have rushed task-based care delivery. Are these things good ideas, are they too inflexible? What are your views on those measures?

MS ATTRIDGE: So in relation to the first two, absolutely. So for Uniting NSW/ACT, we already have in place that all of our care delivery is delivered by a minimum of a cert III worker and the vast majority of what we do is delivered by a direct workforce. I'm not suggesting that different models can't work because I know that they do and I know Community Options in particular use a contractor model. From our experience in terms of monitoring and checking the quality of the care, that is far simpler when you're employing the staff directly. They have access to your systems, to your care plans and the like, that's much more simpler. They are aware of your policies and your training programs. So we would absolutely agree that the direct care makes sense.

The minimum hours; I think it depends. As long as it's proportionate to what's being delivered, I guess. Sometimes clients don't want you there for a long time. I think it's more about understanding what the requests and the requirements of the client are and, again, going back to that capacity and having the capacity to respond to the need is the important underlying piece there.

MR GRAY QC: Mr Corley, can we go to you? Community Options has just been mentioned.

MR CORLEY: When the Community Options system was introduced into Australia in 1990 it was done based on a fund-holding service purchasing model and we still operate under that model. Like all things, it has its advantages and it has its disadvantages. I certainly wouldn't argue that subcontracting across the whole system should be widespread, but it allows a certain flexibility and a certain nimbleness for us to reallocate resources, change providers, change workers when that's in the best interest or request of our client. As some of our providers that we use know, we just ring up and say, "Never send that worker to that person's house again." The benefit for us is that's not our HR problem, that's the provider's HR problem but we can make that decision quickly and we can do that from time to time when a client reports something or is unhappy with a worker.

So, I mean, I understand the basis of the proposal, I think there are huge issues generally with the casualisation of the workforce but I guess I'd argue, as I have previously, that there needs to be some flexibility and capacity for different approaches to work in any dynamic system.

MR GRAY QC: Mr Corley, just a point of clarification, when Community Options subcontracts a provider, and it is very largely a model in which Community Options does that, as I understand it. Firstly, is that correct?

MR CORLEY: Yes.

MR GRAY QC: Do you know whether the subcontracted provider is deploying a workforce that is directly employed by it?

MR CORLEY: That's a requirement --- we contract all of our providers and we have our own quality assurance program and in, certainly, the agreement that they sign with us, they are not allowed to --- they must deploy their own employees. They can't further subcontract the worker. The other element of our model is we take full responsibility for the service.

MR GRAY QC: Thank you. Commissioner Briggs?

COMMISSIONER BRIGGS: I might follow that up. Do you get from those subcontracted providers information about the training and the qualifications that they then invest in their workers?

MR CORLEY: That's part of our annual audit process. We audit each of our --- as I said in my submission, that's been delayed that year because of COVID. We haven't done our regular schedule of provider audits, but we audit our providers on an annual basis as a minimum. Sometimes we'll audit them more regularly if issues emerge. But they need to demonstrate to us, the provider, the training they provide their workers. We mostly use approved aged care providers in this town. We use some commercial providers but most of the providers we use are aged care providers and we work closely with them. We sometimes choose and we get to know individual workers with individual agencies and we will go to a provider and ask for specific workers from time to time. But, yes, we audit them for training, we audit them for quality assurance processes and all of those, and police checks, et cetera.

MR GRAY QC: Mr St George, is a direct employment model needed to ensure quality and safety, that appropriate training and supervision is in place or is that inflexible?

MR ST GEORGE: Look, as Jaclyn said, I think that direct employment is significantly easier to control. It's significantly easier to train and ensure quality and in terms of incident reporting, complaints management and stuff, it's also significantly more streamlined through direct employment.

With subcontractors, it's very difficult to know, to get them to deliver a model of care as opposed to just a service and I think that as the aged care system develops, that's what needs to happen. I think it's impossible for the aged care system to exist solely on direct employment just due to the scope and the breadth of the amount of clients and the amount of people requiring care and the breadth of, say, a complex care plan requiring so many different services. Especially smaller organisations would really struggle to have direct staff in all of those different types of services in order to facilitate that whole care plan.

If I may, I might just touch on an earlier question you asked, which was what can we do directly now to sort of improve workforce capacity and I would, again, just agree

with Jaclyn and the things she said. I think one of the key points is people need to come into the sector and be retained and competing with the hospital sector where people have a more significant level of clinical attainment, or the disability sector where people are seen as, like, specialist skills, both with greater levels of remuneration in the community sector, is a significant structural problem.

I think that the workforce shortages that are projected are a significant structural problem which will mean that there will always be supply side shortfalls and in order to overcompensate --- overcome those supply side shortfalls, we need certain innovative solutions. One I would suggest would be adopting, like, e-Health record that is basically able to facilitate communication between all stakeholders. Another one I would say, like, with a projected shortfall of say Allied Health and nursing staff of 220,000 in the next five years, we would probably need some kind of net migration solution to open up skilled migration in for those jobs.

And, finally, I think training also needs to be more targeted and more streamlined in terms of the holistic client journey. I think we could make significant strides as an industry if everyone, like, told the same story to the client about where they are in the aged care journey and how they're going to progress and what could happen. And I think that that training, or that direction, should come from the Government and they should say, like, this is how we want all organisations to talk about the aged care system so there is less consumer dissatisfaction or consumer confusion around where they are and what's happening in the system.

I think that that could make a significant difference to people's experience as they go through the system and even with the fact that they may be waiting or they may not be receiving services like to their assessed level, all of that could be streamlined into a more holistic conversation that all providers are able to have on the same footing.

MR GRAY QC: Thank you. Just finally for the other panellists, I take it from Mr St George's response just then that the idea of an e-Health record, or I think you called it the stratified risk-based care plan, this is not something that Mr St George's organisation currently has available in digital form to share with the providers with whom his organisation brokers services. Is that correct, Mr St George? It's something that you think should be in place but is not yet in place?

MR ST GEORGE: Yes, very aspirational.

MR GRAY QC: What's the capacity of the other providers who are on this panel at present to move to technology of that kind? Is it in the pipeline? Do you have anything resembling it now? Mr Corley, does Community Options have a digital platform of some kind, a business-to-business recordkeeping system through which it can maintain a plan of this sort?

MR CORLEY: Not currently. We have probably one in the pipeline. One of our software providers is working on an integrated platform that providers that we use could also access, but we're probably some way away from that at this point in time.

MR GRAY QC: Ms Broer, I understand that the Meals on Wheels volunteers and employees do make reports in relation to their impressions of people's needs, when people are receiving services from Meals on Wheels. Is that, in effect, an IT system within Meals on Wheels or is it shared more broadly?

MS BROER: No. Each service would have its own digital platform. I think the intent of the My Aged Care service provider portal was to give some visibility over the service plan for people. I don't think that's working at the level that it could and certainly not as described by Mr St George. So I think there would be some opportunity for development in that area. Meals on Wheels currently would have a fairly manual process of identifying an issue and then making telephone calls to family carers, GPs or others involved in a person's care if issues or concerns arose. And similarly do now with Home Care Package providers for whom we deliver services under brokered arrangements.

MR GRAY QC: I see. And finally, Uniting. What's the state of information communication technology relating to sharing plans with --- sharing plans across the organisation or sharing plans with services with whom Uniting has to interact in order to holistically care for clients of Uniting?

MR VOUKELATOS: So, Mr Gray, maybe I could respond to that initially. So the Uniting Care approach involved is to develop with a participant, and for the participant to develop what I call a shared care plan with a goal-directed care plan that looks at a range of different service types, they need to interact together. A role for a care manager or case manager is to actually bring those services together and to have that documented in one place for the participant to actually understand what their care requirements are and how those services interact.

We have obviously a client information management system, as every organisation does in this room. Does it extend to broader organisations, business to business? No. Can it? It's been a question that's been asked over the last 15, 20 years. What does integration look like on that front? For that to happen there needs to be investment made by providers and also Government in particular, to ensure there's a more sophisticated electronic recordkeeping system beyond what we have at My Aged Care.

MR GRAY QC: Thank you, Mr Voukelatos.

Commissioner, if that's a convenient time, that concludes the most pressing questions I wish to raise with this panel and I would seek to have them excused.

COMMISSIONER PAGONE: Thank you. Commissioner Briggs, do you have any further questions you would like to ask?

COMMISSIONER BRIGGS: I do, thank you, Commissioner Pagone. Thank you, everybody, for the contributions so far. I've found it a helpful session. I'd like to

pick up a bit more this issue on the workforce and its development. I suppose there are two parts to my question. Firstly, what do you do now in terms of the development of your workforce, and in the future, how would you see the task of up-skilling and reorientating the workforce to be more proactive around a people-centred system in the future? So over to you, whoever wants to contribute, please kick off.

MR ST GEORGE: I'll jump in. So at the moment we have a multidisciplinary team meeting every six weeks with Allied Health staff. We look through sort of case studies, incident reports and we talk about how we are applying the philosophy of wellness and reablement into the delivery of all the services that we have. We also do organisational training probably every month to every six weeks as well in order to continually hammer in the philosophy of wellness and reablement and consumer-directed care as a journey that we're on as an organisation, that we are continually evolving the service delivery that we use in order to deliver better service.

It is sort of about five years ago when I came into the aged care industry, I noticed that the community sector was very under-developed. There was a lot of fragmentation and there was a lot of services that weren't really communicating well with each other and the overarching philosophy guiding the industry was met with sweeping changes. I think over the last five years or six years, those changes have been implemented progressively by all organisations and they are beginning to show seeds. However, everyone is just at the beginning of that journey, and that is understanding that there is a concept of which they're delivering service but the implementation in which they do that and how they do that, and then the effectiveness of outcome measurements I would say is still at a very virginal state in the industry.

I think that with the community sector being under-developed, it is very difficult to provide staff with, like, career progression in a structured environment, something that the hospital is very, very good at. You know, you would go in and you would work your way up seven different, like, you know, levels of expertise and you would be --- you would experience a range of more, like, specialised people training you. And with an under-developed system, that's not something that we can provide yet. But it would be good to recognise the importance of the preventative model of care in the community sector in order for Government to create those pathways for all staff who engage in the community sector so that they can see that being in the community is not a transient step towards going to acute care or going to disability care, but it has a progression and the things you learn about are not just for the job; they fit an industry.

And when people adopt that identity of being a community sector worker, and they own the fact that they can manage people's chronic diseases, help them adopt lifestyle changes in order to be more independent at home and have more wellness and quality of life in what they do, then we will be able to see a more sustainable retention in the industry. However, I would say that with the state of where things

are, while they've improved, it's difficult to create that vision with the infrastructure that we have and, yes, so we basically have to make it up.

COMMISSIONER PAGONE: Mr Corley?

MR CORLEY: Thank you, Commissioner. A person-centred service happens at the point of service. That's the primary --- you know, we can have organisations can claim they're person-centred and have great policies and that's fine, but it's at the point of service. And the greatest complaint we get from our clients and probably one of the weakest aspects of the brokerage model, is where they don't get consistency of support worker. And we spend a lot of time working with our providers to get consistency of support worker and to allow that relationship to develop at the point of service so that there's a level of trust between the person, their family and the support worker.

And I think if you're really going to transform this system, it's focusing at that point of relationship and investing in those workers and investing in the families to develop that relationship.

COMMISSIONER PAGONE: Looks like Ms Broer?

MS BROER: Yes. Looking at it from the perspective of organisations that have a large voluntary workforce delivering services, Meals on Wheels SA has 7,000 volunteers around the State of South Australia and three-quarters of them engage with us for less than 100 hours every year. Many of them are not digitally literate and so our approach has tended to be through useful, succinct, written information, peer-to-peer induction and orientation to the service and the support currently that we can afford with the level of funding that we have is for only less than 20 people and fewer full-time equivalents who are supporting the volunteers that are doing that peer-to-peer training model.

So for future growth in that, additional, appropriate funding that covers the cost of quality and safety and training of staff and volunteers will enable us to provide a richer level of training to the volunteers around person-centred care.

COMMISSIONER PAGONE: Yes, Mr Voukelatos. You're on mute, I'm afraid. You should be okay now.

MR VOUKELATOS: From the Uniting Care perspective, Uniting Care by virtue of its mission, is there to support and work closely with the most vulnerable Australians. In order to do that, what we have done over our history is interrogate the evidence base but also create the evidence base to actually support good person-directed care. As Mr Corley put it, at the point of a relationship on the ground. So beyond organisations having sufficient safeguards and frameworks in place, it's how we actually have gone about introducing mandatory training, making sure that our staff are suitably skilled to deliver the care that's required, but to do that from a relational perspective.

In terms of taking that forward, and while I do appreciate the valid propositions from Senior Counsel, they are bold and they move to access and they talk to the need to respect everyone and have --- and be relational in nature and keep it personal as well. Is that for the sector to move to that forum, there needs to be the capacity in there to look at things like self-reflection, resilience, what good person-directed care looks like, moving away from just the institutionalised settings that we are in which is wedging people into certain service lines and looking at them holistically. So I think that's going to be a major challenge. And then also for the workforce of the future is how do they respond to services that people really need? As that evolution happens, and we've seen that with the NDIS, new service modes and types have evolved which means that participants are in control and they actually inform process. So there's a whole redesign of the service system and I think the capacity of organisations to move into more customer-centred evolution offered would be the proof in terms of what the outcomes look like for a person and their family.

COMMISSIONER BRIGGS: If I might just try to draw that to a conclusion, I think what you're saying is the entire system needs to reform and that a relational system or approaches need to be built into the formal training that's provided for the workforce, but also operationalised provider by provider, and constantly focused, developed, evolved to take the system forward? So, thank you, I really appreciate those inputs. That's all from me, Commissioner Pagone.

COMMISSIONER PAGONE: Thank you, Commissioner. And Mr Gray, you popped up again.

MR GRAY QC: Yes. I repeat myself at a more appropriate juncture now. Could I ask that the panellists be excused, subject to any further questions that you might have?

COMMISSIONER PAGONE: No, thank you very much. I just wanted to join with Commissioner Briggs in thanking each of the panellists. It's very, very good to have your wealth of experience and knowledge in informing the approaches that have been recommended by counsel assisting us and the group of people behind them who are helping in organising and moulding the proposed recommendations. It is important they be tested with, as it were, people who are likely to run them and have got the experience and knowledge that each of you have. We're very grateful that you've given the time and energy before today's session and that you've put up through this session the kind of information that you have. So thank you to each of you for doing that.

I do now formally excuse you from further attendance. Thank you.

THE WITNESSES WITHDREW

MR GRAY QC: Could we resume at 2.10, Commissioner?

COMMISSIONER PAGONE: Yes, I think so. We'll resume at 2.10.

ADJOURNED **[1.22 PM]**

RESUMED **[2.12 PM]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Thank you, Commissioner. Just for continuity on the transcript, I'll mention that Mr Ahilan St George has provided a response to the propositions we've been discussing in written form, and that has been included in the general tender bundle at tab 93.

I believe there's an appearance to be announced.

COMMISSIONER PAGONE: Yes, who do we have?

MS HILTON: Elyse Hilton, I act for Hireup Pty Ltd.

COMMISSIONER PAGONE: Thank you, Ms Hilton. Yes, Mr Gray.

MR GRAY QC: Thank you, Commissioner. I call Jess Timmins of Hireup.

JESSICA TIMMINS, AFFIRMED

EXAMINATION BY MR GRAY QC

MR GRAY QC: Ms Timmins, you represent Hireup. What's your position in Hireup?

MS TIMMINS: I'm the Head of Service.

MR GRAY QC: Thank you. And could you give an outline, please, of the origins of Hireup and what Hireup does, what its main operations are?

MS TIMMINS: So Hireup was founded by two siblings, Jordan and Laura O'Reilly. They had a younger brother with disability and they saw that there was a better way that supports could be delivered. So Hireup was founded and we're an online platform that connects people with disability with support workers who suit their

needs and share their interests.

MR GRAY QC: Is Hireup a registered NDIS provider?

MS TIMMINS: Yes, we are.

MR GRAY QC: And could you tell the Commissioners about the different modes of management or support management of NDIS services that are available under the NDIS framework?

MS TIMMINS: So there are three ways that a participant's funding and plan will be managed. There are self-managed individuals who have kind of complete control over how they use their funds; there are plan-managed participants who are supported by plan managers to expend their funds, and then there are agency-managed users who their funds are held with the agency.

MR GRAY QC: And does "agency", in that context, refer to a provider?

MS TIMMINS: No, that refers to the National Disability Insurance Agency.

MR GRAY QC: And what forms of services does Hireup provide? Does it provide services to self-managed, plan-managed and agency-managed clients?

MS TIMMINS: Yes, we do.

MR GRAY QC: And does it provide plan management services itself?

MS TIMMINS: No, we don't.

MR GRAY QC: Now, what are the functions of the platform when it comes to workers who want to make themselves available over the platform, and what's the relationship between Hireup and those workers?

MS TIMMINS: So all of our support workers are employed as casual employees of Hireup. So they are able to create a profile on the Hireup platform and then be reviewed before becoming an employee and they can then interact with people with disability on the platform who are looking for support workers to provide support.

MR GRAY QC: And what is the scope of the services provided by the casual employees who are made available for deployment on Hireup?

MS TIMMINS: So there's eight different types of support on Hireup and they're all within the boundaries of the support worker job description. But the eight different types of support include personal care, help around the house ---

MR GRAY QC: We'll go to the website, shall we?

MS TIMMINS: Sure, yes.

MR GRAY QC: Operator, please bring up the website, the Hireup website, the page How Hireup Works.

Thanks, Ms Timmins, I interrupted you. You mentioned help around the house?

MS TIMMINS: Yes. As you can see on the screen, personal care, in-home care, help around the house, transport, therapy support, out and about supports, specialist, high needs supports and education and employment.

MR GRAY QC: Just stopping at specialist high needs support, is that still a form of personal care or is that some sort of therapeutic or clinical support?

MS TIMMINS: It's typically personal care.

MR GRAY QC: Right. And how does this part of the website work? This is directed at people who are seeking services, is it?

MS TIMMINS: Yes.

MR GRAY QC: But these categories are also relevant from the perspective of the person offering their services as a casual employee of Hireup. Is that right?

MS TIMMINS: That's right.

MR GRAY QC: And if I want to become a casual employee of Hireup, do I nominate which categories of services I'm prepared to offer, is that how it works?

MS TIMMINS: Yes, exactly.

MR GRAY QC: And could you explain how Hireup then ensures that those people are appropriate to be providing the relevant category of services?

MS TIMMINS: So for the main categories of support, there are some really key verification steps that every individual employee goes through before they become approved to be an employee of Hireup. But particularly for the specialist supports, we really work with the person with disability who is going to be receiving those supports to check that they have the appropriate allied health plans or clinical plans in place to support the support worker to do that work safely. In addition ---

MR GRAY QC: Sorry, I'll come to that in a minute, but firstly, can I ask what are the steps Hireup takes, if any, to ensure that a worker offering to perform services in a particular category is an appropriate person to be providing services in that category? Is there some form of checking of their qualifications or anything of that kind?

MS TIMMINS: No, we don't check qualifications. We do collect those and then the person with disability, if they have a requirement for a specific qualification for them individually, they can check those with the support worker.

MR GRAY QC: Thank you. Understand. And how does Hireup match a request for services by a person seeking services with an appropriate worker or appropriate list of workers who have nominated to provide services in the relevant category?

MS TIMMINS: So I guess there are a couple of technologies that people can draw on. Firstly, they can search for support workers in their area and they can specify what types of support they're looking for. We also have a recommendations program that will show a person with disability some specific support workers that could be a good match for them, and then we also have a jobs board where a person with disability could post, basically a job ad, advertisement, and have support workers apply to work with them.

MR GRAY QC: Okay, thank you. I might just take those points and ask you a couple of further questions about them. If we could just ask the operator to click on, say, the specialist high needs icon. There are a number of detailed items within specialised complex support that appear on the website. That's probably a bit small for a lot of people to read on their screens, but they include manual handling, lifting, hoisting, transfers, anaphylaxis, allergies, et cetera, so we're getting into quite specialised services. Perhaps some of these would have to be performed under clinical --- under a plan formulated by a clinically-qualified person. Is that right?

MS TIMMINS: That's correct.

MR GRAY QC: But is it the case that the casual workers on Hireup are not themselves taken to be clinically qualified, they don't need to be clinically qualified? You're, in effect, relying on some form of planning by a clinically-qualified person being done outside Hireup's structure. Is that how it works?

MS TIMMINS: That's correct, yes.

MR GRAY QC: And in practice how does that come about? So you only provide NDIS services at Hireup, is that right? You don't provide aged care services?

MS TIMMINS: No, we don't.

MR GRAY QC: So we're not talking about the aged care system per se, but in the NDIS context, how does that come about? Who provides that clinical planning and is there any clinical oversight involved?

MS TIMMINS: So perhaps a good example would be behaviour support and restrictive practice. So an individual who requires a positive behaviour support plan and perhaps restrictive practice strategies, they will be funded through the NDIS to have that work done by a behaviour support practitioner or a clinical psychologist.

So they are able to work with a practitioner to develop the strategies and the plans that they want to use when they're receiving supports, and then they're able to provide that to Hireup, for example, to review that plan prior to them receiving services and then they're able to use that plan to train their support workers.

MR GRAY QC: Okay, thank you. And just going back to the point about from the worker's perspective, how do they nominate for --- how do they offer themselves to be providing services as specialised as this? Is that simply a matter of their own discretion? Do they think, "Well, I think I could provide specialised supports in the nature of enteral feeding, I think I'll just nominate to do that" or is there anything more to it than that?

MS TIMMINS: They do nominate themselves to provide those supports and, of course, they can then make a decision on an individual case-by-case basis as to whether they want to provide those services. So, for example, if a person with disability was to reach out to them and ask them to provide, say, bowel care support and they didn't feel comfortable, they didn't feel like they had the experience, they could decline to work with that individual.

MR GRAY QC: Okay. And from the point of view of Hireup's employment structure, including any quality assurance or training program, does Hireup have any sort of process of supporting employees who are taking on these quite complex tasks, or is it simply a matter of the discretion of the employee and it's left at that?

MS TIMMINS: So we do have a team that supports both people with disability and support workers who are delivering more complex supports and so that will, from the support worker side, that can be about checking that they feel comfortable, checking that they have access to all of the information they need, so the plan, for example, and checking that they are feeling ready and confident to provide those supports.

MR GRAY QC: All right. Now, from the perspective of the user of Hireup, what functionality is Hireup offering to them which can, in effect, empower them when it comes to autonomy in arranging their own supports, the times at which those supports will be given, the people who will give them?

MS TIMMINS: So, yes, we've harnessed technology to really allow a person with a disability to build a strong, reliable, consistent relationships with the support workers that work on our platform. They're then able to use different functionality such as our booking management system to say to a support worker, you know, "I would like you to work every Monday from 9 to 12", to book that into that system and then allow that support worker to be paid for that work as they complete it.

MR GRAY QC: So, looking at the website again, if I need catheter care and I click on that, and I go through a process of saying where I live, do I get to a point where I can nominate times I'd like those supports to be provided and then that generates a list of people and I can look at their profiles? Is that how it works?

MS TIMMINS: Not exactly in that order but, yes, certainly the key elements are there. A person with disability will create their profile, they will nominate the types of support they're looking to receive on Hireup. They will then use our technology to find support workers that could be a good match for them and then they will book them and roster them in.

MR GRAY QC: Returning to, in effect, the internal arrangements within Hireup and in particular that casual employment model, why did Hireup decide to adopt an employment model, first up, and why a casual employment model, secondly?

MS TIMMINS: So I think the decision to be an employment model was a really profound one for Hireup and has really driven our culture and the way we think about supports. I think our founders believed that the duty of care that's created when you are an employment model can lead to higher quality support outcomes for people with disability and so we really wanted support workers to feel part of our team and committed to those same quality outcomes.

MR GRAY QC: And why casual employment?

MS TIMMINS: Yes, sorry. I think casual employment obviously allows support workers and people with disability to have the flexibility to work when it suits them. So that was the best option for us to start with.

MR GRAY QC: And is there an award that applies to the conditions of employment for the casual employees on Hireup?

MS TIMMINS: There is, yes.

MR GRAY QC: And does Hireup have any plans to offer different employment models?

MS TIMMINS: Yes, we do.

MR GRAY QC: And what's that? And what are you doing to investigate that?

MS TIMMINS: So I think we believe that the future of work is about having a spectrum of employment options available. So the next step on that evolution for us is the trialling of a permanent employment model for disability support workers, and we've designed that model around the relationships that people with disability and support workers have through Hireup.

MR GRAY QC: When I asked you the question about why had Hireup chosen an employment model, you referred to a belief about a better quality and safety outcomes or better quality outcomes, and you referred to supports of employees, support that can be given to the workforce. When you say support to the workforce, what exactly do you have in mind? When I asked you the questions about the categories of support that are provided, it seemed that, in large measure, it's up to the

employee to nominate which categories of support they want to provide including quite technical ones. So what is it exactly that Hireup does to support its workforce to be able to provide the sorts of supports that Hireup is offering on the platform?

MS TIMMINS: So I think a really key support is obviously the investment in learning and development for support workers. So by providing support workers with access to different training they can build their skill set and experience to be able to provide more complex supports, as an example.

MR GRAY QC: And does it stop at learning and development or is there other support that's provided?

MS TIMMINS: No, there is other support. So, for example, we can conduct check-ins with our support workers. Through COVID, we've started running online sessions to listen to the challenges that support workers are facing at this point in time, to be able to respond to those challenges and provide them with key information about how they can work safely through COVID, as well as, for example, in the bushfire crisis, we were able to offer different financial support to our support workers who are volunteering as fire fighters. So I think what it creates is a mindset around support that enables us to respond to the context that that support worker is in.

MR GRAY QC: Is the training or the learning and development tailored to the nominated areas of work that the worker has included in their profile on Hireup?

MS TIMMINS: Yes, we are tailoring.

MR GRAY QC: And in addition to check-ins and learning and development, is there any other support that you see as an advantage of the direct employment model of engagement of a care workforce?

MS TIMMINS: I think a great example would be the support that's offered to support workers who injure themselves, whether physically or psychologically, through Hireup --- through their work on Hireup. So we have a dedicated injury management team that supports any injured worker to make a claim for Workers Compensation, to receive alternative duties to complete whilst they're unable to provide support work, and to eventually return back to work. I think that's a really important difference for our support workers.

MR GRAY QC: Can I just ask you a bit about the internal structure of Hireup, not in great detail, but is it the case that you're running a large team called "service" or the service team, but within that there are various other teams; is that right?

MS TIMMINS: That's correct, yes. Yes.

MR GRAY QC: One of them, in fact, relates to injuries by employees, does it? Is that how it works?

MS TIMMINS: Yes. So we have a trust and safety team. Within that, there are people specialising on injured workers and their return to work. There are people specialising on instant response and complaints handling.

MR GRAY QC: Now I want to ask you about what happens --- I think the website might still be up. We can take it off in a minute. But this area that we were looking at was the complex or Specialised (Complex) Supports, wasn't it?

MS TIMMINS: That's correct.

MR GRAY QC: Is there a team within Services that is responsible for clients who have specialised needs of that kind?

MS TIMMINS: There is, yes. We have a complex support team.

MR GRAY QC: And about how many, in rough percentage terms, are we --- how many clients using Hireup have needs of that kind?

MS TIMMINS: It would be about 20%.

MR GRAY QC: Okay. And what are the functions of that group when it comes to the supports that are needed for the individual clients and for supervision or direction of the workforce of personal carers who are looking after them?

MS TIMMINS: So there's a strong focus on helping a person with disability to join the platform and to make sure that we have all of the information that we need in order to deliver supports safely. So, again, to take a behaviour support example, that might be the provision of their behaviour support plan for review by our complex support team. That also is around ensuring that the person with disability understands how to select their team, how to make sure that their team are trained in the safe use of that plan, how to draw in allied health professionals to support that training and that guidance. And then for a support worker, it is also about making sure that they understand what's required of them to provide that type of support, that they understand what reporting obligations that they might have and that they know that they can raise concerns or ask questions of the complex support team, if they have them, along the way.

MR GRAY QC: Thank you. Now, I should have asked you to describe what else is done within the Service team. Is it correct that there's an on-boarding team as well?

MS TIMMINS: That's correct, yes.

MR GRAY QC: So can you just answer, without going into all of the details, can you just answer this: is it the case it's not simply a matter of a client choosing on the website the domain of complex or specialised support, it's actually a process by which a team within Hireup looks at the support plan that's been generated for the

client and makes some sort of decision about whether complex support is going to be needed? Is that right?

MS TIMMINS: Yes. So there are a range of different inputs, I guess, into helping us understand what types of support that individual is looking for and whether we need to provide more tailored on-boarding experience. So that includes the profile that they've created, some answers to some key questions about what types of support they're looking for, as well as other things like phone and email conversations to really understand more.

MR GRAY QC: And is there an analysis of whether the person is going to fall within that roughly 20% portion of your clients who are going to need that more tailored management of their needs? Is that right?

MS TIMMINS: That's correct, yes. And then that's transferred to the complex support team.

MR GRAY QC: Now, with the complex support team --- sorry, I withdraw that, I'll start again. Generally speaking, do you regard the clients on your platform, perhaps the 80% of clients who aren't clients with complex support needs, as self-managing their support plan?

MS TIMMINS: Yes. So they're definitely self-managing their supports within the context of Hireup. They might be using any three --- any of those three funding mechanisms that the NDIA provides.

MR GRAY QC: Yes, thank you. Now, when it comes to the 20% or so of clients who are in that domain of complex needs, are they self-managing?

MS TIMMINS: Some of them may be, yes. Well, again, they're self-managing in the context of Hireup. That's consistent, no matter the type of support you're receiving. But, again, they might have varying forms of funding arrangements with the NDIS.

MR GRAY QC: And what then is the role of the complex support team? Is it just to keep an eye on the way in which a person in that group is self-managing?

MS TIMMINS: Yes, so I think it's important to call out that we have --- people with disability on Hireup can nominate an account manager that can support them to use Hireup and to train support workers. So for someone with more complex supports, they might nominate an account manager to support them, in which case our complex support team would be working with both the account manager and the person with disability to make sure that everything's working in the way it's expected to.

MR GRAY QC: Typically, who is an account manager likely to be? Could that be a family member?

MS TIMMINS: Yes, it's typically a family member, an unpaid person in that individual's life.

MR GRAY QC: All right. And can you tell the Commissioners about the safeguarding measures, I believe they're called "safeguarding measures", that are taken by Hireup within the context of the NDIS? What are safeguarding measures?

MS TIMMINS: So we made the decision to be an NDIS-registered provider and that decision, I guess, bolsters our existing commitment to quality and safety but also provides a framework for the safeguards that we need to put in place. I guess the key safeguards that we have in place are mandatory training for support workers in certain topics. We also have a post-booking feedback form that allows support workers to provide information about what happened on the shift, to report any incidents, to raise any concerns. And then we have a 24/7 incident form that's monitored by a team around the clock.

MR GRAY QC: Are there additional safeguards for people with specialised needs who are within that 20% cohort?

MS TIMMINS: Yes. So there are typically, you know, a higher standard of reporting is required. So, again, to draw on the example of behaviour support, support workers who are providing support to an individual, those requirements are required to report the use of restrictive practices, whether authorised or unauthorised, through our platform.

MR GRAY QC: Okay. Now, what's the effect of being registered as an NDIS provider on Hireup's decision to take those steps? Are you taking those steps because you're a registered provider or are you taking those steps irrespective of registration?

MS TIMMINS: I think we'd be taking those steps irrespective of registration. As I said, we've always felt there was a role that Hireup should play in ensuring high quality and safe supports are delivered. But I think what the regulatory framework provides is guidance and direction on how --- what standards should be met and that forces us to think, you know, innovatively across every step of the journey for the person with disability about how we provide quality and safe outcomes. And it also requires you to really analyse your performance against those standards and against those quality outcomes and I think that leads to continuous improvement.

MR GRAY QC: So has it made a difference, in your opinion? Firstly, when did Hireup become a registered provider under NDIS? From the outset or recently?

MS TIMMINS: So we became registered in New South Wales in 2016. So prior to the establishment of the Quality and Safeguards Commission in the NDIS, it was a state-by-state registration process. So we became registered first in New South Wales in 2016, then in the ACT in 2017 and then in all other states and territories in

2018, with the exception of Western Australia who we're still in the process of applying to become registered.

MR GRAY QC: All right. Thank you. And has it made a difference? Are you able to give an opinion as to whether being registered, because of that guidance that's provided by the regulatory framework, whether that's actually made a difference to the rigour of the safeguarding practices within Hireup?

MS TIMMINS: Yes, it absolutely has. It's provided a framework for all of us at Hireup to think about quality and safety in the same way, in a consistent way, and then to make it all of our jobs to make sure that we're designing and building for quality and safe outcomes in everything we do.

MR GRAY QC: Right. Now, we gave you a copy of some draft propositions that have been considered by the Royal Commissioners in light of the evidence in this hearing and we didn't ask you to provide a written response but you indicated that there were some propositions to which you were prepared to make responses, as I understand things. One of those was HC6(b), I believe. That's a proposition that --- it's in the aged care context, of course, and you don't operate in the aged care context, but it's a proposition that engagement of contract and sole trader aged care workers, including through online worker brokerage platforms and labour hire arrangements, be regulated. And, firstly, would that be practicable in a disability context? I guess it must be if you are regulated through having taken registered status as an NDIS provider. Do you have any response to that proposition? Do you believe that would be appropriate in a disability context for all similar businesses, similar to Hireup?

MS TIMMINS: I think that in the context of the disability sector, and particularly the NDIS, the ability for a participant to choose between a registered and unregistered provider is a really important concept and I think we would want to see that maintained, but just speaking from our experience as a regulated employment model, as we've talked through, we've really seen the benefits of that regulation in providing guidance and direction and a mindset and culture around quality and safety. And we would see that others could benefit from that, too.

MR GRAY QC: All right. Now, it's interesting, just in the course of your answer, you said that it would be useful to preserve that choice, or appropriate to preserve the ability of the provider to choose. And why do you say that? Wouldn't that mean that you've got to compete with unregulated platforms who may be not adhering to labour conditions and may be able to compete against you on price, potentially at the risk of quality compromises?

MS TIMMINS: Sorry, what was the question?

MR GRAY QC: So the question is: why do you say it's important that online platforms who provide workers in the care context, or disability support context, be allowed to choose whether to become regulated or not? Why do you say that?

MS TIMMINS: I think the choice I was referring to was for the participant, so the person with disability, for them to be able to choose between a range of different service providers that meet their needs. So for some individuals, they are looking for supports that perhaps don't require as much regulation and there should be great options for them to choose from within that, but there are other supports that could benefit from regulation. So I think really the choice we're referring to there is for the participant, the person with disability, as opposed to the provider.

MR GRAY QC: Thank you. I understand. And how would you discriminate between the services for which regulation is appropriate and the services for which you needn't have regulation and, in fact, it would be useful to accord choice to the consumer, to choose providers who aren't regulated? How would you make that judgment? Is it something to do with the inherent risk of the service?

MS TIMMINS: Yes, I think so. I think it's about whether there can be that fine balance between the dignity of risk for a participant and the duty of care for quality and safe outcomes. So, you know, that choice should be an informed choice by the person with disability, they should know what they are --- what types of support they're receiving. But I think, yes, it really depends on the risk profiles and what each unique individual is looking to receive.

MR GRAY QC: Does it also depend on the capacities of the person seeking the supports and, again, we might be dealing with a very different context here because disability is quite different from aged care. But are you able to answer that question? Does the answer to the question whether to regulate or not also depend on the riskiness of providing services to a particular individual, and in particular, does it depend on their capacity?

MS TIMMINS: Yes, I think that, to speak from our experience, we've always believed that to be a self-manager of your supports on Hireup, there is a requirement for the desire and capacity to self-manage to be present, and that Hireup and models like it aren't going to be for every single person with disability who are utilising NDIS plans. So, again, that's why there should be choice of different providers available depending on that person's desire and capacity to manage their supports in the way they wish.

MR GRAY QC: Does Hireup do anything to try to understand the capacity of the clients who are putting a profile on Hireup and trying to use Hireup to obtain services from your employees?

MS TIMMINS: Yes, so we would --- we have an on-boarding process that reviews each application that's coming in and we draw information out of that. We may have phone conversations or email conversations, to just check and see whether that person might have a better experience using Hireup if they were to have an account manager in place, for example.

MR GRAY QC: And are there cases where Hireup has declined to accept a person

using the platform to obtain services, even with an account manager?

MS TIMMINS: Yes, there are.

MR GRAY QC: And how is that judgment made?

MS TIMMINS: Yes. So it's a mixture of looking at the types of support that the individual's wanting to receive, the social structures and networks that they have in place to make sure that those supports are delivered well and safely, and then it is a judgment by our on-boarding team as to whether Hireup is right for that person right now or ever.

MR GRAY QC: Now, how have you calibrated, how have you worked out the degree to which Hireup should, in effect, intervene in the process of the client being able to just exercise autonomy in using services on Hireup in situations of the kind you've just referred to? How do you know that you've got it right?

MS TIMMINS: I think, you know, it's a question that we're always actively considering and we draw on a range of different inputs. You know, we look at the risks, the risk profile that's emerging, we look at incident reporting and other feedback loops to determine, you know, are we getting it right, should we be intervening? I think what we would say is that --- what we're hearing from our community is not that they want more intervention into their supports, they probably would like to see them be able to be more in control of their own safeguards and their own quality framework. So we keep listening to the community on that one and if we see that that need changes, we'll respond to that.

MR GRAY QC: One of the propositions to which I understand you expressed some willingness to respond was proposition HC3. Again, this is an aged care context. There are different considerations in play, I suggest. For example, the possibility that the person needing the services might be quite old and might be facing quite a dynamic situation when it comes to deterioration of function.

Now, putting that to one side, do you find it possible to answer this question: in proposition 3 we proposed a shift from self-management to shared management where the focus will be around delivering care to meet assessed needs, and earlier we have talked about - and this is consistent with the legislative regime - working in partnership, the provider working in partnership with the older person to make decisions in that regard. Would that be workable in a disability context? Do you have any reaction to that proposal or you --- I'll let you answer. Would that be workable in the disability context or does that infringe on ---

MS TIMMINS: Yes. I think it's really important in the disability context, particularly within the concept of the NDIS, that that commitment to self-management is maintained. But that's not to say that approaches that take more of a shared management approach can't be successful within the context of the NDIS and disability. But I think because the NDIS has been built on human rights

principles and self-determination and self-management are core to that, we would really want to see that maintained.

MR GRAY QC: No further questions, Commissioners.

COMMISSIONER PAGONE: Thank you, Mr Gray. Commissioner Briggs?

COMMISSIONER BRIGGS: No, thank you.

COMMISSIONER PAGONE: Thank you very much. It's a very interesting perspective you bring to our inquiry. It is very interesting to see how your activities in a different but allied related context might provide valuable insights into how we might come up with our recommendations. So thank you very much for the efforts that you've put in, both before today and today. Thank you very much.

MS TIMMINS: Thank you very much.

MR GRAY QC: If Ms Timmins is now excused?

COMMISSIONER PAGONE: Yes, I keep forgetting. Ms Timmins, you're now formally accused from any further attendance.

THE WITNESS WITHDREW

PETER SCUTT, SWORN

EXAMINATION BY MR GRAY QC

MR GRAY QC: Mr Scutt, are you the Founder and Chief Executive Officer of Mable Technologies Pty Ltd?

MR SCUTT: I am.

MR GRAY QC: Mable has provided a number of documents in the nature of submissions and I will just refer to where they are in a tender bundle that the Commissioners already have. There are submissions from Mable at tabs 17, 18 and 19 on various topics relevant to the Royal Commission's inquiry. There is a specific document in the nature of a submission responding to the propositions for this hearing at tab 47, and there is also a supplementary submission at tab 84 relating to the functionality of Mable with respect to care management. That's all correct, isn't it, Mr Scutt?

MR SCUTT: It is.

MR GRAY QC: In that last document at tab 84, it's a brief document, it's a factual account of the functionality of the Mable care manager coordinator feature?

MR SCUTT: That's correct.

MR GRAY QC: Are the contents of that supplementary submission true and correct?

MR SCUTT: They are.

MR GRAY QC: Thank you. Now, if we just start with that document, I will ask the operator to bring up tab 84 of the tender bundle. There's been a good deal said already today, Mr Scutt, I don't know if you've been following the hearing so far, but there's been a good deal said by me and asked by me about care management, sometimes called care coordination, and I'm just going to ask you a couple of questions about this document and about the care management functionality of Mable.

Just for a bit of background, it emerges from the other material you've furnished to the Royal Commission, that Mable is a platform that facilitates engagement between care workers who have put a profile on Mable and third parties who want to engage those workers. Is that a fair summary?

MR SCUTT: That's a fair summary.

MR GRAY QC: And those third parties might be the people who are wanting to receive the care themselves or they might be other care provision organisations. Is that fair?

MR SCUTT: Well, the predominant focus of Mable is connecting people with people. So the predominant person that wants to connect with workers are the individuals themselves, supported by families or a care manager. More recently, we've opened up a platform more fully to providers that might have needed Mable during the current challenges.

MR GRAY QC: Thank you. So that use by Mable to engage workers by organisations is the exception, not the rule, and the model is all about direct connections between people, I might call care recipients and workers, is that right?

MR SCUTT: That's right. And we think connecting people directly is a key proposition of Mable.

MR GRAY QC: Thank you. Now, you also mentioned care managers, just in the course of that explanation, and that there might be a connection with a care manager. Can I just clarify a particular scenario, see if you agree with it. If we're talking about people who are holders of a Home Care Package subsidised by the Commonwealth,

then that person will have a home care provider who, in effect, hosts the package and administers the funds from the package. Is that right?

MR SCUTT: That's correct.

MR GRAY QC: And in some cases, there will also be somebody variously called a care manager or a care coordinator, and there might be other titles, whose role might be to ensure that the individual is getting care that has been planned for that individual. Is that a fair summary?

MR SCUTT: Well, I would say in the case of a Home Care Package recipient, the home care provider is not only responsible for the administration of the funding, they're responsible for the care management. So there will always be a care manager working with the client and, you know, around individualised care plans and making sure that they're able to access the services they need in relation to that. Yes.

MR GRAY QC: So you've corrected my summary to the extent of saying, well, there should always be a care manager. If a person has a Home Care Package, there should always be a home care manager?

MR SCUTT: 100%.

MR GRAY QC: But otherwise was my description accurate?

MR SCUTT: That's right. And that there would be potentially a care manager supporting the client user platform, or there would be a care manager supporting the client and in the case of a Home Care Package it's the same organisation essentially managing the package.

MR GRAY QC: When you say managing the package, you're talking about the funds management?

MR SCUTT: That's right.

MR GRAY QC: That is, paying invoices and --

MR SCUTT: The package.

MR GRAY QC: Thank you. And presumably also, giving a monthly statement to the client of amounts spent out of the package and how much is left in the package and things of that nature?

MR SCUTT: That's correct. All of the responsibilities under package management and care management would remain if they have a client using the Mable platform.

MR GRAY QC: Now, with Mable, a care recipient is able to nominate the kind of

care they need, the area they live in, and to generate, in effect, a list of people who are offering services via Mable that meet the description or match the description that the care recipient has put into the Mable platform. Is that correct?

MR SCUTT: There's a range of filters that people using the platform can use, either when posting a job or when searching for care workers to start to shortlist the people, a group of people who would be suitable for the needs based on the criteria they're articulating through those filters.

MR GRAY QC: And you've explained in your material, but the tailoring or the filtering can be quite detailed, extending to things such as common interests. Certainly, linguistic abilities, in particular languages, not simply what geographic area they're in and what times they're available to work. Is that a correct summary?

MR SCUTT: That's correct. Our experience is that the people who are invited into somebody's home and life to support them, it's a very intimate and personal decision and so it does get down to very much cultural preferences, languages spoken, interests, and people want to form a connection with the people that are supporting them. So that's the foundation of a good relationship.

MR GRAY QC: Yes. Now, in the supplementary submission at tab 84 on the care manager coordinator feature, one of the things you've said is that a Home Care Package client cannot use the Mable platform without the approval of the client's Home Care Package provider. Is that right? There's some sort of block, is there, which would prevent just an individual member of the public using Mable if they tick a box to the effect that they're a Home Care Package holder?

MR SCUTT: So somebody that's not a Home Care Package holder can use the platform if they're privately funded. But when it comes to the process of a consumer signing up to the website and providing information, one of the things we look for is their source of funding. So if it's a Home Care Package is their source of funding, then we would require --- our process is to actually understand who their Home Care Package provider is and we could contact that Home Care Package provider to verify that their client is able to use Mable to assemble a tailored team of support. So, without that verification, the client is not able to spend Home Care Package funds on the Mable platform.

MR GRAY QC: Thank you. And as you've said, you expect that in every case of a Home Care Package holder, there will be a care manager appointed by the home care provider hosting that package, correct?

MR SCUTT: Correct, because it's their responsibility to do care planning with the client to provide care management as part of the Home Care Package.

MR GRAY QC: And you've said in the document that the way you've constructed Mable allows the provider to create log-ins for its care managers so they can see the activity on the Mable account; is that right?

MR SCUTT: That's right. We've set up the structure where there can be an organisational log in, they can set up log-ins for all the care managers and the care managers can be linked to their clients using the platform.

MR GRAY QC: On the last page, page 3, we'll just ask the operator to go to page 3, under "Functionality", there's a list of functions, "The care manager platform feature enables each care manager to", and then there's a number of things that can be done. Is that an exhaustive list of what the Mable platform as a whole enables each care manager to do?

MR SCUTT: I would say fairly comprehensive list. I think the two aspects of a client using Mable for a home care provider is the care manager continues to obviously have an ongoing relationship and dialogue with their clients that are using the platform, they can have an ongoing platform with the workers the client engages and via the log-in they have a lot of oversight capability as listed here.

MR GRAY QC: All right. I'm interested in that idea of the provider having an ongoing dialogue with the worker that is appointed. It doesn't appear, from this list, that there's any functionality on the Mable platform by which the care manager can interact with the worker directly. Is that right?

MR SCUTT: I think if you look at some of the functionality here, they're aware of which workers are being engaged by their client, via the platform, they can look at their profiles, they can look at their respective documents.

MR GRAY QC: I understand that, Mr Scutt, but can you just answer my question first and then I will let you explain those points, because it may be that there are indirect ways in which the provider can interact with the worker. But am I correct in saying the Mable platform itself doesn't provide a means of direct interaction with a worker appointed by the provider's client? Is that right?

MR SCUTT: That's more or less correct, other than the case manager can essentially log in as the client and see all of the discussions that are happening between the client and potentially also send a message. But most of that interaction happens off the platform.

MR GRAY QC: Okay. So you're saying that the case manager can assume the identity on the computer of a client and send a message?

MR SCUTT: They can, if necessary, log in as the client to support the client using the platform. So whether it's to log in to help the client formulate a message to a worker or post a job or approve a service log, they can take those actions on behalf of clients that are linked to them.

MR GRAY QC: Okay, that's useful to know. Nevertheless, it's not a design feature, that's a bit of an exception, a bit of a work around, is it?

MR SCUTT: Well, I think it's a recognition that when using the Mable platform, the consumer can operate the Mable platform on their own with oversight by the care manager, or the care manager can support the client using the Mable platform in more or less a supportive decision-making process where, if necessary, they can help, you know, review some of the profiles on the platform, they can help formulate the messages by logging in as the client and supporting them to use the platform.

So it's actually a contemplated design feature that the care manager can actually support their client using the platform.

MR GRAY QC: What's your opinion of, firstly, the legal relationship between Mable and the workers who put their profiles on Mable, in effect, offering themselves for engagement as care workers? What's that legal relationship? Is that an employment relationship? What is it?

MR SCUTT: No, I think the care workers that offer their services via the platform, they sign up as members of the platform and they accept the terms of use including abiding by codes of conduct. So essentially they're customers of the platform, they're not our employees, we're not contracting with them other than as a client or customer of the platform.

MR GRAY QC: And what about the relationship between the home care provider who is hosting the package and providing those administrative functions, funds administration, and also care management? What's the relationship between the worker and the provider, in your opinion?

MR SCUTT: Okay, so I think, in our model, it's the client engaging directly with workers on the platform and the care manager can --- or the approved provider is required to make sure they comply with the, you know, Aged Care Act and the functions that are required and I think the relationship is one where --- essentially, I would say, at best they may be considered to be subcontracting those services but I think it's really the client engaging those services directly.

MR GRAY QC: All right. So let's just take that a step at a time. You started by saying the clients directly retaining the worker and you finished by saying that. In the middle, there was a reference to, at best, it could be subcontracting but we might come back to that. One of the things you also said was that the provider is required to ensure that "they", I take it you mean the worker, complies with the relevant standards, which are the standards scheduled to the quality of care principles, is that what you have in mind?

MR SCUTT: No, what I think I was referring to there is that the approved provider themselves is responsible for complying with those quality standards.

MR GRAY QC: Yes, all right. So the approved provider is required to ensure that those standards are met even by the work provided by a worker directly engaged by

the clients, is that your position?

MR SCUTT: Could you just repeat that question for me?

MR GRAY QC: Yes, yes, it's difficult. It comes out of what you said about the approved provider being required to comply with the standards, and it's a conundrum, in my submission, that's raised by your model. You've said the provider is required to ensure that the standards are met by the care that's provided. But you've also said that the provider is probably not engaging the worker. The client is engaging the worker. My question, firstly, have I got that summary of your opinion correct?

MR SCUTT: That's right.

MR GRAY QC: Okay. Next question. In the absence of a legal relationship between the provider and the worker who has been obtained and engaged by the client, not by the provider, how is it, you say, that the provider would be able to ensure that the standards are met by the care provided by that worker? They're not under any sort of obligation to comply with directions of the provider, are they?

MR SCUTT: So how I would answer that is that the provider can rely on the operations of the platform for part of the answer to responding to complying with the quality standards. So, for example, in an agreement with a home care provider we give some undertakings in terms of how the screening process works on the platform, so they can be confident and have undertakings that all workers on the platform have a police check that's not more than three years old, that we've applied a police check policy in assessing that police check, that they've undertaken reference checks, that they have certain qualification checks for the services they offer, which I can talk to in detail, that they have insurances in place. So there's a number of features on the platform that give the provider comfort that those features are aligned with many of the requirements under the quality standards.

But in addition to that, the provider is able to, through the oversight functionality here, understand the services that have been engaged by the client, the qualifications of those workers, they can see the shift notes, they can see incident reporting, they can see the qualifications of those workers, and they have a direct dialogue with their client in are they getting the outcomes they are seeking? They can also ask workers on the platform to provide more information.

So between the safeguards that are built into the operations of the platform which they have comfort around and commitments from us to operate the platform in those ways, they also are able to stay in contact with their clients and have oversight of the clients' activities on the platform. There's enough understanding in addition to their own capabilities to be able to comply with the quality standards.

MR GRAY QC: All right. So I think what was missing in all of that, I mean, I'm not seeking to go diminish the weight of those incidental measures and the screening and

the visibility through the care manager platform functionality that you describe, those are, no doubt, important, but there isn't an ability to direct the worker, is there?

MR SCUTT: No. The provider doesn't direct the worker. We don't direct the worker. The workers are independent contractors in most cases providing services directly to their clients.

MR GRAY QC: So you're making available this level of visibility to care managers of providers, but there's no compulsion on you to do that, I suggest, is there? You're not regulated in any way to require that level of visibility?

MR SCUTT: So we're not directly regulated to provide that level of visibility, but there is a couple of motivators for us. One is that we believe very much in the value of care management to people that want to self-direct or self-manage their funding. We're very big advocates of care managers being independent of service provision, so they stand beside the client. So we want to basically be able to allow care managers to support their clients using the platform and effectively engaging a team of their own.

The second motivation is that there are many home care package clients that want to take this level of control. It's really important to them who they engage to provide these services and because the provider is a regulated entity, we do whatever we can to help that provider meet their regulatory obligations. So there's certain things they can rely on us for, around police checks and the operations of the platform, but we also want to give them this level of visibility, one to improve the outcomes, and two, to be able to meet their level of obligations.

MR GRAY QC: What is, in your opinion, the legal relationship between Mable and those providers who are hosting Home Care Packages and providing care when they should be providing care management? What's that legal relationship? Is it subcontracting, what is it?

MR SCUTT: The care provider logs into the platform, they become a member of the platform, they sign up to the terms of use and so they're a customer of the platform.

MR GRAY QC: You've got a criticism of our proposition HC3 for shared management. You say --- and when I say "you", I'm referring to Mable's submissions, this in particular is GTB47 at page 9.

Operator, we can take tab 84 off the screen now, thanks.

You say "Shared management should only be offered as a choice", it shouldn't be a default form of management, and you refer to the existing regime under the User Rights Principles, which, in effect, require a partnership approach to budgeting for care and itemising a budget for care in the home care context. And you've said, if we put up tab 17, please, operator, at page 9, you've said that our proposition about shared care management implies that providers will have power over what services

will be delivered to meet assessed needs, rather than consumers have the capacity to make these decisions.

Mr Scutt, if we put up tab 17 at page 9, at the foot of the page, that's an earlier submission where you were --- I beg your pardon, operator, GTB17 at page 0002. Yes, thank you. And at the foot of the page you refer to --- look, I withdraw that. We can take that off the screen, thanks, operator.

You're concerned about shared management, have I summarised it correctly, that you believe that shared management should only be offered as a choice, it shouldn't be a default requirement?

MR SCUTT: Well, I think the context of my answer there was to say that I think it was also in a following part of your proposition, is that we're moving away from self-management and I think self-management is a critically important option for consumers, particularly with, you know, a desire to build capacity and for consumers to be informed and have access to care management, and I guess the question about shared management is really what's defined shared management, and the fear that there is generally a bit of an imbalance in power and information that exists between consumers and providers and a fear that sort of shared management, if self-management is withdrawn as an option, really continues to have the provider having an undue amount of influence over the provision or the choice of services for consumers.

MR GRAY QC: In one of your earlier submissions, this is tab 17 at page 0022, you referred to --- I'll just let the operator bring that up, but I will just paraphrase it in the meantime. You referred to consumer-directed care and you said in the context of consumer-directed care, duty of care should be more clearly defined as supporting a person to achieve their chosen outcome. This is near the foot of 0022, operator, "As supporting a person to achieve their chosen outcome as long as they are acting reasonably, considering both the risk and rewards, and where necessary explaining the risks and possible ways to mitigate the risk which may include building the consumer's natural safeguards available in their community."

COMMISSIONER PAGONE: It seems to be a wrong page.

MR GRAY QC: It's 0022, at the foot of page 0022. Not 0002 but 0022. Thank you. I'll just let you --- at the foot of the boxed section is the passage I just read out, Mr Scutt. If you could just have a look at that? "In the context of CDC, duty of care should be more clearly defined as supporting a person to achieve their chosen outcome, as long as they are acting reasonably", et cetera. Mr Scutt, isn't that really a description of a shared management model?

MR SCUTT: Quite possibly. I guess the earlier comment was not understanding what was meant by a shared management model, it wasn't necessarily defined or made clear and I guess there's concern about the undue influence providers might have in the imbalance of power in that relationship. I guess I'm talking about here in

this submission is really the whole challenge that the sector has around balancing duty of care with dignity of risk and the desire for --- and it's in, you know, CDC legislation, around the desire for people to be able to make choices about their life that will involve a level of risk, the dignity of risk, you know, balanced against the duty that care providers have to keep clients safe. And so there's an unresolved conundrum or tension in those two things and it was an attempt to try to work out how to resolve those things.

MR GRAY QC: All right. If we go now, operator, please, to tab 37. This is a statement of Dr Paula McDonald, and Dr McDonald has conducted a deal of research into digital platforms, in particular other forms of brokering of labour, including in the care context. If we go to page 002, she says --- she identifies a number of criticism, Mr Scutt, of those models. She says, "There are critics that argue that the organisation of platform work fragments work, de-skills professionals, places pressure on pay rates and reduces employment security." Just to take each of those in turn. Referring to the fragmentation of work, Dr McDonald is referring there to the fact that the arrangements for work might be spread throughout the day and the week at odd times and there isn't continuity of work time, making it very difficult for some people to organise their lives. Is that a fair criticism, in your opinion?

MR SCUTT: No, I don't think it is. I think from a number of perspectives, you know, Mable as a platform isn't an on demand or gig platform, it's a platform that connects people and allows them to form ongoing relationships. So it's not a piecemeal work. The other challenge in the home care is the fact that people with individual needs, preferences, abilities and interests that are all geographically spread. They live in homes and communities all over the country and are being provided services through approved providers, and in trying to meet the needs and preferences of those individuals. The existing sector today exhibits these characteristics. So a lot of the workers would complain that they have uncertain rosters, they're not paid for travel time, they might start at the beginning of the day and have gaps and then have further work at the end of the day because, typically, the clients that are engaging them are restricted to the people they work for. One of the things I think with Mable, when you actually bring large numbers of people together in local communities around a relationship model, you're actually able to get workers, you know, work schedules that are more flexible and fitting in with their requirements. They're agreeing those schedules directly with their clients. When you put two people together, they're actually much more flexible together in working out what works for both parties.

MR GRAY QC: One of the benefits that you highlight in your submissions, of the Mable platform, is it makes the care package dollar go further.

MR SCUTT: That's correct.

MR GRAY QC: And you point to, in effect, lower rates, lower unit rates for the provision of personal care services over Mable compared with other models such as direct employment models. Is that right?

MR SCUTT: I actually point to two drivers of that. One is that the current charges for package management and care management can be fairly significant. In many cases that can be up to 35% of the package, so that leaves 65% of the package to spend on services and you may be engaging those services at sort of $55, $50 an hour. Part of the challenge for providers is there is a lot of work in that rostering equation to try to make sure changes to rosters have implications for the rest of the workforce and the rest of the clients. So when you shift some of the ability for consumers to work out the rosters and make choices directly with workers, you reduce some of those charges. So you can reduce the administration and care management fee maybe from 35%, it might to 15 to 20%, or 25%. So there's more money for services, and then you're able to engage those services directly from a team of your choosing and it might be at $40 an hour versus, say, a provider charging $55 or $60. Those two factors mean you can potentially get almost double the hours in some cases from the same funding.

And I think as you pointed out earlier, there's a direct relationship between the amount of support you receive, reducing the risk of somebody going into, say, residential aged care or needing more expensive services. So we certainly think those extra hours are a big driver of quality of life and having more relationships in your life and being able to do things beyond just the basics of, you know, receiving domestic assistance or your clinical support, that you can actually use that support to remain engaged with your community and maintain relationships.

MR GRAY QC: Is the other side of that coin an erosion of pay rates and job security?

MR SCUTT: Not at all. I think the exact opposite is the case. So independent workers on our platform offering social support and personal care Monday to Friday, they're now earning on average over $36 an hour and so the worker can be better off and have choice and control and flexibility in managing their own work arrangements and the client can be better off in terms of a lower fee and more hours of work. And in fact, more hours of support. More hours of support translates to more hours of work available for that support team. Again, if you're doubling the hours of care and support from the same funding, that's doubling the amount of work available to communities around Australia at higher average rates.

MR GRAY QC: You mentioned one of the implications of the use of Mable is lower amounts spent on care management. Can I just ask you about that and what that implies. Is this essentially a product or a platform that's tailored to some people who are on Home Care Packages, but is not appropriate for people with complex and intense needs who require a good deal of care management?

MR SCUTT: So there's two parts to that question. I think the first one is a lower cost for package administration and potentially the care coordination piece of care management. So you're no longer having to manage that roster, which is quite a time-consuming and expensive piece of the operation of a provider when they're

trying to roster services to clients that are geographically dispersed with individual preferences. As far as care management goes, you know, people need different levels of care management depending on their circumstances and the complexity of need. So, in our view, you know, and I think this is part of your proposition which I applaud you for, is that care management should be separately funded according to need.

So some people will require initially low amounts of care management, they may be just requiring a little bit of support to, you know, support their independent living, people may end up with quite complex clinical needs with fewer family members around them and requiring a lot of care management that may vary over time. So I think care management is something that should be independent of whether they use the platform or engage their services in other ways. But I do think there is a lower cost of care coordination that is also charged for through the care management fee.

MR GRAY QC: Just back on the labour conditions, you mentioned $36 an hour for personal care. Didn't Mable, at the time of engaging with the Victorian On Demand Workforce Inquiry inform that Inquiry that the lowest wage payable for work mediated through Mable's platform was $23.50 per hour?

MR SCUTT: Yes. So when we provided that information, we have a protection for workers that they can't be engaged at a rate that would cause them to earn below minimum wage after accounting for super and platform fees. It's now $25 an hour, not $23.50 an hour. So that's gone up. But also at the time we made submissions there, the average rate of earnings of personal care workers and social support workers on the platform was between $32 and $33 an hour. One thing we're seeing consistently is average rates rising, about 8% per annum. That points to the fact that it's not a race to the bottom that people typically criticise platforms for. In fact, consumers really value the people that support them and want them to be fairly rewarded and feel valued. It's absolutely no evidence on the platform it's a race to the bottom. In fact, the data suggests the opposite.

MR GRAY QC: Again, Mr Scutt, assuming that what you've done with respect to visibility for care managers and what you've done there by building in a floor for the rates that can be negotiated over Mable, based on at least the minimum wage, assuming those are good things, there's still no compulsion on an online platform to do those things. You're effectively doing them because you're persuaded that it's good practice to do them, but you're not being compelled by regulation to do them, is that right?

MR SCUTT: That's correct. And I think one of our company values is do the right thing always. I think the team believe in that 100%. But I think it's also the right thing to be doing for a business. We think of our business as a for-profit, for-purpose business. That unless we actually deliver on the purpose we don't have a sustainable business and so having sensible safeguards in place that protect both customers of the platform, the workers and the consumers, I think is just --- you know, you don't have a long-term future if you're not thinking about that.

MR GRAY QC: Now, you've responded to a proposition that we've put regarding workers engaged through online platforms need to be regulated, or the mode of engagement of those workers needs to be regulated. You've given qualified support to that in your response to our propositions. You've said the regulation needs to be proportionate to the services and size and you pointed out to the differences between aged care and NDIS and a measure of some form of indirect regulation in the NDIS context through the direct imposition of an obligation to comply with a code of conduct. But in the aged care context, can I ask you would it be appropriate that online providers such as Mable, who are offering a platform on which personal care workers can be engaged and remunerated by Commonwealth subsidies, some form of regulation of those platforms is appropriate to ensure these minimum safeguarding steps that you've mentioned are taken?

MR SCUTT: So a part of our qualified support there is not understanding what regulation is intended, so that's why there's qualified support for that. Some level in aged care, we think we operate within a regulatory framework because there is an approved provider allowing the clients to use the platform and we're giving undertakings to them around some of the safeguards we have on the platform. As you pointed out, in the NDIS environment, even unregistered providers are subject to regulation. They're subject to abiding by a code of conduct, they can be subject to complaints and incident reporting that can trigger investigations and workers being banned from the sector. Those sort of worker-level regulations, I think, make sense. They have application across NDIS and they have application across aged care. I'd like to see workers abide by an aged care code of conduct. But I'd also like to see some sort of unification of the framework that exists in disability with aged care because, increasingly, workers are working across both client groups and I think there's a real opportunity to create some uniformity and efficiency in how you might regulate workers ---

MR GRAY QC: What about the platforms themselves?

MR SCUTT: Well, just workers that are --- you know, being able to regulate at a worker level, having some uniformity of approach would be beneficial.

MR GRAY QC: No, I understand you were saying that in your submission, but my question to you is what about regulation of the platforms themselves? Given that Commonwealth subsidy is being made available to remunerate the workers who are offering their services over these platforms, isn't it reasonable and proportionate that there be regulation of those platforms to ensure that at least the sorts of safeguards that you've spoken about, that Mable is taking, the steps that Mable is taking by way of safeguards, should be made mandatory for such online platforms?

MR SCUTT: I think a proportionate approach that understands the role of platforms, that they're not a provider, they're a platform that, you know --- platforms that introduce people, and that they potentially could be regulated to ensure that workers offering services via those platforms meet some of the regulatory requirements of

those workers. And that's essentially the approach we would take in the NDIS space in any case without it being formalised, that's the approach we take in aged care without it being formalised.

MR GRAY QC: Operator, please bring up tab 82, Mr Versteege's statement. I'm going to put to you a proposal that Mr Versteege is advancing to the Royal Commission. I believe this has been brought to your attention.

MR SCUTT: That's correct.

MR GRAY QC: Very briefly, then, Mr Versteege in a passage beginning on page 0005, at page 27, refers to one of the results of the adoption of consumer-directed care for Home Care Packages and the phenomenon of the high administrative charges that you referred to, Mr Scutt. Mr Versteege points to one consequence of these things being a "free market workaround", they're his words, "that has been developed, involving a broker operating outside the aged care regulatory framework." I don't know whether you would accept the description "broker", is that a term you would apply to yourself, Mable? Are you a broker?

MR SCUTT: No, we're not. That's where --- we're a platform that introduces people, but I think this is a misconception about how Mable operates within the Home Care Package market because ---

MR GRAY QC: Okay, just hold that thought. It may be relevant to a question I might ask you. So you don't agree with the description of "broker". Mr Versteege says, at 28, that the process is as follows, a broker, accepting that you disagree with that description, registers care staff who pass a police check, are adequately qualified professionally and have a current professional registration, if required. Do you actually take those steps? Do you vet the qualifications of the people who load profiles onto Mable?

MR SCUTT: That's right. So we have a thorough vetting process as part of the on-boarding of workers on the platform. So they're all required to have police checks.

MR GRAY QC: I know about the police checks, but the qualifications?

MR SCUTT: Absolutely.

MR GRAY QC: So if a worker says "Look, I'm able to do enteral feeding", do you check they've been trained in that?

MR SCUTT: What our approach is, and that will help answer the question, is that different services on the platform require different qualifications that have to be evidenced. So if you're offering social support and domestic assistance, there's no specific qualification. If you're offering personal care, we need evidence of a cert III or a cert IV in an individual support or aged care or disability support or a similar

qualification. Within personal care, of high-risk services like assist with medication, we look for that specific module in your training which would be in a cert IV but not in a cert III. If you are offering nursing services around health, we require your AHPRA qualification, we will check the AHPRA database. So there's some really care screening around qualifications. And within each category that people are approved, they can offer a restricted set of services. So a personal care worker can offer a number of different services that is are available to be offered by the platform if they've evidenced their qualification. So, showering and dressing, toileting, assistance with medication.

For example, they can tick various services. If they do tick "Assist with medication", it triggers a further check that they can evidence that they've done those services. So I can provide you with more fulsome information about the services but if it gets into the sorts of services you're referring to, it's not going to be able to be provided by a personal care worker, it's going to be provided by a nurse, more than likely. It's a qualification that would fit within the nurses services that could be provided by the platform.

MR GRAY QC: Perhaps that's right, perhaps that's not. Perhaps it could be done under the supervision of a nurse. But we'll move on from that. Thank you for providing that information. Mr Versteege goes on, "Care staff who pass vetting by the broker are listed on the broker's online program. A package recipient selects the carer listed on the platform and informs their approved provider of their choice." He then says the package provider acts as a mailbox, receiving invoices and paying the invoices and the broker pays the staff who have their own ABNs and are independent contractors. Keeps their insurance up to date, et cetera.

He then specifically refers to Mable as an example of this model in his opinion, and he refers to Mable's charges, being 5% charged to the home care recipient and 10% to the care worker. Is that how it works or does that net out as 5% each or is it 10% from the worker and 5% from the carers?

MR SCUTT: So the workers and their clients agree rates directly for each engagement. So if they agree $40 an hour, we add a 5% consumer platform charge, $2 an hour, and we have a worker platform charge of 10% which is $4 an hour. So in that case ---

MR GRAY QC: So you're getting 15% of the agreed amount?

MR SCUTT: That's right. Or we're getting 14.3% of the amount the consumer pays, which is $42 in that example. So we're getting $6 on $42 which is 14.3%, is the actual fee that Mable ends up receiving in total.

MR GRAY QC: And you've constructed that model, have you, as a competitor of the administration charges that Home Care Package recipients are usually charged and it's competitive with that administration charge?

MR SCUTT: No, I think they're unrelated charges. So the administration charge is for administering the Home Care Package and making, you know --- all of the things that go into administration charge, Mable's fees are related to the connection via the platform and related really to more service delivery. So it would compare more to the traditional provider might charge $55 to $60 an hour to provide personal care and social support. If $40 is agreed between the platform, the total costs for delivering services is $42 and our fee is related to the delivery of those services. It obviously covers far more than what's being suggested here. It covers, you know, not only all of the screening activities, the actual building and maintaining of the platform, the insurances that the workers have the benefit of, but it covers things like access to our learning hub, where there's over 100 courses available freely, our whole incidents and complaints management process which is incredibly comprehensive. But there's a lot more involved ---

MR GRAY QC: Thank you. I will stop you there. I think you've probably gone beyond just answering my question, and thank you. Just to conclude, after making some points about whether there's, in effect, inconsistency or doubling up between the fact that a client is still paying an administration charge, if they are, to their provider, as well as the fees charged by Mable, I'll pass over those, and thank you for your information on that.

Mr Versteege's conclusion is that the involvement of brokers without approved provider status in administering the Home Care Package program should be banned in the interests of both consumers and care staff. The point, I think, is not only making --- he's not only making a point about the administration charges and the platform fees and whether there's, in effect, double up and unfairness to the consumer, I think he's also making a point that, as he puts it, there's a model here that takes the provision of Home Care Packages outside the aged care regulatory framework over which the Quality and Safety Commission has scrutiny. What's your response to that point, particularly that safety point?

MR SCUTT: I don't believe that we're operating outside aged care regulatory framework. The aged care regulatory framework still imposes the responsibility for care management and meeting the quality standards on the approved home care provider who is allowing their client to engage a team of people via the Mable platform and still has ongoing supervision and oversight and comfort around the people they're engaging. So in the spirit of consumer-directed care, it's actually a way of empowering consumers to have more choice and control, authentic choice and control. And in terms of the costs of those services, using Mable, you're doubling the hours of care and support, you're able to reduce your typical administration charges, which in our mind we're not charging an admin charge, our fees are in relation to the engagement of support and services, so essentially inherently part of the cost of engaging the service, not an administration of the package or the funding, that rests with the approved provider.

But the actual benefits of our model are quite profound, I think, to consumers and workers.

MR GRAY QC: Aren't there going to be people who have complex needs, the needs for integrated care of various kinds, which will involve the need for a team-based approach, perhaps an interdisciplinary team, careful coordination about the medications they're receiving, the allied health that they need, the mobility strategies that they might need, there might be a host of comorbidities that they're dealing with. Doesn't need of that kind require, firstly, a team-based approach, and secondly, a direct employment model where there's close supervision of the way care is being delivered? And I'm talking about home care package holders who might have needs of that kind.

MR SCUTT: No, and I certainly accept it's a team-based approach and I think one of the great things about Mable is it can accommodate a medical model and a psychosocial model. You can build the team around your specific needs of nurses and allied health people if you need them, along with a variety of other services. So one of the things that we really emphasise is to build a team tailored to your requirements. I think there are some consumers that are particularly vulnerable, you know, whether, as you point out, due to physical limitations or challenges communicating or just their social context and it may be that an approved provider employs the staff, may be a more suitable solution. But I also think, you know, consumers have a great capacity to make decisions about what's important to them in their life, particularly if there's a care manager standing beside them. The care management function becomes incredibly important to be able to make sure you assemble a team consistent with your needs, your assessed needs.

So I think whilst I think there's some merit in that, I would look at a platform and say there are people with complex disabilities on Mable that have a desire to manage their own team and with the support of family and support coordinators and advocates, they're able to do that effectively. Now that may not be the right approach for every person who is particularly vulnerable, so there needs to be different models available and in some cases Mable won't be the right model for certain people.

MR GRAY QC: I have no further questions, Commissioners.

COMMISSIONER PAGONE: Thank you, Mr Gray. Commissioner Briggs, do have you any questions you would like to ask?

COMMISSIONER BRIGGS: Just one. It's really about the mechanism for ongoing training, learning and development and if you were watching the session we had just before lunch, we were talking about the need for a significant transformation of the workforce to a genuinely person-centred model, but also the need to up-skill the workforce. So I'd like to hear how Mable goes around workforce learning and development and how you would see a future model operating to accommodate your needs for up-skilling the workforce?

MR SCUTT: Well, we are, thank you, Commissioner, we are absolute advocates of up-skilling the workforce. We do that on Mable through two main mechanisms.

One, the workers that are approved on Mable have access to our learning hub. There's over a hundred courses there with subject matter experts ranging from core essentials which could be safe at work or preventing and responding to violence, abuse and neglect, to the COVID-19 infection control training. So there's a bunch of courses available that we would think are quite core and essential. And then there's opportunities for up-skilling and development across subjects to do with dementia or autism or person-centred approaches. We are absolute advocates of person-centred approaches here at Mable and we've people that have spent 20 and 30 years advocating for that approach.

The second main avenue we have is we proactively work with the TAFEs and RTOs around training opportunities for the workforce on Mable, looking at where there are gaps. So, for example, we've recently worked with TAFE New South Wales around making 500 spots available for the new infection control skill set that's being developed. We're also having those conversations with TAFE in Victoria. We've also recently been able to recently offer workers on the platform an availability to start their cert III by undertaking the first four modules free of charge and then are able to complete it at a discounted rate. We've also offered through TAFE New South Wales 60 assist with medication opportunities that are fully subsidised. So we work very proactively with the TAFEs and RTOs.

One of the things that I think we've said in our submission is that, you know, whether people are choosing to work for themselves or they're employed, they need equal opportunities to access training and development opportunities. So, again, one of the core focuses could be to work much more closely in our mind with the VET sector, to actually look at where the workforce gaps are and make sure that the right training is being developed and certainly for us, person-centred is a really foundation skill, supported decision making. We run courses in that for workers on the platform in partnership with the New South Wales trustee and Guardian, and those are the foundation skills that we think all workers in the sector need.

COMMISSIONER BRIGGS: Thank you (inaudible) ---

MR SCUTT: Sorry, I didn't hear that.

COMMISSIONER PAGONE: Commissioner Briggs, I think we have a problem with the connection. We can't hear you very well. Mr Scutt, it looks to me as though the connection between you and Sydney seems clear enough. Can you hear me?

MR SCUTT: I can hear you very clearly, Commissioner.

COMMISSIONER PAGONE: It's the connection in Canberra that has gone down. We might just adjourn for just a minute or two whilst we try to remake that connection, Mr Scutt. Just don't disappear.

ADJOURNED **[3.53 PM]**

RESUMED **[4.02 PM]**

COMMISSIONER PAGONE: We will now resume. Mr Scutt, I'm sorry for that lengthy interruption to our service, to our broadcast. I just wanted to ask you a question about the matter that Mr Gray raised with you earlier on. You will recall that he asked you about our proposition, I say "our", his proposition HC6(b), about suitable employment and engagement arrangements, and that the response from Mable was described as "qualified support" and then there are some words on page 13 in which the qualified support is set out. The general model that Mable has can be described in all sorts of ways and I don't really want to engage in broad and largely incomplete and not wholly accurate descriptions. But it's essentially a model, as you've described, as allowing people to connect with each other, and I understand that. No one would think of regulating the White Pages just because you've got a list of plumbers that somebody can ring up from time to time.

But this isn't quite that, is it? And the Mable model does have terms and conditions with the various customers and the clients and one of the things that we could do is to recommend the regulation of platforms like yours so as to ensure that part of the terms and conditions of agreements that are entered into between the various participants pick up obligations so that, for example, the provider and the worker might effectively have the kinds of powers of direction and control that Mr Gray was talking about.

What I'd be interested to know from you is the extent to which your model is agnostic to that kind of regulation of you and the extent to which regulation of that kind makes your model unworkable?

MR SCUTT: Okay. So I think, you know, what is workable for us is that for workers offering services via the platform that the provider has some obligations around the screening processes that make sure those workers are suitable from, you know, police checks to reference checks, to certain qualification checks, the sorts of things that you would think any platform operating in this sector should do that's sensible. I think the only thing I'd probably like to consider is whether that changes the way our platform operates to the extent that we are agnostic as to consumers engaging workers via a contracting relationship or an employment relationship. I think I just need to think through whether it has any implications if we're agnostic as to whether the provider was to have a different sort of relationship with their workers on the platform. Something I'd like to give consideration to, Commissioner, if that's possible.

COMMISSIONER PAGONE: I understand. That's a fair answer to a question that you didn't have notice on. Yes, I think it would be useful to get an answer to questions like that. So some of the criticisms that are made of the Mable model are, from your point of view, some of the features that make the Mable model work more

smoothly and what I suppose I'm wondering about is whether one can have the cake and eat it at the same time, namely whether you can allow your platform to have the kind of connecting effect between workers and those acquiring the service, whilst at the same time having the providers being able to direct and control some of the provision in a way that blends both the overlying quality controls without necessarily making the model economically and/or administratively unworkable.

MR SCUTT: I appreciate the proposition. As the model operates today, there is overwhelmingly positive outcomes as reported by consumers and workers in engaging by a model that connects people directly. So I think avoiding --- you know, losing the power of that ability to form relationships locally around mutual choice, I think is really important for the future of the aged care sector.

COMMISSIONER PAGONE: I understand that, and what Mr Gray may say is that that's because we're very fortunate of having somebody like Mr Scutt running it. But if it's not Mr Scutt but somebody else, how can one make sure that the good things that Mr Scutt would like to have are the things that anybody else would bring to the table as well?

MR SCUTT: And I think in relation to that, having some, as we just discussed, some regulation around the sorts of things the platform might do to vet workers offering services via the platform are important, including things for us. We run a very comprehensive incidents and complaints management process. People can report in multiple ways, we investigate them, we track them, we report on them, we assess them for continuous improvement. It's the sort of things you'd expect a well-run platform to incorporate into their operation.

COMMISSIONER PAGONE: Anything arising from that? No. Thank you. Thank you, Mr Scutt, thank you for your very considered and detailed submissions, both in writing and for being available for our questions today. We are very grateful and we are better informed. So thank you.

MR SCUTT: Thank you very much for the opportunity.

COMMISSIONER PAGONE: I formally excuse you from further attendance.

MR SCUTT: Thank you.

THE WITNESS WITHDREW

MR GRAY QC: Time is getting on, however we do have another witness we'd like to call. He's an overseas witness so we would like to accommodate him now. I call Professor Dr Jos Schols of the Netherlands.

PROFESSOR JOS SCHOLS, CALLED

COMMISSIONER PAGONE: There's Mr Schols.

MR GRAY QC: Professor Schols, can you hear us?

PROFESSOR SCHOLS: Yes, I can hear you.

MR GRAY QC: Apologies for keeping you waiting and thank you for your attendance. The next voice you will hear is the associate. I withdraw that. The next voice you hear will be me.

Commissioners, I have an application to make that Professor Schols not be required to give an oath or an affirmation before giving his evidence. That's because I have concerns that that may involve notification requirements under such things as The Hague Evidence Convention, given that Professor Schols is over in the Netherlands. It's a question of some uncertainty and difficulty and I'd prefer to avoid the risk of triggering notification requirements.

COMMISSIONER PAGONE: Yes, thank you, Mr Gray. I think in the circumstances we won't require Professor Schols to swear an oath or make an affirmation.

Professor Schols, it may be a matter of some bewilderment to you, all this. The oath or the affirmation is usually administered on the basis of a formal invocation of some higher order that you will tell the truth. We'll now be left to your own good judgment to do so. Thank you.

EXAMINATION BY MR GRAY QC

MR GRAY QC: Professor, what is your full name?

PROFESSOR SCHOLS: My name is Jos Schols.

MR GRAY QC: Thank you. And are you a Professor of Old Age Medicine, is that the correct description?

PROFESSOR SCHOLS: Yes, that's correct. At Maastricht University.

MR GRAY QC: Thank you. And what is your expertise and experience in the long-term care of older people in the Netherlands?

PROFESSOR SCHOLS: I am a Community Chair Attrition and Nursing Home Physician since 1987. I've worked in long-term care since 1987 and since 2004 in

research related to old age medicine and chronic care at Maastricht University where I have the Chair in Old Aged Medicine.

MR GRAY QC: Thank you, Professor. I'm going to ask you a series of questions and I do ask that you indicate to the Commissioners to the best of your knowledge and belief what the true and correct answers are, and if you don't know, please do say so.

In summary form, what types of publically-funded support and long-term care services are available for older people in the Netherlands and, Professor, if you wish to respond by referring to the three key legislative pillars of the Social Support Act, the National Health Care Insurance Act and the Chronic Care Act, please give a summary under each?

PROFESSOR SCHOLS: There are three laws related to home care and long-term institutional care where people who need social support can apply to the Social Support Act, for which they have to go to the municipality and the municipality can offer them standard services or customised services. Standard services, for instance, are facilities for social contact, for Meals on Wheels service. Customised services are, for instance, domestic help to clean the house, means to adapt the house to your disabilities, and possibilities to get wheelchairs or customised day activity programs. People who need nursing care at home can apply to the Health Care Insurance Act and this will enable them to get personal care or nursing care at home and the Health Care Insurance Act also provides the care provided by a general practitioner, a physiotherapist in the community and also hospital services.

People who need 24-hour residential care, so care in a care home, can apply to the Chronic Care Act and the Chronic Care Act base their stay and their care they get in these care homes. It's important to know that all three Acts, the services you get from all three Acts, can be provided in kind, or you can, in all three Acts, get a personal budget. I checked that extra this weekend with an insurer to know if this is right. So all three can also be --- provide you a personal budget.

MR GRAY QC: Thank you. And that personal budget can be spent at the discretion of the person receiving the care, provided it is on services that meet the legislative descriptions, is that a correct assumption?

PROFESSOR SCHOLS: Yes, yes, that's correct.

MR GRAY QC: Some slides had been prepared from OECD data which I'll now ask the operator to display. They are at tab 86 of the general tender bundle, please, operator. While they're coming up, I will just ask you, Professor, what is the distinctive mixture of different types of long-term care in the Netherlands when compared to other developed countries? And if you could answer by reference to institutional or residential care on the one hand, and care at the home on the other, what is the distinctive feature of care in the Netherlands and its history?

PROFESSOR SCHOLS: If I'm honest, I can mainly compare the Netherlands with other European countries and in Europe, we have three models of care. The Netherlands has the Scandinavian care model, a Scandinavian care model, which means there is an intensive care services at homes and in institutions. You also have the Continental model, for instance executed in France, with almost the same amount of formal and informal care, and you have the Mediterranean model, for instance, in Spain and Italy, with mostly informal care and less developed formal care services. So the Netherlands can be characterised by the fact that there is intensive professional care at home and also in institutions.

MR GRAY QC: How does the mix --- I'm sorry?

PROFESSOR SCHOLS: That also means that we spend a lot of money to these long-term care services.

MR GRAY QC: Thank you. And if we just look at the graph on the right-hand side and, operator, if you could expand that for people viewing the web-stream, "Care in Institutions", on that graph we also have Australia in green, Netherlands in orange and the OECD average in red. Is this graph depicting that the Netherlands' percentage of long-term care recipients by proportion to population is actually reasonably high, above the OECD average, but not as high as Australia?

PROFESSOR SCHOLS: Yes, but it was even higher in --- before 2015. These are data from 2020. Before 2015, when the long-term care reforms started, we were at a level of, say, 7 to 7.5%. So before 2015, we were at the same level as Australia regarding care in institutions. But now we are downsizing, downgrading the level of care in institutions to come to the European mean of around 3 to 4. So in the next --- in the coming years we will even go more to the OECD mean level.

MR GRAY QC: So, Professor, just in summary form, why did the Netherlands decide to change direction and reduce the percentage of people who are cared for in institutions and how has that been achieved? If you could answer those two questions together?

PROFESSOR SCHOLS: Yes. The reasons is that it was too expensive and healthcare, we are very worried that we can't pay our healthcare services in the future so that's why we started to downsize the care in institutions. It also fits in the preferences of older people themselves who want to age in place as long as possible. And how did we try to achieve it? We have tried to achieve it by making a long-term care reform and changing the laws. Before 2015, we didn't --- we only had Healthcare Insurance Act and we only had the Exceptional Medical Expenses Act and after 2015, the Exceptional Medical Expenses Act was divided into the Social Support Act and the Chronic Care Act and the Social Support Act was not paid anymore via the healthcare funds and that means a reduction in healthcare funds.

MR GRAY QC: So in terms of describing the practical effect of those legislative changes, what changes to funding were made or to other incentives were made that

has reduced the number of people in institutions and has that led to more support for them at home?

PROFESSOR SCHOLS: Yes. When you want to decrease the number of people in institutes, of course you have to take care of the fact that you empower the informal care at home and also the formal care at home. So extra efforts were made to empower informal care at home via support of the Social Support Act and also to lead to more professional care at home. And how did we decrease actually the number of care in institutions? By making it more difficult to get an indication for residential care. And nowadays you only see people with very complex problems who get care in institutions.

MR GRAY QC: Thank you. And just taking one of the aspects of supporting people at home, which was providing them with, I can't remember the exact word you used, but higher levels of care, so separate from the support of informal care and focusing on the direct funded care that people receive at home, has there been more funding put into caring for people with complex needs at home?

PROFESSOR SCHOLS: Yes, yes. When the Exceptional Medical Expenses Act was changed into the Social Support Act and the Chronic Care Act, also part of the amount of money which was in the budget of that original law was skipped to the Healthcare Insurance Act by which it was able to provide more care at home.

MR GRAY QC: Now, under the Chronic Care Act, if a person is indicated after their needs assessment for care in an institution, residential long-term care, but they choose to remain at home, is it true that they can take the funding that would have been provided for their care component in a residential care facility and spend it as a package at home?

PROFESSOR SCHOLS: Yes, that's --- I can only say yes because that's the truth, yes. But you have people with very complex needs who want to stay at home while they maybe should be better off in an institute and they can stay at home until the maximum of the care package which would be paid for in the institute. So if it's even more expensive to stay at home and even more care is needed and more money is needed, then they actually have to go to an institute. So it's right what you're saying.

MR GRAY QC: And how is that working? Is that part of the suite of reforms that have had the effect of reducing the percentage of people who are in institutional care?

PROFESSOR SCHOLS: That's working because there isn't --- in terms of contact between the providers and the client and his or her family at home, and there is a lot of efforts been made to further improve the concept of shared decision-making, so there is a constant --- and that is possible because the care is regulated via care plans. So if you provide care via a care plan and you see that the care is getting complexer and complexer, during the regular evaluations, you discuss with the client and his family whether it's still possible to get the care at home or not and normally in a

rational way, this always gets to the right solution. Sometimes there are some problems if you talk about people who are cognitively disabled because they do not always understand evaluations, and then you have to take some other measures together with their families.

MR GRAY QC: Thank you. And does that involve, say, the appointment of a guardian to make decisions for the person?

PROFESSOR SCHOLS: Yes. Yes, yes.

MR GRAY QC: Now, could we just ask a few questions of you concerning the detail of assessment and funding under the three different legislative ---

PROFESSOR SCHOLS: That's possible, yes.

MR GRAY QC: So, firstly, supports under the Social Supports Act, you said that this is supports administered by municipalities. Does the funding of those supports provided by municipalities come from social insurance, taxation or something else?

PROFESSOR SCHOLS: The implementation of the Social Support Act is financed from tax money and personal contributions. The Government manages this money and distributes this money to the municipality through a Special Municipal Fund. So it's a special fund developed for the municipalities and it's not a fund belonging to the healthcare funds. The distribution of money mainly looks at the composition of the population in a specific municipality and to other characteristics such as the number of inhabitants, the number of old people, the number --- of the average income of people, et cetera, et cetera. So the Government gives every municipality, according to some characteristics, money from this municipality fund, and from that, the municipalities pay the activities from the Social Support Act.

MR GRAY QC: Now, this next question, I don't know whether I should ask it specifically only about the Social Supports Act or whether it might also be relevant to the other two Acts, but I will ask it anyway. How is the assessment of a person's need for social support made and if it's made in a process which also involves assessment of whether care under the National Healthcare Insurance Act and possibly care under the Chronic Care Act is also required at the same time, please do tell us?

PROFESSOR SCHOLS: Thank you for this question. There are some differences. So I will try to be as short as possible. A request for care under the Social Support Act can be made at the social support booth of the municipality. Thereafter, a representative of the municipality, who is also part of the district social care team, visits a client at home and assesses, together with the client, which care is necessary in addition to the informal care which is already present. And after agreement, that assessment is the basis for the care indication to get the actual supports. Do I need to tell it also for the other three Acts, or do you want to wait with that?

MR GRAY QC: I'll ask about those in just a minute when I come to them.

PROFESSOR SCHOLS: Sorry, sorry.

MR GRAY QC: Thank you. So it is a separate assessment and it also involves generating a plan with that municipal official?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Thank you. Now, is there any need for monitoring the safety of the services that are provided or their quality, or is that something that is only done for personal care services and nursing services and similar things? So we're just talking about social support still?

PROFESSOR SCHOLS: Yes. The care offered via the Social Support Act is done by providers that have been contracted by the municipality and they have to stick to service delivery and quality agreements which are made nationally. So they must work according to national regulations and care quality, they must have an intrinsic quality system that is checked by external auditors or municipality judgments every year.

MR GRAY QC: Thank you. Now, at the start of your evidence, or at the start of this session, you mentioned that all three kinds of care can be taken as a package, at a budget, I think you said, at the option of the care recipient or the support recipient. So with respect to social support which is provided by direct contract between the municipality and a particular provider who has an agreement with the municipality, how does that budget work? Does the client get to choose between different providers or ---

PROFESSOR SCHOLS: The client can choose --- when the client has a personal budget, he or she can choose a provider him or herself. But if the municipality, for instance, has a contract, a major contract with one of the larger providers in the municipality, then the client gets the service from that provider and the municipality will say to the client, "It's this or that provider who will come to your home to provide the services". And then they get the service in kind.

MR GRAY QC: Thank you.

PROFESSOR SCHOLS: It's always the municipality who determines that in case of no personal budget.

MR GRAY QC: Thank you. And where there is a budget, then the person has a choice to purchase those services from someone else, is that right?

PROFESSOR SCHOLS: Yes. But then he also has to choose out of a range of providers who are accepted by the municipality.

MR GRAY QC: Thank you.

PROFESSOR SCHOLS: So it must be providers who fit into the national regulations and it cannot be an arbitrary provider.

MR GRAY QC: Thank you very much. I will now ask about care in the home which you've previously described to me as home care. This is the Dutch equivalent of home care. We also have --- we have quite a technical expression for home care, but in the Netherlands, is home care the proper description of care that's provided under the National Healthcare Insurance Act to older people in their homes?

PROFESSOR SCHOLS: Yes, and then in 99% of the cases it's district nursing care, yes. It's personal nursing care people get via this law.

MR GRAY QC: And is it correct to say that there are a number of gradations of nurses, beginning with assistants who are, in effect, just providing personal care without any clinical element?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Going right up to highly clinically-specialised nurses?

PROFESSOR SCHOLS: Yes. I can shortly summarise it by when someone --- when a client at home receives nursing care at home via this law, the indication for this service is made by the district nurse and the district nurse is a highly-educated nurse who is the leader of a team of nurses from different educational levels starting with assistants and going up to higher educated nurses executing more difficult tasks, for instance, related to wound care or medication services, et cetera, et cetera.

MR GRAY QC: Now, Professor, is this the Buurtzorg model? Is it the nurse-led model? How is this different from the Buurtzorg model? Is the Buurtzorg model a special version of this kind of care?

PROFESSOR SCHOLS: I will try to tell it shortly. If you want to know more, first, if you want to know more about Buurtzorg, really contact --- you have to contact Jos de Blok, the CEO of Buurtzorg because he developed his model and he knows everything about that. Why did he develop this? He developed this because traditional home care services, in traditional home care services, the teams led by district nurses are part of large organisations with a lot of bureaucracy and they do not have a lot of self-steering power and Jos de Blok was the person who said "I want these teams really work together with clients and their families and I want them give more responsibility, more self-steering abilities and they must not suffer from all these large organisations, all these managerial layers in these organisations which keep them from their own work."

So the issue is that in the traditional home care services, you have these teams led by a district nurse and in the model of Jos de Blok, Buurtzorg model, but in the model of

Jos de Blok, they have more self-steering abilities and possibilities than in the traditional services.

MR GRAY QC: Thank you. Just to be clear, the title "district nurse", it doesn't necessarily mean that they're in charge of a district, I understand?

PROFESSOR SCHOLS: No.

MR GRAY QC: It's a top tier of nurse?

PROFESSOR SCHOLS: We call this, we call this nursing services provided via the Health Care Insurance Act, we call this district nursing because they always work in a certain part of the city and municipality but it's not the --- I think the meaning you give to the word "district", I think this is much larger, but we call this district nursing and we have stolen this name from the UK. It's not the right word to use in a hearing, but we use this because in the literature, the English literature, it's always referred to as district nursing.

MR GRAY QC: Thank you. Now, the funding arrangements for care under the National Healthcare Insurance Act, is that funding financed by social insurance?

PROFESSOR SCHOLS: No, no. National Healthcare Insurance Act is executed by healthcare insurers and they have budget agreements with individual providers, healthcare organisations. It's financed by healthcare funds from the Government, not by social care funds, and nationally, the healthcare insurers receive their money from the Government based on the actual number of clients and some other parameters they provide. And every citizen in our country pays an income-related premium related to the Healthcare Insurance Act and if they actually receive care, there is also an own contribution for both care related to the Healthcare Insurance Act and ---

MR GRAY QC: Thank you. So when I use the expression "social insurance", if I take away the word "social" and I replace that with "compulsory government-managed insurance", is that financed by compulsory government-managed insurance?

PROFESSOR SCHOLS: Yes, yes, that's right.

MR GRAY QC: Thank you. And let's ask now about assessment of need for home care under the National Healthcare Insurance Act. Is that done by the district nurse or by people under the supervision of the district nurse?

PROFESSOR SCHOLS: It's done by the district nurse who determines the care indication and the extent of care which is needed and there is a strong contact between the district nurse and the general practitioner. It's often the general practitioner who advises the family to seek for home care services via this Act because he or she sees that there are problems in the home situation and that nursing care is needed.

MR GRAY QC: So the district nurse is both managing the team that provides the home care and doing the assessment?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Who are these nurses employed by?

PROFESSOR SCHOLS: The district nurses are employed by the providers themselves.

MR GRAY QC: And who appoints the providers?

PROFESSOR SCHOLS: Now, the providers are organisations by themselves. So, for instance, the organisation of Jos de Blok or a traditional home care organisation employs district nurses and they have this task to do.

MR GRAY QC: And can a particular person seeking care, home care under the National Healthcare Insurance Act, choose their provider?

PROFESSOR SCHOLS: They can choose their provider, yes, indeed. But, of course, again, it is important that the providers are providers which have been contracted by the healthcare insurer. So if --- because the healthcare insurer is executing the Healthcare Insurance Act and they contract the providers, but if in a community or in a municipality or city, there are four providers contracted by the healthcare insurer, the client may choose his or her own provider he or she wants to get care from.

MR GRAY QC: Thank you. And I should know this, but how many healthcare insurers are there? Are there many or just one?

PROFESSOR SCHOLS: No, no, no, I think --- I don't know the exact number, but I can look that up later, but I think there are at least 10 to 15 in the Netherlands. Yes.

MR GRAY QC: And so this is a model whereby there's a compulsory premium related to income, and it's made compulsory by Government and the insurance is managed by private insurance providers, is that right?

PROFESSOR SCHOLS: Yes, yes.

MR GRAY QC: Thank you. Now, what about the regulation --- sorry, I should just ask. Yes. The monitoring and regulation of the quality of the home care that's provided, how is that done and who does it?

PROFESSOR SCHOLS: Counsel, there is a national quality framework on district nursing which applies for all providers of district nursing. The healthcare inspectorate in the Netherlands is monitoring the care provided by the home care

services and in addition to that, the care insurers who contract the care providers, who provide home care, they may ask additional parameters, but mostly they try to tune that with the healthcare inspectorate. But the healthcare inspectorate actually knows what's happening on the level of the client.

MR GRAY QC: How is the funding level determined by the insurer? Is that linked to the assessment of need by the district nurse?

PROFESSOR SCHOLS: The insurer always looks to historical data from the provider and the amount of budget a provider gets depends on the number of clients he or --- the provider has, and the mix of care complexity which is provided by the care providers. So small care providers get less money than the larger care providers, but that is logical.

MR GRAY QC: And turning now to the Chronic Care Act, is that insurance-based or is that funded through taxation?

PROFESSOR SCHOLS: The Healthcare Insurance Act is paid via a special law, the Chronic Care Act --- sorry, sorry, I'm making a mistake. The funding by the Chronic Care Act is a separate funding and provided by the Government and every citizen also pays a monthly premium in --- based on their wages to pay for the Chronic Care Act. So they have a monthly premium for the Healthcare Insurance Act, but also a monthly premium for the Chronic Care Act and the Chronic Care Act is executed by specific officers of the regional care insurers, we call them the administration officers, and they get their money via the Government also based on regional characteristics, the number of clients they have to take care for and development in the past, and the care insurers, these administration officers, only contract acknowledged providers and the clients, what I say, next to their premium they pay during their labour periods, their labour period in their times until they get retired, they pay also an income dependence own contribution when they get the service. So I hope this is clear or do I have to tell it again because it was a little bit disturbing in the beginning?

MR GRAY QC: No, it was very clear. It was very clear, thank you, Professor. You were talking about the funding arrangements under the Chronic Care Act and how the funds are financed, and it's essentially similar to the National Healthcare Insurance Act in that there are insurance arrangements.

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Through compulsory premiums paid by people during their working lives?

PROFESSOR SCHOLS: Yes, yes, yes.

MR GRAY QC: Now, my next question is how are those premiums determined? Are they uniform across the country? Do they depend on the chosen insurance

provider? And are they calculated by some actuarial method?

PROFESSOR SCHOLS: Care under the Chronic Care Act is provided by care packages. There are 10 care packages, so --- and I will try to explain this shortly. If a care home provides care to clients, these clients get a care package. For instance, care package five is the package for people who need dementia services and care package six is for people who need physical care in the care home, and, for instance, care package 10 is needed for people who mainly come to the care home for palliative care.

Now, every care package has --- an organisation gets an amount of money for every care package but this differs because the lower care packages are not so expensive than the more complex, the higher care packages. So care package 10, an organisation gets more money for care package 10 than for care package four, for instance. And how do organisations get their overall budget for this law? That is because the administration office of the insurer can look to the developments in the past in how the mix of care packages is present for this provider.

And most care packages are related to five and six, dementia care or physical care, and the more complex care packages are always lower in number and depending on the number of clients who get care package five and six, there, the main budget is on --- be determined.

MR GRAY QC: Thank you. So that was very useful information about the funding levels or packages, to use your expression, is that the Dutch word that's used? Is it "package"?

PROFESSOR SCHOLS: We use --- yes, we call it “zorgzwaartepakket” care package, yes, we call it “care package”.

MR GRAY QC: And they are, in a sense, 10 different levels of funding and the overall funding by the insurer of the organisation depends on the case mix, or the mixture ---

PROFESSOR SCHOLS: Yes, yes.

MR GRAY QC: -- of levels across the population who reside in that organisation's facilities?

PROFESSOR SCHOLS: Sorry. When this first started, you always have to look to developments but nowadays insurers can really see that there is a --- there's a balance in the mix because when an organisation has 500 beds for dementia patients or 500 beds for people who need physical care, the insurer office knows that they need 500 times care package five and 500 times care package six and they are the main care packages who are provided.

MR GRAY QC: And the care package also describes a bundle or a group of services

that are needed to meet certain levels of need, by the sounds of it, or certain kinds of need, for example, dementia care?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Thank you. That was very clear. Could I go back and ask a question on an earlier topic, the financing?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Under the two Acts, National Healthcare Insurance Act and Chronic Care Act that involve compulsory premiums, compulsory premiums are levied on people during their working lives to help finance those two Acts. How are the premiums determined?

PROFESSOR SCHOLS: They are determined by the Government.

MR GRAY QC: Is it one premium across the whole country for every ---

PROFESSOR SCHOLS: Yes, yes, yes. It's one premium for everyone and ---

MR GRAY QC: Depending on income?

PROFESSOR SCHOLS: Yes --- no, it's one premium --- it's one --- now, the premium is a percentage of someone's income and the percentage is nationally determined so if someone earns a lot of money, they actually have to pay more than someone who has to pay --- or who earns less. But these percentages are determined by the Government for both the Healthcare Insurance Act and the Chronic Care Act.

MR GRAY QC: And do you know, Professor, these are questions without notice, forgive me, does that premium, does the collection of those premiums fully fund the requirements under those two Acts or do they have to be topped up by taxation revenues?

PROFESSOR SCHOLS: I think this is very important question because you see, in general, and in many countries, that the costs for healthcare, they grow every year. So mostly they have to be topped up, yes. May I shortly repeat one thing? These premiums are paid during the work life, but when people actually get the care, later, they also have to pay an own contribution. But that's when they get the care, and that own contribution, in addition to the premium they have paid during their work life, is also depending on the income they have after their pension.

MR GRAY QC: Thank you. In the Netherlands, do you know what, roughly speaking, is the --- I don't know, the percentage or proportion of people who choose to take their care as a budget rather than in kind?

PROFESSOR SCHOLS: I do not know it exactly. But I think I have to say only that

very --- the most care is still offered in kind. And that's --- I can honestly say between 85 and 90% is offered in kind. But I think in the future, personal budget will grow in number and what you see especially in the Netherlands is that especially younger people who read them in very well into the services that are possible, especially the younger people who need chronic care, use more the services via a personal budget than the older people aged 70 and above.

MR GRAY QC: Are you able to answer this? If it's too speculative just tell me. But do you have an impression as to whether the provision of the care in kind is really best suited to being met by organisations that directly employ all their care workers and their nurses?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: And --- it is?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: It is better to be directly employed?

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Why is that? Is that because of the need for supervision, training? What is it?

PROFESSOR SCHOLS: When you see it positively, you can say it's because they have more inference on the quality control, the supervision, et cetera, but you also can say it's a little bit negative but I always go out from the best in people, is that if you see it negatively it's because these providers have to give up their organisations. So when they get to service in kind, they are more sure about the money they get every year.

MR GRAY QC: Yes. And on the other side of the coin, if it's an individual budget, even if that's only 10 or 15% of cases or around 10% of cases, is it less important that the care be provided by organisations that directly employ their staff? Is there more room for independent contracting or is that just not a feature of the Dutch landscape?

PROFESSOR SCHOLS: The issue is that there is more room for independent contracting and that's why during the years in which we have experienced this personal budget, there were some quality issues raised because when the care is provided by a contractor who actually fits to the national regulations, then they are supervised by the healthcare inspectorate. They were also contractors, independently contracted, which did not actually fulfil all regulations and then it's --- you sometimes see quality issues raised later in time and that has been an issue and we are working on it, to actually take care of the fact that even when someone has a personal budget, he or she should contract a provider which has been contracted by the insurer.

MR GRAY QC: Thank you. Now, I want to ask you, in the time we have left, a couple of detailed questions about the regime for monitoring quality and safety by the National Healthcare Inspectorate, in particular, but if you want to tell us about the other methods of monitoring involving the use of accredited auditors, then please do that as well. What are the main tools that are available to the inspectorate and to the auditors? Are there quality indicators in widespread use in the different forms of support, home care, and chronic care when used in the home?

PROFESSOR SCHOLS: Yes, and I think this is more general for all types of care, so that makes it a little bit easy. But every organisation that is contracted to provide home care or institutional care is obliged to have an intrinsic quality system which is audited by an external organisation every year. This intrinsic system makes clear how you have organised your services, how you checked them, how you do your quality controls, et cetera, et cetera. Next to that, organisations having such an intrinsic quality system which is audited by this external organisations, they have to provide quality indicators to the National Healthcare Institute and these quality indicators provided to the National Healthcare Institute, who assembles all these quality indicators from the different institutes or organisations, can be checked or looked in by the healthcare inspectorate. For home care, there are two types --- there are three types of indicators at this moment. For home care, we have the net promotor score of clients. The net promotor score is a score in which clients and their representatives judge, via a figure, how they assess the quality of the provider. Figure one is very low, figure 10 is very high.

There's also --- these organisations also must provide an indicator which shows how active they are to improve this net --- national net promotor score and they have provide an indicator which accesses the extent to which client data are systematically and automatically registered in the right way. So if you provide care at home, do you gather the data you need to provide tailored care to the client? This is for home care organisations. If you look to institutional care organisations, you mean care homes, they also have to provide the net promotor score, they also have to provide data on safety indicators for clients, for instance, the prevalence of pressure ulcers, the prevalence of malnutrition, the use of restraints, an indicator on medication safety and on advanced care directives. And at this moment, we are developing for both sectors, the home care sector and the institutional care sector. We also develop qualitative instruments which use a narrative approach to assess the client experiences related to, respectively, home care and institutional care.

MR GRAY QC: Thank you.

PROFESSOR SCHOLS: Every year ---

MR GRAY QC: Sorry.

PROFESSOR SCHOLS: Yes, every year the healthcare inspectorate and the insurer visit the organisation, the home care organisation, and the care home. They can use

the data from the National Healthcare Institute to get an overview on how this organisation is performing, better or worse than the mean, better or worse than other organisations in the region, and they can visit these organisations, talk with the director, talk with professional, talk with clients, talk with family, to get an overall view on how the institution or organisation is performing, and the healthcare inspectorate finally makes a report of every visit they make with the recommendation to improve care at different points they see which are not sufficient enough.

MR GRAY QC: And you said "every year". Is that the same for every provider, irrespective of how good or bad their performance has been in the past?

PROFESSOR SCHOLS: I have to be honest, it's meant to be done every year. The insurer every year visits, that's true. The healthcare inspectorate wants to do that every year, but if we look to daily practice, they mostly visit an organisation once or two or three years because they have personnel --- they don't have enough inspectors to do that in every organisation in the country. But in fact they aim to do it every year. At least they look every year to the data provided by the organisation and if they see something which is not going good in the data, then they actually will come. But mostly the health inspectorate does it once every two or three years.

MR GRAY QC: Now, you said in home care there's those three indicators, two of them around the net promotor score or activity to improve it. And there aren't any objective clinical care indicators that are applied in home care. That's home care provided under the National Healthcare Insurance Act, correct, Professor?

PROFESSOR SCHOLS: That's correct, at this moment. In the past there were some indicators, but nowadays we only have safety or clinical data related to institutional care, but I know that in the near future, also in home care, some of these clinical indicators will be used again.

MR GRAY QC: Why is that so?

PROFESSOR SCHOLS: Shortly, in addition to my information, is that it was reduced because of the reforms in home care and the Government and the healthcare inspectorate wanted to reduce the bureaucracy for district nurses and other nurses in home care because we have a lot of problems to get enough staff working and that's why they wanted to reduce the bureaucracy and that's why they didn't oblige any more to have also these clinical indicators. But they will come back in the future.

MR GRAY QC: If we go to the slides that the operator showed us before, and if we go now to slide 5, which is page 0005, please, operator? We see that for home care, which is the figures along the top half of the page, we see that there's home care recipients in each year aged 65 or over, and there's a series of years starting in 2005 going through to 2018. And in 2015 there's quite a large drop in the numbers of people receiving home care who are aged 65 or over.

PROFESSOR SCHOLS: Yes.

MR GRAY QC: The figures go from about 380,000 to 260,000.

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Now, this was also happening --- that downward trend was also happening in institutional care.

PROFESSOR SCHOLS: Yes.

MR GRAY QC: Is that part of the reforms, the reform process you were talking about?

PROFESSOR SCHOLS: Yes, I think this is a very nice slide because it clearly shows what happened since 2015 when the Chronic Care Act came into force and the Social Support Act, and the care provided by the Social Support Act is not shown in this slide because it is not provided via healthcare funds, and that's the reason. And you really ---

MR GRAY QC: Thank you. So --

PROFESSOR SCHOLS: Okay, then I stop.

MR GRAY QC: So, in short, while it looks like over 120,000 people have disappeared, they haven't disappeared, they've been moved onto support by the Social Support Act?

PROFESSOR SCHOLS: Yes. That's correct.

MR GRAY QC: And indeed, there's probably more than that being cared for because there's been a drop in the number of people in institutional care and they're probably being cared for by home care at about this time, from about this time?

PROFESSOR SCHOLS: Yes, since 2015 also the number of institutional care clients dropped. What I explained to you already, because there was a focus on ageing in place, and the people who stay longer at home, they get services from either via the Social Support Act or the National Healthcare Insurance Act.

MR GRAY QC: Thank you. With respect to the quality indicators, in 2015 those safety and clinical indicators in home care were taken away, were disappeared, but now there's a proposal to bring them back. Is that because, what, there's been a consensus of expert opinion that in fact they are a good idea to have them in home care after all?

PROFESSOR SCHOLS: Yes, let me be clear. In the Netherlands, most care offered at home and care in institutions is offered by organisations who have home care services and care homes. For instance, I am working in Maastricht for 1.5 days still,

in a large chronic care organisation who has a very large part of its services provided by district nursing and also has 15 care homes. And what we tried to do --- the problem of the current services is that they are good of quality, but they are rather fragmented. So home care is organised via the Healthcare Insurance Act, nursing home care is offered via the Chronic Care Act, and what we want to strive for in the future is to get more integrated care. So what we know is that an organisation which provides home care, and nursing home care, knows the client already when he gets home care, and when a client is admitted to the nursing home within the same organisation, in fact you should achieve more continuity of care which also means that you should look to quality more in continuity and not fragmented.

But the issue is why the clinical parameters stopped in home care is that we started in 1998 with only one clinical parameter in care homes and in home care which was the prevalence of pressure ulcers, which is a very major problem in chronic patients. But, thereafter, there was an intensive growth of parameters; malnutrition, restraints, continence, et cetera, et cetera, et cetera, and that's why we said when this quality framework started, we stopped with all these clinical parameters and tried to choose, together with the clients, together with the families, and together with the organisations and the professionals, in the future the new clinical parameters we actually need.

In nursing homes, we had 12 to 20 parameters and now we only have five of these clinical parameters, I mentioned them already. But the quality framework of nursing homes was established earlier than the quality framework of district nursing. The quality framework of district nursing came into force two years ago and now we are developing gradually also new clinical indicators, but with the aim to have a low number of that, not too many, because people are really complaining about the bureaucracy, where they have to provide so many figures to the National Healthcare Institute.

MR GRAY QC: I will ask the operator to display tab 62. This document is a list of potential home care indicators that could be collected from existing Australian administrative data, Professor, and in a home care context. If we go to page 0312, we see the beginning of the list. And, operator, if you could call out just the base of 0313 as well and display them together, we'll get the entire list. I repeat, these are just potential candidates for quality indicators in home care in Australia, these are not currently being collected in home care in Australia.

Professor, do you know what is the progress of the thinking about the development of quality indicators for home care in the Netherlands again, which clinical indicators are considered to be appropriate for reinstatement as quality indicators for home care in the Netherlands?

PROFESSOR SCHOLS: In the Netherlands, we are also very interested in the use of multiple drugs, so polypharmacy. We are very interested in the use of psychotropic drugs which means high sedative drugs, or anti-psychotic drugs. We are very interested already before we had suffered the COVID pandemic in the use of

antibiotics, so in the use of --- in the way infections are treated, and we are very interested in falls. When I used these ones, yes?

MR GRAY QC: Thank you.

PROFESSOR SCHOLS: But you can look to outcome parameters or you can look to process parameters. If we look to polypharmacy and look to, for instance, advanced care planning, we are also experimenting nowadays more and more with indicators which look to the process of care. For instance, the use of medication reviews is also a parameter we are testing at the moment because you can look to how many patients use 29 drugs or more, but then you still do not know the process how this is managed. If a patient has many drugs, it's important to know whether the medication is regularly reviewed.

That's why we are now also experimenting with process indicators and the same goes, for instance, for advanced care directives. You can look to the number of patients who have an advanced care directive, but you can also look to the process. Are there regular meetings with the client and his or her family to talk about proactive care planning?

MR GRAY QC: A couple of further questions, Professor. If a person has been assessed as indicated for help under the Chronic Care Act, so that they could go into a care institution, but they choose to remain at home, do the quality indicator regime --- do the quality indicators get collected for them at home, do you know?

PROFESSOR SCHOLS: Yes, because --- I have to be clear about that. When a person is indicated to get care in a care home, but he chooses that he wants to get the same care package at home, then it's mostly the organisation who provides the care home services who also provides the care in the home situation and then this care falls under the Chronic Care Act, and then the same indicators apply for people who are admitted to a care home.

MR GRAY QC: Thank you. You mentioned that the quality indicator data goes to the National Healthcare Institute. Is that a repository of these data and other healthcare-related data?

PROFESSOR SCHOLS: Yes, yes. Yes, and ---

MR GRAY QC: Is it made available to the public? Is the public able to see how a particular provider performs on these metrics?

PROFESSOR SCHOLS: Until 2018, 2018, so two years ago, the clinical data were mostly assessed by independent institutions, for instance, our university does already for many years research on safety indicators and then we make the national reports. Until 2018, also the healthcare insurers make national reports about the day-to-day data, but since 2018, since these data go to the National Healthcare Institute, they are --- this is a repository and the National Healthcare Institute makes national reports

and in the future national dashboards which you can compare organisations in the country very fast, so mostly digitally.

But and they have to start with that activity still and they would have start with it in this year but because of the COVID pandemic, this has been delayed.

MR GRAY QC: And will this be the new form of performance rating of providers? I understand that the Netherlands has moved away from an index that used to be published?

PROFESSOR SCHOLS: Yes. Now --

MR GRAY QC: Is this going to be the new form of performance rating by which the public can judge between providers?

PROFESSOR SCHOLS: Yes, yes, yes. But there are more developments because you can judge a provider only on clinical data, you can judge a provider only on qualitative data, and you can judge a provider on how he's performing financially. We are now thinking about developing new types of looking to quality of care, new dashboards, which show how a provider is performing on clinical data, on safety data, how he's performing from the judgment of clients and families, how he or she is performing on the judgment of its personnel, for instance, what's the number of --- what's the percentage of sick leave, how do healthcare staff experience the care they provide, and on financial data.

So we are now gradually thinking of the development of a more comprehensive way of looking to quality of care. Because, for instance, a short example, if you have an institute which is very medically orientated, if you have a care home which is very medically orientated and they provide perfect pressure ulcer care, maybe this institute is not performing well if you look to daily life for clients or daily activities and for welfare, and clients, they always also look to that type of aspect. They also want to enjoy their meals, their activities, the way they can get social participation when they are in the institute, et cetera, et cetera. So that's why we are now thinking about a more comprehensive approach to quality of care, and that all data from the National Healthcare Institute may be used to develop such a picture which looks to quantitative data, qualitative data, financial data and staff experience data.

MR GRAY QC: Thank you, Professor.

MR GRAY QC: I have no further questions.

COMMISSIONER PAGONE: Yes, thank you, Mr Gray. Commissioner Briggs?

COMMISSIONER BRIGGS: No questions, thank you. Thank you, Professor, that was very interesting.

COMMISSIONER PAGONE: Yes, indeed, Professor, it was exceptionally

interesting. We really are indebted to you giving up your morning to us. It's been very, very informative indeed and will develop our thinking significantly. We thank you for your time and services and I hope you enjoy what is left of your --- the beginning of autumn, I presume.

PROFESSOR SCHOLS: It's still early in the morning and I will go to work now.

MR GRAY QC: Thank you, Professor.

COMMISSIONER PAGONE: I presume, Mr Gray, that I don't need formally to excuse this witness?

MR GRAY QC: We didn't ---

COMMISSIONER PAGONE: Subpoena.

MR GRAY QC: No, that's correct. Thank you, Commissioner.

COMMISSIONER PAGONE: Anything else tonight?

MR GRAY QC: That's the business for today.

COMMISSIONER PAGONE: So we'll adjourn until 10.00 tomorrow?

MR GRAY QC: Yes, please.

MATTER ADJOURNED AT 5.14 PM UNTIL 10.00 AM, TUESDAY, 1 SEPTEMBER 2020

Index of Witness Events

Index of Exhibits and MFIs