Written Response of Australian Unity to the Witness Statement of Rosemary Anne Dale dated 6 March 2019

1 Background

1 In her role as a care worker at Australian Unity, Ms Dale delivers a range of services to clients under at least three separate funding programs for home care services: the Home Care Packages (***HCP***) program, the Commonwealth Home Support Programme (***CHSP***), and the National Disability Insurance Scheme (***NDIS***).

2 In her Statement, Ms Dale does not identify the proportion of clients she provides services to under each of the HCP, CHSP and NDIS programs. Of the clients on Ms Dale's current regular roster, only two are HCP clients, and of the 70 hours that Ms Dale works per fortnight, only 2.5 of those hours relate to her HCP clients. Based on her current roster, of Ms Dale's client-facing hours (in other words, excluding any paid travel time), she spends approximately 65% of her time with NDIS customers, 30% with CHSP customers and only 4% with HCP customers. See *Attachment A* for a copy of her current roster, which has been hand annotated with the funding type for each client, based on our records management system, Procura.

3 During the last two years from 12 March 2017 to 12 March 2019, Ms Dale has only ever provided scheduled services to a total of seven HCP clients (two of which are her current clients, three of which were 'one off' visits and two of which she saw only two and six times respectively). See *Attachment B* for the relevant extracts from an 'Employee Visit History Report' relating to Ms Dale generated from our records management system, Procura.

4 In the above circumstances, we are therefore concerned that:

(a) Ms Dale's evidence conflates services which are provided separate and distinct funding programs, being HCP, CHSP and the NDIS. The NDIS is not within the scope of the Commission's inquiries, and we note that the Commission's initial request to approved providers did not include CHSP; and

(b) Many of the matters upon which she proposes to give evidence are unlikely to be within her personal knowledge or experience, given her limited work with HCP clients and the fact her role as a care worker does not include broader operational responsibilities.

5 In addition, a number of the matters raised by Ms Dale do not accord with the records that we hold on those matters (for example, in relation to her training and payments for travel time).

6 We have set out below our detailed response to each of the key aspects of Ms Dale's evidence. In doing so, where relevant, we have enclosed supporting documentation. We have redacted, as far as possible, personal identifiable information of Ms Dale's clients and other Australian Unity employees in each of the supporting documents.

2 Training, learning and development

7 In response to paragraphs 13 to 21 of the Statement:

2.1 Our training program for home care

8 It is not correct that Ms Dale has not received any formal training whilst working for Australian Unity. We provide a range of face-to-face and online (eLearning) training for our staff, and there is evidence to support the position that Ms Dale has participated in those programs.

9 By way of background, in 2016, Australian Unity Home Care Services Pty Ltd (**AUHCS**) acquired the business assets and transferring employees of the Home Care Service of NSW from the NSW Government Department of Family and Community Services (**FACS**). At that time, staff

members had access to an online training system known as the eLearning Facility (or, colloquially to staff, **ELF**). As part of transitional services arrangements, we maintained access to this ELF system for transferring employees such as Ms Dale.

10 In around April 2018, we transitioned our online learning into our overarching human resources management system, People Connect. The learning management system (or **LMS**) forms part of People Connect and records online training undertaken by staff against their HR profile.

11 All client-facing staff in our home care business are expected to undertake training, on induction and annually where applicable, on the following topics:

(a) expected employee conduct and standards;

(b) the Code of Ethical Conduct in practice;

(c) customer service;

(d) health and safety;

(e) manual handling of people;

(f) abuse and neglect;

(g) driver safety; and

(h) fire safety.

12 With reference to Ms Dale's comments in paragraph 15 regarding correction of answers for online training, we confirm our LMS system does generally allow for learners to go back and forth within the relevant module. This enables the learner to review incorrect answers, to ensure they understand the appropriate way of doing things, rather than only knowing the way they had answered the question was incorrect. However, to the extent there is a competency test at the end of a module, that is not the case—if a learner does not meet the minimum pass rate for that particular training (for example, 75 or 80%), they would need to re-do the entire module.

13 In relation to manual handling training, which Ms Dale specifically references in her Statement, FACS had a team called MoveSafe which consisted of 10 occupational therapists (seven permanent and three temporary). The MoveSafe team provided training at each branch for care workers with respect to manual handling, safe lifting, etc. The MoveSafe team transitioned to Australian Unity at the time of the transfer from FACS. This team continues to operate as part of our Remedy Healthcare business and also continue to provide training to care workers on manual handling, albeit in a more centralised model (as at today, there are five occupational therapists in the team).

14 Since the introduction of NDIS and HCP portability, specific training has also been conducted at each branch to enable service coordinators, in particular, to manage funding and customer expectations for these programs.

2.2 Ms Dale's training record with Australian Unity

15 With respect to the training that we are aware Ms Dale has completed since she transferred to our employ:

(a) Ms Dale attended a full day face-to-face training program we offered to care workers (known as the 'Care Worker Day') on 15 November 2018. Ms Dale was paid for her attendance and the training related to topics such as health and safety and abuse and neglect of clients, amongst other items. See *Attachment C* for a copy of the Training Attendance List signed by Ms Dale.

(b) Ms Dale also completed face-to-face complex manual handling training on 15 May 2018, conducted by the MoveSafe team. Again, Ms Dale was paid for her attendance at this

training. See *Attachment D* for a copy of the MoveSafe Course Attendance Sheet signed by Ms Dale, as well as an outline of the procedures that were demonstrated as part of that training. She is also scheduled to refresh her manual handling training in May this year.

(c) Ms Dale completed additional online training through both ELF and LMS. See *Attachment E* for a copy of her training record of completed learning modules.

16 We note that, in particular, it is not correct that Ms Dale has not had dementia-related training. She completed an online course on 10 February 2018 that we promoted internally for interested staff to undertake.

17 There are a limited range of formal qualifications that relate to care workers in the home services sector. As Ms Dale notes in her Statement, she had already attained several of those qualifications prior to the transfer of her employment. We note that Ms Dale has recently expressed an interest to undertake an additional qualification (Certificate III in Individual Support). This was in response to our seeking levels of interest from care workers regarding further training opportunities, and has been supported by her Branch Manager.

2.3 Higher qualifications

18 In addition to the 'in house' training noted above, since transfer from FACS, AUHCS has supported 504 care workers in NSW to attain an externally recognised qualification (see *Attachment F*):

(a) 113 x Certificate III in Individual Support;

(b) 313 x Dual Certificate (Certificate III in Individual Support and Certificate IV in Disability);

(c) 46 x Dual Certificate (Certificate III or IV in Disability and Certificate III in Health Support);

(d) 5 x Certificate III in Disability;

(e) 12 x Certificate IV in Disability; and

(f) 15 x Certificate III in Health Support.

19 A further 150 care workers are currently undertaking a Certificate III in Individual Support or a dual certificate qualification (Certificate III in Individual Support and Certificate IV in Disability).

3 Work conditions

20 In response to paragraphs 22 to 31 of the Statement:

3.1 Rostering

21 When the Home Care Service of NSW business was operated by FACS, care workers operated on a fortnightly, paper-based roster whereby they could essentially devise their own scheduling by self-rostering services, as there was no connection with the branch to manage changes by clients. Therefore, so long as the care worker saw their rostered clients, it was largely left to their discretion to arrange sequencing, what time they would attend a particular client, the most appropriate travel route between clients, etc.

22 Upon acquisition, and following transition of all care workers onto Australian Unity's systems, care workers were provided with mobile phones that connect to the Procura client records management system. This has enabled services to be rostered in a more systematic manner, with sequencing now largely managed by allocations coordinators within each branch, although there is still some capacity within the terms of the current Enterprise Agreement for care workers to self-roster. Allocations coordinators also have access to a specific software tool (known as

EasyRoster) to integrate Procura data with Google Maps data—this assists accurate time and distance calculations for rostering of care worker travel requirements.

23 This change has also been driven by client expectations—with the full implementation of consumer directed care and portability of funding in February 2017, HCP clients no longer accept that they should have to wait at home for their care worker to arrive at the care worker's preferred time. Clients expect that care workers will arrive at the time the client has been told by Australian Unity, as their approved provider.

24 With respect to Ms Dale specifically, she has travel time rostered in for all clients in her current roster (*Attachment A*), with exception of Thursday. It is important to note that the roster is scheduled in advance and, in the usual course, the allocations coordinator would resolve this discrepancy (ie the fact there is no travel time allowed) prior to the day. See *Attachment G* for evidence of Ms Dale's historical rosters, which highlight that she always has travel time included.

3.2 Split shifts

25 As noted above, it is reasonable to say that care workers generally used to enjoy greater flexibility over their schedules when they were employed by FACS. They are now more constrained in having to arrive and depart a client's service at a specific time, as directed in their roster.

26 With respect to the comments in Ms Dale's Statement regarding split shifts (or 'breaks of engagement' as noted in her roster), it should be noted that none of Ms Dale's HCP clients are the subject of split shifts.

27 However, for the benefit of providing an insight for the Commission to this industry practice, the reason for split shifts is largely due to the requirements of clients. Many personal care services, in particular, enable the client to get up in the morning (showering, grooming, dressing, etc) or to go to bed in the evening. It is therefore not possible, given the size and breadth of our home care business, to schedule all of care workers only at their preferred times or only in blocks of time.

28 Additionally, the current Enterprise Agreement provides for break of engagements and associated entitlements—these are the same conditions as the previous Copied State Award, which was the applicable industrial instrument for employees such as Ms Dale who transitioned from FACS. It provides for paid kilometres for the care worker to return home and then attend their next rostered client.

3.3 Travel time and distance

29 As part of the paper-based rostering system described in paragraph 3.1, care workers would record their own travel time in attendance, kilometres and the like. They returned their completed paper roster back to the branch at the end of the fortnight and the updates were entered into the system and paid accordingly.

30 We now use Procura and its geo-tracking functionality to record actual kilometres and time travelled on the mobile device carried by the care worker as they travel around. Procura will put in a period of time for travel in the roster based on estimations.

31 Additionally, we have a reconciliation process called 'Timekeeping' which is conducted daily at each branch. If the scheduled data in Procura is inconsistent with the actual data received from the mobile device used by the care worker, this will be indicated in an exceptions report that is reviewed by allocations coordinators. If, for example, kilometres or travel time is greater than estimated, or the service time is greater than scheduled, these exceptions are reviewed and adjusted for client billing and care worker payroll calculations (where appropriate). See *Attachment H* for a Timekeeping report related to Ms Dale specifically.

32 Therefore in summary, care workers are still paid for kilometres and time travelled—it is just managed by the branch instead of by individual care workers and is more accurately recorded through the mobile phones the care workers use to access their roster, client data, etc.

3.4 Home safety checks

33 When the business was operated by FACS, care workers used to conduct home hazard checks for clients. With industry changes (such as the introduction of consumer directed care and the NDIS) our way of working has changed. Previously, and under FACS management, service coordinators spent at least 80% of their time in the branch office, rostering or doing other administrative tasks. Their role has now changed so they are more client facing.

34 Home safety checks are still done annually, but they are now carried out by service coordinators, not care workers. This forms part of the annual care plan review process that is completed with the client in their home.

35 Specifically with respect to Ms Dale's two HCP clients, these checks have been completed as scheduled by the relevant service coordinator. See *Attachment J* for a copy of those checks completed in November and December 2018 respectively.

36 In addition, care workers are able to submit a hazard report for any hazard identified in the course of executing their duties for a client via our health and safety reporting system, SolvSafety, which is accessible on their mobile phone.

3.5 Casualisation

37 As already noted by the Commissioners, the home services industry is facing significant workforce shortages and there is a sector-wide difficulty in attracting nurses and care workers. Australian Unity has actively participated in workforce-related research, such as that conducted by the Aged Care Workforce Strategy Taskforce, led by Professor John Pollaers OAM.

38 With respect to Ms Dale's statement, it should be noted that she works from the Eastern Sydney branch, which services clients in the Sydney harbour region. The branch office is located in Maroubra.

39 There are particular difficulties in finding care workers in affluent areas like Eastern Sydney. Given care workers are generally considered to be low-paid workers, it is unlikely they would be able to afford to live in the area in which they work if they are operating from that particular branch. Therefore, it is usually necessary to find care workers who are willing to travel, sometimes significant distances, from their home to that location.

40 In addition, we have restrictions under our current Enterprise Agreement for care workers such as Ms Dale. It can only give a minimum of 30 hours work per week on a permanent contract. If that cannot be offered, then the Enterprise Agreement requires that the employee must be engaged on a casual basis. See *Attachment K* for a copy of the Australian Unity Home Care Service NSW Enterprise Agreement 2017 (and page 12, Part B Employment Conditions, Section 12 Contract Hours for this specific reference).

41 In the Eastern Sydney branch, there are currently 113 care workers (compared to as at February 2017, when there were 124 care workers):

(a) 31 casual – 27%

(b) 82 permanent – 73%

42 Australian Unity has a workforce strategy related to our home care business that was endorsed by our board of directors in May 2018. This indicates a target state of 15% casual workforce. It

should be noted that at that time, there was a 29% casual mix. Currently across our entire home care footprint there are 3,898 care workers:

(c) 976 casual – 25%

(d) 2,922 permanent – 75%

43 This indicates there has already been a 4% shift towards permanent employment for care workers in less than 12 months since the workforce strategy was enacted.

3.6 Other workforce-related matters

44 With respect to Ms Dale's comments regarding interview processes (paragraph 31 of her Statement), we have recently piloted a new program called "A Great Start". This aims to remove some of the deterrents for new care workers when applying for jobs (such as the lengthy application form). It offers applicants alternative means of application, such as a video or audio response to a pre-screening questionnaire. The intention is to reduce barriers to entry, particularly if English is not the applicants' first language. However, we still have face-to-face interviews being conducted, appropriate background checks being made, and induction training occurring.

45 With respect to turnover of staff, our statistics indicate that for the month of February 2019, the turnover rate was 1.9% for all care workers and Eastern Sydney (Maroubra) was 1.7% for the same period.

46 With respect to injuries at particular points of an employee's tenure, our statistics do not align with the comments made in Ms Dale's Statement. In fact, our statistics indicate that, as related to workers' compensation claims for the period 1 July 2017 to 30 June 2018, approximately 65% of claims were made by employees with tenure of five years or greater (and, of these, approximately 75% were made by employees with 10+ years of employment). Therefore, the majority of injuries are not occurring with newer employees in their first two years of employment.

4 Funding and Consumer Directed Care

In response to paragraphs 32 to 35 of the Statement:

4.1 Conflation of CHSP and HCP issues

47 Because HCP clients do not pay a co-contribution at Australian Unity, it appears Ms Dale's comments in paragraphs 33 and 34 relate to CHSP clients, not HCP clients. Further, whether services were provided by ADHCS (referred to in this document as FACS) or by us is irrelevant to whether clients are funded under CHSP or HCP.

48 We have continued to grandfather certain 'maximum cap' arrangements that were in place when the Home Care Service of NSW was operated by FACS. This means that currently, we have 618 legacy clients whose co-contributions for CHSP services are capped at $108 per month.

49 We note that these arrangements often represent a disincentive for clients moving to a HCP—these clients are often receiving services through CHSP that are well in excess of the 'entry level of support services' intended to be provided by CHSP.

4.2 Fees and case management

50 We offer two choices for HCP case management—'Pay As You Go' on an hourly rate, where a customer is only charged for the time they use the service (for example if they call needing us to arrange for equipment to be ordered, allied health services to be arranged, etc) or a monthly flat fee (which gives clients peace of mind that they are paying the same amount each month, even if intensive case management is required, such as post-hospitalisation).

51 As noted above, arrangements related to case management are managed by services coordinators, not care workers.