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

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

CANBERRA

10.02 AM, FRIDAY, 13 DECEMBER 2019

Continued from 12.12.19

DAY 73

MR P.R.D. GRAY QC, counsel assisting, appears with MR R. KNOWLES SC and MS B. HUTCHINS
MS C. HARRIS QC appears for the State of Victoria
MS S. KAY appears for the State of Tasmania

MS HUTCHINS: Commissioners, the next witness we call this morning is Ms Rhonda Payget. She will give evidence regarding her mother's experience at a residential aged care facility in Sydney. Her account highlights issues regarding access to primary and specialist health care for people living in residential aged care and the importance of proper care coordination. I call Ms Payget.

COMMISSIONER PAGONE: Yes. Thank you.

<RHONDA LEONA PAYGET, AFFIRMED [10.03 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Ms Payget, please state your full name for the Commission.

MS PAYGET: Rhonda Leona Payget.

MS HUTCHINS: You have prepared a witness statement.

MS PAYGET: Yes, I have.

MS HUTCHINS: Operator, please call up WIT.1306.0001.0001. Is this a copy of your statement signed 27 November 2019?

MS PAYGET: Yes, it is.

MS HUTCHINS: Have you had the opportunity to read it recently?

MS PAYGET: Yes, I have.

MS HUTCHINS: Are there any amendments you would like to make to the statement.

MS PAYGET: No, there's not.

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

MS PAYGET: Yes, they are.

MS HUTCHINS: Thank you. I tender that statement, Commissioners.

COMMISSIONER PAGONE: Yes. The statement of Ms Payget will be exhibit 14-32.

EXHIBIT #14-32 STATEMENT OF MS PAYGET DATED 27/11/2019 (WIT.1306.0001.0001)

MS HUTCHINS: Thank you. Ms Payget, your mother is currently 85 years old and she resides at an aged care facility in Sydney.

MS PAYGET: That's correct.

MS HUTCHINS: What's her current health condition like?

MS PAYGET: I don't know how to describe it overall but she's in poor health, so she had a stroke when she was 76 and has had declining health since that time.

MS HUTCHINS: And mentally is she still cognitively able to make her own decisions.

MS PAYGET: She is cognitively able to make her own decisions as she has been all along.

MS HUTCHINS: Yes. And when you say her physical health is not well, what are some of the physical limitations that she has?

MS PAYGET: So she's permanently in a wheelchair. She – she's permanently in a wheelchair, she has no use of her left arm as a result of the stroke and very limited use of her left leg and her use of her left leg has declined over the years, and she went into the facility when she could no longer walk, so she was walking until three years ago, and that's just with decline in the muscles in her left leg as a result of the stroke.

MS HUTCHINS: Yes. When you refer to the stroke, is that the stroke she had when she was 76 years of age?

MS PAYGET: That's correct.

MS HUTCHINS: And at that time she was still living in the community.

MS PAYGET: Yes, but fully independent, no health issues, high blood pressure, but yes, a fully independent busy life.

MS HUTCHINS: Yes. And what was your mother's life like, I guess, in the time prior to the stage of having a stroke and entering aged care?

MS PAYGET: Well, at the time she had the stroke she was planning a trip overseas. She had done quite a lot of travel, very busy with different activities with friends. So she would be out of the house every day fully taking care of herself and her life and still driving at that stage as well.

MS HUTCHINS: And after the stroke she moved into a retirement village for a period of time.

MS PAYGET: She was in her own home for, I'm going to say less than a year, I can't quite remember the timeframe and then there were modifications to the home with ramps and so on, and then she sold that and moved into a retirement village for five – just under five years.

MS HUTCHINS: And by the time she needed to move into the residential aged care facility, what were the main reasons why she needed to make that move?

MS PAYGET: She had had a number of falls while she was at the retirement village. At that stage, she was still – had – was – could walk short distances. Because she had a stroke, she can't use a walker and she's got no use of her left hand so she was just using a quad stick so that's quite difficult. She had a number of falls, went to rehab, got back to walking again but on the last – after the last occasion she could no longer get back to walking, and was permanently in a wheelchair and therefore she couldn't stay at the retirement village.

MS HUTCHINS: Who assisted your mother when it came to finding a residential aged care facility to move into?

MS PAYGET: My two sisters and myself, yes.

MS HUTCHINS: What were the types of things you were looking for?

MS PAYGET: Well, the physical environment, I think, is important in – in – the parts of Sydney where we were looking at, a lot of the facilities didn't have – had very small rooms and were quite expensive, so obviously cost was a factor. It was the – the services that could be offered, although I guess at that time we were – we didn't know what we didn't know in terms of the services we would be requiring. We had had some experience with residential care in that my mother had been in respite care twice, and that – where she had respite care was really, I guess, our starting point in looking at residential care. So we looked at a lot of different rooms.

Part of it is restricted by availability so availability and cost narrow down the search, if you like, and then it's a matter of assessing what's available in those parameters.

MS HUTCHINS: When you were at that point when your mother was entering into residential aged care, what did you understand would be provided by the facility in terms of access to the medical care that she might need?

MS PAYGET: To be honest we probably didn't think about that enough at the time. Our assumption would – would have been or was that her – her medical needs would be met by the facility. And so, for example, we didn't really ask questions about access to specialists and so on. That was kind of an evolving information gathering exercise, I guess. At the time, we were mainly concerned with her – I guess her daily

physical needs being met and how that would be done and the understanding was she would have 24-hour care because she needed assistance with toileting, is really – yes.

MS HUTCHINS: Yes. And prior to entering the residential aged care facility did your mother have a regular general practitioner that she saw?

MS PAYGET: She – when she was living at home, the same practitioner for many years – in excess of 20 years. And in the – when she was in the retirement village they had a doctor – they had rooms for a doctor and so there was a doctor who visited there so she had the same GP for the years that she was there.

MS HUTCHINS: Yes. And then when your mother moved into this new facility was she able to bring the same general practitioner with her?

MS PAYGET: Well no, because he – it was a different area so we needed to look for a general practitioner, so the area where the – the facility is is close to where my mother used to live, and so we went back to her general practitioner who had cared for her all those years. Her general practitioner was retiring and wasn't able to provide a referral as she didn't know any – no other general practitioners in her practice, she was in a reasonably sized practice were taking on new clients in aged care facilities. And then my sister rang a number of other GPs in the area and so we were really left with a referral to a GP through the facility that my mother went into.

MS HUTCHINS: Yes. And what arrangements were put in place in terms of visits by the GP at the facility?

MS PAYGET: No specific arrangement, and that's an example of a question we didn't ask at the time about how that would work, and I guess our assumption was that it would be similar to how it had been at the retirement village where the retirement village had a relationship with the doctor and the doctor came. That was our assumption. And so we were never really clear from the beginning about how the clinical care was to work, and we knew, of course, there was a registered nurse on the floor where my mother is and our primary point of contact has been through her. But we never formally had a discussion about what the clinical care model was.

I mean, obviously, when my mother went into the facility details of her medical history and so on were given to the facility and her medication and so on. But it's only very recently as a result of writing my submission that I really came to understand the model, if you like, that the – that the facility uses, yes.

MS HUTCHINS: And do you have a sense of how many people the GP visits at the facility?

MS PAYGET: No, but there are primarily two GPs and there is over 100 people at the – at the facility.

MS HUTCHINS: Yes. And how is your mother's relationship with her general practitioner?

MS PAYGET: She – she doesn't really trust him. They just – he may be a good GP, but they just don't have a good relationship, and her need is really to feel like someone is looking at her as a whole person; that's her words. And I think that the GP deals with specific issues as they arise. But it seems to me that there isn't a sort of proactive care plan that's developed by the GP as you would normally expect in the community.

MS HUTCHINS: Do you communicate directly with the GP or do your sisters?

MS PAYGET: We're not able to communicate with the GP. I understand that's the GPs choice because the facility says it's – it's not a policy that they have. So our primary point of contact is the registered nurse in the facility. A GP, not her main GP, but another GP who saw her has contacted family members on a few occasions when there has been a particular issue, and that's been appreciated.

MS HUTCHINS: When you say that you're not able to communicate with the general practitioner, have you specifically had conversations before with facility staff where you've asked to attend appointments or, you know, you've asked to be able to call him on the telephone, or how was it that that understanding came to be?

MS PAYGET: Asked to talk to him on the telephone and we were told that he doesn't speak to family members on the telephone. If we happen to be there when he was seeing my mother, we can, obviously, sit in on the appointment with – if my mother consents to that, which she does; so there hasn't been a problem with that, except that we never know when the GP will see her. So – there's no formal appointment process.

My understanding is that the – they have a doctors' book and they write certain things in the doctors' book – that the doctor needs to look at, and the doctor is there two days in the week; so we're aware of the days, and when the doctor sees my mother is up to the doctor, and that's part of the problem, because not only can a family member not be there, but my mother isn't necessarily in her room or ready for – prepared for an – for the appointment. So that can impact on the usefulness of the appointment, I think; yes.

MS HUTCHINS: When the GP does see your mother, where are those consultations held?

MS PAYGET: I can't answer that for sure, but sometimes they're in her room. She has said that he's seen her when she's been in the coffee shop and will say "How are you?" and things like that. I don't know whether he then counts that as a consultation, because there's no – it's not obvious to me, what – the reconciliation between the appointment and his – when he makes bill to Medicare or charges Medicare for a consultation; so - - -

MS HUTCHINS: And do you have a view about whether that's satisfactory, for a consultation to be happening in a public place?

MS PAYGET: Well, it's not satisfactory. It needs to be in private, particularly – well, I think in all situations that should be private; yes.

MS HUTCHINS: And if a mandatory requirement was introduced – that there must be a private place for consultations – do you think it would be appropriate, for consultations to happen, say, in your mother's room rather than needing to, say, be in a separate consulting – specific consulting-room?

MS PAYGET: I think the resident's room is suitable and, probably, comfortable for the resident. I think in a – when a person is in institutional care, they have so little control over their life and what's happening. In many ways it's like a hospital environment, with people coming and going and checking, and you never know when things are happening. So if a resident was able to have an appointment time with the GP, then they can mentally prepare themselves for that and also know that that's happening and have a little bit of control over that.

So I think it's more resident-centric, for the resident to be able to have some control over that. I think one of the difficulties is with facilities having relationships with GPs to come into the facility and so on, because my understanding is that the GPs just have a relationship with the facility and then just bill Medicare directly. So there's a lot of goodwill in that type of arrangement, I think; yes.

MS HUTCHINS: Yes. And you note in your statement that you have recently obtained and reviewed the Medicare billing that's occurred in relation to your mother.

MS PAYGET: Yes.

MS HUTCHINS: What observations can you make about what you've seen in the billing-history?

MS PAYGET: Well, the – I was just really specifically looking at the issue of GPs; so the Medicare record is for three years, and there were a hundred – 128 GP visits that were billed to Medicare in that time by 15 different general practitioners. And primarily there were two GPs which accounted for – I think, just over 70 of those visits, and then there were a number of other GPs who were after hours or – I don't know when they attended. You can see from the billing if it's after hours or not; so they were, I guess, called in by the facility for some reason. Yes.

MS HUTCHINS: And on the face of it, that appears to be quite a reasonable number of attendances. Do you think that that's resulting in good care for your mother, that number of visits?

MS PAYGET: I think the care is very reactive. So whatever is happening in that moment – so when GPs were called in, something has happened in that moment. I don't know what it was or what the result of it was. And my view is that, if there was more pro-active and preventative attitude to care, where you had a regular care plan that was updated every six months, you may be able to pre-empt some of those issues and be able to have care more consistently provided.

MS HUTCHINS: And through conversations with your mother, have you obtained a sense of the nature of those consultations?

MS PAYGET: It's very difficult, and I think part of that is just because lots of people are coming and going. She knows the – or she will talk about the primary GP, who was – I think that was – about half of the visits were made by the primary GP. And his – the billing-records show that the majority of his visits are just a – I think it's level B, just a less – a short visit, and so he is dealing with some short issue that's occurred. And the – I think there was only twice, where he – where that GP was involved in a care plan. Theoretically there should be a care plan and a family meeting at least annually to discuss a care plan. We have had two family meetings that have been instigated by the family, and in that period, the GP – there was only – I think, only one medication review for example. So to me that highlights perhaps the lack of attention to looking at my mother as a whole person, which is what she wants.

MS HUTCHINS: Yes. And in your statement, you point to an example of an experience that your mother had in October of 2019 in relation to issues that she was having with blood circulation in her left foot.

MS PAYGET: Yes.

MS HUTCHINS: And so what was the problem that she was having at that time?

MS PAYGET: Well, it's consequent upon the stroke – so it's just about blood circulation in her foot, because her foot's fairly immobile – and concerned about the integrity of the – I guess, veins and arteries in her foot. So her foot was sometimes discoloured, very cold, which were indicators that there may be a problem with her circulation.

MS HUTCHINS: Yes. And so a referral was required for your mother to see a neurologist?

MS PAYGET: The neurologist appointment was not to do with her foot. So the neurologist was as a result of – my mother's stroke and seizures is why she sees the neurologist. So – the neurologist did take a whole-person approach and identified that issue.

MS HUTCHINS: Yes. I see; so your mother was at a routine appointment with her neurologist.

MS PAYGET: That's correct.

MS HUTCHINS: And it was at that appointment, that the neurologist identified there was an issue with the blood circulation in her foot?

MS PAYGET: Yes, and it was also in preparation for that appointment, because the referral had been inadequately done, and we knew that my mother had seen a geriontologist, which was instigated by the facility, but there was no notes or referral from the geriontologist to the neurologist, and the geriontologist – I attended that appointment with the geriontologist, and he was talking about the medication which had been prescribed by the neurologist, and so we felt it was important, for the neurologist to be aware of what the geriontologist thought about that, because we wanted her to make the decision about the anti-seizure medication, but the referral hadn't been done by the geriontologist, and the referral by the GP didn't even mention that.

So my sister organised to get a copy of the notes that the geriontologist had – wrote, and when we got a copy of the notes, there was, incidentally, on those notes, information from a podiatrist who had seen my mother, I think, in the October, who made a comment about the circulation in her foot. But nothing had been followed up or done; we didn't even know about that until my sister requested the notes and we saw that there. And then – because my sister provided those notes to the neurologist, then she looked at the whole person.

MS HUTCHINS: Yes. Yes. So the podiatrist had been arranged by the facility to see your mother.

MS PAYGET: Yes, and that's a regular appointment.

MS HUTCHINS: Yes. Yes. And so the podiatrist had made reference to the blood-circulation issue.

MS PAYGET: That's correct.

MS HUTCHINS: But nothing came of that note.

MS PAYGET: That's right. As far as we know. Yes.

MS HUTCHINS: As far as you know, and it was only when your mother was at the neurologist, that that was picked up.

MS PAYGET: Yes, and we then became aware, that that was an issue and then, yes, followed it up.

MS HUTCHINS: Yes. And so besides the neurologist – are there any other specialists that your mother sees?

MS PAYGET: She sees a cardiologist; that's an annual specialist appointment as well, and the – my mother's been seeing that cardiologist for many years. So – prior to entering the facility.

MS HUTCHINS: And – yes. And any further specialists?

MS PAYGET: As needed. So she – I talked about the skin specialist in my statement. So that's something that arose since she's been in the facility.

MS HUTCHINS: Yes. And when it comes to arranging specialist appointments – is that something that is done through the general practitioner?

MS PAYGET: The skin specialist was referred by the general practitioner after we raised the concern about the lesion. So that was a – I guess, a reactive referral, but that referral was made by the facility. And then we followed up with – on that with the subsequent referral that was requested by the family. The – when my mother sees the neurologist and the cardiologist: that's followed up by the family; the appointments are made by the family, and we take her to those appointments.

MS HUTCHINS: Yes. And you mentioned before in the instance you were describing that you would or your sisters would be responsible for collecting the information to make sure that it was available for the specialist; is that right in relation to medical records?

MS PAYGET: Well, on that last occasion, we did that. We – I'm not quite sure, whether we've done that on other occasions. I don't think we do that for the cardiologist, just because he's familiar with my mother's history. So - - -

MS HUTCHINS: Yes. And so do those specialists have access to the care records of the facility in terms of what's been happened with her ongoing care?

MS PAYGET: Not to my knowledge. No.

MS HUTCHINS: No. And how is it, that your mother accesses the specialists? Do they ever come to see her in the facility, or do you need to take her out?

MS PAYGET: It's always an appointment at their offices; yes.

MS HUTCHINS: And how is it, that she gets from the facility to the specialist?

MS PAYGET: Well, she – as she's permanently in a wheelchair, we arrange a wheelchair taxi, accommodation, and my mother pays for that; she's – has a subsidised-wheelchair-taxi booklet, but we - - -

MS HUTCHINS: Yes. And does she attend by yourself, or is she assisted by your sister or yourself?

MS PAYGET: She would need assistance; so she always has a family member with her.

MS HUTCHINS: Yes. And does the facility offer any services in terms of assisting external visits if, say, you or your sister weren't available?

MS PAYGET: I don't know. I don't know. I think, theoretically, yes, but we – I don't know the details of it.

MS HUTCHINS: An idea that the Commission has been exploring during the course of this hearing is making it mandatory, for residential-aged care facilities to have information systems, IT systems where all the care notes and records could be kept so that they might be accessed by, say, an external specialist or if your mother needed to go to hospital. Do you think that that's something that she would be comfortable with, including her records on a system like that?

MS PAYGET: I guess, if privacy could be addressed in whatever system, IT system is proposed, but for someone in my mother's position, it would be very useful, to have a consistent electronic record, because she's been to a number of hospitals. So during her time in residential care she's been to two separate hospitals. As far as I'm aware most of their records are still written records as well. So whoever is treating her has a very inadequate history. The facility prints out her list of current medications which is sent with her in the ambulance.

So the times when she's been taken by ambulance to hospital there's no family member. She goes with the ambulance officers there, and has her list of medications and what – I don't know what other information goes with her. Perhaps her presenting problem. So we have had an issue with medication because my mother's on an unusually high dose of Keppra which is four – because she's had a stroke and seizures and so the translation of the dose, it was correct – what the facility sent was correct. When the hospital wrote it down, they wrote the incorrect dose, and that was only picked up by my sister.

So – and then there was this process where they then checked and double-checked and then the dose was finally corrected. So if there was an electronic record perhaps issues like that could be – could be addressed as well as just her – her history of incidences as well.

MS HUTCHINS: Yes. Turning now to the topic of advance care directives which has been a matter the Commission has heard some evidence about this week, have you had any discussions with staff at the facility about planning for your mother's, you know, advance care plans?

MS PAYGET: When we went into the facility, as I said in my statement, the process was quite good and clear about what had to be provided and they requested any powers of attorney and advance care plans, but since that time, no, we haven't had any discussion with it. So they have a copy of my mother's power of attorney

and my mother doesn't have an advance care directive – because that's what it's called, isn't it – and the only discussion we've had about that is really in hospitals when she's been critically ill. We've had that discussion twice with doctors in ICU.

MS HUTCHINS: And the nature of the discussions you were having with the doctors in the hospitals, was that in relation to things that might have been more comfortably spoken to in a different circumstance?

MS PAYGET: Yes. In our situation we have spoken to our mother about it. We don't have anything in writing. So we have that information so we were comfortable to make decisions at a critical time. But I can see how it would be very useful to have an advance care directive in writing as those crises arise.

MS HUTCHINS: Yes.

MS PAYGET: Yes.

MS HUTCHINS: Does the facility have a clear understanding of the discussions that you might have had with your mother in the past about what to do in particular situations?

MS PAYGET: No.

MS HUTCHINS: Do you think that you would be assisted by receiving further, you know, education or support by someone, whether it be through the facility or through another avenue when it comes to these types of matters?

MS PAYGET: Advance care plans?

MS HUTCHINS: Yes.

MS PAYGET: It would be useful to have perhaps some printed information about care – advance care directives, and the process, yes.

MS HUTCHINS: With the issues that you've raised today in terms of trying to coordinate care that your mother is receiving, whether it be with the GPs or nursing staff, in-house and access to specialists, do you think that there would be some merit in mandating a requirement that there be one key individual that's identified as, say, a care coordinator that you could use as that central point to know who's responsible for coordinating care when it comes to your mother?

MS PAYGET: I think that's a critical part of trying to have resident-centric care is to have a central care coordinator who can address those inquiries. In our experience the – the de facto care coordinator has been the registered nurse who is on the floor where my mother is in residential care. But then there is an issue about the capacity of that RN to fulfil that role because she has a number of other roles and is very busy. And that may prevent the RN from being more proactive in having preventative care

or a – regular meetings about a care plan and so on to try and make it a smoother process. I think there is merit in having a mandated nominated care provider because in the first instance it just gives families someone – knowledge about who you should go to because it was quite a journey for us to understand that process.

MS HUTCHINS: Thank you. Is there anything further that you would like the opportunity to say to the Commissioners today?

MS PAYGET: I think that staffing in residential care facilities is really a critical issue and there are some terrific people who are there and particularly, as I said, the RNs who do have – in our experience, have a very close working relationship with the resident. The RNs probably know my mother – in my mother's case, know her the best and what her care needs are. And there is a lot of other issues that flow from that including – which I know the Commission has looked at about mental health and the rates of depression in institutional care. Institutional care is very challenging and so I think those primary relationships are so critical to any experience that a resident has.

And part of an RN being able to fulfil that role is just being able to have the time to do it. So that any consideration of having someone nominated as a care manager, I think, or a case coordinator, would need to go alongside having some mandated staff ratios or some way that the person can really fulfil that role well.

COMMISSIONER PAGONE: Ms Payget, thank you very much for giving your evidence and telling us about your experiences. The Commission is, as you've heard, looking at some broad issues in these hearings and it's important that we remember and that the public sees that these are real issues that impact upon real people like you and your mother. We are grateful that you have shared your experiences with us and it will help us be informed when we're looking at the issues more generally. Thank you for attending.

MS PAYGET: Thank you.

COMMISSIONER PAGONE: You're excused from further attendance.

MS PAYGET: Thank you.

<THE WITNESS WITHDREW [10.38 am]

MS HUTCHINS: Thank you, Commissioners. The next witness we will call today is Dr Clare Skinner who is a specialist emergency physician and the director of emergency medicine at Hornsby Ku-ring-gai Hospital. She's also the chair of the emergency medicine network of the Northern Sydney Local Health District. Dr Skinner's account highlights issues with residential aged care facilities that may lead to avoidable hospital transfers, problems with hospital transfers between residential

aged care facilities and the provision of palliative care to people living in residential aged care.

COMMISSIONER PAGONE: Yes. Thank you.

MS HUTCHINS: I call Dr Skinner.

<CLARE ALICE SKINNER, AFFIRMED [10.39 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Dr Skinner, could you please state your full name for the Commission.

DR SKINNER: Yes, I'm Clare Alice Skinner.

MS HUTCHINS: And you have prepared a statement for the Commission.

DR SKINNER: Yes.

MS HUTCHINS: Operator, please call WIT.1302.0001.0001. Is this a copy of your statement dated 25 November 2019.

DR SKINNER: Yes, it is.

MS HUTCHINS: And have you had the opportunity to read it recently.

DR SKINNER: Yes, many times.

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

DR SKINNER: No, thank you.

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

DR SKINNER: Yes, they are.

MS HUTCHINS: Thank you. I tender that statement, Commissioners.

COMMISSIONER PAGONE: The statement of Dr Skinner will be exhibit 14-33.

EXHIBIT #14-33 STATEMENT OF DR SKINNER DATED 25/11/2019 (WIT.1302.0001.0001)

MS HUTCHINS: Now, Dr Skinner, before turning to your direct experience through your role at the emergency department, I also note from your statement that you have some experience with residential aged care through three of your grandparents that have been in aged care.

DR SKINNER: Yes, I do.

MS HUTCHINS: Yes. And what observations can you make about the experience of care that they have been given in residential aged care?

DR SKINNER: I think first of all I would like to acknowledge the hardworking care of a lot of my colleagues who work in community practice and aged care facilities. Most of what they do is very good. The experience with my grandparents was patchy and I found – I found – my grandparents had a medical insider in the family – actually, a few of us, and it was still very hard to coordinate their care and actually the experiences of Ms Payget are very similar to my experiences despite being a medical insider. We found the aged care facility expensive, availability was difficult. There were very caring people inside them, staff ratios were low, and it was very difficult to coordinate, particularly, specialist and general practice care within the facilities.

MS HUTCHINS: Yes. And you note at paragraph 9 your belief that the – sorry, that your knowledge of the health system and your professional relationships was very useful to your grandparents in their care. Why was that?

DR SKINNER: There are a number of occasions when there were plans to send my grandparents during acute situations to the emergency department where I knew of systems within the community that could treat them in situ, and I was able to intervene and provide care in place rather than a transfer to hospital.

MS HUTCHINS: Yes. Thank you. Turning to your professional experience, in your current role you have three clinical shifts in an emergency department a week; is that correct?

DR SKINNER: Yes.

MS HUTCHINS: Your hospital has also established an in-reach model called the Geriatric Rapid Acute Care Evaluation team - - -

DR SKINNER: Yes.

MS HUTCHINS: - - - or known as GRACE, where senior nurses provide advice and services to aged care facilities.

DR SKINNER: Yes.

MS HUTCHINS: Yes. And as part of that GRACE model, you attend regular meetings between representatives of local health networks and aged care facilities.

DR SKINNER: Yes, we do that quarterly, I think.

MS HUTCHINS: Yes. And the purposes of those meetings is to help fix or encourage better results in the interface between the hospital and the aged care facility.

DR SKINNER: Yes, we encourage – it's part of just building relationships, creating networks, and trying to smooth care and share information so we that can provide resident-centred care, basically.

MS HUTCHINS: Yes. You identify in your statement that you're seeing an increase in the number of transfers from residential aged care facilities to the emergency department for assessment. What are the common reasons for referrals that you see?

DR SKINNER: So I'd say this is something I've really noticed since I began practicing in the early 2000s. The most common reason we'd see a transfer to the emergency department is because a resident has fallen, and they need a physical assessment. But it'd also be things like a resident having a fever, coughing, a change in their level of consciousness or a symptom like chest pain, abdominal pain, vomiting, diarrhoea, something like that. It's quite varied. They're often after hours, and I think in a lot of cases these are things that – you know, the philosophy of emergency departments is "we're here to help".

There's no wrong door, and if someone lands in the emergency department we try to do our best, but there are a lot of things that potentially could have been dealt with in place if the system had been available to support that. So the estimates are that roughly 65 per cent of transfers to emergency departments from aged care facilities are for conditions that could have been treated in place.

MS HUTCHINS: What are those estimates based on – or that assessment based on?

DR SKINNER: They're based – they're based on comments a colleague has made to me who's doing some research about this across Sydney.

MS HUTCHINS: Yes. And why is avoiding unnecessary hospital transfers of particular importance for this cohort?

DR SKINNER: I think people are elderly, they're quite often frail. There's poor sharing of information between aged care facilities and emergency departments which makes assessment difficult and error prone. People are very prone to becoming confused, uncomfortable or disorientated. Emergency departments are

very crowded, they're noisy, there's bright lights, there's a lot going on. They're not very pleasant environments and I say that as someone that spends a lot of hours a week in one.

And I think if you can – if you can treat someone in another environment it's kinder to do that. There's evidence that there's – you know, you exacerbate confusion in emergency departments. There's a high risk of falls in the emergency department environment, and there's actually a high risk of obtaining an infection or a hospital-acquired complication while you're in hospital. So it's not that we don't want people there but there's actually research evidence that there are safer ways to provide care to people.

MS HUTCHINS: Yes. And what are the issues within the facility that are giving rise to these avoidable hospital transfers?

DR SKINNER: I think that we operate in a health system that was designed for acute episodic care for young people, and a lot of our protocols are designed for young people, and we haven't yet caught up with the complexity of our aging population. We're in a very risk-averse phase in society. We like to think we can manage all risk, and when we have protocols, such as our head-injury protocol that says everyone must receive a CT scan for this, this, this reason, we tend to do that, because we're following the protocol, rather than thinking "Hey, is this transfer and this CT scan actually going to be in this patient's best interest, and will it alter our outcomes?". So I think that's – part of the problem is we're very protocol-driven, and the protocols were designed for single-system problems for a younger cohort of people who aren't carrying co-morbidities and frailty as well.

MS HUTCHINS: You mentioned earlier that you see more transfers after hours; why do you think that is occurring?

DR SKINNER: I think there's less – there's very little availability of afterhours clinical advice to people in the aged care sector, and I think everyone's frightened. We're frightened, we'll miss something. I know I'm quite frightened of missing something in my practice, and so the automatic response becomes to send someone into acute hospital environment for an urgent assessment rather than thinking pragmatically, "Is this going to alter things? Is this the kindest and safest thing to do for this resident, and could this wait till morning and have a more holistic assessment in situ?".

MS HUTCHINS: When you have a person present from a residential-aged care facility, what's the quality of information like – that's transferred with them?

DR SKINNER: It's very variable. Often we get a lot of printed-out notes. They're often photocopies of photocopies. There's occasional – there's usually, five or six lines there for presenting-problem and past medical history. There's usually a couple of handwritten words. They're, usually, broad-brushstrokes terms; so you might have something like confusion or dementia, but you won't have any details about the

diagnosis or which specialists are involved or what treatment's been tried. You might have something like cardiac failure but no details around what caused that condition. It's very, very difficult.

Often in terms of the presenting-complaint – you'll just get a word like "fall" or "vomit" or "fever". You won't get any detail around it. And actually occasionally – we have a usual practice, which is – you will try and ring and get a corroborative history from someone who's assessed the patient, but even when you call, you often find that the shifts change or the RN's not available, because they're carrying a major workload. So it's – the transfer of information between the aged care facility and the acute hospital sector is very, very error-prone. Occasionally it's fantastic, but most of the time it's quite limited.

MS HUTCHINS: And how often, when you receive a person, would you need to make that telephone call to try to ensure you've got the right information?

DR SKINNER: Most times.

MS HUTCHINS: If a requirement was introduced – to mandate the exchange of information from a residential-aged care facility to the hospital when the patient is transferred – what do you think should be – what would you think should be included in any such requirement as a minimum?

DR SKINNER: So I have a wish list, that every single – I had high hopes – the person-controlled electronic health record – I have to admit. But I have a wish list; everyone should have a really, really good health summary. It should be compiled by the person with the assistance of their general practitioner or a skilled nurse, and that should be the definitive document; it should form the basis for what we work on. It should be updated in an authorised way that's accountable, and that should move with the patient electronically.

So they could own it. I've seen people who own this on a memory stick. With my own family members I help them compile this on a Word document, but I think there's a way we could do this much better. There were some initial attempts to try and do this in the mid-2000s, when we started to digitise health records, but what we've seen now is health – the electronic health records we do use are very fragmented, and often what we're using is cut-and-pasting of previous junior-clinician notes rather than having a really good definitive health summary that every single person owns that must be compiled by someone senior in a way that is authorised and built with the patient.

MS HUTCHINS: Yes. Yes. So any requirement that there be provided, say, a resident summary, you say, should go beyond requiring a summary to actually specify a form of what it should include?

DR SKINNER: It shouldn't be five words written in pen on – in the middle of 27 pages of photocopied notes. It should be a really tight template-based clinically – really sensible comprehensive electronic document.

MS HUTCHINS: And you mentioned access to electronic records; would you support mandating a requirement that facilities have software that's interoperable with, say, My Health Record or something that could be accessed - - -

DR SKINNER: Yes. I think electronic records are really good, but again I would urge some caution around the type of software you use and its operability for working clinicians; so there's been a lot done in this space, and there's major advances, but a lot of the software we do use isn't – is clunky and difficult to use. But I'm hoping for advances in that soon. So – yes. I think electronic would be really useful, but we need to be careful about the design.

MS HUTCHINS: And in terms of My Health Records as an – My Health Record as an option – do you have any views about the appropriateness of that?

DR SKINNER: It's in its very early days. At the moment, when you click into My Health Record, you find a catalogue of lots of stuff, and you'd have to dig deep into lots of different documents to find critical information, which is why again I would really like each person to have a really good comprehensive template-based digital health summary compiled by their GP and updated regularly.

MS HUTCHINS: When a resident comes to your emergency department, what's the assessment process that you need to go through?

DR SKINNER: So when a resident comes in, we – they, usually, arrive by ambulance; the paramedic will hand over to the nursing- and medical staff. The patient's triaged, and that's just a quick assessment for urgency, not complexity. And that's – a bit of a misnomer in emergency medicine is – complexity is actually our problem, but we triage by urgency. So the triage number doesn't tell you how complex a person is, which is a big misunderstanding. And then a medical officer will pick up the patient, and we start from scratch. In emergency medicine we have the notion that everyone belongs in the emergency department, and we'll do a comprehensive assessment.

We tend to focus on the acute issue, but we tend do what we call a systems review, which is to do a big broad-brushstrokes look at their context and the other clinical problems. Particularly often with patients from aged care facilities who are frail and elderly – we'll often find that, even though they might've presented because they have a sore wrist or have had a fall, the reason for that might be that they have an underlying infectious disease or a problem with their medications or something deeper. So we need to be a little bit sceptical and suspicious in the way we go about things. So we look at the immediate, but we move beyond it and look broad – more broadly at the patient.

MS HUTCHINS: Yes. And do you find that this level of assessment at times goes beyond the assessment that's been occurring within the facility?

DR SKINNER: It's really hard for me, because as I said, I have really poor records, and I think the quality of care that's provided is really varied. There – a number of my patients have really excellent GPs, and they come with fantastic things, and I feel confident. I do feel occasionally though that – someone comes in with a fall, and I'll look at their medications and go "Wow. They're on 30 medications, and it looks like they've just been historically building up, and it's time that – they need a comprehensive review." And I do struggle with whether that's my job in emergency department as an episodic clinician, but occasionally I'll flag that to one of the geriatricians on our outreach service, to do a review.

MS HUTCHINS: Is it always apparent to you when you see a person, that they've actually come from a residential-aged care facility?

DR SKINNER: Yes, it is. Yes. It's flagged by the ambulance service; in fact, at my hospital, if an ambulance is called to an aged care facility – that's flagged for us, and we'll often ring in advance and offer help to try and keep the person in situ.

MS HUTCHINS: Right. So you'll receive notification that there's been a call-out for someone at the facility, and you step in at that stage yourself? Your outreach does.

DR SKINNER: Our outreach – the outreach service will get in touch with a facility and say "Hey; what's going on? Can we send – can we contact a GP? Can we call our hospital-in-the-home service?" Not because we don't want people, but more because often we find that, if we – if it's something like a catheter change – we can send the community nurse to do that rather than the transfer to Emergency.

MS HUTCHINS: Yes. And in relation to your observations about instances of poor-quality information exchange – why is that of a particular issue for this cohort of patients that you'll see?

DR SKINNER: I think it's an issue for every cohort of patients, but it's particularly an issue for people as they get elderly, as they have more complex chronic illness, and it's a fine balance; every decision you make about them can't be just relating to the single specialty that's the problem at the moment. It has to be in balance of all of their conditions. So you can't just change one medication without thinking about what the effects that's going to have on their other medications, their kidney function, their liver function, cardiac function et cetera. You really need to be mindful of their physiology and the impacts that your decisions will have on their whole system. It's a balance.

MS HUTCHINS: Yes. And has it been your experience, that you've observed greater instances of people coming with dementia or other cognitive problems, that it affects their ability to be accurate historians?

DR SKINNER: Absolutely, and so – there's a number of reasons why patients can't communicate clearly, and confusional states is one of them – including acute confusional states like delirium, but also language barriers and also things like hearing- and visual loss are a big problem too.

MS HUTCHINS: When it comes time, for a resident to leave your setting, do you find that there's appropriate availability for them to receive subacute rehabilitation?

DR SKINNER: That's really difficult. I think part of the issue we've got from the acute hospital system is that the aged care facilities vary greatly in what they offer. So within my catchment I have a number of very large facilities, and they provide excellent – differing levels of care within the same facility. They provide a clinic environment; they have a sort of sickbay environment, where you can move for a period of higher care and rehabilitation, but that's not available at a lot of the smaller facilities. And it's very, very difficult for me as an acute-sector clinician, to know what I'm sending someone home to. We routinely contact the facilities before we transfer home and ask if they're safe to take people back. And we do try to send our outreach service – we get our outreach service involved early, because they can help us work out whether it's appropriate, to transfer that resident back, or whether they need a period of inpatient rehabilitation, or we can provide some support, with our rehab team going and visiting people in facilities as well.

MS HUTCHINS: And what is the type of support that your rehab team is able to provide?

DR SKINNER: I have to admit I don't work for that service, but they provide physiotherapy, occupational therapy, dressing-care, that sort of thing.

MS HUTCHINS: Yes. And what are some of the issues that you face when it becomes time, to discharge a resident back to their facility from the ED setting, the hospital?

DR SKINNER: So part of the trouble we've got is the facilities have very, very variable staffing. And if we've made a medication change or a care-plan change, we can only send a patient back after hours to a facility that has a registered nurse available to enact that care plan acutely. A number of the facilities in my area only have enrolled nurses or assistants in nursing working after hours, with which means they're unable receive patients back from acute hospitals after hours, which can mean those patients actually need a brief admission just to wait for a transfer home. We also have issues with arranging appropriate transport, because there's a lot of demand on that service as well.

MS HUTCHINS: Does – the Commission's testing a proposition, that there should be a requirement introduced to the effect that, where a hospital is discharging a resident, that discharge should only occur once a discharge summary, including a medication list, has been provided to and acknowledged by the facility. Would you see any practical difficulties in a requirement such as that?

DR SKINNER: The first thing – the facility will need to have someone around who's clinically senior enough to be able to receive that and comment on it, which will mean they'll need a registered nurse 24 hours per day. From my emergency-department perspective – we provide every single patient with a discharge summary at the moment anyway. That's the standard of care mandated by my professional college. It's not perfect, but that's the standard. So that wouldn't be a problem, but just how we share the information is a problem.

So in the health sector generally we're still relying on fax machines, and a lot of facilities and general practices now no longer have a fax machine. So we need to – there's a major project here which, I think, would actually benefit all patients, around updating our technology and doing this through shared electronic records and email. We – I ..... the earlier comment, that if we're going to do this live, we need to have enough staff around, that they can do it live. It can't be something where the nightshift is too busy until the morning to receive a patient back from the hospital.

MS HUTCHINS: And is that something that happens often in your experience?

DR SKINNER: Yes, it is.

MS HUTCHINS: And what happens in those circumstances with the resident or the patient?

DR SKINNER: Well, often when we're waiting for transport or we're waiting for the facility to okay things, they'll, literally, just stay in the emergency department, waiting for those things. I think we need to work better at having other places in hospitals, where people can wait. They're, literally, just waiting, and it's not very kind, and it's very disorientating and confusing. It's not a good environment.

MS HUTCHINS: In your statement you've observed that there's residential-aged care facilities that are better equipped to meet the aged care needs of residents within the facility compared to others, which can help prevent unnecessary hospital transfers. In your experience what are some of the key features that these good practices have?

DR SKINNER: Yes. I think the larger facilities do this well because they have an economy of scale that allows them to provide some clinical services. So they'll have physiotherapists, general practitioners et cetera registered to work within the facility, and that means they can actually have relationships, and they can have clinicians who get to know the residents well. I have to admit – it was interesting, listening to the conversation about general practice, and I'm not a GP, but I think the model where you expect a fee-for-service general practice, running a busy private practice, to go in and see an aged care resident is unrealistic.

That – we need to start thinking about how we run medical workforce into aged care facilities quite differently. There's some scope for telemedicine here, but I think there's also scope to have a specialist workforce that, literally, works in aged care,

trains in aged care, is proud to work in aged care and develop skills there and can have ongoing relationships. I'm concerned about fee-for-service in the aged care-facility environment. I think, potentially, it should work a little bit more like hospitals, where people are actually contracted to provide a holistic service rather than episodic care, because with complex patients it's about longitudinal relationships; it's not about one-off events.

MS HUTCHINS: Yes. And in terms of growing and encouraging particular segments of that workforce – what are your views on the role of nurse practitioners?

DR SKINNER: I'm really encouraged by the growth of nurse practitioners in nursing-homes, because I think they're a group that can, potentially – got lots of skills, lots of training and can work in the aged care environment and liaise with doctors and GPs and other groups. So I'm encouraged by that. I think it's a good environment. It's a good thought. I have a – I have to admit I haven't got a developed notion of how it might work, but I think, potentially, they – that person could provide the clinical care, holistic clinical care and actually become the care co-ordinator, roll that – I think that's, potentially, really useful and deserves exploring.

MS HUTCHINS: Yes. And in terms of the care-coordinator role – do you think that that's best fulfilled by someone sitting within the facility, or do you think a third party could fulfil that role?

DR SKINNER: It's really tricky, because the most important thing that a patient can have with someone in that role is a good relationship and trust. And I like the notion that patients have a regular general practitioner and that's the person they always see. But we need to be realistic about people – there's a flexible workforce; people aren't always available, and this is now a 24-hour business. So I think we need some shared models. And so I actually think, probably, the model of a nurse practitioner based in the facility, liaising with a general practitioner – and I'm not sure, where they're located – might be a good medium.

MS HUTCHINS: Yes. And in terms of encouraging, say, a multidisciplinary-team model which might include also the involvement of external specialists – how do you see that as working practically within the facilities?

DR SKINNER: I think you need to – I like the idea of clinic rooms in the facilities and somewhere where someone can see. I think, if you had someone who's based in the facility and knows the residents well, actually you'll find a lot of the need for visiting people in specialist rooms might disappear, and I think we haven't explored telemedicine enough.

So at the moment, a lot of our funding-structures rely on patients being physically in the environment of the clinician to bill, because it's fee-for-service, and I think we need to explore different funding-models which allow some flexibility around telemedicine and around visiting specialists. I also do think we've overspecialised. I

think we – I think medicine's overspecialised, and there's a role for very good generalists in this space. I'm a generalist, though. I'm biased.

MS HUTCHINS: And what level of care do you think that facilities should reasonably be expected to be able to provide without needing to go to external help?

DR SKINNER: I think – so I completely want people with acute injuries to be able to visit emergency departments; they are not wasting our time. They belong with us when there is an acute intervention that's needed immediately. But I think a lot of routine care – that if it was planned better – so things like routine catheter changes, routine feeding-tube changes, routine medication reviews – that with planning and co-ordination could actually be pro-actively designed to reduce the rate of sort of crisis-like interventions that are required.

MS HUTCHINS: And what do you think needs to occur on a practical level? In facilities where you're not seeing that type of care being delivered, what's required?

DR SKINNER: I think you need higher levels of clinical – senior clinical staff who can make decisions, and you need relationships, because medicine is all about relationships. It's about trust; it's about deep knowledge of the patient, and you need – I honestly think you've described a lot of it, which is – you need good recordkeeping systems; you need good relationships. You need good care co-ordination, and it needs to be pro-active. It needs to be well-documented, and it needs to be pragmatic and sensible and take the person's context and wishes into account.

MS HUTCHINS: And when it comes to the outreach service that your hospital provides – what are the main types of things that they're doing to assist people in residential aged care?

DR SKINNER: They tend to visit to do stuff like the catheter – so we do a lot of capacity-building as the first thing. So if we find a facility's calling for routine catheter changes, we'll actually offer to go out there and run a teaching-session with their nursing-staff to teach them how to do it. We provide a lot of co-ordination with the outpatient clinics at the hospital. So we try to be the bridge between – make sure that things happen and arrange transport. We often – if someone's had a fall, often our – my outreach service will go and attend the patient in situ and arrange for the mobile X-rays to go past. We can do dressings. We can arrange intravenous antibiotics through our hospital-in-the-home service. There's actually a lot we can do without bringing the person into hospital, but it requires knowledge and relationships and communication.

MS HUTCHINS: Yes. And we mentioned earlier the quarterly meetings that are held between your health network and the facilities. How productive has that been when it comes to building those relationships and getting better care outcomes?

DR SKINNER: I think a lot of the relationships actually happen from the day-to-day clinical encounters. Where the regular meetings are useful is we can identify problems and practically try to smooth them out. So just even trying to keep an up-to-date register of the facilities in our areas, what facilities are available within those, what hours people can be contacted, who the case manager is. Just even that sort of basic information is a really useful thing that comes out of the regular liaison program.

MS HUTCHINS: What are the other types of issues that you discuss?

DR SKINNER: We talk about transfers after hours. We talk about interactions with the primary health care network. We talk about what – we run regular education sessions around aged care with the general practitioners and we talk about what sorts of topics we might want to include in those. We talk about attitudes and processes within the emergency department, so we've tidied up some of our practice within the ED based on feedback from those meetings, so they're really quite useful.

MS HUTCHINS: Yes. I would like to turn now to the topic of advance care planning. You express a view in your statement that advance care planning as currently designed doesn't work.

DR SKINNER: Yes.

MS HUTCHINS: Why do you think that is?

DR SKINNER: I think the trouble with advance care planning is we've got templates that – it's not guided enough for me. So we've got templates that people use and they include a lot of options that may or may not be relevant to the person's current context. And I think they create the artificial illusion of choice. I know that can sound a bit paternalistic but legally speaking medical officers are not meant to – we are not duty bound to provide care that we believe is clinically futile. When you have advance care directives that allow people to select options which would be clinically futile in their clinical scenario, then I believe the advance care directive is actually problematic.

I think the other problem with advance care directives is you have templates that people can get online or they can get at the post office, and they'll sit and fill them in when they're young and fit, and they'll choose things like "I don't want blood products" or "I don't want intubation" when that would be medically sensible. And there's not much clinical guidance to what goes into the advance care directives, and I think the process of advance care directives should be a more multidisciplinary formal thing, so I think – you know, an advance care directive – I think an end of life planning session should occur whenever anyone moves into residential aged care. Not because end of life is necessarily imminent but the conversation should be had.

And I think that's got to involve the patient, their family and carers, the general practitioner and the residential aged care staff and it's got to be pragmatic and

realistic. So if someone says I would like this person to receive full intensive care, you know, and life support when they come to hospital, but yet you know that a sensible rational clinician – I've got a role in resource stewardship, I have to be mindful of that as well – is not going to provide that, then that advance care directive has actually made the situation worse. I think that end of life planning conversation needs to be pragmatic and realistic and guided by senior clinicians with experience in end of life care, and not be something that patients and their families can do without that level of guidance where then they might actually be set up – it's setting up clinicians and the families themselves for disappointment and failure when they encounter the acute hospital environment.

MS HUTCHINS: What kind of experience have you had when it comes to the situation where you receive patients that don't have any plans in place?

DR SKINNER: When patients don't have any plans in place and I believe they're at end of life, which is a situation I have a lot of experience in, I will have a very nuanced thoughtful conversation with the patient and their carers. I often do it with the patient themselves if they are capable of understanding. I will do it with the family offline as well. I will try wherever possible to involve the clinicians that know the patient well from the community, and we will make decisions together about where we proceed. But I will try to make sure that I'm heading that conversation in the direction of acceptance of what is clinically meaningful, not just following what's in a document for the sake of it.

MS HUTCHINS: And you express a view in your statement to the effect that the time that a person is presenting to the emergency department is not the ideal time for those types of discussions, you know, to be first had.

DR SKINNER: No, I think this is a – I think it should be a routine process that happens, and I think, you know, the transition point from moving into aged care is possibly a sensible place to have it. But it might also just be something that sits on a schedule at a certain age group within our community or there might be some key trigger events that mean an end of life – a multidisciplinary end-of-life planning conversation occurs. And I think we have to be careful about what we call it because end-of-life planning doesn't necessarily mean you're dying right now. It could mean, hey, this is a good opportunity to do it later, so we probably need to work out what it's called a bit better.

MS HUTCHINS: Yes. And in terms of any – the introduction of, say, a mandatory requirement for residential aged care providers to assist in that process, what do you think would be the appropriate involvement of a residential aged care provider in that regard?

DR SKINNER: I think they're a stakeholder around the table but I think you need senior clinicians with experience of end-of-life care and palliative care to be involved. I don't like mandatory, I have to admit; I would rather create incentives for people to do this well rather than mandatory. But I'm constantly surprised by

people that come into emergency in extremis and no consideration has ever been given to their end-of-life wishes, despite the fact that they've been on a pathway with a deteriorating chronic illness for several years.

MS HUTCHINS: So in terms of this multidisciplinary meeting that you're proposing, what do you think needs to be done practically to encourage that to occur?

DR SKINNER: I think we need to, again, look at funding structures and our staffing structures within aged care facilities, and look at which workforce should be doing this and training them and remunerating them properly to do it well. It can't – this can't be an add on; it needs to be something we encourage, so it possibly needs its own Medicare item number or it needs KPIs around it, but it needs to have some sort of structure to support it happening.

MS HUTCHINS: Yes. Turning to the topic of palliative care, do you have instances where you receive people in your emergency department who potentially could have – it's a potentially avoidable admission if they had have been receiving palliative care treatment in the facility?

DR SKINNER: Yes, we receive a lot of people who are dying, where the ambulance is called and they're actively dying and they literally come into emergency. And I'm a senior clinician; I have the clinical authority to say, "Let's just move to comfort-based care rather than acute intervention". And I think that's something we could do much better. I think we've got a problem with training, and I think that palliative care is a relatively new specialty and we haven't – we're starting to see palliative care moving into aged care but again, our health care system is currently designed around acute episodic care for younger people.

So the palliative care came out of the cancer services, but we've always thought of aged care and dying as dying is a routine part of aged care, and I think we need to start nuancing that a bit and actually preparing people better, and having a workforce that is trained to support that process better. And I understand why people are anxious about dying because we as a community don't deal with it well and – but I think this is something where we could do a lot of capacity building within aged care facilities to provide this really well and to be comfortable and actually proud of providing people with doing this well.

MS HUTCHINS: And in your experience with aged care facilities in your network are the facilities well equipped to be providing appropriate palliative care at the moment?

DR SKINNER: It's highly variable. We're very lucky at my hospital because we have a staff specialist palliative care physician, and he's got a very good outreach into our local aged care facilities including capacity building, but that's not the case everywhere.

MS HUTCHINS: And do you think that the facilities themselves should be well equipped to provide palliative care without the need or the reliance on outreach services?

DR SKINNER: I don't know, I can't comment on that. I just – I just feel it's – a lot of people are transferred to emergency departments when they are actively dying, and I think there's a mix of it not being recognised or a mix of people not feeling they have the authority or permission to provide palliative comfort-based care rather than acute interventional care.

MS HUTCHINS: Yes. In terms of an issue that we've touched on briefly already today in your evidence in relation to the view that the fee for service model is perhaps not the best model to achieve good care outcomes; if there was the introduction of a new funding model to encourage greater care within residential aged care facilities, what are the elements that you would like to see of that care that's being provided?

DR SKINNER: I really think that we could do – so aged care facilities are not something that people choose to do. They go there because they have to, because they're carrying a lot of complex and chronic care needs. I think a lot of families do believe that aged care facilities take more responsibility for medical care than they currently do. And I think if you change the workforce such that you could do stuff like have – have practitioners who are regularly based in the facility who do regular ward rounds, who do proactive care reviews, who develop care plans, hold regular multidisciplinary meetings with families and patients, I think we could move to a much more proactive model and I think that would stop the reactive medicine which is sending people into acute hospitals in the middle of the night for often quite minor problems.

MS HUTCHINS: Yes. In your statement you say:

> *We need to develop mechanisms that allow the acute and aged care sector to work together better to provide coordinated care, to minimise duplication of resources and to prevent the shifting of costs and risk.*

DR SKINNER: Yes.

MS HUTCHINS: Do you have any suggestions to the Royal Commission how this could be achieved?

DR SKINNER: Yes, well, part of the problem we have here is, obviously, aged care sits with the Federal government and acute hospital care sits with a State government. So we've got a lot of inter-jurisdictional problems with protocols and funding models, and I don't quite know how you solve that but I think it stems from that and I think we need to – I know with my GRACE outreach model, in terms of the funding of it, we had to accept that, yes, the hospital was providing some in-reach care into nursing homes but it actually saves the hospital money if we do it. And I

don't like talking about money because this should be about people and their care, but I think we need to develop some funding models are where the States and the Commonwealth government come into partnership because this is transitional care.

So fee-for-service Medicare happens in the community. In hospitals we have salaried and contracted medical practitioners. If we need them to meet in the middle, we don't – at the moment there's a complex system of you have to get the GP to refer to a clinic, and it goes backwards and forwards. We need to actually acknowledge that this space exists and build a funding model that allows us to do this well. That's true of both the money but it's also true of decision-making authority and risk, who owns people, where are the protocols, because at the moment the State governments are building protocols that impact on nursing homes which are beyond their reach. And we need – we need to be working from the same set of protocols and those protocols need to be purpose-designed for the people that they're talking about, not just using, you know, cardiac protocols, head injury protocols that were researched on 40-year old men.

MS HUTCHINS: Yes. And in terms of building the workforce, there's been a suggestion that one way to encourage nurse practitioners may be through the introduction of some type of scholarship fund for university study.

DR SKINNER: Yes.

MS HUTCHINS: Is that something that you think would be beneficial?

DR SKINNER: Potentially. I can't really comment on that, sorry.

MS HUTCHINS: Yes.

DR SKINNER: I think there are lots of people who would quite like to be nurse practitioners and I think – I think, basically, creating jobs where they can be independent and take pride in their work is a good start but, yes, it is expensive to do a masters and to become a nurse practitioner so scholarships would be a good start.

MS HUTCHINS: Thank you.

DR SKINNER: Thank you very much.

MS HUTCHINS: There's no further questions, Commissioners.

COMMISSIONER PAGONE: Dr Skinner, thank you for giving your evidence. You're in a very important position and able to give us an insight from different perspectives. It's been very helpful indeed.

DR SKINNER: Thank you very much. Good luck.

COMMISSIONER PAGONE: Yes. Thank you.

<THE WITNESS WITHDREW [11.17 am]

MS HUTCHINS: Commissioners, we now have a scheduled break, I understand.

COMMISSIONER PAGONE: Sorry?

MS HUTCHINS: We now have a break scheduled.

COMMISSIONER PAGONE: Yes. We might even, I think, possibly make up some time. So half past?

MS HUTCHINS: Thank you.

ADJOURNED [11.17 am]

RESUMED [11.34 am]

COMMISSIONER PAGONE: Yes, Mr Knowles.

MR KNOWLES: Thank you, Commissioners. Yesterday, the Royal Commission heard from four senior State Government health public servants about the interfaces between the aged care and health systems. We now call senior health public servants from the remaining four State and Territory jurisdictions. They are Dr Maggie Jamieson, Acting Chief Executive of the Northern Territory Department of Health; Mr Terry Symonds, Deputy Secretary of the Health and Wellbeing Division of the Victorian Department of Health: Mr Michael De'Ath, Director-General of the Australian Capital Territory Health Directorate; and Mr Ross Smith, Deputy Secretary of the Tasmanian Department of Health. Perhaps if each of them could take the oath or affirmation at this stage.

COMMISSIONER PAGONE: Yes. Thank you.

<MARGARET ISOBEL JAMIESON, AFFIRMED [11.35 am]

<TERRENCE LLOYD SYMONDS, AFFIRMED [11.35 am]

<MICHAEL HAROLD DE'ATH, AFFIRMED [11.36 am]

<ROSS JASON SMITH, AFFIRMED [11.36 am]

COMMISSIONER PAGONE: Now, there's some appearances we should be taking.

MR KNOWLES: That is so, yes. Thank you, Commissioner. Perhaps if the parties with leave to appear can announce their appearances at this stage.

MS C. HARRIS QC: If the Commission pleases, Claire Harris. I appear for the State of Victoria.

COMMISSIONER PAGONE: Yes, Ms Harris.

MS S. KAY: If it please the Commission, my name is Kay. I appear on behalf of the State of Tasmania.

COMMISSIONER PAGONE: Yes. Ms Kay. Yes, Mr Knowles.

MR KNOWLES: Thank you. If I can start with you, Dr Jamieson; can you tell the Royal Commission your full name.

DR JAMIESON: Margaret Isobel Jamieson.

MR KNOWLES: Yes. And You have prepared a statement for the Royal Commission dated 8 November 2019 which bears the number WIT.0567.0001.0001. Have you read your statement lately?

DR JAMIESON: Yes, I have.

MR KNOWLES: Are there any changes that you wish to make to it?

DR JAMIESON: No, thank you.

MR KNOWLES: Are the contents of your statement true and correct to the best of your knowledge and belief?

DR JAMIESON: Yes, they are.

MR KNOWLES: Thank you. I seek to tender the statement of Dr Maggie Jamieson dated 8 November 2019.

COMMISSIONER PAGONE: The statement of Dr Jamieson will be exhibit 14-35.

EXHIBIT #14-35 STATEMENT OF DR JAMIESON DATED 08/11/2019 (WIT.0567.0001.0001)

MR KNOWLES: Mr Symonds, could you please tell the Royal Commission your full name.

MR SYMONDS: Terrence Lloyd Symonds.

MR KNOWLES: Yes. And you have prepared a statement for the Royal Commission dated 13 November 2019 bearing the number WIT.0565.0001.0001.

MR SYMONDS: Yes.

MR KNOWLES: Yes. Have you read your statement lately?

MR SYMONDS: I have.

MR KNOWLES: Yes. And are there any changes that you wish to make to it?

MR SYMONDS: No.

MR KNOWLES: Are the contents of your statement true and correct to the best of your knowledge and belief?

MR SYMONDS: They are.

MR KNOWLES: I seek to tender the statement of Mr Terry Symonds dated 13 November 2019.

COMMISSIONER PAGONE: That statement will be exhibit 14-36.

EXHIBIT #14-36 STATEMENT OF MR TERRY SYMONDS DATED 13/11/2019 (WIT.0565.0001.0001)

MR KNOWLES: Mr De'Ath, could you tell the Commissioners your full name.

MR DE'ATH: Michael Harold De'Ath.

MR KNOWLES: Yes. And you have prepared a statement dated 8 November 2019 bearing the number WIT.0572.0001.0001.

MR DE'ATH: Yes.

MR KNOWLES: Have you read your statement lately?

MR DE'ATH: I have.

MR KNOWLES: Yes. And are there any changes that you wish to make to your statement?

MR DE'ATH: There are no changes.

MR KNOWLES: And are the contents of your statement true and correct to the best of your knowledge and belief?

MR DE'ATH: Yes.

MR KNOWLES: I seek to tender the statement Michael De'Ath dated 8 November 2019.

COMMISSIONER PAGONE: That's exhibit 14-37.

EXHIBIT #14-37 STATEMENT MICHAEL DE'ATH DATED 08/11/2019 (WIT.0572.0001.0001)

MR KNOWLES: Now, Mr Smith, can you tell the Commissioners your full name.

MR SMITH: Ross Jason Smith.

MR KNOWLES: Yes. And you are here giving evidence in the place of the secretary, Ms Kathrine Morgan-Wicks.

MR SMITH: Correct.

MR KNOWLES: Yes. And you're familiar with the contents of the response given by her to the Royal Commission on 8 November 2019 which bears the document number WIT.0569.0001.0001?

MR SMITH: I am.

MR KNOWLES: Yes. And have you read that response lately yourself?

MR SMITH: Yes.

MR KNOWLES: And are there any things in that response that you yourself would like to change?

MR SMITH: No.

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

MR SMITH: Yes.

MR KNOWLES: I seek to tender the response given by the Secretary of the Tasmanian Department of Health, Ms Kathrine Morgan-Wicks dated 8 November

2019, the contents of which Mr Smith has confirmed are true and correct to the best of his knowledge and belief.

COMMISSIONER PAGONE: Yes. Well, I'm – my attention has been drawn to the fact that my list of exhibits had omitted on the typed list number 14-34. So we've skipped a number and we may as well put that witness statement there.

MR KNOWLES: Yes. As the Commissioner pleases.

EXHIBIT #14-34 RESPONSE BY THE SECRETARY OF THE TASMANIAN DEPARTMENT OF HEALTH, MS KATHRINE MORGAN-WICKS DATED 08/11/2019 (WIT.0569.0001.0001)

MR KNOWLES: Now, can I say something at the outset to the four of you. Obviously, the main purpose of the evidence today is to obtain an indication of the position of each State and Territory about a series of propositions that are being tested by counsel assisting at this hearing this week. There are many points to be covered on those propositions and so I therefore ask, wherever possible, that you keep your responses as succinct as you possibly can. If I can start with the topic of the responsibilities of the various players in the provision of aged care and health care services to those in aged care, Mr Symonds, if we can go to paragraph 19 of your statement, and it should come up on the screen in front of you for those of you that don't actually have a copy of his statement in hard copy; you have referred to the notion that:

> *Facilitating access to health care is the core responsibility of the residential aged care service.*

And if we can also bring up now Mr De'Ath, your statement at paragraph 41, and there you have said that:

> *Approved providers, relevantly, should provide and fund a high standard of best practice health care to residents.*

Can I start with you, Mr De'Ath. What do you consider that obligation described by Mr Symonds as facilitating access to health care extends to?

MR DE'ATH: In terms of the Territory responsibility, or the Commonwealth?

MR KNOWLES: No, in terms of that residential aged care provider responsibility.

MR DE'ATH: Certainly.

MR KNOWLES: Where do you see the boundaries of that particular facilitation of access to health care.

MR DE'ATH: So we would see that the residential aged care provider would ensure that their residents are appropriately connected with the various health resources that are provided within either primary care sector or the Territory-provided health service.

MR KNOWLES: And in terms of that connection that you describe, would that include arranging an appointment with a relevant medical practitioner?

MR DE'ATH: We would expect so.

MR KNOWLES: Would it include taking a resident to that appointment?

MR DE'ATH: We would expect so.

MR KNOWLES: So transporting a resident, escorted by staff of a residential aged care facility is something that would fall within the remit of responsibility of that aged care facility?

MR DE'ATH: Again, we would expect so.

MR KNOWLES: Can I ask the other members of the panel, does your view accord with what has been said by Mr De'Ath; perhaps starting with you, Dr Jamieson.

DR JAMIESON: Yes, it does.

MR KNOWLES: Yes. And Mr Symonds.

MR SYMONDS: Yes.

MR KNOWLES: Yes. And Mr Smith.

MR SMITH: Yes.

MR KNOWLES: Yes. Can I ask, in terms of access – facilitating access, would that include providing – and I will return to you now, Mr De'Ath, would it include an obligation to provide telehealth facilities?

MR DE'ATH: I wouldn't be able to comment on that, I'm sorry. I'm not aware of that – whether that would be a responsibility or not.

MR KNOWLES: Yes. Okay. Can I ask the remaining members of the panel for their views on whether or not that would be something that would fall within the terms of the scope of responsibilities for a residential aged care provider? Starting with you again, Dr Jamieson?

DR JAMIESON: Within the Territory context, I would say yes. Sometimes the distances to care for a specialist are lengthy and to have access through telehealth

within the facility would be extremely helpful. It would save the person a long journey in many cases, and enable care at the first juncture.

MR KNOWLES: Would that obligation to facilitate access as such, would it also require staff at the facility who could operate the telehealth function and remain in any telehealth conference to assist with understanding perhaps what is actually required by a specialist or other medical practitioner who is undertaking the consultation in that way?

DR JAMIESON: Absolutely.

MR KNOWLES: And can I ask for your view on that, Mr Symonds.

MR SYMONDS: Yes, we think that's a very reasonable expectation to provide telehealth facilities. We think telehealth allows residents to avoid inconvenient and sometimes, you know, possibly unsafe journeys to hospital, long waits to see specialists there. So we think there's lots of reasons why that's a reasonable expectation. We also have experience in Victoria of models of care that use telehealth in Bendigo and a lot of the Mallee region, you know, upwards of three-quarters of specialist assessments are now delivered by telehealth to aged care, so we know that it's possible.

We know that in some other parts of the State our specialists services say they don't use telehealth because they don't believe the aged care facilities are properly set up at their end. So we do think there is a willingness and we've demonstrated it can work, so we think it's a reasonable expectation to provide better and more convenient care for residents to have that provided in aged care.

MR KNOWLES: Just following up on something you said there, Mr Symonds, while there might be an expectation that that ought to be an obligation imposed on residential aged care facilities, would you agree that the fact that those – that functionality doesn't exist in many residential aged care facilities would tend to demonstrate some confusion about the precise limits of what the responsibilities of residential aged care providers are?

MR SYMONDS: I doubt there's confusion. I'm sure aged care providers know it's not mandatory to provide telehealth at present, but I think we have plenty of experience on our side of what a difference it would make, and so therefore I conclude that if it was mandatory, if it was definitely expected more clearly, that would help with promoting uptake.

MR KNOWLES: Yes. Mr Smith, do you have a view on these matters yourself?

MR SMITH: Yes, I guess if we go back to your original thing around the responsibility to facilitate the access - - -

MR KNOWLES: Yes. That's what I'm putting.

MR SMITH: I'd say that's the – that's the overwhelming principle. My view is I would be reluctant to say blanket things around technologies like, you know, telecare and what have you as well, because they may not – you know, they may not necessarily be suitable for a particular patient's need and a particular patient episode. I think if we're always making sure that we're being governed by the idea about facilitating patient's access to the right care I would say yes, as opposed to saying a blanket, you know, telehealth care or ..... health care or whatever is – is something that everyone should have. It's access to the right care that should be the principle.

MR KNOWLES: Do you see there being a need, given the frailty and lack of mobility of many people living within residential aged care facilities for there to be, in order to facilitate that access, provision made somewhere to ensure that specialists can at least visit residential aged care facilities, that they have appropriate facilities at the facility for specialists or other medical practitioners to conduct consultations in?

MR SMITH: Yes. And again, I think, you know, anything that enables people to get access to the care – to the care that they need as close as possible to their residence or their home, I think is something that we should be, you know, we should be facilitating and supporting.

MR KNOWLES: Do you think there should be some sort of obligation on residential aged care providers in clear and explicit language that they provide access to visiting medical practitioners to a private and well-lit space together with necessary equipment and necessary clinical staffing support for consultations?

MR SMITH: Again, I would – I would go back to the principle that I think if the overriding principle is making sure that the facility is able to access the right care for the patient in a particular context at any given time and if that involves – if that's one way of doing it or that's the appropriate way of being able to deliver that care for that patient or that cohort of patients, I would think that we should be exploring that.

MR KNOWLES: What about you, Mr De'Ath? Do you see there being merit in some specific clarification of requirement in that way?

MR DE'ATH: I, certainly, see merit in the clarification. I think, if I were to look at that from a residential-aged care provider perspective, they would want clarification about what they should be providing.

MR KNOWLES: Yes.

MR DE'ATH: And we would want to know that the necessary agreed requirements were met.

MR KNOWLES: Yes, and in terms of a private and well-lit space – that could well be a resident's room, provided that they were in that on their own.

MR DE'ATH: Correct; so the definitions are important.

MR KNOWLES: Yes. Mr Symonds, do you have a view on the questioning in relation to whether or not there ought to be some statutory requirement imposed on a residential-aged care provider to provide that sort of space as well as the facilities that facilitate consultations from visiting medical practitioners?

MR SYMONDS: Yes, I do, and I agree with the last comment you made about a resident's room. I think the earlier witness we heard, the family member, made that comment herself, that it may be her parent's room, that is a suitable place for that consultation to occur. But I do think clarity around that would help.

MR KNOWLES: Yes. Dr Jamieson?

DR JAMIESON: Yes. I would endorse those comments and support them. I think it is important, that – a person has a right to privacy when they're meeting with their specialist in an appropriate setting and one in which they feel comfortable as well.

MR KNOWLES: Yes. Now, the reason I've asked you those questions is really just to highlight that perhaps there's a lack of clarity in some ways about the responsibilities of various parties in providing healthcare to residents in residential aged care in particular. Would you agree? There is a greater need for clarity of the respective responsibilities of those charged with providing medical – healthcare to residents in aged care facilities, Mr Symonds?

MR SYMONDS: Yes, I would. If I could cite the example of part 3 of the Quality of Care Principles attached to the Aged Care Act – that includes a fairly prescriptive list of healthcare services that should be provided, and I quote the heading at the top of the page of part 3 – to be provided for all care recipients who need them. And that includes for example nursing-services that include initial assessment and care planning, ongoing management and evaluation, establishment and supervision of a complex pain-management or palliative-care program, concession care and maintenance of tubes et cetera, and it goes on.

We believe that's a pretty good guide to the healthcare responsibilities that aged care providers have under the Act. But I would share with you that, when I raised this with a colleague who works for a private aged care provider during the week, they pointed out to me that there are words on the page that include services by nurses for example, acting within their scope of practice, and if they don't have sufficiently qualified nurses, they can't provide the services that are in here. They also pointed out the words "that services may include", not "must include", and so that – it occurs to me, that people are reading this page in different ways.

MR KNOWLES: Yes.

MR SYMONDS: And we read this as a good guide to the services that should be provided, but private aged care providers might read this as an optional list.

MR KNOWLES: Yes. Do – can I ask each of you otherwise on the panel whether you agree with what Mr Symonds has said about there being a lack of clarity in respect of the obligations that a residential-aged care provider has to provide healthcare to residents in the facility? Can I start with you, Mr Smith?

MR SMITH: I guess I would say that it would probably vary, but I would support the idea that providing greater clarity would be a positive move.

MR KNOWLES: Yes, and Mr De'Ath?

MR DE'ATH: I'm very pleased, Mr Symonds has cited the document and the list, and I support his remarks in relation to the importance of the wording and points of clarification and what we would, probably, refer to as some grey area and discretionary area that could be tidied up in the interests of residents.

MR KNOWLES: Dr Jamieson?

DR JAMIESON: Yes. I would agree; the list makes an excellent backdrop against which providers could determine services, but there are some clarifications that would be useful.

MR KNOWLES: Do you also agree, Dr Jamieson, that what one party's responsibilities are will also depend on the nature of responsibilities that another party or other parties have in the provision of healthcare?

DR JAMIESON: Healthcare doesn't happen in isolation, and people move through various parts of the system. So it's really important, that they're connected and understand ..... each part of the system can do as a complement, as a support and as an enabler, and I think that's an important component, and I don't think there is real clarity around the difference in roles within aged care.

MR KNOWLES: Yes. So in addition to the roles and responsibilities of residential-aged care providers, do you see there being a need for a greater clarity of understanding of the role and responsibilities of other health-services providers for those in residential aged care or receiving high levels of care in the community?

DR JAMIESON: I think so. I think there is often a misunderstanding of what's available, what's – what they can access; health is an intensively complex business and one in which we perhaps have not communicated well with other partners as to what we can do and what our limitations are as well.

MR KNOWLES: Is it a question of what you can do or what you should do as one party and what another party should do in terms of governance at least – isn't that critical to good governance, that there's an understanding of each party's roles and responsibilities?

DR JAMIESON: Absolutely. Absolutely.

MR KNOWLES: Yes. Do you agree with that, Mr Symonds?

MR SYMONDS: Absolutely.

MR KNOWLES: Yes. Mr De'Ath?

MR DE'ATH: Yes. I certainly do. And as my statement has provided, I think we can see where in the Australian Capital Territory we've taken steps to provide some co-ordinating role and supporting the system being more coherent.

MR KNOWLES: Yes. Mr Smith, can I ask for your views? Do you depart from anything that's been said by others?

MR SMITH: No, no. I would .....

MR KNOWLES: Can I go to paragraph 33 in your statement, Mr Symonds, where you've referred to the Victorian Government welcoming a collaborative process to develop a nationally consistent model of appropriate healthcare for people in aged care, with clear roles and responsibilities across key actors. Has that idea been taken up with other Governments, the Commonwealth and other jurisdictions?

MR SYMONDS: I'm not aware of any specific processes for a model of care to be agreed nationally for healthcare in aged care. If that's the question you're asking - - -

MR KNOWLES: Yes. Yes; has there been a – some sort of move towards trying to resolve that?

MR SYMONDS: No; there have been discussions, I suppose, a bit along the lines of your previous question about roles and responsibilities. There are discussions, as you may know, between States, Territories and the Commonwealth at the moment about how we best measure transfers of people from aged care facility into the hospital system, delays for people accessing aged care in the hospital system. These are issues that arise round the provision of healthcare, but I don't – I'm not aware of a process to develop a more prescriptive model of care for healthcare that would be shared and supported by all of the various parties including aged care providers, Commonwealth-funded GPs for example, and specialists working in either private practice or the State system. I'm not aware of a process to develop that model of care collaboratively across States and territories.

MR KNOWLES: Do you – yes. Would you then have a sense of what the key features of the model of care that you refer to in paragraph 33 might look like and how it would be implemented in practice?

MR SYMONDS: I would say that the evidence the royal Commission's heard to me is suggesting a sort of convergence of views. I have heard about models of care across several States and territories for example, where tertiary services, specialist services are developing in-reach or outreach models of care that varied slightly, but

all provide some kind of specialist care into aged care facilities. I think the evidence that I've heard from people describing those models all points out the key role of primary care in supporting or underpinning those models. And numerous witnesses including earlier today have pointed out some of the gaps that exist in basic nursing-care for example, in aged care itself.

So I don't think we're that far away – to be honest – from the key features being described along the lines I've just mentioned, basic nursing care, perhaps along the lines of part 3 of the Quality of Care Principles, good primary care you may have heard described from other witnesses and specialist care along the lines of models described yesterday from Queensland, this morning in WA, some of the stuff described in our own statements, our residential in-reach models that are now available statewide. They vary slightly, but I think they share common features.

MR KNOWLES: Yes. Yes. Well, I definitely want to come back and explore with all of you those outreach, in-reach services to which you've just referred. But can I ask each of you whether you have a conception of how the overall model of care which Mr Symonds has just referred to – whether you have a different view to that which he has described or whether you broadly agree with the view that he has as to how that model of care would work for people in residential aged care, particularly accessing healthcare? Can I start with you, Mr Smith?

MR SMITH: I'm not – in terms of a consistent model or whether it's a consistent frame-work – I'm not quite sure. My view is – I think you would start with a frame-work of principles or things that you want to achieve and maybe look at testing different models to see whether – in different settings, through pilots to see whether or not they actually meet the framework. But I might be taking Mr Symonds' meaning of "model" in a different way. But I would think that in principle – yes.

MR KNOWLES: Yes. Mr De'Ath?

MR DE'ATH: I do believe that we know a lot about things that work or have been trialled and haven't worked so well. When I look at – for example in my statement describe, I think, four key programs that the territory Government has funded which really indicate the need for better co-ordination, better access to GPs, better in-home, in-residence support, better co-ordination, triaging and so on and, certainly, in the palliative-care space, extensive supports. So I think those attempts on the part of State and territory Governments point to a very, very important need, an unmet need at times, to have a far more coherent view of what the model of care or models of care look like in aged care.

MR KNOWLES: Dr Jamieson?

DR JAMIESON: I think there is a need to establish a practice across aged care that will meet the needs of complex conditions that are apparent in aged care, and I'm not sure, that – at this current moment in time, that we have a standardised way to address that across our system.

MR KNOWLES: Yes. I don't know whether any of you heard the evidence that was given by Professor Len Gray and Professor Leon Flicker yesterday. They endorsed a proposition, that there's a need for agreement between Commonwealth and State and territory Governments, setting out clear definition and delineation of respective roles and responsibilities of, on the one hand outreach and other hospital-led services and on the other hand other sources of clinical care, such as residential-aged care services and primary-care services. Do you agree, for that need for a documented and detailed agreement at that higher level about respective roles and responsibilities, Dr Jamieson?

DR JAMIESON: Yes, I do.

MR KNOWLES: Yes? And Mr Symonds?

MR SYMONDS: Yes. I do.

MR KNOWLES: Yes. Mr De'Ath?

MR DE'ATH: Yes. I do.

MR KNOWLES: Mr Smith?

MR SMITH: Yes.

MR KNOWLES: And Professor Flicker also accepted that the national health-reform agreement was an appropriate mechanism in which to set out the details of such an agreement. Can I ask for your views on that proposition, whether that is an appropriate place in which to set that content out? Can I start with you, perhaps, Mr Symonds?

MR SYMONDS: Yes. I think that's an appropriate place to set it out at a high level. I think the national health-reform agreement has a – in its various forms it can have a long gestation period, and it's – I think our experience is – can be difficult to interpret and prosecute, but it's – but as a high-level commitment, shared commitment among all jurisdictions, I think, it's a perfectly reasonable place to put it. It's an agreement about health, and we are talking about healthcare for people in aged care; so it's a reasonable place to sit that.

MR KNOWLES: Yes. Yes. Mr De'Ath?

MR DE'ATH: Yes. I'd concur with those comments and in particular the nature of the time it can take, to settle to a national health-reform agreement, as some concern and would not want to see this important work in any way held up by ..... process, but I agree. It's the right process, and it may or may not be for the Commission, to direct how expedient a process settling the national health-reform agreement could be.

MR KNOWLES: Yes. Dr Jamieson, do you share those views?

DR JAMIESON: Yes, I do.

MR KNOWLES: Yes. And Mr Smith?

MR SMITH: The national health-reform agreement is one potential vehicle. It's not the only one. My feeling is, whatever the vehicle is, it doesn't matter, as long as there is some sort of - - -

MR KNOWLES: There needs to be some documentation of that decision; yes.

COMMISSIONER BRIGGS: Might I just intervene and – we were told yesterday by the secretary of the department of health in the Commonwealth that the next national health-reform agreement is moving along very swiftly and indeed likely to be finalised before we complete our work here. Is it possible within those agreements, to provide additional schedules or items over time, or in those circumstances, is it therefore necessary, to have an additional reform agreement?

MR KNOWLES: Mr Symonds, perhaps if you - - -

MR SYMONDS: If I could – the national health-reform agreement does fore-shadow and require other processes in various ways, business rules and schedules and other things. So if I understand the question – there's no barrier to the national health-reform agreement including a high-level commitment to do that work and develop such a schedule or agreement that would then be attached in some way to the national health-reform agreement. I can't think of any reason why that wouldn't be practical, to do that.

COMMISSIONER BRIGGS: Thank you.

MR KNOWLES: I take it, none of you disagree with what Mr Symonds has said, the remaining members of the panel? That's at a higher level. At a more local level residential-aged care providers' responsibilities: as we have heard earlier in the evidence, they can be stipulated in aged care legislation. What about other parties' responsibilities at a more local level: how can they be stipulated or enforced at a more local level? Can I ask each of you to consider that? Mr De'Ath?

MR DE'ATH: Yes. I think we can see, certainly, the opportunity for that; as I indicated earlier, there are a range of things that we are doing, which would, probably, be some of the things that would fall into those various things that would be stipulated. So from our perspective that is, probably, not a lot of hesitation. I think the issue comes down to – between Commonwealth and State, territory Governments about how various components of things are resourced to provide those services and meet even existing – let alone new – expectations.

MR KNOWLES: Yes. Mr Smith, do you have a view on that in terms of local – at the local level, the definition of other providers' responsibilities outside of the residential aged care facility?

MR SMITH: I agree with the concept, but I think in practicality we'd have to be very careful of what we're doing, because I think – we did hear, I think, from Ms Payget this morning around sort of ideas around residents and their ability to choose, and if we're talking about, potentially, people where we'd have mandated co-ordinators acting on behalf of residents – I think we'd have to be very careful about how we look at something like that, to make sure that we are incorporating at every step the resident's wishes, the resident's consent around how that process would work. So I think it's a sound idea. I think we'd have to be very, very careful around the application.

MR KNOWLES: Mr Symonds, is there scope for local definition of roles and responsibilities of those other than the approved provider?

MR SYMONDS: Yes; is the proposal you're testing that providers in a local area should also have a documented agreement between them as to who does what in addition to the agreement between Governments?

MR KNOWLES: Yes.

MR SYMONDS: I have no problem with that idea at all.

MR KNOWLES: Yes. And Dr Jamieson?

DR JAMIESON: I think that would serve to add to clarity of process.

MR KNOWLES: Just picking up on what was said earlier about the national health-reform agreement and starting with you, Mr Symonds – do you agree? That agreement should include a specific commitment by State and territory Governments to provide access to aged care residents to State- and Territory-funded services?

MR SYMONDS: I have no problem with that. That is an entitlement that they have under existing law as residents of States and territories, but it wouldn't be the only example of the National Health Reform Agreement repeating an entitlement that already exists in other law.

MR KNOWLES: What's an – is another example the Medicare principles, for instance?

MR SYMONDS: That's right. For example, we have lots of discussion about, for example, the right of patients to choose to access health care regardless of their insurance status. In fact, the agreement, I think, says that numerous times, even within the same agreement and it already exists elsewhere as well as an entitlement so that's one example of how the National Health Reform Agreement, I guess, could add emphasis to entitlements that might exist elsewhere. And if that's what you're thinking as the potential benefit of doing it there's no barrier to that.

MR KNOWLES: Would you see those State and Territory-funded services also being referred to explicitly as including subacute rehabilitation including for people who are in residential aged care or receiving high level care in the community?

MR SYMONDS: So again, I'm sorry, just to clarify the question, should the entitlement that might be reflected in the National Health Reform Agreement to State and Territory-funded services include the full range, including subacute rehab?

MR KNOWLES: Yes.

MR SYMONDS: Yes.

MR KNOWLES: Yes. Dr Jamieson, do you have a view on that in terms of that explicit commitment set out in a document such as the National Health Reform Agreement?

DR JAMIESON: I think being explicit about access to service is a good thing.

MR KNOWLES: Yes. Mr De'Ath.

MR DE'ATH: I would agree with a general principle of being explicit and clear.

MR KNOWLES: Yes. Mr Smith.

MR SMITH: I'd have to be convinced on what the actual need is because I guess we would regard that as a given.

MR KNOWLES: Can I turn now to a topic that you've already raised, Mr Symonds, and that's the multidisciplinary hospital-led outreach services which is part of what is being considered in the course of this week, in particular the effectiveness of local hospital network-led multidisciplinary outreach services for people living in residential aged care or receiving high level care in the community has been considered. It's fair to say, having regard to the evidence this week, that witnesses including State, other State and Commonwealth Government witnesses have broadly supported that model of care. I think it's also fair to say that thus far witnesses have tended to reject the notion that those models of care are only to be used for the purposes of hospital avoidance, for instance.

Can I ask each of you for your views about what the purpose of this particular model – well, firstly, whether or not you see benefits on such a model of care existing nationally and, secondly, what you would regard the purpose of that model of care to be, broadly speaking, starting with you, Dr Jamieson.

DR JAMIESON: I think in principle it would be a good thing. I would like to note that the Territory does have difficulty in recruiting allied health staff so a multidisciplinary team becomes difficult. But as a principle, I think it's important

and one that we should have an expectation for, for people, regardless of where they are.

MR KNOWLES: Just following up on that answer, do you think though if the resources are available that it is something that would benefit people who are living in residential aged care or receiving high level care in the community?

DR JAMIESON: Absolutely. Care in the right place for people is always an excellent principle and so if that can be done as an in-reach process, then that's a good thing.

MR KNOWLES: Yes. Mr Symonds?

MR SYMONDS: I think the main benefit for that model - - -

MR KNOWLES: Victoria already has something of this nature in large part across the State, would that be fair to say?

MR SYMONDS: That's right. So all of our metropolitan services, regional services, and a fair number of our subregional and smaller services are funded to provide residential in-reach programs and we believe the benefits of that are well beyond hospital avoidance. They are – they're the, you know, safest and most convenient and accessible way in which residents can access specialist care which many or most of them need, given the nature of their health needs that we are aware of for aged care residents.

MR KNOWLES: Mr De'Ath?

MR DE'ATH: I would absolutely agree that it's well beyond hospital avoidance. It's – you know, a lot of this work that we are engaged in is about maintaining the best quality of life and providing the highest quality care which is sort of overriding – overarching principles. What I – and we, again, would be supportive of the notion of the multidisciplinary approach. We've already seen significant benefit from that, for example, in our palliative care needs round model is one example where the benefits are overwhelmingly in favour of such an approach. What I would say is that in developing up whatever that looks like going forward is that it would need to be cognisant of, I think, two things. One is already – the things underway within State and Territories, that they are doing that and working well; that may be part of the approach.

So that is an important consideration as we would – as we go forward in developing such a model, and ensuring we didn't lose what was working well and bring something else in. The other one is being alive to the context; the ACT is a compact geographical territory, the Northern Territory is vast, and what are the implications for the various contexts that exist and workforce considerations and so on I think are of overwhelming importance to consider as such a notion would be developed.

MR KNOWLES: Yes, thank you. Mr Smith.

MR SMITH: Look, I think we're all trying, not just in relation to aged care facilities, to be able to address this gap that we have with increasing numbers of people with chronic conditions and many, you know, multiple conditions as well. And that, you know, obviously that's fairly well concentrated in aged care facilities but we're all trying to be able to address this gap between the GP and their capacity to provide episodic care and the gap between needing to actually genuinely attend a tertiary facility and receive acute care, and we're all looking to be able to provide that gap so that we can make sure that we're providing that care as constantly. Now, whether or not – I would be very, very reluctant to support an idea of a single model. My feeling is, as some of my colleagues here have suggested, making sure that we are picking up on what's working well elsewhere and building on that.

My feeling is we should be very open minded about a lot of products. So we've got the community rapid response model that we've developed and adopted in Tasmania and received approval for that to receive activity-based funding. We've got particular areas that we are looking to develop that, including in conjunction with aged care facilities. But we're also looking at health links, you know, we're looking – you know, my feeling is the notion of a single model, I would be very – I would be very wary of. I think we need a suite of things to be able to adapt them to local conditions and local patient circumstances.

MR KNOWLES: It's conceivable, isn't it, Mr Smith, that you might have a single model but it just has enough flexibility built into it to work in particular regions where there are different practical circumstances that present.

MR SMITH: Yes, I think that's the key thing. It needs to work on the ground for patient cohorts in particular communities. That's the fundamental requirement.

MR KNOWLES: Yes. Can I ask, you've all given evidence about what does exist in your respective States and Territories by way of hospital-led outreach services. Can I ask all of you, starting with you, Dr Jamieson, what, to your knowledge, prompted the establishment of the outreach service in your respective State or Territory? What was the need that was seen to exist that was sought to be filled by the outreach service in question?

DR JAMIESON: I think in the Northern Territory, we are seeing for the first time, really, a growth in an ageing population. Unlike other jurisdictions we've not had a long history of having an ageing population. Obviously, we've had ageing in place but not in the numbers; the numbers are growing, and as such, we are much more aware of an older population in the Territory. And so for us it's not just about hospital avoidance to have these things, but to enable people to live in their own homes, supported in their homes as long as we possibly can as well as supporting people in residential aged care.

So we see these as really important ways and mechanisms to start helping to enhance the quality of life for people who are ageing, regardless of where they are. And I would like to say that some of our providers, of course, are Aboriginal-controlled organisations and health services who deliver culturally appropriate care which is an imperative for us in many of our services.

MR KNOWLES: Yes. Mr Symonds? I should perhaps direct the question a little bit differently to you. In rolling out residential in-reach across the state, what made that possible in particular in Victoria, and what were the challenges that you faced in actually doing that?

MR SYMONDS: So one of the things that made it possible is certainly a clear state direction to services that we expect the program to be rolled out. There was evidence the Commission heard earlier in the week from Dr Montalto who pointed that out and pointed out the benefit of a clear expectation from the state on service providers and I agree with that, and that's our experience. A clear commitment to funding predating the National Health Reform Agreement. Obviously, that also helps to incentivise providers.

And also connected to some of the improvements in data that I might add around capture of residents coming from aged care facilities to hospital because we attached funding to the program and created an incentive there for health services to better capture data about those residents coming in, and I think strong clinical leadership, obviously. We have a number of geriatricians, in particular, across the State who've championed the model, promoted models of care amongst their colleagues, established systems within their own health services. That's a vital ingredient for any program like this.

MR KNOWLES: Are you aware of any particular challenges that were faced in rolling that out statewide across the State?

MR SYMONDS: I might reflect that funding remains a challenge and some of the variation in models of care that we have across the State; we don't have a single model of care across the State. There is some variation. For example, some health services have a nurse-led residential in-reach program. A very small number would use a nurse practitioner, a number use – will have a geriatrician lead for the service. They all provide access to a full range of specialist services offered by the health service but the residential in-reach program itself might be differently composed and funding is an issue because, as Mr Smith pointed out, these programs are eligible for joint Commonwealth and State funding but the price that is paid for these programs is, like everything, funded under the National Health Reform Agreement based upon classification, you know, describing it in a certain way, having it costed in a certain way, and if it's not prescribed and described properly, classified correctly and costed appropriately, then it won't cover the full range of services.

So, for example, some of our geriatrician-led residential in-reach programs fund or access MBS, the Commonwealth-funded Medical Benefits Schedule, to have the

medical components of that program effectively access the private service funded by the Commonwealth for residents and that – that's a sort of a – sort of a route, I suppose, to access funds for that program. It would be a relatively straightforward exercise if there was agreement about the core components of a model to then cost that model and set a new price for that model that does appropriately remunerate medical, allied health and other components of the model but that's not the way the price has been set to date, and so that remains a challenge for these programs.

MR KNOWLES: So on that basis, do you see there being a need for funding models to be reflected in the National Health Reform Agreement to any hospital-led multidisciplinary outreach service of this kind, Mr Symonds?

MR SYMONDS: The funding model doesn't need to be changed for this. The funding model is perfectly capable of coping with - - -

MR KNOWLES: The funding itself.

MR SYMONDS: - - - new clinical models, but the price – the funding model just needs to be directed or, you know, pointed at this particular model and there needs to be sufficient consensus around what the care is that is required, and there are examples, radiotherapy, home enteral nutrition, there are other examples of where the Independent Hospital Pricing Authority has done some targeted work to cost and then price specific treatments where there are concerns over access or price being a barrier. We would expect that a similar process could occur here. The other thing I might add is that once the price is right, budget will become an issue. There are caps on the Commonwealth contribution to State-funded services and various jurisdictions are already at or close to their cap.

If the price is to rise for this particular service to incentivise a certain model of care, if the budget does not increase accordingly, or the cap does not increase accordingly, then we will fund more of a higher priced procedure at the expense of something else and that will create other tensions in the system. So there is initially, I think, if I could just sort of go back over that there's a need to be clear about the model of care. You sound like the Commission – it sounds like the Commission is forming a view about that based on evidence it's heard; there's been a need to price that but there will eventually also be a budget consideration and all of those things need to be considered, probably in that order.

MR KNOWLES: Can I ask you Mr Smith, just in terms of – we've heard in terms of Victoria there is a – there's been a statewide coverage. Are there – in terms of the systems – the health programs that is exist in Tasmania, are there gaps in coverage and if so can you say why those gaps exist?

MR SMITH: Look, I think some of the gaps that we're talking about here are as much about us rolling out some of our offerings. I talked before about the community rapid response which, really, you know, the hospital system putting together a nurse practitioner-led support to work in conjunction with a patient's ED,

whether they be in a residential aged care facility or, you know, in the broader community. And we're looking to be able to roll that out across the State. So currently as it is, we know that it's viable in some of the larger urban centres and within 30kms of the urban centres because we have issues around, you know, being able to attract appropriately skilled nurse practitioners as we start to move that – roll that program out in the north-west of the State that's a challenge.

So they're the sorts of barriers in terms of being able to have that density to be able to provide that service in an effective way and that probably gets to the point of, you know, Mr Symonds' sort of model around sort of making sure that the price that's paid for some of these treatments is adequate because sometimes the price of providing, you know, some of these services in a larger urban centre is adequate but when you're providing them in a rural setting where the distances are greater, the costs are greater, it doesn't quite cut the mustard but they're equally needed as well or they equally need to be adapted. So I guess from my perspective, that's where I think we need to get to some of this sort of stuff about single prices funding mechanisms.

I agree with Mr Symonds. I think the basic mechanisms are there. I think we need between us and, you know, the, you know, the Independent Hospital Pricing Authority to be able to be more open to areas of innovation around these sort of things because I think we will make a lot of mistakes as we go through but we will learn through those as well. But I think we've got to continue to innovate in this area because, you know, this is where the growth is. It's in that gap between the GP and the hospital setting and that – that affects residential aged care residents, I think, more than most.

MR KNOWLES: In terms of the question that I'm asking, is it the case though that in Tasmania you do have gaps in - - -

MR SMITH: Yes.

MR KNOWLES: - - - service delivery in respect of ComRRS that exist by reason of the fact that – you referred to some of the difficulties, people live in remote areas - - -

MR SMITH: Yes.

MR KNOWLES: - - - where it's difficult to provide the service.

MR SMITH: Yes.

MR KNOWLES: Are there other reasons for gaps of service in Tasmania, not just geographic but in terms of the time of the availability of the services?

MR SMITH: Well, yes, I think, ideally, you would always like to be able to have all of these outreach services or anything like that that works with people in their home to be 24/7, 365 days a year. That's not always possible. It's not always possible to

recruit staff for that, particularly in regional areas. I think in terms of, say, the ComRRS service I think we – we try to be able to keep that service so that it can respond to a patient's needs within four hours and there's a contact time, I think in the north, between about 7.30 and 9.30 at night. Would we continue to want to improve so that it's around the clock, absolutely, but it's hard.

MR KNOWLES: Has there been any evaluation – I'm going to ask each of you about this in terms of your respective outreach services; has there been any evaluation conducted to ascertain what does and what doesn't work? And I'll start with you, Mr Smith.

MR SMITH: Well, again as we're – if I can speak again about our community rapid response – there was, certainly, an evaluation done from the initial pilot; that was done in the northern region of the State, and it was regarded as ensuring that patients received care in their home or closer to their home or within their GP clinic in a number of instances where, if that service wasn't there, they would've, probably – not probably – they would've ended up in a hospital setting; they, probably, would've ended up in admission. And, as Dr Skinner said today, for a number of these types of episodes, that's totally the wrong place for these patients. So – yes. I guess we rolling – government – the Tasmanian Government's rolling that out on the basis of what we found out, this does work, does ensure that people can get the care they need and stay outside of the hospital system, not because it's inconvenient to the hospital, but it's more appropriate to their patient – to their care needs.

MR KNOWLES: Yes. Yes. Mr De'Ath, have there been evaluations of outreach services in the Australian Capital Territory?

MR DE'ATH: I think the one that I would cite formally is the formal evaluation of the palliative-care-needs work trialled, which did show a marked reduction in length of stay in hospital and overall number of hospital admissions, but also as well as – improvement to some core outcomes such as of course quality of death and dying and staff confidence in supporting people who were – people at the end of life; so – and I think the evidence is building through a variety of these programs. That is one example I can clearly provide that says there are things here that work and work well and support people at a very vulnerable time in their lives.

MR KNOWLES: Yes. Mr Symonds?

MR SYMONDS: Yes; there have been evaluations of our residential in-reach program across the State. I think we have provided those reports previously to the Commission. I don't think we have provided published evidence, but I'm happy, if you are, to provide you today with a paper from Age and Aging 2015, which was a study over a number of years of 1300 patients enrolled in one of our residential in-reach services that does demonstrate reductions in hospital admissions, length of stay, other improvements associated with a geriatrician-led model. It's one example of our statewide program, but it has published evidence. Happy to leave that with you today.

MR KNOWLES: Yes. Thank you. That would be appreciated. Dr Jamieson, have there been evaluations of the outreach services in the Northern Territory and their effectiveness?

DR JAMIESON: Our community geriatric outreach service was only established in February of this year, and it won't be until next year, when we do an initial evaluation of that.

MR KNOWLES: Now, in terms of evaluation of these services – can I go again to your statement, Mr Symonds, at paragraph 43? And in that you have referred to – reports of referrals were being received, requesting in-reach to undertake procedures in aged care services, the Victorian Government believes, would be most appropriately delivered by the provider, such as management of syringe-drivers that administer medicines at end of life and attending to routine wound care for residents. There is also a reference to this kind of unintended consequence in an earlier statement given by the secretary of your department of health, Ms Kym Peake, in which she also referred to unintended consequences of this kind. What has the Victorian department of health done to address unintended consequences of this kind, where people are using the service for purposes other than that which it was intended for?

MR SYMONDS: So we have developed training-programs available to nurses within aged care facilities and clinicians within aged care facilities around health assessment in an attempt to increase the skill levels and capability within aged care services. The residential in-reach programs themselves, because they connect to GPs and the clinical staff within aged care facilities – none of our residential in-reach programs can be delivered in isolation, and the reports I've got from speaking to staff who deliver those programs are that there are – they believe there are benefits in terms of education and increasing confidence and skill levels among staff that they interact with.

But we're up against – I guess, some hard limits here in terms of the availability for example, of clinical staff after hours. Doesn't matter, what we do with the staff that we talk to in an aged care facility, if the only people available after hours are non-clinical or if it's one clinician to 80 to a hundred residents. Those are hard barriers that are going to make it pretty difficult, to address the issue described in this paragraph. And I should clarify; nothing about this issue changes our belief that it's our responsibility, to provide appropriate specialist care to residents within aged care.

MR KNOWLES: Yes.

MR SYMONDS: But I think to your question that – excessive or inappropriate referrals would be best avoided and - - -

MR KNOWLES: Is one way of avoiding that – comes back to the issue that was raised with all of you earlier on – a clearer definition of respective roles and responsibilities?

MR SYMONDS: I think clearer responsibilities would, definitely, help. They wouldn't be as good as providing 24-hour clinical coverage within aged care facilities. As I pointed out earlier on, there are already clear statements in our view of responsibilities, but they haven't changed that; so I think it gets to the issue raised by the first witness today, who raised the importance of 24 hour, seven days a week clinical coverage mandated in facilities so that there are people there able to attend to the basic needs that are being called out in this paragraph.

I might add Ambulance Victoria, who receive the triple-O calls from aged care facilities: their report to us is that perhaps a quarter of the calls they receive do not result in an ambulance transport, and for some of those calls instead Ambulance Victoria will themselves contract a private nursing service or private medical staff to attend and deliver some of the care, and they've reported the same issue to us, which is some of those things shouldn't be necessary, but they do it to avoid a costly and wasteful transport to hospital, which is inconvenient for the resident and takes an emergency ambulance crew off the road. So that's why they put in place those programs to substitute for the kind of basic care around catheters and wounds and other things in aged care.

MR KNOWLES: Yes. Mr De'Ath, you were nodding a moment ago; do you have a view that you'd like to express on this particular topic?

MR DE'ATH: I think there's much of what Mr Symonds says that resonates very much with me. I would, in the part about defining responsibilities – I think, clearly, that would go to workforce specificity and capability and qualification. We do this in all ranges of government work, childcare workers for example, and so on. So I think the time has come – to be much clearer about what is required within a residential aged care facility that addresses on site with residents in the first instances to high quality, safe care.

MR KNOWLES: Yes. Mr Smith and Dr Jamieson, do you agree with what's been said by the other two panellists?

MR SMITH: I think the clarity thing is quite important here, and we have similar – we've received similar things, but it's often anecdotal, very difficult, to be able to measure, but you would expect, I think – you would say that overall, yes, making it very clear, about what the residential facility's responsibilities are vis-à-vis the broader health system, I think, would help to reduce this.

MR KNOWLES: Just in terms of the outreach services that might form part of the multidisciplinary-outreach proposal that is under consideration by counsel assisting – you yourself, Mr De'Ath: you've referred to the programs that exist in terms of palliative-care outreach in the ACT. Can I ask each of you whether you see those kinds of services, specialist palliative-care services, forming part of such a multidisciplinary outreach service – and perhaps if I start with you, Mr De'Ath?

MR DE'ATH: I haven't thought deeply into how those arrangements would work. My comments earlier were about ensuring we didn't lose the quality and effect that we are currently having; so that would require further thought. So I, probably, won't comment on that any further, other than to say I think there are important interfaces; there's been comment on the primary-care sector, in particular GPs, where there needs to be far greater thought about – and planning about how that interface works, because the notion of embedding within a centre or GPs feeding in – we've tried various things in that space, and it's – it is challenging.

MR KNOWLES: Yes.

MR DE'ATH: So my over-arching comment, I think, is it requires careful thought and planning and examination of the efficacy of any sort of approach that might be taken.

MR KNOWLES: Can I just follow up on that, though, Mr De'Ath; do you see there being some benefit of bringing under this umbrella of these particular services a range of specialist services, including palliative care, including subacute rehabilitation and other services that would otherwise fall between – I think, what Mr Smith referred as to pure primary-care practice and what one sees in hospitals?

MR DE'ATH: That being your question, I would agree.

MR KNOWLES: Yes, and can I ask the remaining of you on the panel what you would say in respect of bringing those sorts of specialist services under the banner of such a multidisciplinary outreach service? Dr Jamieson?

DR JAMIESON: In principle, yes, I would agree. I think the issue for us at the moment in the territory is one of limited resources to undertake that.

MR KNOWLES: Yes. Mr Symonds?

MR SYMONDS: Yes, although I would add that that palliative-care service as provided as part of a specialist outreach service would be a supplement to what, we think, should be the palliative care provided by all of the clinicians involved in the care of the resident. I don't think we would support a proposition that palliative care needs to be only a specialist service. I refer again to the Quality of Care Principles that cite palliative care as one of the examples of services that should be provided by nurses within aged care facilities to all residents who need them; the silver book published by the college of general practice includes palliative care as one of the components of care to be provided by GPs who work and are accredited to work in aged care facilities, but on top of that, we have no concerns at all about palliative care being part of the specialist services offered through the outreach program.

MR KNOWLES: Yes. Yes. Mr Smith.

MR SMITH: I think, to pick up on Mr Symonds' point – I think it's a very important thing, to be able to – in terms of specialist palliative care services – to understand that some of the best bang from the buck you can get is the way they work with the existing care team and provide that consult. So – yes. In principle – and I think that's what we would try to do anyway.

MR KNOWLES: Yes. Can I ask you, Mr De'Ath, in terms of the palliative care needs rounds model – that's been described earlier; so I won't get you to describe that now. It's been described by Ms Nikki Johnson earlier on. Were there any barriers to the implementation of that model in the ACT, and if so, what were they?

MR DE'ATH: Not that I am briefed on or aware of. The information that I have is fairly overwhelmingly positive about the work. Obviously the issue of resourcing always comes up, and we have been working with Commonwealth Government about support for that, and there is a support for that to continue to expand and develop the work. But we are – we're very pleased now, and our clinical staff are very, very pleased with this work and outcomes and – as are consumers.

MR KNOWLES: Yes. Now, can I move to another topic at this stage? And I realise that all of you have given evidence about your respective palliative care services that exist at a State level, but if I can move now to transfers to and from hospital for people living in residential aged care – again in each of your statements you've referred to guidelines that exist for – in particular, discharges or transfer from hospital into a residential aged care facility. And for instance, Mr Symonds, in your statement you've referred to the requirement that there be a transfer of care summary sent to a patient's GP within 48 hours, also to an aged care service, if they are in residential aged care. Now, can I ask the remaining panellists; what do your respective guidelines state in terms of the timeliness with which any discharge summary or the like should be given to a person, and to whom is that discharge summary directed to be given under the guidelines? Can I start with you, Mr Smith, in that regard?

MR SMITH: In general?

MR KNOWLES: Yes.

MR SMITH: Our standard through our service plan with the Tasmanian health service is 48 hours. However, in respect of residential-aged care facilities, we have sort of a model that was developed some time ago in partnership with the aged care sector, the primary health network, Primary Health Tas, as well as – it's often colloquially referred to as the yellow envelope, and the whole purpose of it is that it transfers with a patient, and it was deliberately designed to be able to get around any tech issues; so it can be handwritten and whatever, and it travels with the patient. Now, there's a lot of support for that, and that works; it's, obviously, not a high-tech solution, but – and I checked this morning in terms of this question, anticipating it; we believe that through that model, that low-tech model – that we, probably, have a

greater adherence to making sure that we have good transfer of care through that particular model, because we have sort of ownership and commitment.

MR KNOWLES: Is there a backup or copy? Are there arrangements made to ensure that whatever is in the yellow envelope is – a copy of it is kept somewhere else?

MR SMITH: Yes. Yes. Absolutely, but the principal idea is, when the patient transfers, the information goes with them, rather than – they're transferred and it'll turn up in the next few days.

MR KNOWLES: Yes. Dr Jamieson, what is the position in terms of the Northern Territory for timing of the conveyance of that material, and to whom is it actually provided?

DR JAMIESON: My understanding is that it is provided under the National Safety and Quality Health Service Standards for communication to other providers, and it would, generally, go to the general practitioner for that person.

MR KNOWLES: So that accords with the minimum requirements that are set out in the national standards; is that correct?

DR JAMIESON: Yes. Yes.

MR KNOWLES: Yes. And, Mr De'Ath, what is the position in the ACT?

MR DE'ATH: I think I would concur with what I've just heard and – been a strong focus on timely discharge summaries and going back to the referral and process as well. So we maintain a strong focus on it as well, I can say; we do see the consequences of that at any stage being inadequate as delaying appropriate treatments and supports for residential-aged care residents and affecting their outcomes. So – I don't know there's too much I could add.

MR KNOWLES: Is the position in the ACT the same as that we've just heard of from Dr Jamieson in the Northern Territory, that it broadly corresponds with the minimum requirements of the national standards?

MR DE'ATH: I believe so.

MR KNOWLES: Yes. Is it fair, to say that, despite those national standards, there are variations not only in the way in which this is done but the timing by which it's done and who actually receives the information, whether it be the GP or the residential aged care service or both? Do you agree, all of you, that there is regional variations of those kinds?

MR SYMONDS: Yes.

MR KNOWLES: Yes? Yes. Mr Smith, you're nodding.

MR SMITH: I believe so.

MR KNOWLES: Yes. And do you think that there is some need for some greater degree of standardisation across the board in relation to these standards of discharge, providing discharge summaries on a person from residential aged care leaving a hospital? Can I ask all of you if you agree that that would be a worthwhile thing?

MR SMITH: I guess from the hospital out, we do.

MR KNOWLES: Yes.

MR SMITH: We do have a standardised requirement - - -

MR KNOWLES: Yes, you do, yes.

MR SMITH: So, yes, I'm just saying in terms of that, I'm not – I'm talking beyond just residential aged care facilities. So I'm sort of thinking just strengthening guidelines and rules doesn't make it more likely to happen. I think we need to make sure that we're making it a key priority for care providers to prioritise that body of work to make sure it gets done.

MR KNOWLES: Do you think the national standards need to be more explicit about the particular case of discharging a person from a hospital into a residential aged care facility?

MR SMITH: I – no. I would think that we should be aiming for the same level of standard regardless of where someone's discharged to, whether it be home, to the GP, to the residential aged care facility, and it should be a high standard.

MR KNOWLES: Well, is there perhaps particular need for an even greater standard when you are sending a person back to an environment in which they are relying on others to attend to their clinical needs and care in respect of often very complex comorbidities?

MR SMITH: No, I would – I think I know what you're getting – my view is we shouldn't – we should accept that it should all be to an adequate standard according to the patient's need.

MR KNOWLES: Well, in that regard, if you were going home and you don't have a cognitive impairment, and you're able to understand what's being told to you about what you need to do when you go home in terms of your post-discharge treatment, that might be a different situation to a person who does have a cognitive impairment living in a residential aged care facility who needs the assistance of others to care for themselves?

MR SMITH: In that circumstance, yes, I guess the – I was thinking more about the comparison that if I've had a complex procedure.

MR KNOWLES: Yes.

MR SMITH: And I go home, what my GP receives.

MR KNOWLES: Yes.

MR SMITH: Has all of the relevant information that he or she needs to be able to understand the medical treatment I had, the medication I had.

MR KNOWLES: Yes.

MR SMITH: So in that sense I don't think we should. I think they should all be to a high standard.

MR KNOWLES: Sure. But do you think there's some additional requirement specific to people being discharged into residential aged care? Isn't that reflected in your yellow envelope system?

MR SMITH: Yes.

MR KNOWLES: Yes. Well, do the remainder of you agree that there needs to be some sort of degree of specific requirement included in relation to discharge of people from one care setting in a hospital to another care setting such as a residential aged care facility? Can I start with you, Mr De'Ath?

MR DE'ATH: Well, without referring to the specific wording, being fully aware of the specific wording, I think in the general principle on so many things in terms of what we are looking at is consistency and coherence in the interests of, you know, patients – residents, so as a general principle, yes, absolutely.

MR KNOWLES: Yes. Do you agree, Mr Symonds?

MR SYMONDS: Absolutely there should be greater standardisation and higher standards around handover of residents or patients from one care setting to another. If I can just add a couple of comments, I do think it's one where we should widen our view from discharge summaries. Discharge summaries are one document. If I could just read from Victorian research that was published:

> *Medication changes made in hospital are frequently not explained in medical discharge summaries. Discrepancies between discharge summaries and discharge prescriptions occur in up to 80 per cent of cases.*

There are risks I think, in us – our expectations of discharge summaries as a fix for the clinical problem of handover, and I think we should widen our view to the

handover as a process rather than focusing on the document and a policy requirement around the discharge summary itself.

So our expectations – or I think a reasonable expectation would be that before a patient is transferred from a hospital back to an aged care facility, two human beings have had a conversation on the phone, for example. Ideally, nurses talking to each other about the care of the patient to make sure there has been an actual conversation. The discharge summary should be transferred as soon as possible or as close as possible to the time of the patient's transfer, ideally at the time of the patient transfer.

MR KNOWLES: Well, it's not really, ideally. It should just happen that it is provided, shouldn't it, at the time of the transfer? Is there any reason why that can't be done?

MR SYMONDS: There are some logistical issues.

MR KNOWLES: What would they be?

MR SYMONDS: Discharge summaries are completed often in hospital by junior medical staff. Those junior medical staff, as now reported widely in the media, are working long hours, completing a range of tasks for their superiors and for the hospital and completing a discharge summary might be competing against seeing a patient in the emergency department, helping another patient actually get out of the hospital, attending to a patient on the ward and, therefore, at the moment for some of them at least I think they will be completing discharge summaries somewhere down that order of priorities but it may not be the top priority. I would be cautious, I think, about setting a policy requirement which meant that other clinical priorities for junior medical staff were either delayed or that patients were waiting unnecessarily in hospital for the resident to get to that particular task. Sometimes waiting, for example, overnight if they have missed a window of opportunity to get a patient back to an aged care facility.

I – I think – I think there are consequences around some of those policy requirements given the environment in which they will be applied and I guess my point was to say that if we see handover as a process, there are ways to ensure that the clinical needs around handover are met that may not require a discharge summary, for example, to be sent and acknowledged before a patient is transferred if, for example, a high quality in-person handover has occurred. If it – if the discharge summary is high quality and is sent as close as possible to the time of transfer and, ideally, as this paper suggests, even enter a medication chart sent so that when a patient returns to a facility, even if they have a discharge summary that is accurate, they also have with them a document that will legally enable the administration of drugs.

Whereas at the moment we know of examples of patients returning with a discharge summary but the aged care facility then having to call a locum medical service, arrange for a doctor to attend hours later or overnight, and fill out prescriptions for drugs they're not familiar with, and so the discharge summary hasn't fixed any of

those issues. So we think there should be a wider view around what is required. We have no concerns about setting a high standard for handover, but a discharge summary is one – is a relatively blunt instrument in that wider process.

MR KNOWLES: It's fair to say, though, that some documentation should pass at that time - - -

MR SYMONDS: No question.

MR KNOWLES: - - - of a person actually arriving on the scene at the residential aged care facility that at least provides some direction as to the immediate care needs of the person, the medication that they should be taking and the like simply because an oral handover of the kind that you're describing is just between two people and one person may leave their shift within a matter of moments and - - -

MR SYMONDS: Yes.

MR KNOWLES: - - - there might not be any document that can be used for the rest of the people at the residential aged care facility. Would you agree with that?

MR SYMONDS: I have no concern about that being an ideal. I am just raising, I guess, a concern about making that a requirement for a patient to leave hospital when there are other processes that might occur around it and given the perhaps unintended consequences of delaying a patient's discharge from hospital if that is the policy requirement. But I have no concern about that as an ideal.

MR KNOWLES: Dr Jamieson?

DR JAMIESON: I think it's about communication. Certainly in the Northern Territory we work with our hospital discharge care coordinators, they liaise with family, aged care facilities and external agencies as part of the process of discharge, and when someone has been in hospital for a longer time they have regular meetings with aged care facilities to ensure that things are beginning to be set in place for those people being discharged. It's not foolproof, of course, but it is a part of the discharge process and the summary is one part, and I would agree with Mr Symonds that it is often the end point but there are processes that you can put in place through active communication of the stakeholders.

MR KNOWLES: Yes. Can I ask each of you, is there – it's – is there – am I right to say that in terms of a data item, there's no aged care identifier in hospital and ambulance datasets, is that correct, that a person has actually come from a residential aged care facility or lives in a residential aged care facility?

MR SYMONDS: I don't think that is correct.

MR KNOWLES: Yes. What exists in terms of what you have in Victoria?

MR SYMONDS: So we have codes in our datasets and I – I think the AIHWs recent work for the Commission has actually highlighted what, on the face of it, looks like excessive transfers to Victorian hospitals from aged care facilities. To me that demonstrates that that data is available. It is captured. Our view is that it's not – it's not an aberration in data capture. It actually shows that if we pay attention to data, there's better capture of that data, so – but it does – to me it does show that that data is available and could be captured.

MR KNOWLES: But is it being captured by way of a particular data item that goes to whether or not a person is living in residential aged care?

MR SYMONDS: Yes. I would add, I understand the national requirement around that data is – limits the data to the person's first presentation to hospital, and not to subsequent presentations. If that's right, I think that is unnecessary and – and might distort the data. Our own data requirements on our hospitals at a State level - - -

MR KNOWLES: Yes.

MR SYMONDS: - - - allow for every admission and presentation from aged care to be captured and recorded in that way, not only on their first presentation or admission.

MR KNOWLES: Yes.

MR SYMONDS: And I think it's important to get as full a picture as possible of people's transfers.

MR KNOWLES: Isn't that the difficulty that in terms of some data collection it's simply cited as a person returning to their usual place of residence, rather than returning into a residential aged care facility, and that can distort the collection of data; would you agree with that?

MR SYMONDS: I do agree with that, and I understand there's a problem with the national data requirements.

MR KNOWLES: Yes. Do the remainder of you agree in terms of that collection of data about people being discharged of hospital to their usual place of residence when it actually is a residential aged care facility?

MR SMITH: We've got capacity to record it. The extent to which it's diligently and appropriately recorded is something we could do more on, but again there are the – we do have the capacity within our data collection systems. Whether every board clerk or what have you is recording that correctly and appropriately, I would say probably we could do better work on that.

MR KNOWLES: Yes. Mr De'Ath.

MR DE'ATH: Thank you. We are building the ability to record into our digital health record, however, I think, again, the issue is how consistent is that approach across States and Territories and linking with the Commonwealth. I might add too, if I could, on the discharge summary issue, and I agree with everything that has been commented on in that regard, but just to demonstrate the importance that we see in this work as, in part of our health system we have taken up a collaborative approach against – across our major hospital, residential aged care, some providers, GPs to undertake a quality improvement initiative. Now, I'm sure we're not alone in that in the Australian Capital Territory but many of the things that were raised are being considered in that improvement initiative about how this could be done much better. Consistency, again, across the country would be valuable.

MR KNOWLES: Yes. Dr Jamieson, you've referred in your statement to the trial of a new system, I think it's called Acacia, in the Northern Territory.

DR JAMIESON: Yes.

MR KNOWLES: How is that used in terms of residential aged care facilities?

DR JAMIESON: It isn't yet. It's in the process of being built and we're acknowledging there that this will be part of the build process.

MR KNOWLES: Yes, and what is envisaged in terms of how it would be used then in residential aged care facilities?

DR JAMIESON: It's about the collection of data, it's about sharing of data and how best we can do that, and about the care summaries and discharge summaries, of course, would generated through Acacia as well, so we're hoping that that will increase our timeliness as well.

MR KNOWLES: Who would have access to that data system? What are the parties that would have access to it?

DR JAMIESON: It's mainly internal to our own clinicians. So it wouldn't be – aged care facilities would not be able to access that system.

MR KNOWLES: Right.

DR JAMIESON: It is an NT Health based system that we're building.

MR KNOWLES: Would there be benefits to aged care facilities being able to access it at least for reference?

DR JAMIESON: I think that would depend on what that would mean and having an external person – an external group accessing the internal system is problematic.

MR KNOWLES: Yes. Is Acacia expected to be compatible with My Health Record?

DR JAMIESON: I would have to take that on notice. I'm not sure. It's not an area that I work with.

MR KNOWLES: Mr Symonds, you've referred to improved data collection in your statement at paragraph 146. Is it fair, to say that there is a need for improved data systems in the health-aged care interface? And in that regard, can I ask you specifically; are you aware of the interoperability of your own data systems with My Health Record? Can I start with you, Mr Symonds, in that regard?

MR SYMONDS: Yes.

MR KNOWLES: There's two parts to that.

MR SYMONDS: Sure. So was the first part asking whether I - - -

MR KNOWLES: There is room for improvements in the data management in the health system.

MR SYMONDS: It's an easy question to start with; so – yes. Definitely. There's room for improvement. I might just comment; the AIHW's work for the Commission is the first time that we have seen good use of the linked data already available, particularly to the Commonwealth but to accredited linkage Authorities, to get a clear picture of the experience of residents in aged care and their access to healthcare. So we commend the AIHW for that, and we would expect or hope that that's the basis for regular reporting along those lines and not only ad hoc for the purposes of the Commission.

In terms of My Health Record – Victoria doesn't have a single electronic medical-record platform across all of our health services. We are most of the way towards connecting our health services to My Health Record. Easily the majority of our beds now are covered by systems that are able to upload and view, upload data to My Health Record and view data in My Health Record. I can't comment on how visible that is in aged care facilities. But we have no concerns about that. It's a direction that we are committed to. We are most of the way through it. And we have no concerns about that being the basis for a shared view of residents' health data across aged care and health.

MR KNOWLES: Yes. Mr De'Ath?

MR DE'ATH: Our digital health record is seeking to capture the residential-aged care-facility component and looking to support aged care facilities themselves to be able to view the record. I think many of us also are participating in the cross-jurisdictional health and aged care interface data project.

MR KNOWLES: Yes. You've gone to my next question – but I'll come to that in just a moment – which will be my final question of each of you, but were you saying that your system is also compatible or interoperable with My Health Record and integrates with that?

MR DE'ATH: Now, that I would have to take on notice.

MR KNOWLES: Yes. And Mr Smith?

MR SMITH: Definitely; room for improvement. I'd, probably, have to seek advice in terms of My Health Record and the compatibility.

MR KNOWLES: Right. I've got two questions – I apologise – rather than one. The first question was in relation to what you've just raised, Mr De'Ath, and that is: what plans or work is in place, in train to create interoperability between the jurisdictions' various data systems in the health space?

MR DE'ATH: So the particular project that I cited – I'm informed that some of the core functions of that improve the understanding of the key interfaces between health and aged care – developing a series of indicators that enable a national approach to identification, monitoring and response to new and existing issues, analysis of key barriers and enablers and testing of a monitoring-mechanism to support comparable and streamlined reporting.

MR KNOWLES: Yes? Mr Symonds, are you aware of those sort of measures for interoperability between cross-jurisdictional health data systems?

MR SYMONDS: Yes.

MR KNOWLES: Yes. In terms of my final question – it just concerns subacute rehabilitation. One of the propositions that's been considered this week is whether or not the national health-reform agreement should include performance targets for States and territories to ensure patients over 65 years, particularly those living in residential-aged care facilities, receive an appropriate period of subacute rehabilitation with funding tied to meeting this requirement. Can I ask each of you for your view about that type of requirement, tied to funding, being included in the national health-reform agreement? Mr Symonds?

MR SYMONDS: I don't agree with a target around any population getting a particular treatment, because it has to be based upon what will those residents need and want for their care. And there are potential perversities attached to every performance target, and I think the performance targets – if we're looking for targets – are around identifying what healthcare people need and want as recorded in their own plans and then whether they're getting that, rather than picking subacute rehab any more than for the general community we'd pick elective-surgery procedures and say a certain proportion of the population must get this procedure. It doesn't seem like the right approach to performance. We should start with what it is, that residents

need and want, and measure whether they're getting that; that should, of course, include subacute rehab, if that is what they need and want.

MR KNOWLES: Yes. Mr De'Ath?

MR DE'ATH: Yes. I'm inclined to agree. I'd, probably, really want to better understand the problem we're trying to solve before, probably, saying much more on that. This is not an area where I'm aware, that we have a significant problem. So – which again takes me back to – I, probably, want to understand the problem .....

MR KNOWLES: Yes. Well, perhaps to assist with that: some of the evidence we've received suggests that what rehabilitation services people receive may in part depend on the environment that they're returning to and, if they're returning to a residential aged care facility for instance, for whatever reason – presumptions about what might be provided to them there – they will receive less access to subacute rehabilitation than those would – who are returning to a home in the community, for instance.

MR DE'ATH: Thank you for that clarification. So appropriate and fair, equitable access to the right care at the right time and the right place would be the guiding principle, I would've thought. So we – I would be supportive of efforts to improve the outcome for aged care residents in that regard.

MR KNOWLES: Mr Smith?

MR SMITH: I'd agree, that – I wouldn't support KPIs or measurement on the number of treatments provided in a particular area. Something that gears towards the outcome we're looking to achieve – and that might be in this case patients returning to their residence in aged care facility and retaining or regaining the mobility that they had before they went in. Those sort of things, I think, are more useful, but I think things that are looking at measuring the delivery of activity by health practitioners are less useful.

MR KNOWLES: Dr Jamieson?

DR JAMIESON: I think a specific KPI's perhaps not useful, but rather – but the principle of access towards having a system whereby, regardless of where you're being discharged to, based on your clinical need and – if you require subacute care, then that's what you should get, regardless of your next destination post hospital.

MR KNOWLES: Yes; thank you for that. Sorry, Mr Symonds; you're leaning towards the microphone there. Did you have something to add to - - -

MR SYMONDS: Counsel, if I could – part 3 again of the Quality of Care Principles is not a bad place to start. They have a section, 3.11, on therapy services, again in the context of a list, to be provided to all residents who need them by the aged care facility; that includes maintenance therapy designed to maintain care recipients'

level of independence, more-intensive therapy delivered by health professionals or care staff as directed on a temporary basis designed to allow care recipients to reach a level of independence, excludes intensive long-term rehab required, for example following serious injury or illness, surgery or trauma. That's not a bad description, we think, of the level of rehab and maintenance and therapy and allied health services that should be provided by aged care services, and the exclusion – it doesn't say this, but, presumably, it refers to the responsibility of State-funded specialist services, and we have no concern about that.

MR KNOWLES: And – which could form even part of those outreach services which we've referred to earlier.

MR SYMONDS: That's right.

MR KNOWLES: Yes. I have no further questions for the panel, Commissioners.

COMMISSIONER PAGONE: Thank you for your assistance in this hearing-session. It's been very useful, to hear the balance of the States and Territories after the ones that we heard yesterday. So thank you very much for being here. And I'm not sure, whether you formally need to be excused from further attendance. If you do, then you are.

<THE WITNESSES WITHDREW [1.15 pm]

COMMISSIONER PAGONE: Adjourn till 2 o'clock, please.

ADJOURNED [1.15 pm]

RESUMED [2.07 pm]

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Commissioners, in preparation for this hearing, staff of the Royal Commission prepared a series of 20 propositions which seemed to us to be possible solutions to key failings in the interface between aged care and health care. We provided the propositions to many of the witnesses in advance of them giving their oral evidence to assist them to give considered evidence about the propositions. Throughout the hearing, we've been developing and testing those propositions. In light of some of the evidence you've heard, we are reconsidering some aspects of the propositions. We propose to provide a revised version of the propositions shortly to all parties who obtained leave to appear in this hearing to enable them to make submissions in response to them in accordance with

the timetable that you've directed, which I will mention at the conclusion of this closing address.

While this hearing has been about the interface points between the two systems, at its heart it's about the health care needs of older Australians. The evidence you have heard has provided insights into the extent to which the interfaces do not work and the detrimental impact this has on people's health and quality of life. Commissioners, you've heard from five daughters about the experience of their parent or parents in residential aged care. Almost all spoke about their parents' difficulties accessing or choosing a general practitioner and the impact on their health. Speaking of her frustrations about her father's inability to access a GP when he needed one urgently, Rhonda McIntosh said:

> *Dad's still an Australian. He's still entitled to Medicare, like we all are. He should be able to see a doctor when he wants to or when he needs to. He shouldn't have to wait until we're able advocate for him.*

Ms Payget told the Royal Commission that there's a lack of choice with respect to her mother's GP. Her mother has said that she feels that the GP at the facility doesn't listen to her or pay attention to her as a whole person. Ms Payget has difficulties obtaining information about her mother's care and it's not clear to her whether the GP or the aged care provider has a responsibility for managing her mother's care. Jennifer Walton believed that her mother was unnecessarily transferred to hospital in circumstances where her regular GP was not available and the after-hours locum GPs who visited her mother failed to understand the behaviours associated with her dementia.

Kris Stevens gave evidence about her parents' difficulty seeing their regular GPs when they entered residential aged care because of her understanding that the GP was busy and it was a stretch for him to see all of his patients. Poor clinical care at residential aged care facilities was also a feature of their evidence. Ms Stevens give evidence about the significant consequences of her mother's undiagnosed urinary tract infection and later the development of a stage 4 pressure injury that was not properly treated by her aged care provider on her evidence.

Ms McIntosh recounted a number of occasions when the staff in the aged care facility were slow to respond or perhaps unaware of the medical needs of her father, despite obvious deterioration which ultimately led to further hospitalisation for unregulated diabetes. Kate Davis gave evidence about her mother's lack of access to quality palliative care and her surprise at the lack of capacity of the facility to provide such care. Ms Walton gave evidence about her mother's inability to access specialist rehabilitation as well as her physical decline which was partly caused by a series of falls at the facility. She attributes this decline in her mother's health to the hospital's lack of understanding of her mother's dementia symptoms or an inability to accommodate them.

Dr Clare Skinner, a specialist emergency physician, told the Commission this morning that in her personal experience with three grandparents in residential aged care, coordination of care was, and I quote "very difficult", Dr Skinner observed that the emergency department is seeing increasing numbers of transfers of residents from aged care facilities for assessments, mostly after-hours. She estimates roughly half of these transfers are potentially avoidable and involved conditions that Dr Skinner thinks could have been treated in the facility.

Hamish MacLeod, who lives in residential aged care but was unable to give oral evidence at this hearing explained in his statement that he has experienced difficulties getting access to health care from GPs and specialists. He has also had to change his GP on a number of occasions when the GP stopped attending the aged care facility and was replaced by someone else. The importance of rectifying these critical points at which health care services are absent, inaccessible or disconnected is self-evident. It puts people's health and lives at risk and diminishes the quality and safety of their care. As Ms Walton said:

> *Continuity of care should be the standard not the exception and it shouldn't be a fight to get consistent care across aged care and health settings. They should work together and provide wraparound support for people.*

This reform can only be achieved through the combined actions of the Australian Government, the States and Territories and aged care and health care providers themselves. The first overarching proposition of this hearing is that the system of funding primary health care for aged care recipients needs far-reaching reform. Remuneration of primary health care practitioners purely through fee-for-service payments under the Medicare Benefits Schedule does not create incentives for the kinds of primary care needed by residents of aged care facilities.

The weight of the evidence before the Royal Commission is that blended funding models are needed for people in aged care who have high level needs. Blended funding models would usher in new, more proactive, integrated and teams-based models of health care. In light of importance I will address this point in some detail now. Traditionally, primary health care, both in the community and in residential aged care has relied on GPs and has been provided under a relationship between a GP and their patient, remunerated largely on the basis of consultations but nearly half of primary health practitioners are not providing services in residential aged care facilities, and the AMA says that a large minority of those who still do visit probably have plans to reduce visiting or cease altogether soon.

Many of the witnesses this week, including the panel of primary care providers who appeared on Monday, Dr Paresh Dawda, Dr Troye Wallett, and Ms Sue Irvine agreed that funding issues were a significant barrier to primary health care practitioners providing quality and timely care for people in residential aged care facilities. As you heard from Dr Wallett:

The MBS structures don't make provision for GPs working in aged care facilities.

It doesn't provide for the amount of time spent with residents' families, facility staff or on administrative tasks, with this work going unpaid. This creates a disincentive for GPs and witnesses also agreed that reforms to the MBS in March 2019 to encourage GPs to visit aged care facilities have had limited impact as they have not balanced the loss of earnings experienced by GPs who leave their clinics to attend residential aged care facilities. Dr McGowan, chief executive of the South Australian Department for Health and Wellbeing suggested that:

Fee for service is quite detrimental to integrating –

the services in question. In addition, Dr Wallett explained that the itemised fee for service model provided incentives for reactive care over proactive care. That is, it's based on episodic care and volume which is not suitable to meet the complex health care needs of people in residential aged care. This point is consistent with direct account evidence received by the Royal Commission. For example, Rhonda Payget's evidence earlier today characterised the primary health care given on to her mother as reactive. Good access to high quality primary health care services, particularly from GPs, is fundamental to the health of people in aged care.

The way in which this care is funded and provided must change. Structural reforms are needed to the way primary care is funded for people living in residential aged care to encourage proactive, preventative care and care coordination. Several witnesses expressed their opinions about these matters. Just this morning, Dr Skinner expressed her view that we need to think differently about how to:

Run medical workforce into aged care –

in light of the need for longitudinal relationships rather than care for one-off events. Dr Dawda advocated for a blended model, including a mix of the current fee for service model and capitation payments for a fixed amount per person irrespective of the type and number of services delivered with the possibility of building in additional payments to encourage certain practices. Dr Wallett and Dr Poulos supported similar approaches. Against this, Professor Morgan explained that the Royal Australian College of General Practitioners remains supportive of fee for service as a model that encourages access and adequate care provision but is not against capitation.

Dr Bartone supported MBS items to compensate doctors for telehealth, supervision of others in a delegated care model and related travel and administrate tasks but said adjusting financial levers alone would not address the problem. The Commonwealth has indicated that it's exploring blended funding models for primary care. The models discussed this week all have their advantages and disadvantages and will need to be closely considered. Professor Len Gray suggested that the barriers to GPs attending residential aged care may extend beyond issues with remuneration. He

suggested a need for structural arrangements to establish an allegiance between GPs and aged care providers.

It's our submission that any funding reforms will need to take into account nurse practitioners as central actors in the provision of effective primary health care to people in aged care. Sue Irvine spoke about the role that nurse practitioners can play in improving access to primary health care. Her evidence was that nurse practitioners are well suited to coordinating care with family members. They can also provide mentoring and training for nursing staff and other staff within the residential aged care facility. She said the presence of nurse practitioners does not replace but rather complements the existing primary health care services. However, Dr Bartone warned about the limitations to this approach due to his views on the differences between GPs and nurse practitioners' respective scopes of practice.

Ms Irvine's assessment is consistent with the evidence of Thomas Woodage, an aged care facility manager, who described the positive experiences he had when working at facilities which engaged visiting nurse practitioners. The evidence of Peter Jenkin and Nikki Johnston, both of whom are palliative care nurse practitioners, reinforced the benefits of nurse practitioners playing a significant role in aged care settings. The Commonwealth has argued that there's a strong case for enhancing the skills of registered nurses in aged care.

Throughout the week, we also explored a number of other propositions related to supporting increased access to primary care, including amending the Royal Australian College of General Practitioners accreditation standards to remove barriers to accessing practice incentive payments, and providing scholarships to increase the number of nurse practitioners. Commissioners, the discussions and the views of the witnesses this week on these issues will be useful when you come to make your final recommendations on those points.

The second area that I wish to focus on in these remarks is the need for increased availability for secondary care services for people in aged care who have deteriorating health conditions and subacute needs. Many of the witnesses trained in health medicine or nursing gave evidence that the complexity and chronic conditions of frail older people receiving aged care means that health care is best provided in situ, where they live. We've suggested that all people in residential aged care and all people receiving high levels of aged care in the community should have access to State and Territory local hospital network-led outreach services for this purpose.

In an effort to avoid unnecessary hospitalisations and to improve older people's access to health care, all States and Territories have established some form of outreach, sometimes referred to as in-reach, into aged care facilities and some into people's homes. Commissioners, you heard this week in particular about the benefits of Queensland Health's CARE-PACT initiative. Ms Meegan Beecroft and Dr Terry Nash described how it has improved health care service delivery for residents of aged care facilities and how it has also educated aged care staff.

Dr Michael Montalto explained how these types of services such as Hospital in the Home have allowed people to receive treatment in their residence that would otherwise have been provided in a hospital. In addition to improving care outcomes, there are savings from avoidance of unnecessary hospitalisations. Ms Johnston told us about Clare Holland House which runs the highly regarded palliative care needs round program. This program integrates specialist palliative care into residential aged care. She explained that the program's benefits include capacity building for residential aged care staff, involving families and residents in palliative care discussions, and access to multidisciplinary specialist palliative care services as appropriate.

Yet we heard that these outreach programs are patchy in coverage and subject to local funding arrangements and the readiness of the relevant local hospital network to participate. We explored with a number of witnesses the idea of establishing these outreach services more consistently across Australia. Many of the witnesses such as Professor Gray, Professor Leon Flicker, Dr Burkett, Dr Hullick, Dr Bartone, Dr Nash, Ms Beecroft, Dr Montalto and Professor Poulos supported the proposition, with some qualifications, relating to the need for flexibility to address local circumstances, clarity of the role of primary care professionals and adequate clinical governance to ensure there is continuity of care.

A number of witnesses made the important point that these programs must focus on improving the quality of health care and not hospital avoidance per se. Professor Poulos warned there could be an inherent tension between hospital avoidance and long-term care provision and that this would need to be resolved in outreach design. Dr Burkett and Dr Hullick argued that benefits to the health system such as reduced emergency department presentations would flow on if the primary goal of improving quality and choice is addressed. States and Territories were concerned that national reforms would not be flexible or nuanced enough to allow for the variations needed in different locations and for different client groups.

Dr Hullick called for what she termed flexible standardisation of these outreach services to ensure consistency but to allow for flexibility in how that is achieved in a local context. There is no doubt that the ability to be flexible with regard to regional conditions is a key element of any such model. Mr Symonds, on behalf of the Victorian Department of Health noted that one unintended consequence of more extensive outreach programs into residential aged care facilities might be that facilities and GPs may abdicate their proper responsibilities to meet the health needs of the people who need care. Dr Wakefield, Director-General of Queensland Health argued that these programs are an effective "workaround" but do not provide the GP level support that's necessary.

We asked Professor Flicker whether it could be argued that there would be no need for these services if there was appropriate access to comprehensive and effective primary care. He strongly disagreed with the notion that improvement of primary care for residents in aged care could obviate the need for multidisciplinary specialist outreach services, saying that those people who are the sickest with the most

complicated care needs, those in residential aged care, really do require specialist care just like every other Australian. In our submission, the systematic introduction of outreach services will need to occur in conjunction with a strengthening of primary care and a clearer and better enforced role for residential aged care providers taking responsibility for the provision of health care to the older Australians living in their facilities.

In addition, specialist outreach needs to be supported by a realignment of responsibilities at the governmental level. Dr Wakefield was clear that this outreach model would need to be supported at an intergovernmental level with appropriate shared funding. He said:

> *I don't see how we can redesign and improve the system without the two funders potentially coming together and in good faith really being prepared to shift the funding model.*

And by "two funders" he means the Commonwealth on the one hand, and the relevant jurisdiction on the other. Dr Burkett said that there would need to be a "coherent effort for partnership", not just funding arrangements between Federal and State or Territory Governments. Professor Flicker said that:

> *If you want something done you've got to make it clear at the higher level -.*

he was referring to the inter-jurisdictional level –

> *...exactly who's responsible for what and where the money is coming from, otherwise people will retreat from the space.*

He also noted that there needs to be action at the local level. The Commonwealth secretary, Ms Beauchamp, said the principles put forward in our proposition for establishing outreach services at the national level are sound. Commissioners, on the weight of the evidence it's clear that these services should be an essential part of improving access to health care for aged care recipients. The clearest testament of this is that each jurisdiction has funded programs or at least trials of such services in recognition of the gaps that presently exist in relation to specialist services for residents in aged care.

We also explored a number of other propositions directed to other issues relating to the interfaces between the health system and aged care. One such proposition was that specialists should be given incentives to provide greater levels of services into residential aged care facilities. Witnesses such as Dr Morgan, Dr Bartone and Professor Poulos generally supported the proposition, with some expressing views on how this might be achieved in practice. Another was that there should be greater emphasis on patients who are 65 years or over receiving appropriate periods of subacute rehabilitation post hospital attendance.

Professor Poulos supported this idea and suggested that it could be achieved by attaching specific funding to the resident. A number of jurisdictions also supported this, subject to negotiation over the requisite funding. Another was that there should be performance indicators relating to the rate of ambulance callouts to residential aged care facilities. However, this suggestion was met with opposition by some witnesses and with caution by others.

Putting to one side the notion of imposing a performance indicator, Dr Montalto and Dr Nash considered collection and reporting of this information to be a useful suggestion for an improved understanding of hospital activity. Dr Nash warned that a performance indicator in this space may drive change in the direction that may not improve care in residential facilities. This warning was echoed by facility-manager-providers Judith Gardner and Thomas Woodage, who raised concerns about how the data would be interpreted and used.

Another such proposition was that there should be better data collected on use of State- and Territory-funded health services by aged care residents to inform policy, monitoring and design. There was a substantial consensus among the witnesses on this issue. A number of witnesses, including Professor Gray and Professor Flicker, said there's a significant problem in Australia about data collection at the interface between health and aged care as – Dr Hullick said:

> *We have to understand the data, and at the moment that data is actually very difficult to see in the State health system. So I think at a systems level, an evaluation level, a research level, we need good access to the data.*

We propose the adoption of an aged care marker in admitted-patient hospital data reported by the States, and this was substantially supported by the witnesses. We note Dr – Mr Symonds evidence this morning on that point, and we'll be following up that issue. Dr Wakefield wished to have access to linked datasets, which might obviate the need for an aged care marker, he said. And he explained that reforms of the records systems to include a marker face technical challenges.

Another proposition that garnered substantial consensus is that older people's health information must be better shared across the interface, particularly during hospital transfers. Requirements for standardised clinical handovers to occur contemporaneously with transfer should be imposed on both the aged care and hospital side of the interface. Hamish MacLeod's evidence demonstrated the startling consequence of poor interface between aged care and hospitals, when his hospital records had mistakenly been sent to another hospital and not to the residential-aged care facility concerned.

We asked whether hospital-discharge protocols are needed to ensure that discharge summaries are provided to residential-aged care facilities. A number of witnesses, including Dr Hullick, Ms Oxley and Mr Woodage, agreed. As Dr Burkett said,

a discharge of a frail person to a residential-aged care facility should meet the same standard as a discharge to another health facility to support the nurses and care workers who are required to take on the responsibility of care for that person.

Another of our propositions concerned interoperability between the health-management systems in aged care and in healthcare. Dr Burkett made a powerful case for live data interoperability between My Aged Care and hospital-based services. Dr Hullick noted that a flexible approach to how this might be achieved was required but endorsed the notion of real-time live access. Queensland has a platform which can achieve real-time access to hospital records by medical practitioners who might be receiving a discharged patient into their care, and according to Dr Wakefield: legislation is in preparation for this access to be extended to registered practitioners, specifically, nurses, in residential-aged care facilities, but that's just Queensland.

Facility-managers drew attention to the challenges associated with the discharge of people from hospitals back to residential-aged care facilities without adequate communication and delays in the transfer of discharge summaries and information between GPs and facilities. They suggested these could be addressed through shared software with visiting GPs or joint utilisation of My Health Record, and the possibility of a live interface was also raised. Again, the evidence on these matters will be relevant when you come to make your final recommendations.

Commissioners, while work can be done to improve the range and availability of primary and secondary care services, there's another side to this issue. That's the extent to which approved aged care providers are obliged to ensure that the people who reside in their facilities receive the care they need. The evidence suggests that there is a degree of uncertainty about what exactly aged care providers are funded to do when it comes to ensuring that care-recipients receive medical care. They are funded to provide nursing-services but not services provided by medical practitioners.

However, they are to provide assistance – that's a quote – in obtaining health-practitioner services under schedule 1, part 2, of the Quality of Care Principles. How far this goes is not clear. This sits uneasily with the requirement in schedule 2, that the organisation delivers clinical care that optimises the person's health and wellbeing, and with the organisation's clinical-governance obligations, newly imposed by standard 8 of schedule 2.

Our understanding of Ms Beauchamp's evidence is that the Department of Health accepts the need to clarify these responsibilities or – to use her word – to strengthen the relevant provisions. This is not the only area of uncertainty, and merely amending the subordinate legislation is not likely to be an adequate solution. As Dr Lyons, Deputy Secretary of the New South Wales Ministry of Health suggested, clear agreed delineation of relevant roles and responsibilities for the entire spectrum of care needs must be reached at the intergovernmental level.

This leads to the third and final area I wish to address in these closing remarks, which is the proposition that the role of aged care providers needs to be expanded and clarified to support people in aged care to receive the healthcare they need and to ensure that there are no gaps in responsibilities for providing that care. This may include appointing appropriate staff, such as the medical director that Professor Gray proposed, ensuring the facilities support visiting practitioners, improving recordkeeping and adopting modern technology such as telehealth.

Throughout the week, we asked our witnesses whether in a future aged care system there is a role for a care co-ordinator for older people with high care needs to help them manage and navigate the right health and aged care services. While the notion of improved care co-ordination met with general support, multiple witnesses argued that their role, their respective role, GP, nurse practitioner or facility nursing-staff as the case was – that that role was the one best suited for care co-ordinator. This eloquently makes our point. There needs to be clarity about the respective roles of health professionals and aged care staff and designation of a care co-ordinator for each person in aged care who has high-level needs.

We also heard about the need to increase palliative-care competency within residential-aged care facilities, whether that be through an outreach model or through replicating Resthaven's model of employing a palliative care – beg your pardon – a palliative nurse practitioner to ensure an aged care provider delivers high-quality palliative services to its residents. An important part of the evidence was the need for aged care facilities to have the skills to engage in advance-care-directive processes so the directives are comprehensive, available and up-to-date throughout the palliative process. Regardless of the method, the extent to which aged care facilities deliver palliative care and the point at which those services should be supported, enhanced or complemented by State and Territory palliative services is another area requiring clarification.

Finally I want to quote from Professor Flicker. He said:

> *Currently, at a Commonwealth and at a jurisdictional State and Territory level, decisions are being made – to remove themselves from this area, because it's someone else's responsibility, and that's completely wrong. This is me in a few more years; this is you. This is all of us. And we should be trying our best to make sure, that the standards of healthcare we have is as good as it can be, and the quality of life of older people who are disabled, who have complex medical problems: that should be maximised at all times.*

The Royal Commission can, through the final recommendations you will make in due course, do much to focus the attention of the Governments on the points of real importance. But in the end, it will require hard work and good-faith negotiation between the respective Governments and their officials. The outcomes Professor Flicker demands will only flow when the Governments agree on these interface issues in the spirit of urgently improving the systems for the benefit of us all.

Commissioners, you've made a written direction in chambers for post-hearing submissions. Counsel assisting will, by 5 pm on 20 December, provide our revised propositions in written form to parties who have leave to appear in this hearing. Those parties may, by 5 pm on the 3rd of February 2020, provide the royal Commission with written submissions addressing matters the subject of the hearing. We expect that the parties' submissions will address our propositions in their revised form. And they may address other matters in the hearing, if the parties so choose. If a party seeks to rely on fresh documents – this should be explained as a component of those post-hearing submissions. Finally the parties will have the opportunity to provide submissions in reply to the other parties' submissions by 5 pm on 6 February 2020.

Commissioners, there's a matter of house-keeping. Could I tender, on a – on the basis that it is not to be published and it will be subject to the non-publication direction that you've already made, the Deloitte report in relation to the evaluation of CARE PACT which has been made available to you.

COMMISSIONER PAGONE: That, presumably, should be given a separate number.

MR GRAY: Yes, please, Commissioner.

COMMISSIONER PAGONE: So that will be exhibit 14–38 with that confidentiality order attached.

EXHIBIT #14–38 THE DELOITTE REPORT IN RELATION TO THE EVALUATION OF CARE PACT WHICH HAS BEEN MADE AVAILABLE

MR GRAY: Thank you.

COMMISSIONER PAGONE: Is there anything else?

MR GRAY: No. That concludes the hearing.

COMMISSIONER PAGONE: Adjourn sine die, please.

MATTER ADJOURNED at 2.42 pm INDEFINITELY

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