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TRANSCRIPT OF PROCEEDINGS

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THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

ADELAIDE

2.21 PM, FRIDAY, 22 FEBRUARY 2019

Continued from 21.2.19

DAY 9

MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P. BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL

COMMISSIONER TRACEY: Please open the Commission. Yes, Dr McEvoy.

DR McEVOY: If the Commissioners please. Over the past two weeks, the Royal Commission has had its first substantive hearing. The hearing has been structured to provide background and context to the Commission's future work which will involve inquiring into detailed aspects of the aged care system in Australia. This hearing was designed to ventilate the issues of key concern to organisations that had deep interest or involvement in aged care, and to identify aspects of the system and lines of inquiry that will need to receive attention from the Royal Commission in the coming months.

Over the last eight days of hearing you have heard evidence from no fewer than 28 witnesses. In their own way, each of these witnesses had something valuable to say about the quality and safety of aged care in Australia, or about the particular challenges that were presented. We heard at the outset from Mrs Barbara and Mr Clive Spriggs. Barbara's husband and Clive's father was Bob Spriggs. Mr Bob Spriggs was a patient and resident at Oakden in South Australia, a dual mental health service and residential aged care service.
The regulatory failure at Oakden was justly described by Ms Janet Anderson, the head of the newly created Aged Care Quality and Safety Commission as a sentinel event in the regulation of aged care in this country.

The system let the Spriggs family down badly. At the time, Oakden was operating with accreditation from the then Australian Aged Care Quality Agency. Mrs Spriggs explained that reflecting on her experiences this accreditation was of great concern to her and she questioned the training and accountability of the accreditors. In their subsequent review of regulatory failure at Oakden, Ms Carnell and Professor Paterson found the regulatory framework to be overly process-driven and flawed. Oakden was in a real sense an outcome of a defective regulatory framework. That framework was directed to regular three year accreditation cycles, accompanied by predictable accreditation audits.

Those audits would not necessarily reveal the true state of affairs. The regulatory design paid insufficient attention to risk profiling and to directing regulatory scrutiny to where it was most needed. Investigative capabilities needed to be improved. The system needed a fundamental overhaul. The Carnell and Paterson review consulted in 10 detailed recommendations covering a range of regulatory issues, touching on such things as the need for effective information capture and sharing and risk profiling, a serious incident response scheme, an enhanced complaints regime based on transparent information sharing, mandatory conditions and reporting around restrictive practices involving chemical or physical restraints with clinical oversight from a new regulatory commission's chief clinical adviser into the use of psychotropics.

Mandatory participation in the national quality indicator scheme in expanded form in due course, and a star rating scheme to inform the public and drive incentives for

improvements in quality on the part of providers. Accreditation would be fundamentally redesigned around the need for risk profiling and unannounced visits, with objective and consistent application of clearly defined standards. The Carnell and Paterson report containing these recommendations was delivered in October 2017. Almost 18 months down the track, those recommendations are only partly implemented and progress on some of the required actions might fairly be regarded as slow.

Both the secretary of the Department of Health and the new commissioner of the new Aged Care Quality and Safety Commission gave evidence during the hearing. It must be acknowledged that the establishment of the new commission is a significant change to the regulatory framework. The new commissioner, Ms Anderson, has suggested that the commission is not taking a radically different approach to the way that the predecessor agencies approached the sector. That said, Ms Anderson acknowledges that there is further work to be done by the new commission.

Commissioners, we do not invite you to make any findings on quality and safety issues on this occasion. However, in light of the state of implementation of the recommendations from the Carnell and Paterson review and other points raised in the evidence, there does appear to be a suite of regulatory framework issues of ongoing concern. They will merit continuing scrutiny over the course of the Royal Commission's inquiry. The Royal Commission has also heard evidence from Mr Ian Yates of COTA Australia, the Council on the Ageing; from Professor John McCallum from National Seniors Australia; from Ms Justine Boland of the Australian Bureau of Statistics; from Ms Louise York with Mr Cooper-Stanbury of the Australian Institute of Health and Welfare.

From Mr Craig Gear of OPAN, the Older Persons Advocacy Network; from Mr Paul Versteege of CPSA, the Combined Pensioners and Superannuants Association; from Ms Susan Elderton of Carers Australia; from Associate Professor Edward Strivens, a geriatrician and President of the Australian and New Zealand Society for Geriatric Medicine; from Professor Deborah Parker of the Australian College of Nursing; from Ms Annie Butler of the Australian Nursing and Midwifery Federation; from Ms Glenys Beauchamp, the secretary of the Department of Health; from Ms Janet Anderson, the commissioner of the Aged Care Quality and Safety Commission; from Mr Harry Nespolon, the president of the Royal Australian College of General Practitioners; from Ms Maree McCabe of Dementia Australia; from Ms Patricia Sparrow of Aged and Community Care Services Australia; from Mr Sean Rooney of Leading Age Services Australia.

From Mr Nicolas Mersiades of Catholic Aged Care; from Ms Claerwen Little of UnitingCare Australia; from Ms Melissa Coad of United Voice; from Mr Matthew Richter of The Aged Care Guild; from Mr Anthony Bartone, president of the Australian Medical Association; from Mr Gerard Hayes, the national president of the Health Services Union. The Royal Commission has also heard evidence from Ms Kaye Warrener, the wife and carer of Mr Les Warrener, a home care recipient; from Ms Margot Harker, a home care recipient; and Mr Barrie Anderson, husband and

carer of his wife, Grace Anderson, who lives with dementia and has experienced both home and residential care.

Each of these witnesses gave the Commission valuable insights into their personal experiences in dealing with the aged care system. As Mr Gray QC observed at the outset, the aged care system is complex. Changes have sometimes been made in an ad hoc way, addressing problems in isolation rather than the system as a whole. There have been many changes made over recent decades. There have been many inquiries and reviews. Despite reviews over recent years having recommended a series of reforms, the perspectives which the Royal Commission has heard over the past two weeks strongly suggest that key participants consider that the way we care for older Australians needs to change and that it needs to change fundamentally.

Mr Hayes of the Health Services Union made the following important points. In his view, the morality of Australians falls to be tested in the way we care for our ageing population. Older Australians, the children of the 1920s, thirties and 1940s who rebuilt Australia after the Great Depression and the Second World War are entitled to a level of care and respect which the aged care system too often denies them. Whether the cause may be inadequate support to enable a person to stay in their home or whether the cause may be insufficient or inadequately trained staff to look after them in residential care or whether they are not getting access of the kind they need to GPs and allied health professionals, or the quality of life they deserve in their residential care setting, there were many views expressed in the hearing that the system is too often failing the people who need its help.

As we said in opening, part of the problem is cultural. Older Australians are valuable members of our community but all too often we do not value the contribution they have made. If we do value their contribution, the way in which we care for them does not demonstrate that we value it. The dominant narrative too often casts older Australians as a burden, rather than a blessing. The Royal Commission rejects that narrative and calls for a culture of appreciation and respect for older Australians. But this must be more than a mere statement of aspiration. What follows, Commissioners, attempts to draw together some of the key evidence which the Royal Commissioners heard over the past fortnight. Future hearings will hear in more detail about all of these issues.

Let me turn to the scale of the problem. There are several factors which are converging to put serious strain on the provision of aged care for older Australians. The first is population growth. The Royal Commissioners heard evidence about the relative increase in numbers of the population over 85 years. Expressed as a proportion of the total population, this cohort will roughly double by 2066. In numeric terms, this means that the resident population as at 30 June 2018 included 503,700 people aged 85 years and over, accounting for approximately 2.02 per cent of the population. By 2066, that figure is projected by the Australian Bureau of Statistics to grow to between 3.6 per cent and 4.4 per cent.

The second factor is the increasing number of Australians suffering from dementia. There are presently around 436,000 Australians living with dementia. By 2056 this number will rise to 1.1 million or one in three older Australians. The Australian Bureau of Statistics predicts that dementia is likely to become the leading cause of death for Australians in the 2020s. Associate Professor Strivens, who gave evidence about the range and complexity of potential clinical conditions associated with ageing, identified the single biggest risk factor for the development of dementia as simply an increase in age.

The third factor is that as people age in greater numbers, they desire to remain in their homes for as long as possible and to be cared for in their homes. At present, older Australians experience significant delays in accessing appropriate support in their homes. The fourth factor is that the aged care sector is apparently beset by a range of serious workforce issues. The attraction and retention of staff is problematic and there are concerns about the skills base of parts of the labour force. Inadequate remuneration, which is often closely correlated with the levels of available government funding, is a real problem which impacts on staff morale. In turn, it seems that this is likely to impact on the quality and safety of the care older Australians receive, although exactly how and to what extent is an issue for further inquiry.

The fifth aspect of this is the ways in which Australians in residential aged care face impediments in obtaining health services from the public health system. This presents real challenges. The Royal Commissioners heard evidence about how the Medicare system can sometimes discourage doctors to service residential aged care facilities and about how older Australians in residential aged care facilities are often directed to the public health system, when it would be preferable that this not occur. There are other problems concerning the interfaces between the health system and the aged care system, such as conflicting priorities on the part of the players in the two systems and poor transfer of critical information, including clinical care-related information.

Sixthly, there was a range of perspectives presented in the hearing to the effect that the economic sustainability of the aged care system faces significant challenges now and into the future. These are not limited to the workforce supply issue I just mentioned. Serious issues for concern have been raised about the structures and sustainability of the present funding models more generally, and questions have also been raised about the adequacy of the rate of return necessary to attract and retain capital investment. These issues will be given detailed scrutiny at a hearing later in the year.

The hearing we have just concluded has served to provide an indication of the scope and nature of these problems, from the perspectives of some of the key organisations in the field. The Royal Commissioners heard that on the basis of 2017 data, 902 organisations operate 2672 services in residential aged care, providing 200,689 funded places. The average occupancy rate is 92 per cent. Residential care is overwhelmingly filled with people aged over 85 years. Approximately 28 per cent of

females aged 85 and over are in residential care. The ageing population is evidently growing and it seems that clinical care needs are becoming progressively more complex and acute, requiring attention for longer and longer periods of time.

Against this background, funding is a central issue. Mr Yates of the Council on the Ageing said that it is critical that a population linked benchmark of funding is provided to accommodate the natural increase in funding necessary as the ageing population increases. Mr Versteege of the Combined Pensioners and Superannuants Association described the issue of access to aged care as the first and foremost feature of aged care safety. If care is needed and it is delayed, then the deterioration in a person's health can be very rapid. There is some evidence that capacity in the system is increasing. Mr Richter of The Aged Care Guild gave evidence of an approximately 20 per cent increase in the number of beds amongst his members from 1 October 2015 to 31 December 2018. It has been suggested that approximately 83,500 beds will be required in residential care over the next 10 years.

The kinds of care available on the current funding arrangements are threefold, each with funding-based limits. The Commonwealth Home Support Program or the CHSP provides funding for home-based interventions such as shower rails and other household aids together with assistance with shopping and gardening, and things of that kind. Home-based visits for medications to be applied are also available. The average age of a person who accesses the Commonwealth Home Support Program is 75 years old. Under the CHSP, certain aged care services are provided at a subsidised price. Problems can arise, however, if a service provider shuts down or skilled staff move away. Inevitably there are services which would further assist older Australians on a Commonwealth Home Support Program but which the package is not funded to cover.

Home care packages, levels 1 to 4, are the next step up. The average age of a person receiving a Commonwealth home care package is 80 to 81 years, depending on gender. Following an assessment by an ACAT team, or an ACAS team in Victoria, an older person may have to wait much longer than initially advised for the package to commence. Very often, the person remains in the dark. The Royal Commission heard troubling evidence about this from Ms Kaye Warrener. Ms McCabe of Dementia Australia said that someone who is assessed as a level 2 might need a level 4 by the time the package actually arrives. Mr Yates gave evidence of people being assessed as a level 4 in anticipation of deterioration during the length of the time they will have to wait until the package actually comes through.

Professor McCallum described the queue as a running sore and a profoundly critical failure. Mr Gear approximated the waiting time as 18 to 24 months for home care packages. Mr Versteege gave evidence that 90,000 people have been approved for for a home care package, but have a dual approval in that they have also been approved for residential care, although they cannot all be accommodated because the occupancy rate for residential care is currently 90.3 per cent. Mr Yates gave evidence of the alarming fact that 30,000 high level home care packages are required, in his view, to clear the home care package queue. In Mr Warrener's case, he was

advised that the waiting period would be about 12 to 18 months. He was then told he would be waiting about three months. To date Mr Warrener has been waiting more than 450 days for his level 3 package to commence. A level 2 package, being a lower level package than he was assessed for, has apparently now come through. Mr Warrener's aged care needs, it may fairly be observed, are yet to be met.

Residential care is the most costly aged care service delivered by the Australian Government and has a much more limited reach than home care. According to the relevant table in Ms Beauchamp's statement, out of about $18 billion in government expenditure on aged care in 2017 and 2018 12.2 billion was expended on residential care. A detailed matrix called the Aged Care Funding Instrument is used by providers to assess a resident's needs and funding requirements. For residential care, the approved provider accesses a person's needs across various things: activities of daily living, cognition and behaviour, and complex health care in accordance with the ACFI. An accredited approval provider seeking to provide residential care to a person conducts the assessment.

Depending on the assessment made by the approved provider, the application of the ACFI results in certain dollar amounts being paid by government to that approved provider in respect of that person. There may be a mix of people's needs catered for by ACFI from facility to facility, and even within the one facility. There is an issue as to whether and to what extent subsidy received by the approved provider of a residential aged care service in respect of a resident is able to be applied in ways that may not be directly related to the care of the resident concerned. The Royal Commission will undertake further inquiries in this regard.

The Royal Commission has also heard that in or about 2014/15 there was an anomalous growth of the ACFI amount paid to residents reported by government, despite there being no marked changes in resident profile. ACFI amounts were generally indexed by inflation, care needs of care recipients and other parameters. The government applied a freeze and in the 2016/17 budget the indexing of certain amounts paid to providers was suspended. Mr Mersiades described the volatility of ACFI by reason of its subjectivity. Indexation is also not keeping up with price movements in comparable sectors of the economy. The indexation applied to the ACFI since 2008/09 has been lower than the growth of costs in the wider economy, particularly wages.

Mr Mersiades said that ACFI is intended to mimic price movements which would be seen in a competitive environment. Mr Mersiades stated that the premise of this is misplaced when the occupancy rates for residential care facilities has been trending down. From the providers' perspective, including Leading Age Services Australia and The Aged Care Guild, the freeze on indexation of the ACFI and changes to the scoring rules in 2016 was effectively asking providers to continue to deliver the same services for less funding. It is apparent that this has imposed financial pressures on providers. Mr Rooney from LASA stated that the changes to indexation were in response to a view within government that a large proportion of providers were

behaving in a way that was seeking to maximise the ACFI scoring; however, LASA has advanced a view that the funding was insufficient and that acuity was increasing.

Since that time, Commonwealth funding to aged care has increased and funding per client to the ACFI has also increased. Indexation of the ACFI is being restored but not to the prior indexation amounts. In addition to ACFI, other various forms of subsidy in the form of capital investment may be received by providers from the government. In relation to oversight and transparency, the secretary of the Commonwealth Department of Health gave evidence that all the information was available to it for both home care and residential care and that there was auditing and oversight. The secretary described the allocation of home care packages prior to 2017. They were allocated to providers as part of the aged care approvals round; ACAR as it's known. Since February 2017 packages are assigned to eligible recipients who then select their preferred provider to which a subsidy is paid. The department is apparently now considering alternative allocating residential aged care places to consumers, rather than to providers through the ACAR.

In relation to residential care at least, without the critical input of working out what the cost of care is for a person in residential aged care, it would appear that the department's ability to conduct meaningful analysis is a work in progress for the department. In relation to home care, the secretary said the department has a pretty good handle on the funds; however, it is unclear to what precise extent there is oversight of acquittals by approved providers in home care. The Commission will continue its investigation in this respect. The Royal Commission heard significant preliminary evidence on the question of the sustainability of the system. Sustainability is a significant issue for the aged care system and it is one that will be a focus of the Commission's work.

By way of introduction to this issue, the following observations may be made: first, and in terms of the architecture of the system, the government receives advice from a number of sources, including the Commonwealth Aged Care Financing Authority, the Department of the Treasury also produces the intergenerational report which does medium to longer term planning beyond what is in the budget from year to year. Secondly, the Australian Nursing and Midwifery Federation gave evidence to the Commission about what it regarded as a lack of realistic goals from management in aged care facilities. Those residents who need the most care may not attract sufficient funding to allow the extra staffing they require; however, families of residents often expect that residents will be getting one on one care for most of the day, either all waking hours or 24/7 despite the fact that this is impossible.

Despite being accessed as high for the ACFI, the Commission heard that often health care needs are ignored as a key component of aged care. Clinical records tend to be very poor. Mr Versteege considered that the ACFI should be reviewed urgently, noting that the figures it delivers for funding almost look as if the figure is plucked out of the air. Ms Melissa Coad of United Voice told the Commission that the change in home care packages to individualised funding has made it more difficult for home care workers to be able to have staff meetings or training in paid

time and that this may be because with individualised funding there is less flexibility available. Where previously there was a pool of money in relation to which a provider of home care packages had some flexibility to make adjustments, depending on changes in care needs, there is now less ability to do this.

Now that there are individual budgets for each person receiving a package, providers are required to acquit relevant money against an individual budget which gives them less flexibility. Ms Patricia Sparrow of Aged and Community Services Australia reported that ACSA members have capacity to take on more home care packages but there is currently no funding to do so. Professor McCallum of Seniors Australia stated that more money is needed to reduce the home care package wait list. Ms Sparrow also gave evidence to the effect that funding has not kept pace with increasing complex health needs of residential care consumers.

Mr Richter, on behalf of The Aged Care Guild argued that the sector is not performing well from a financial perspective. The return on assets, he said, is negative. Nonetheless, the Guild's members return on average a positive return on assets. The issue of capital return is one to which the Commission will return in some detail. It is worth noting that the ACSA report found that if ratios are changed to include more home care, for example, level 5 packages, and less residential care, there would potentially be a significant saving which could be reinvested to improve residential care. LASAs position on funding is that there must first be a determination of what needs exist in the community and then what services are required to meet those needs and then what standard of quality and safety is required for delivery of those services.

The industry is also calling for a cost of care study because without knowing what the cost of care delivery is, it is not possible to be sure that the subsidy provided is appropriate or adequate. Once the cost is determined, the appropriate subsidy amount can be determined and measures implemented to ensure the transparency of quality. Mr Yates considered that the refundable accommodation deposits are not a desirable major funding source because some providers view refundable accommodation deposits as their capital. When there is a major collapse and a provider cannot refund an accommodation deposit, the rest of the industry is then forced to pay by the imposition of a levy and there is a lack of transparency in relation to how the providers are managing these funds. As I have said, the Commission has significantly more work to do in analysing the sustainability of the sector.

Can I turn, Commissioners, to the question of access to the system which has been a matter about which significant evidence has been received. It is apparent that people are regularly experiencing issues accessing the system, both in terms of understanding what services are available and assessing the quality of services available and how to make complaints when the need arises. My Aged Care was intended to be the entry point for consumers to access Australian Government-funded aged care services. However, Mr Gear of the Older Persons Advocacy Network explained that many people struggle using the internet and telephone and

need direct face-to-face assistance. Many organisations, including COTA, have advocated in the past for the inclusion of a face-to-face service as part of My Aged Care; however, this has not eventuated. A limited trial is apparently only now commencing.

It seems that people are having difficulties understanding what services are available to them. This is evident, for example, from OPANs evidence that it receives more requests for advocacy to understand and negotiate the home care packages than requests for advocacy regarding the provision of quality care. We've heard that such access problems are exacerbated for people in hard-to-reach populations, including those with complex needs and those with limited access to technology. There are private companies offering services explaining the system and negotiating and managing home care packages. OPAN delivers the National Aged Care Advocacy Program which is funded by the Australian Government. This program provides advocacy support and information to older people and their representatives receiving or seeking to receive Australian Government-funded aged care services. Because of the importance of these services, whether they are sufficient warrants close consideration.

Professor McCallum of National Seniors Australia told the Commission that consumer literacy is limited. Most people that have been through assessment don't know there is a place to make a complaint if there is a concern. There are calls from witnesses for a major community literacy initiative to be undertaken with a focus on better communication about services from providers and their trusted advisers, improved information services and more consumer-friendly websites and call centres. The government has been making changes to the aged care system to assist people to make choices about the care they receive.

To do this, people must have access to information to enable informed decision-making. The Commission has heard from numerous witnesses that people are you faced with inadequate information on a range of matters from calculation of fees to the availability of published information on standardised quality indicators, allowing for comparison across provider performance. Mandatory participation in a quality indicators program for residential care has recently been announced.

Can I turn, Commissioners, now, to the subject of dementia. The Royal Commission has heard important evidence about the scourge of dementia. It is clear that understanding and accommodating the needs of Australians with dementia will be critical to the design of the aged care system going forward. As I have said, by the middle of this century the projections are that one in three older Australians will be suffering from dementia and it will shortly become the leading cause of death for Australians. At present, around 50 to 60 per cent of people living in residential aged care facilities have a diagnosis of dementia.

Ms McCabe of Dementia Australia raised a series of matters warranting further investigation by the Commission including issues around community awareness, dementia diagnosis, the lack of dementia specific staff training, the lack of facilities

designed to support people with dementia and ensuring that there are allowances in the funding for adequate services for the specific care needs of dementia patients. Many of the witnesses identified a need for a variety of innovative care models to be considered for future implementation to better address the needs of people with dementia. The Royal Commission will give more detailed consideration to these new models at its May hearings.

The use of physical and chemical restraints, in particular in the case of people living with dementia or in the case of certain kinds of mental health conditions is a matter of concern that has been highlighted in reports relating to serious failures, such as those described by Clive and Barbara Spriggs regarding Oakden. Professor Strivens has mentioned reports based on overseas studies of 80 per cent of people in residential aged care being prescribed psychotropic medication with 10 to 20 per cent efficacy rate based on a Dutch study. What the applicable rates are in the Australian aged care system are very important issues for inquiry.

Australian Institute of Health and Welfare data suggest a significant upward trend in the prescription of psychotropic medication amongst older Australians, increasing with age. The Commission will need to do further work in this area also. In a media release on 17 January this year the Minister for Senior Australians and Aged Care announced that chemical and physical restraint in aged care homes will be better regulated following an 18 month examination of this issue. The nature of these regulations is currently unclear with Ms Beauchamp of the Department of Health telling the Commission that the department is currently working on options to put to the Minister.

Given the complexity of issues, identifying the requirements for effective regulation and how to implement regulatory reforms presents real challenges. Dr Nespolon believes regulation of chemical restraints is not the answer because it does not take into account different situations and contexts. Dr Bartone points to a need for the availability of an appropriately trained workforce to combat this issue. Trying to understand why a person is presenting with challenging behaviours is a critical and fundamental first step in understanding why a clinical situation is occurring. What is apparent from the evidence is that the misuse of physical and chemical restraints is a prevalent issue that the existing system is failing adequately to address. Once again, the Commission has more work to do.

Can I turn, Commissioner, to interfaces with the health system. Through the secretary, the department gave evidence that older Australians receive support from the health system through mainstream programs and services such as the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme, hospitals, specialist services, primary care, mental and allied health services. The medical professionals, advocacy groups and provider representatives all raised issues with the ability of the elderly to access these services. Mr Mersiades of Catholic Aged Care described the current health system design as fragmented in that there are a number of funders, budget-holders and accountability arrangements.

Older people have complex needs and it is difficult for them to access services they need across a range of disciplines. The Royal Commission heard substantial evidence also about the issues faced by people in residential care accessing these service. The Commissioners heard that there is a common misconception that residential aged care is a standalone health care service. The reality, however, is that it does not receive adequate funding to provide GP services, dental services, mental health services, hospital care and end of life care. It is often difficult for residents to leave a facility to see an outside health service which has obvious consequences for the standards of care a resident receives.

Taking access to general practitioners as an example, where a person is not able to leave their residential aged care facility because of mobility issues, or the capabilities of the provider, they're reliant on a GP to visit them. Several witnesses have identified that this often results in residents not having access to their GP of choice. There is a tension associated with general practitioners continuing to provide ongoing care through attendances with their patients after the transition to residential care. Whether there will be continuity of that relationship will depend upon the location of the aged facility vis-à-vis the GP, and of critical importance, on the willingness of the GP to attend upon a nursing home. That continuity is important as the established practitioner, with their understanding of the patient's clinical history, is much better equipped to respond to the nuances and concerns that their patients may have.

Dr Bartone of the AMA identified for the Commission a myriad of issues from the perspective of GPs when treating patients in residential care. Let me mention just two. First, according to Dr Bartone, the level of compensation provided to GPs under the Medicare rebate system does not reflect the time required to attend on a patient in residential aged care. Dr Nespolon's evidence was strongly supportive of this view. Further, when an attendance is made, it is often difficult because of an absence of a consulting room, poor record-keeping, the absence of a nurse and the fact that there may often not be a proper handover or communication with the facility.

Dr Bartone's view is that the difference between what a GP can charge for nursing home visits, which are almost always bulk billed, is such that GPs do not receive adequate compensation for what is a vital service, particularly when regard is had to the travelling times involved, handover with a nurse, locating patients and other incidents of what are in effect house calls. His evidence would tend to suggest that the current schedule rates for aged care visits represent a significant barrier to the delivery of aged care and that significant increases will be required. Dr Bartone also spoke of the practice of receiving calls from residential aged care facilities requiring the provision of clinical advice, despite there being no Medicare rebate available for these kinds of calls.

There is a case to be made that much of the work that GPs do in nursing homes is not remunerated or at the very least under-remunerated. Dr Bartone's evidence that a mere five minutes might be involved in reporting to relatives on the phone following

a consultation is likely to understate what happens in practice. In large part, it would appear that the system depends on the goodwill of GPs and an ongoing desire to deliver care, despite the paucity of their remuneration. Dr Nespolon's evidence was that it was left to GPs to perform a range of unremunerated administrative jobs for their patients residing in residential aged care services. In effect, Commissioners, GPs make a substantial subsidy available to the Medicare system.

Secondly, there appear to be significant problems relating to interfaces between residential aged care services and hospitals. Dr Bartone believes that there is a high level of transfers from residential aged care facilities to hospital emergency departments for conditions that could be managed by a general practitioner should proper handover notes and appropriately trained staff be present in residential aged care. Mrs Spriggs gave evidence of this having been a particularly distressing aspect of her experiences in relation to the treatment of her husband, Bob. A number of suggested improvements were presented, including establishing consulting rooms in residential aged care facilities and providing Medicare rebates for technology-based consultations to enable the use of video or telephone.

It is clear that the workings of the Medicare system in the context of residential aged care bears particular scrutiny by the Royal Commission. Dr Nespolon also identified issues of concern relating to hospital transfers. Dr Nespolon also spoke of the related issue of the need for improvement in end of life care available in residential aged care settings. Residential aged care facilities are of course not hospice facilities. Funding is available in limited circumstances for end of life care. However, we have heard evidence from various witnesses that such funding is difficult to obtain and is often received too late. It has been suggested by a number of medical professional and provider peak group witnesses that funding arrangements should be amended to allow for end of life services in residential aged care. This might involve funding appropriate equipment and services or funding for palliative care specialists to offer appropriate solutions in residential aged care.

The Commission heard evidence of issues relating to the transfer of older Australians between hospitals and their homes or residential aged care facilities. Communication breakdowns often occur resulting in treatment and medication mismanagement and instances of people being discharged from hospital without adequate arrangements in place for their care. My Health Record may go some way to addressing these problems, although witnesses such as Professor Parker of the Australian College of Nursing caution that this will not be enough on its own. Mr Versteege of the Combined Pensioners and Superannuants Association suggests that moving towards an integrated system as is seen in Holland and Germany, for example, is a potential solution to these integration issues which is worth exploring.

Can I turn next to the very substantial issue of the workforce. In the context of residential and home care, the Commissioners has heard about and from the representatives of the workforce that delivers care, the nurses and personal care attendants, from the doctors who interact with that workforce and those with an eye on training of that workforce. The Commissioners heard evidence from the ANMF,

the national representative body of the various States and Territory unions concerning nurses, from the Health Services Union whose membership includes residential personal care attendants, allied health professionals, including physiotherapists, pathologists, cleaners, cooks, clerks and managers, and United Voice whose members include personal care attendants who are working in home care.

Let me say something, Commissioners about the personal care attendant. The most common personal interaction in aged care is between the personal care attendant and the resident. The evidence suggests that the typical personal care attendant is a woman in her 40s and 50s. Her work is hard and poorly remunerated. She is typically qualified, employed on a casual or part-time basis, and needs to work in other jobs to make ends meet. She will not make a living wage, meaning that on an hourly rate of about $21 on a part-time or casual basis, personal care workers struggle to earn enough money to live adequately. Whilst personal care workers describe the work as very rewarding and they value the time they're able to spend with residents, they report that it is labour intensive work and often delivered hurriedly with service providers requiring them to be task-oriented.

Personal care attendants who work in home care do not have the time to do their jobs properly. The experience of Ms Harker, on the other hand, is to the effect that her carers have often been unskilled, sometimes from overseas, and that they often require direction from her. If remuneration is anything to go by, the work of personal care attendants in the aged care sector is not adequately valued. There are no minimum qualifications required for someone to work as a personal care attendant and, aside from a police check, there is no pre-employment screening. Both the issue of whether there should be minimum qualifications and the issue of whether there should be a screening database are live issues for the Royal Commission to consider.

Bearing in mind the wage and conditions of people working in aged care, any minimum qualification-based accreditation scheme would need to recognise the financial constraints of those people. A mandatory minimum qualification was supported by United Voice and by the HSU. United Voice supported a national register of personal care workers and gave evidence that it would improve the morale of people working in those roles as well as provide recognition of the value of their work. People currently working as personal care attendants report a desire to receive specialised training in relevant areas such as dementia and medication management. This Commission heard evidence of personal care attendants attending to people on their own time, without being paid, because they knew they were the only contact the person had, and that they didn't otherwise have the time in the rostered attendance.

Let me turn to the registered nurse. The evidence as to the centrality of the nurse in residential aged care came from a number of sources. According to Professor Parker, the nurse has a far broader skill base including, amongst other things, comprehensive pain assessment, wound assessment and continence issues and should be delivering that sort of care. Whilst enrolled nurses and unregulated workers can collect

information, communication with geriatricians and general practitioners relating to medication management should only occur via the registered nurse.

Professor Parker also spoke of their role in essential clinical assessments of persons in residential aged care or people requiring home care working in conjunction with GPs and geriatricians. Much of this evidence was echoed by the evidence of Ms Butler. Dr Bartone gave evidence of the importance of proper handovers involving communication with nurses following a visit to an aged care facility. Where that does not occur – which would appear to be more common than might be thought clinically desirable – important issues may be missed or delayed, tests not carried out, or vital information not passed on, with the potential for unnecessary transfers to emergency departments of hospitals.

The evidence seems to point towards a trend involving an increase in the face-to-face care delivered by personal care attendants to residents, being at the expense of the number of hours of care that are delivered by nurses. Although better paid than the personal care attendant, the aged care registered nurse is almost certain to be employed under an enterprise agreement, the conditions of which are materially less attractive than those under comparable State public health awards. There was also a suggestion in the evidence that aged care does not offer the nurse the same degree of support and career advancement that counterparts in State and Territory health systems may enjoy.

Critically, although registered nurses have a clear supervisory role and will plan care to be delivered by the enrolled nurses and unregulated workers, workload pressures can often mean that there is simply not enough time in a shift to carry out best practice clinical care. The position of the ANMF is that chronic understaffing is a key contributor to an increasing number of instances of substandard care. Let me turn to informal carers. These are the people who care for family and friends without pay and without adequate support. The 2015 ABS survey of Disability, Ageing and Carers found that just under half of the nation's 860,000 carers looked after a person who was over 65.

Incredibly, a 2015 Deloitte Access Economics review which was commissioned by Carers Australia established the total value of informal care in Australia to be $63 billion, up from $40.9 billion in 2010. The Commission heard evidence that informal care to older Australians makes up a substantial amount of that figure. The evidence would tend to suggest that carers need opportunities for support, for training and respite. Commonsense would indicate as much. Respite, in particular, is a way of giving carers a break and would appear to be critical in preventing social isolation and to ensuring that carers get some time off.

It seems that respite is not accessible. Often, where respite is offered within a residential care facility these places can be used as a try before you buy, as it were, for those entering residential care, and cannot be used flexibly for a night or over a weekend, but must involve a minimum two week stay. Although it seems the proportion of informal carers will decline in the years to come because of changing

demographics, the demand for their services will no doubt continue and will increase. It seems that this will result in an increased demand for paid carers, and greater pressure on informal carers along with greater need to provide them with support.

At the broadest level of generality, common concerns have emerged from the evidence as follows: first, the complexity of the residents' needs has increased over time, which is compounded by an emphasis or preference, as Ms Harker's evidence made clear, to remain at home for as long as possible. These factors have led to an increase in the acuity of the resident, the point being, as Ms Butler explained, that many low intensity residents of the past are now staying at home and their places are being taken up by residents with high needs. Secondly, there is a need for a larger, better educated and better skilled workforce. This is not a new theme, nor is it being heard for the first time; however, evidence thus far suggests a trend in staffing away from nurses that often produces the unacceptable situation that there is no registered nurse on duty overnight, meaning that care workers are required to make decisions they are not trained to make and unnecessary admissions to hospital are arranged when better management by a nursing professional could have dealt with it.

Thirdly, there are barriers associated with the attraction of staff and further barriers associated with their retention. The evidence provided by the guild concerning the retention and churning of nursing staff amongst its eight members, and to a lesser extent personal care staff, is a major cause for concern. These concerns were issued in the evidence of Ms Butler. Fourthly, care staff want better training. In this respect, there was evidence that they feel that they're unable to do their jobs to the best of their ability. The evidence suggests that there are two aspects to this. First, there is the time afforded to them to carry out necessary care tasks. Secondly, there is the required and additional training and education available to them. Indeed, the evidence of Ms Coad on behalf of United Voice was to the effect that current minimum training requirements are insufficient and that better training will allow staff to provide a better quality of care.

Fifthly, the nature and extent of the link between the factors I've just mentioned and safety even quality outcomes will be a focal point in the Royal Commission's work. In addition to the valuable evidence of Ms Spriggs, Ms Harker and Ms Anderson, the Commissioners also received evidence of the experience of aged care recipients directly and indirectly through other sources, in particular from the survey evidence provided by the ANMF which reveals multiple accounts of substandard and dangerous clinical practice where important aspects of care are missed, and paints a picture of a system under a high degree of stress.

This leads to an issue that has attracted sharply contrasting views amongst the witnesses to date. The issue of whether appropriate minimum staffing levels and skills mixes can be objectively measured and perhaps made mandatory, and the pros and cons of any form of mandatory ratio regime. It is, of course, too early for findings to be invited on the suite of questions that are raised by these important issues. But the available perspectives on these topics expressed in the hearing are

illuminating and useful for the work of the Royal Commission that lies ahead. In due course, the Commission will need to give consideration to material of the kind represented by the ANMF Aged Care Staffing and Skills Mix Project report 2016.

This evidence, which was tendered, was an evidence-based study commissioned by the ANMF and must be seen against a background where, although under the ACFI the funding paid to providers is linked to the particular health care needs of their residents, there is no regulation concerning the shape or form of the delivery of that care. Curiously, providers are largely left to their own devices when it comes to the staffing of each facility. Intuitively, given that the centrality of the resident/nurse/carer dynamic, it might reasonably be supposed that there would have been a rationale dealing with the minimum number of face-to-face hours between nursing staff and residents and that it might be associated with the subjective need and acuity of each resident. According to the ANMF study, sadly, this does not appear to be so. This will be one of the perspectives the Royal Commission will need to consider in its future work.

According to the ANMF, there are no standards or regulations that deal specifically with how many staff and at what skill level ought properly to be rostered on at any particular time. Further, there is no shortage of evidence that current practice, although by no means universal, contemplates a nurse being on duty at all times. The ANMF study provides the first basis for a methodology regarding the allocation of staff that is evidence-based, supported by credible research and is peer reviewed. It is a valuable starting point for understanding the process at work and for examining what is needed to deliver safe, quality care. It is in the hands of aged care providers to identify any alternative framework or model to suggest improvements with the attention to the delivery of safe and appropriate care.

According to the ANMF, to leave the issue up in the air to be determined without a rational basis is not an attractive option. Also according to the ANMF, to describe such an approach in terms of fixed ratios is apt to mislead, given that the evidence-based approach would seem to embrace flexibility that is based on the individual care needs of each cohort of residents. The resident profiles that underpin that analysis, as to which there was considerable evidence, clearly contemplate that the higher category patient has the greater need. At the very least, the model represents a starting point which is capable of refinement and development. On the ANMFs case the need is pressing. The churning of nurses and, in particular, the loss of graduate nurses would appear to occur at a disturbingly greater rate than for personal care attendants. The ability to retain nurses and in particular nursing graduates is likely to represent a further significant barrier to the delivery of adequate person-centred care.

Evidence from the people who received aged care and their carers has highlighted the human perspective as to how care is delivered as well as a number of themes that require further investigation. In the case of home care, the evidence of Kaye Warrener, the carer of her husband Les, demonstrates that there are problems in the delivery of the appropriate level of home care to those with the most need. Despite having been assessed and approved with the level 3 package in November 2017, no

funding for him was available by that time. By March 2018, Mrs Warrener was told that he had moved up the queue and that a three month wait was expected, only to be told on 5 February this year that he had been assigned a level 2 package that could commence immediately. Mrs Warrener still does not know when the funding for her husband's package will eventuate.

It is important to emphasise, Commissioners, that delays of this kind impact regressively on lower income older Australians who can't afford to go to the market to buy the relevant services in quite the same way as others on higher incomes. The evidence of Ms Harker from Canberra illustrates that there will be occasions when even a level 4 package will not be enough to meet the home care needs of the person with a strong desire to remain in their own home. To get the morning and evening care that she needs, Ms Harker requires both a level 4 package for her evening attendances and a Commonwealth home support package for the mornings, albeit delivered by different providers.

Her evidence is instructive as to how the carers sent to her are often young people with few qualifications, who often require her direction as to the tasks that need to be accomplished. She focuses attention on the need for clear lines of communication with providers of what is termed consumer-directed care, illustrating that often her provider or the coordinator of her care will be interstate and struggling to find staff to meet her ongoing need seven days on a twice a day basis. She makes the valuable observation that under the current arrangements people like her at the top of levels 3 and 4 do not have the funding to cover all of their needs, unlike in the past where providers were able to draw upon funds for lower level clients to make up shortfalls. Her evidence also highlights flaws in the market for such services, particularly in relation to the location of these services, and their ability to match consumers with concerns. When one of her providers failed, it led to disastrous consequences. In circumstances where care was to be delayed for days, her quality of life was severely compromised.

The evidence of Barrie Anderson, which we heard yesterday, and his moving story of the journey that he and his wife, Grace – his wife of 64 years – are currently travelling traverses both home care and residential care and demonstrates how the role of the carer is critical to quality outcomes for residents. His experience of responding to Grace's needs over 19 years following her diagnosis at the age of 66 bears out the evidence of Ms McCabe from Dementia Australia about the importance of communication with the person who suffers from dementia. Mr Anderson's observation that staff seem more motivated towards residents who can talk bears out the issue that will be further explored concerning the capabilities of all face-to-face staff to respond adequately to the challenges presented by dementia.

He points to the importance of attending to resident dental health, which he pays for himself in the case of his wife. Mr Anderson's compelling evidence of how he has come to communicate with Grace should resonate with professional and other carers. Mr Anderson also puts forward proposals for the future that are central to the remit of this Commission. He points to the special skills needed for staff to enable them to

respond to the person with dementia and the need for the basic dignities of residents to be respected. He points also to the need for continuity in carer interaction with residents and he spoke positively of cluster model communities where those with dementia might be accommodated. This, too, will be a focus of further hearings, Commissioners. The simplicity of his message, to try and walk in Grace's shoes, belies its force.

Can I say something about the responses and submissions which have been received by the Commission. The Commission continues to receive submissions from people who received care from family members and from workers in aged care who have approached the Royal Commission to tell their stories. To date, we're extremely grateful to have received over 1200 submissions. These submissions are being carefully considered and are essential for shaping the course of the Commission's inquiries. I wish to remind those listening that as the Commissioners advised during the preliminary hearing, the submissions portal will remain open until at least the middle of the year. We encourage those who wish to make a submission to continue to do so.

As to the largest 100 providers who were sent information requests, the Commission has now received 90 responses. Responses from the remaining providers were due on 8 February. Those responses continue to come in and are being reconciled and reviewed. The Royal Commission will conduct hearings, as we've said, in all capital cities and a number of regional centres. The anticipated dates for hearings for the balance of this year are now available on the Royal Commission website. The next round will be held in Adelaide starting on Monday, 18 March 2019. This round will focus on home care and the community. The round after that is scheduled to be held in Sydney starting on 6 May 2019. The focus of this round will be on residential care, including, in particular, quality and safety and dementia.

Commissioners, if we are to have a dignified future as we age, we must ensure that our aged care system respects the lives we have led in our younger years. Let me return in closing to the evidence of Mr Hayes, the president of the Health Services Union on this very subject. He recounted a story told to him by a member of his union, how on Anzac Day the carers would dress the old veterans up, men and women, and get them ready for their day of remembrance. The one day of the year, really, when some Australians make an effort to remember the sacrifice of those who have gone before. But once that day was done and the medals were off, the remembrance was over for another year.

The obligation the Australian community owes is not to stop remembering. The challenge is to accord that level of respect and appreciation and dignity every day, and not just on one day of the year. Our aged care quality and safety system must meet this challenge. Our policy settings must take it up. But ultimately, none of this will happen if we, as an Australian community, do not commit to it ourselves. If the Commissioners please.

COMMISSIONER TRACEY: Thank you, Dr McEvoy. Following the hearings that have taken place over the last two weeks and have been designated Adelaide hearing one, it is appropriate that the following directions be made:

(a) No party with leave to appear at this hearing is required to make a written submission.

(b) Any party with leave to appear at this hearing who wishes to make written submissions in response to Counsel Assisting's oral submissions of 22 February 2019 must do so no later than 4 pm on Friday, 1 March 2019.

(c) Submissions are not to exceed 10 pages.

(d) Documents referred to in submissions should be restricted to documents tendered in the course of Adelaide hearing one and must be identified by their document ID and, if appropriate, exhibit numbers.

(e) Submissions should be submitted to the solicitors assisting the Royal Commission; and

(f) It is intended that submissions will be published on the Royal Commission's website.

Copies of this direction will be available from our associate upon the adjournment of this hearing. The Commission will adjourn until 10 am on 18 March 2019 in Adelaide.

MATTER ADJOURNED at 3.39 pm UNTIL MONDAY, 18 MARCH 2019

Index of Witness Events

Index of Exhibits and MFIs