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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

DARWIN

9.56 AM, MONDAY, 8 JULY 2019

Continued from 28.6.19

DAY 31

MR P. GRAY QC, counsel assisting, appears with MR P. ROZEN QC, MR R. KNOWLES and MS B. HUTCHINS

COMMISSIONER TRACEY: Ms Williams, may I invite you very warmly to extend a welcome to country.

MS M. WILLIAMS: Thank you. My name is Mary Williams, I'm a descendant of the Larrakia, Tiwi and Iwaidja. I would like to acknowledge the Commissioners, distinguished guests, ladies and gentlemen. And I would also like to acknowledge my Elders, past, present and future generations of Larrakia but I would also like to acknowledge the Elders, past, present and future generations of many other nations present here today.

The Larrakia traditional owners of Darwin and surrounding regions including Darwin Harbour, east of the Adelaide River and south to the Finniss River; we are the saltwater people and traditionally our lives are dependent on the coast and seas. The Larrakia are known as a Gullumbirringin or Dangalaba after our main totem, The Crocodile. European development was devastating to the Larrakia, with many deaths attributed to introduced disease and dispossession faced by all First Nations people. Today our traditional lands are occupied by the fast-growing capital city of the Northern Territory, Darwin. Within this context of development we face the enormous challenges that relate to the retention of our cultural identity, preservation of our rich heritage, and fulfilment of responsibility in caring for country on behalf of our ancestors and our future generations.

Despite these changes we remain the cultural authority over matters relating to Larrakia Country and People. The Larrakia presence has continued throughout. They have continued to welcome Indigenous and non-Indigenous, with diverse interests in and on our countries for centuries and continue to do so. Historically, the Larrakia welcome Indigenous and international visitors through trade and cultural activities. It is my honour and my pleasure, on behalf of my grandmother and the Larrakia, to welcome you to Larrakia country. Thank you.

COMMISSIONER TRACEY: Thank you, Ms Williams. The Larrakia, as you have told us, descendant from – for your welcome to country this morning. We respectfully acknowledge the Larrakia People as the traditional owners of the land where we gather today and pay our respects to Elders, past, present and emerging. We also acknowledge the rich and diverse Aboriginal cultures that continue in the Northern Territory and extend our respect to all Aboriginal and Torres Strait Islander people who are here today.

This hearing takes place during NAIDOC Week, the theme of which is Voice, Treaty, Truth: Let's Work Together for a Shared Future. This Commission wants to hear the voices of as many people as it can. Building on our recent hearing in Broome, this week we will have the opportunity to hear directly from more Aboriginal and Torres Strait Islander people as well as people who work in Aboriginal community-controlled organisations. We look forward to hearing what these witnesses will tell us about aged care and primary health care in the Northern

Territory, including suggestions for improvement. We are, again, Ms Williams, most grateful to you for coming and extending a welcome.

MS WILLIAMS: And thank you for having me.

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioners. I appear with Peter Rozen QC, Richard Knowles and Brooke Hutchins of counsel assisting. We greatly appreciate the privilege of being here in Darwin during NAIDOC week, the theme of which includes 'Voice, Treaty, Truth', in recognition of three key elements from the Uluru Statement from the Heart. Can I just mention to those present that there is an interpreter of Top End Kriol available here in the courtroom should anyone wish to use that service. The focus of this public hearing of the Royal Commission will be on quality of care and quality of life for people receiving aged care, and access to aged care for rural and regional Australians including Aboriginal and Torres Strait Islander people. The hearing will be conducted into those themes over two weeks in two locations, in Darwin this week and in Cairns next week.

I will make opening remarks about the Darwin leg of the hearing now. At the commencement of the Cairns leg on Monday, 15 July, Mr Rozen, QC will make opening remarks including by addressing matters of particular relevance to Far North Queensland. Mr Rozen QC will make closing remarks about the hearing overall including its Darwin aspects at the end of the Cairns leg of the hearing on Wednesday, 17 July. While the Royal Commission is in Darwin, as well as focusing on those particular themes, the Commissioners will be gaining a deeper understanding of issues affecting the delivery of aged care in the Territory more generally including in remote locations.

Commissioners, you have already heard evidence providing context to the evidence on the themes of this hearing. In the first Adelaide hearing in February, you heard evidence from a range of advocacy, professional and sector bodies and experts as to their perspectives of key issues in the quality and safety of aged care services. In every hearing since then, the body of evidence relating to the issues identified in February have been expanded upon. The quality of aspects of the care relationship between home care providers and those they care for was addressed in the second Adelaide hearing in March. Quality and safety of care provided in residential care settings, with a focus on the needs of people living with dementia, was a key focus of the hearing in Sydney in May.

The Broome hearing in June touched of aspects of quality and safety in the provision of aged care in remote settings. The Perth hearing in late June, although focusing on person-centred and relationship-based care, demonstrated that those themes can be separated from issues of quality of care. Quality of life was also a strong feature of that hearing. At the hearing in Broome, the Royal Commission heard about the delivery of aged care through various models of aged care in remote and very remote areas of Australia. Those models of care include community-based care provided in

community or care centres, including through multi-purpose services. There, the Commission heard from providers operating in remote areas across the Kimberley, South Australia, Far North Queensland, including the Torres Strait, and the Northern Territory.

At this hearing, the Commission will hear about service delivery in rural, regional and remote areas of Australia. I will return to this in a few moments. The Royal Commission has received submissions which address aspects of the themes in this hearing from a number of peak advocacy and practitioner bodies, clinical and care-related organisations, as well as a number of individual practitioners from a range of disciplines and workforce representative bodies. We do not propose to tender these submissions as evidence in this hearing. However, they have been analysed by staff of the Royal Commission and their relevant contents will be taken into account when it comes time for recommendations to be considered.

In a few minutes, I will return to the key themes of this hearing and in doing so I will say more about the linkages between these themes and the evidence you've heard already. But first I will explain the structure of the Darwin leg of the hearing and say something about the different categories of witnesses we intend to call and roughly speaking, the sequence in which we intend to proceed. We intend to commence by playing a pre-recorded direct account of Mrs Mildred Numamurdirdi, an Aboriginal Elder from Numbulwar in the Northern Territory who is a resident in a Palmerston residential aged care facility. The video was facilitated and provided by Danila Dilba Health Service which provides primary health care to Mrs Numamurdirdi. And we respectfully acknowledge the presence here in the hearing room of Mrs Numamurdirdi, and we are very, very grateful for her attendance.

In brief terms, I will now outline the sequence of topics we will cover this week in Darwin, and a few minutes I will say more about the content of the evidence. Today we will hear contextual evidence about Northern Territory health services and community services and their close connection with aged care. In this respect, we will be hearing the evidence of Sarah Brown, the CEO of Purple House, Kim McRae of NPY Women's Council, Donna Ah Chee and Dr John Boffa of Central Australian Aboriginal Congress, Olga Havnen and Dr Sarah Giles of Danila Dilba Health Service, and Michelle McKay of Northern Territory Health.

On Tuesday, we will hear the direct evidence in the first case study, which relates to the care of Mrs Shirley Fowler at IRT William Beach Gardens, an aged care facility in the Illawarra region of New South Wales. Mrs Fowler is living with advanced dementia and is immobile and has special dietary needs. Mrs Fowler's daughter, Lyndall Fowler, will tell the Royal Commission about the impacts of care for her mother's quality of life since 2013. After a very rapid deterioration, Ms Lyndall Fowler will describe her mother's constant battle with pressure injuries, nutrition issues and contractures, amongst other issues, and her tireless efforts advocating for her mother's care. Employees of IRT William Beach Gardens and Mrs Fowler's general practitioner will be giving evidence.

On Wednesday we will hear the direct evidence in the second case study, which relates to the late Annunziata Santoro who resided at Assisi Centre Aged Care, an aged care home in Rosanna in suburban Melbourne conducted by Assisi Centre Limited. Ms Santoro's daughter, Anamaria Ng, will tell the Royal Commission of her experience of her mother's care at Assisi Centre, and speak about her mother having falls on a regular basis almost always at night. Ms Ng is expected to give evidence of being told by her mother's treating doctor that there were maggots in a serious pressure injury on her mother's heel. The Chair of the Board of Directors and the CEO of Assisi Centre Limited, as well as Ms Santoro's GP will also be giving evidence.

On Thursday we will hear direct account evidence from Ms Lisa Backhouse about some very confronting aspects of the decade that her mother, former nurse and midwife Christine Weightman has spent in the aged care system. We will then hear from a number of experts and practitioners who will give evidence on a range of selected clinical and related topics of great significance in the delivery of safe and high quality aged care. We will be calling two of these experts separately, Associate Professor Peter Gonski, a geriatrician and general physician based in New South Wales, and then Professor Johanna Westbrook, an expert in health informatics and patient safety based at Macquarie University in New South Wales. We will then conduct two panels on the discrete topics of continence and wounds. We will also be hearing from the care provider who will explain the care model.

On Friday we will hear additional direct account evidence, this time from Ms Jo-Ann Lovegrove about her father's experiences in the aged care system here, in the Northern Territory. A word of explanation is necessary here. Whereas some of the direct account evidence we lead identifies the name of the person receiving care and the aged care approved provider or aged care service from whom they received it, this is not always possible or appropriate. Ms Lovegrove's account is one of those instances where details of that kind are not identified.

Later on Friday, we will hear evidence from the 2018Pharmacist of the Year SA/NT, Dr Janet Sluggett, a research pharmacist who will give evidence about pharmacy issues impacting on quality care and safety. Then from Catherine Maloney, the acting CEO of SARRAH, the peak body representing rural and remote allied health professionals, and from a panel of witnesses from the Larrakia Nation Aboriginal Corporation. Mr Rozen, QC will then make some brief concluding comments but not a detailed oral closing address. When the hearing moves to Cairns next week, Mr Rozen QC will make opening remarks, call evidence including a third case study and a number of additional experts, direct account practitioner and provider witnesses, and will conclude the hearing with an oral address covering both legs of the hearing.

I will now explain the procedure we intend to adopt for the case studies. Each case study will be conducted separately from the others. There will be a brief opening for each and a discrete case study tender bundle will be tendered. The parties given leave to appear on the basis of their interest in that case study have already been given access to that tender bundle and have received the witness statements of family

members of care recipients relevant to that case study and other statements. Once all the direct evidence in each case study has been called, counsel assisting do not intend to formally close the case study. The parties appearing in the case studies should be aware that comments made by experts later in the hearing about issues arising in the case studies may occur, and they may be relied upon to support findings in the case studies.

There will be no detailed oral closing submissions on each case study. Rather, we intend to seek directions at the conclusion of the overall hearing in Cairns for the provision of written submissions as to the findings that should be made in the case studies, including response submissions by parties granted leave to appear in them, on the basis of an interest in the particular case study, and a brief opportunity for any necessary reply as between those parties.

In this hearing, we will build on what we have heard to date about the delivery of aged care in the home. Anna Ng and Johanna Aalberts-Henderson will talk about the experience of their mothers receiving care under the home care package program before entering residential care. These witnesses will explain how limitations with the packages ultimately formed part of the decision to move their mothers into residential care. Dr Drew Dwyer will explain how the lack of availability of home packages impacts on the broader aged care system. Dr Dwyer will explain that as a result, older Australians are in his words, "frailing" more quickly, often with undiagnosed chronic diseases. This can lead to acute health conditions where older people and their families need to secure residential care in a crisis situation.

Some of the experts in specialist clinical areas such Adrienne Lewis from South Australia Dental Service and Sharon Lawrence from Dieticians Association of Australia, will outline how clinical service provision could be improved in the home care setting. With regards to quality of life, Professor Westbrook and Dr Dwyer will highlight the preference of many Australians to remain independent and 'age in place' in the comfort of their homes for as long as possible. Professor Westbrook will address the importance of social relationships for older Australians receiving aged care at home and will illustrate the impact quality of life has on clinical and personal care outcomes by discussing how social support and amount of service provision, in the home can delay the transition to residential aged care.

Whether provided in the home or in a residential aged care service, the quality and safety of aged care is of critical concern to the Royal Commission. During this hearing, it is not possible to examine every aspect of care, nor is it the intention to analyse specific clinical guidelines or standards. What we will do, however, is to concentrate on some elements of care that not only have a significant influence on clinical outcomes and quality of life in and of themselves, but that illustrate the relationships between personal and clinical care across multiple domains.

We will also recognise the importance of all staff in aged care settings who can all contribute to quality care and a positive quality of life while still working within their respective scopes of practice. We will hear from a number of clinical and academic

leaders in aged care across multiple care domains, including Adrienne Lewis, Dr Joan Ostaszkiewicz, Dr Frances Batchelor, Dr Jennifer Abbey, Dr Drew Dwyer, Sandy Green, Angela Raguz, Geoff Sussman and Catherine Maloney. They will highlight the need for the staff in aged care services to deliver high quality care, while also recognising when outside expertise is required to most effectively support the needs of older care recipients.

Falls are relatively common in older people receiving care, but particularly for those in residential aged care. Dr Batchelor will assist in the assessment of how the risk of falls should be effectively managed in aged care. We will explore the way in which aged care staff can support those with a risk of falling, which can result in serious injury, physical deterioration and high levels of stress and concern. Incontinence is an issue affecting many aged care recipients. Continence care is attended by a range of staff in aged care. We will hear from Dr Ostaszkiewicz and the Continence Foundation about how these issues are managed in accordance with the evidence and the challenges associated with providing clinical care in aged care settings.

The Commission will also hear from those with experience of care that has failed to deliver positive outcomes. This experience highlights the critical importance of identifying and responding with requisite skill to complex care needs, listening to carers and family members, and involving the right clinical experts at the right time. These direct experience accounts will show how poor care in one area with impact on many others, creating more complex care needs, pain, suffering, concern and even disability.

I wish to speak about the Northern Territory context. The Northern Territory's population is over 247,000 people, with 7.2 per cent of the population aged 65 or older. Almost one in five people who might need aged care services are Aboriginal and Torres Strait Islander people over the age of 50. This is about 13 times the national average. The higher proportion of Aboriginal and Torres Strait Islander people who may need to access aged care services is reflected in the service model for the Territory, where about 38 per cent of aged care places available in the Northern Territory are delivered through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Nationally, this statistic is 0.4 per cent.

There are 124 home support outlets in the Northern Territory, 55 home care service providers and 12 residential aged care providers, which cater for 525 residents. The provision of residential care places in the Territory is well below the nation-wide level of residential care places per capita. There are 14 National Aboriginal and Torres Strait Islander Flexible Aged Care Program service providers, which collectively provide 171 residential places and 178 home care places. The occupancy rate for residential aged care in the Northern Territory is relatively high, at 94.4 per cent, compared to the national average of 90 per cent. Today, we will also hear a story these numbers don't tell. We will hear how limited aged care services, cultural factors and the sheer distance which needs to be travelled by remote and very remote community members culminate in unmet needs in the Northern Territory.

When the hearing enters its Cairns leg next week, the setting will be very different. After that, the Royal Commission is holding a community forum in Townsville on Thursday, 18 July to hear more about the state of aged care services in Far North Queensland. In evidence today and throughout the week, we will hear that clinical and personal care and the requirements of individuals relating to their quality of life in aged care settings in the Northern Territory are quite distinct from elsewhere. Factors like culture, standard of living, general levels of health in communities and access to services have a weighty bearing on these requirements.

At the Broome hearing, we learnt about the critical intersection between primary health and aged care. Dr Kate Fox, a general practitioner who works in Broome and in a remote Aboriginal community, explained the health situation for Aboriginal people living in remote locations. This evidence has application to Aboriginal people who reside in remote locations in the Northern Territory, too. She spoke about high levels of complex medical conditions, such as diabetes mellitus, kidney disease, which can progress to renal disease requiring dialysis, chronic obstructive pulmonary disease and heart disease. Dr Fox explained that for older patients who also experienced increased frailty, incontinence and loss of mobility, acute conditions that require an immediate response can overtake opportunities to treat underlying chronic conditions. However, she observed that it was ultimately the chronic disease and the complications it brings that prevents people from remaining on their country where they wish to stay.

We also heard that having to leave country and family is particularly traumatic for Aboriginal and Aboriginal and Torres Strait Islander people. During today's hearing, you will hear firsthand from Mrs Numamurdirdi, who's here in the Darwin area receiving care, a long way from Numbulwar, in order to obtain the residential aged care she requires. Many witnesses have already spoken about the centrality of culturally safe care for Aboriginal and Aboriginal and Torres Strait Islander people, including Matthew Moore of the Institute for Urban Indigenous Health, who gave evidence in the recent Perth hearing. Cultural safety is at the heart of whether Aboriginal and Torres Strait Islanders - Aboriginal people and Torres Strait Islanders will access aged care services, and it profoundly impacts their quality of life once they do engage with aged care services.

Commissioners, today you will hear evidence from some health providers who also speak of the importance of cultural safety in the context of their own services and in the context of their clinical engagement with aged care services. Today we will hear primarily from aged care service providers in the Northern Territory. The evidence will detail the unique challenges but it will also highlight some of the innovative programs being delivered to older Territorians. Sarah Brown from Purple House will give evidence about the crucial dialysis services that Purple House delivers in Central Australia, as well as its aged care services, social support and return to country programs. Since Purple House was conceived in the year 2000, Central Australia has gone from the worst to the best dialysis survival rate in Australia. For older Aboriginal people who would otherwise have to leave their community for dialysis, this is truly life-changing.

Kim McRae, from the Ngaanyatjarra Pitjanjatjara Yankunytjatjara Women's Council, the NPY Women's Council, will speak about the work the council does in Central Australia to support the Central Australian people who live in the tri-state desert region. This work ranges from social and wellbeing programs to disability, respite and aged care services. She will explain the importance of the relationship with primary health care providers in community, as well as primary and tertiary providers in Alice Springs.

CEO Donna Ah Chee and Dr John Boffa will give evidence about the work of the Central Australian Aboriginal Congress, the largest Aboriginal Community-Controlled Health Organisation in the Northern Territory. They will further explain the interconnectivity between primary health and healthy ageing, pointing to the need for better integration between primary and aged care. Commissioners, you will also hear from CEO Olga Havnen and Dr Sarah Giles about the work of Danila Dilba Health Service, an organisation that delivers primary health and other services in Darwin, its surrounding suburbs and Palmerston. Danila Dilba delivers primary health care to aged services three days a week.

The final witness will be Michelle McKay, COO of the Top End Health Service within Northern Territory Health, NT Health, who will address the unique circumstances in the Northern Territory and the challenges of delivering services to an area with the lowest population density of any state or territory. Ms McKay will explain how thin markets across all health and human services in the Northern Territory require government to approach service provision differently so people living here have appropriate levels of access. She will also discuss how different services intersect and how issues in aged care can have flow-on effects for acute and primary health services. Ms McKay suggests the consideration be given to pooled funding arrangements for rural and remote services to a greater degree than at present.

On Friday you will hear from the Larrakia Nation Aboriginal Corporation, an organisation that delivers the Commonwealth Home Support Program and the Home Care Package within Darwin with a focus on people who are homeless or at risk of homelessness. It services a diverse range of clients, including Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse groups. I'll speak briefly again about quality of life. The Commission has heard many witnesses in previous hearings refer to the importance of quality of life in aged care. For example, Bryan Lipmann, CEO of Wintringham, an aged care provider in Melbourne, talked about the importance of people in aged care having an enjoyable life full of opportunities for personal growth and pursuing interests.

Other witnesses in Perth explained that staying independent, maintaining close relationships with family and friends, opportunities for personal growth and adventure and living in a comfortable homely environment are important to older people in maintaining their quality of life, particularly in residential care. In previous hearings, we've also started to hear about the relationship between clinical and personal outcomes and quality of life and the way in which they impact on each

other, a relationship I'll return to. This hearing will focus more explicitly on quality of life, building on what the Royal Commission has already heard.

In the Perth hearing, which concluded less than two weeks ago, the Commission heard about the importance of person-centred and relationship-based care in aged care. Various witnesses defined person-centred care in different ways, but there tended to be common elements, including the importance of good relationships, understanding and embracing the individuality of people and ensuring they have autonomy and control, providing care in a kind, gentle, respectful way by appropriately qualified people. All of these things matter. You heard that person-centred or relationship-centred care promotes or enables quality of life for the older person. I will not rehearse the evidence so recently heard in Perth.

What is quality of life? As the Commission has heard in evidence, the term "quality of life" is often used in the aged care sector by carers, nurses, doctors and providers. The term "quality of life" was first used in medicine in 1966 by J.R. Elkinton in an editorial entitled Medicine and ahe Quality of Life. While the concept has been used in different ways, at its core, it extends medicine beyond mortality and morbidity to a person's experience of life. The Australian Centre on Quality of Life notes there's not one agreed definition of quality of life but defines it as having subjective and objective domains. The objective domains could include observations external to an individual regarding their standard of living, income, education, health status and longevity.

Objective domains are measured through culturally relevant indices of objective wellbeing. Subjective domains of quality of life are based on psychological responses by the individual about their circumstances, and perhaps emotional responses, including their life satisfaction, happiness and self-ratings. Subjective domains are measured through questions of satisfaction. How satisfied is a person with their life? Quality of life in the context of this hearing broadly refers to the extent to which an individual experiences a positive and satisfying life across a variety of domains, including independence, choice and control, social connection, dignity and respect, activities and occupation, environment, including where they live, and food and meals.

Central words and concepts relevant to quality of life which the Commission has and will continue to hear in evidence include dignity, control, social connection, needs and wants, respect, dignity of risk, wellbeing, boredom, frustration. The Royal Commission's terms of reference do not explicitly refer to quality of life but do use terms such as person-centred care, dignity, choice and control that are key concepts related to quality of life. Further, the terms of reference direct inquiry into the quality of aged care services and it is clear that quality of life is fundamental to quality of care. The Commission will hear experts in multiple clinical areas, medicine, nursing, incontinence, falls, wounds, all refer to quality of life as an aspect of and perhaps the most important aspect of care.

Dr Gonski, who describes a model of acute services that focuses on providing this type of care to older people in their place of residence, notes that the most important aspects of quality care is to provide individual personal care to residents. He says that residents will need less care rather than more care if they are enjoying their later years more. There will be slowing of deterioration, less falls, less anxiety and depression, less pain, less use of medications and, therefore, less side effects from medications.

Other clinical experts echo these words in different ways. Dr Ostaszkiewicz focuses in her statement on promoting dignity in continence care, that we need care and dignity to protect psychological integrity, ensuring that they, the people in care, feel safe, respected and dignified. She calls for dignifying continence care and notes that the role and work involved in protecting people's dignity should be valued, recognised and appropriately funded.

Dr Drew Dwyer and Dr Jennifer Abbey, who are both registered nurses by background, call for increased clinical training and knowledge in aged care. They recognise the centrality of quality of life in this care. Dr Abbey endorses previous evidence that focused on the importance of person-centred care. Sandy Green will outline the obligations of nurse practitioners and their role in combining their nursing experience with their medical knowledge to provide a holistic person-centred approach to caring. Adrienne Lewis of the SA Dental Service will highlight how poor dental care can impact health and quality of life outcomes.

The Commission will also hear that improved quality of life improves health outcomes. In Perth, Dr Rungie gave examples of how quality of life activities can have a positive impact on clinical outcomes. For example, the community choir helped breathing techniques for residents living with Parkinson's disease. Similar to Dr Gonski's observations, Professor Westbrook notes there's a growing body of international research which has demonstrated that a high level of social participation and engagement contributes to lower levels of psychological distress, higher self-rated health and better physical function in community-dwelling older adults. Social participation levels are also a good predictor of mortality and use of health services.

This leads to the importance of measuring quality of life outcomes as a measure of quality of care. In Perth, Mr Burton told the Commission that good quality of life is measurable. It's a measurable outcome of good person-centred care. We will again touch on this concept during this hearing and it's likely we'll return to it in discussions of regulation and funding in later hearings. Professor Westbrook will outline research her team have undertaken in relation to community care, noting that the findings will be relevant to the residential aged care context also. One study involved service providers, as part of routine assessment, using tools to ask care residents about their quality of life and social participation. The feedback from clients in the study was, in Professor Westbrook's words, overwhelmingly positive and the care workers themselves drove the ongoing uptake and use of the tool.

Professor Westbrook also notes the work of Professor Julie Ratcliffe of Flinders University as important research in incorporating quality of life assessments in economic evaluations, along with seeking the references of people with cognitive impairment and dementia. We will explore with Professor Westbrook if Professor Ratcliffe's work could have implications for establishing standards, measuring indicators and even funding in relation to aged care. One of the tasks confronting the Royal Commission is to bring together the concepts of the safety of care, the quality of care and the quality of life into a coherent framework that is supported by the evidence and is adaptable to all aged care settings. Doing so is most likely to yield insights into how the system should be designed to provide the best outcomes in all these respects and where the deficits currently are.

There are a number of aspects to this task. To name a few, there's a difference between the safety of care and the quality of care. There's a need to balance individual choice and dignity of risk on the one hand and safety on the other. There are different domains of care, ranging from manifestly clinical care that can only be provided within the scope of practice of clinically qualified professionals to a wide range of personal care activities and other things that must be done to enhance life, including a caring attitude and time to engage. These are all interconnected. For example, a failure in personal care can quickly lead to a clinical issue. Poor quality of life can also become a clinical issue.

This hearing will highlight new approaches that focus on quality of life. Witnesses will describe the Eden Alternative, NewDirection Care at Bellmere, as well as established care providers such as HammondCare. The Commission will also hear from Elsie Scott, a resident of Bellmere. While there appears to be consensus among the clinical experts in the hearing regarding quality of life as a domain of care, there is, at least at face value, tension in practice. The Commissioner - both Commissioners will hear about the tensions that exist in aged care when trying to provide evidence-based high quality personal and clinical care that meets resident family expectations while also recognising that this care is provided in a home, be that the person's usual home or an aged care facility.

On the last day of the Perth hearing, Dr Trigg referred to this as the triple H dilemma - should the design of a residential aged care facility be like a hospital, a hotel or a home? Dr Dwyer, Dr Abbey and Sandy Green, all trained registered nurses or nurse practitioners, call for an increased emphasis on clinical training and skills, clinical governance and recognition of the role of the registered nurse and nurse practitioner. Nevertheless, Dr Dwyer and Dr Abbey reject the conceptualisation of aged care facilities as home-like. Dr Abbey believes that the goal of a home-like environment adds to cognitive dissonance for staff and family, leading to burnout, compassion fatigue, complicated grief, all of which can contribute to abuse.

In contrast, she endorses Professor Joseph Ibrahim's statement that we need to be clear about the purpose of an aged care facility and recognise they are about high-end nursing care and pain management, and she notes we need to acknowledge certain people want to die and are ready to do so. In contrast, Angela Raguz, general

manager of residential care at HammondCare, will speak about the centrality of a home-like environment. She claims that home-like cluster domestic models of care have demonstrated generally improved outcomes for residents, including a better quality of life. She refers to the investigating services provided in the residential care environment for dementia study, which she says found that residents in this type of care had a lower chance of being admitted to hospital, a lower chance of presentation to an emergency department and were less likely to be prescribed a potentially inappropriate medication.

Another domain of care we intend to examine deeply is food and nutrition. We expect to hear about the importance of food security in the Northern Territory. Simply obtaining the basic level of nutrition needed for adequate nourishment is a serious issue for many communities. More generally, Dr Sandra Iuliano and the Dietitians Association of Australia will describe the significant levels of malnutrition or under-nutrition in aged care recipients across the country and the critical improvements in clinical and quality of life outcomes that can result from better nutrition, particularly increased protein intake, including reduced risk of falls, mobility, infection risk, oral and dental care issues and poor wound healing.

As the Dietitians Association of Australia state, inadequate intake of food and fluids by aged care recipients has dire consequences which, unlike in younger adults, are often irreversible. These consequences are multiple but include weight loss and malnutrition leading to reduced muscle strength, reduced ability to repair body organs, poor healing of wounds, increased hospital stays and frailty syndrome, leading to increased disability and falls risk. The honourable Dr Kay Patterson AO referred to anecdotal reports of the inadequacy of meals and the alarming rates of malnutrition in aged care estimated by the Dietitians Association of Australia at the recent hearing.

Reducing malnutrition involves improvements in multiple domains, food planning and preparation, the delivery and presentation of meals and increasing appetite and consumption of meals. It involves multiple players in the aged care sector. Dietitians should be utilised to assess the nutritional value of food and the specific dietary needs of individuals. Cooks and chefs will source, plan and prepare food. Care workers should assist in food and fluid consumption and can identify signs of malnourishment or dehydration or risk of malnourishment or reduced appetites. Nurses and doctors should identify and diagnose malnourishment or risk thereof. Dentists and oral hygienists should be utilised to ensure oral and dental health, a healthy mouth being a critical factor in a person's ability to eat. Speech pathologists have a leading role in alleviating the social and nutritional impact of dysphagia, difficulty in swallowing, which affects 50 per cent of people living in aged care facilities.

Last but not least, it's decision-making by the executives and the boards of service providers which directs the budgets and resourcing necessary for all this to occur and for necessary nutritional, appetising and high-quality suppliers to be obtained, and the organisational structure under them that manages and prioritises all those

operations necessary for those in care to receive proper food and drink is the responsibility of those in governance positions.

The Commission will hear from a panel of chefs who prepare the food in residential aged care facilities. They will provide insight regarding practices implemented by aged care providers that encourage good food experiences for residents and those that do not. Maggie Beer will explain how and why she established the Maggie Beer Foundation. The Commission will hear about the Foundation's fundamental belief that an increased enjoyment of food will contribute to emotional wellbeing, and that improved emotional wellbeing leads to improved physical wellbeing and ultimately quality of life.

Adrienne Lewis will outline the poor oral health provision in aged care and the multiple impacts this can have, including affecting an older person's ability to eat and enjoy meals. Adrienne Lewis believes that care workers should be able to implement recommendations of a good oral care plan. Dr Iuliano will identify research that suggests increased time spent by carers in assisting older people to eat from one to five minutes for snacks and from five to 42 minutes during main meals, leading to increased calorie intake and weight. Dr Frances Batchelor will outline the multiple risk factors for falls, including reduced muscle strength.

In concluding, I will briefly describe some procedural matters. First, document management. The solicitors assisting the Royal Commission have prepared and made available to you, Commissioners, four tender bundles. There is a general tender bundle, documents from which will be displayed from time to time during the hearing overall. And, in addition, there are three tender bundles, one specific to each case study. I wish to tender the general tender bundle as a single exhibit at this point. Documents in that tender bundle may be referred to by tab number, according to the accompanying index which will now be displayed.

During the hearing, it's possible that further documents might need to be added to the general tender bundle. The general tender bundle currently consists of 127 tabs. We will tender additional docs by – documents, that is - by adding tabs to this exhibit consistently with the procedure adopted in the Perth hearing. At the end of the Cairns hearing, we will revisit the tender bundle and confirm how many additional documents have been added during the hearing. Commissioners, I tender the general bundle.

COMMISSIONER TRACEY: Yes, the Darwin general tender bundle will be exhibit 6-1.

EXHIBIT #6-1 DARWIN GENERAL TENDER BUNDLE

MR GRAY: Thank you. In addition, as I mentioned, there are three separate tender bundles, one for each of the case studies. We plan to tender each case study tender

bundle at the commencement of the case study in question as a single exhibit. Again, once each case study tender bundle has been tendered, documents in that tender bundle may be referred to by a tab number according to the applicable index which members of the counsel team will have displayed on the screen at the commencement of that case study. We have put the relevant parties in each case study on notice that we intend to tender and may publish the documents in these tender bundles, some of them in a redacted form.

Those parties have been given an opportunity to object to the publication of documents, including on the basis of confidentiality. Commissioners, during the course of this hearing you may be asked to consider applications for a direction that particular documents not be made public. Any such application should be made in accordance with part G of practice guideline 1 of this Royal Commission. It may not be possible for you to hear and determine such applications during the hearing and they may have to be determined on the papers afterwards.

At the end of the Cairns leg of the hearing, Mr Rozen QC will present a closing address which will reflect the themes of this hearing including this Darwin leg. This will be followed by written submissions which the counsel assisting team aim to complete seven days after the hearing. Parties will leave to appear will have seven days, we propose, from the date of counsel assisting's submission to provide you with their own responding written submissions before you make any findings in the case studies. At the conclusion of the hearing, Mr Rozen will ask you to make directions in that regard. Before we ask the operator to play the video of the interview with Mrs Mildred Numamurdirdi, there will be a brief adjournment and then Mr Knowles will call a witness who will give some contextual evidence about the video.

COMMISSIONER TRACEY: I understood that there was no need for an adjournment.

MR GRAY: Very well. Mr Knowles will – may the Royal Commission stand down for just a few minutes while Mr Knowles attends to a particular matter?

COMMISSIONER TRACEY: There'll be a short adjournment.

MR GRAY: Thank you.

ADJOURNED **[10.47 am]**

RESUMED **[10.59 am]**

COMMISSIONER TRACEY: Yes, Mr Knowles.

MR KNOWLES: I thank the Commissioners for that short adjournment. I would now like to call Dr Meredith Hansen-Knarhoi who is with Ms Mildred Numamurdirdi. I would like also at the outset to express my gratitude to Ms Numamurdirdi for her involvement in the Royal Commission and for being here today. So we have Dr Meredith Hansen-Knarhoi in the witness box. Dr Hansen-Knarhoi, can you tell the Commission your full name?

COMMISSIONER TRACEY: I don't think the witness has been sworn in.

<MEREDITH HANSEN-KNARHOI, AFFIRMED [11.00 am]

<EXAMINATION-IN-CHIEF BY MR KNOWLES

MR KNOWLES: Thank you. Dr Hansen-Knarhoi, can you tell the Commission your full name.

DR HANSEN-KNARHOI: My name is Meredith Hansen-Knarhoi.

MR KNOWLES: Yes, and you've prepared a statement for the Royal Commission.

DR HANSEN-KNARHOI: That's correct.

MR KNOWLES: Yes. And that's document WIT.0233.0001.0001. Have you read your statement lately?

DR HANSEN-KNARHOI: Yes, I have.

MR KNOWLES: And do you wish to make any changes to your statement?

DR HANSEN-KNARHOI: No.

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

DR HANSEN-KNARHOI: Yes.

MR KNOWLES: I seek to tender the statement of Dr Hansen-Knarhoi.

COMMISSIONER TRACEY: Yes, the witness statement of Dr Meredith Hansen-Knarhoi dated 2 July 2019 will be exhibit 6-2.

MR KNOWLES: I think it's dated 5 July, Commissioner. It says 4 on the front but it's signed and dated on the 5th to my understanding.

COMMISSIONER TRACEY: Well, the one that has just come up on the screen is 4 July.

MR KNOWLES: On the front. Yes, and the signature, I believe, is on the last page, the 5th, so I think that date is a bit of a misnomer.

COMMISSIONER TRACEY: Well, the one that is in the folder that we have been provided with – I see.

MR KNOWLES: I apologise, Commissioners.

COMMISSIONER TRACEY: All right. I will go back for the purposes of the record. The statement earlier referred to which is dated 5th July 2019 will be exhibit 6-2.

EXHIBIT #6-2 WITNESS STATEMENT OF DR MEREDITH HANSEN-KNARHOI DATED 05/07/2019 (WIT.0233.0001.0001)

MR KNOWLES: Thank you, Commissioners. Dr Hansen-Knarhoi, you are a GP working for Danila Dilba Health Service in Palmerston.

DR HANSEN-KNARHOI: Yes, that's correct.

MR KNOWLES: How long have you been a GP?

DR HANSEN-KNARHOI: I've been a GP since February 2016. I've been a doctor for seven and a half years.

MR KNOWLES: Can you tell the Royal Commission a little about the Danila Dilba Health Service?

DR HANSEN-KNARHOI: Danila Dilba Health Service is an independent Aboriginal health service providing care for the Darwin, Palmerston and wider community for Aboriginal clients here in Darwin.

MR KNOWLES: Yes, and what's your role at Danila Dilba?

DR HANSEN-KNARHOI: So I'm a specialist general practitioner so I work in the Palmerston clinic four days a week, and one day a week is kind of dedicated to care of – a residential aged care facility which is near to our clinic, Terrace Gardens.

MR KNOWLES: Yes. And what does the work entail in terms of the visits to the residential aged care facility?

DR HANSEN-KNARHOI: So I regularly visit on a Thursday morning. I review the residents that are under my care. I go with an Aboriginal health practitioner, and we do health checks. We do clinical reviews, arrange reviews, if needed and, of course, be available out of hours and on call if the need arises.

MR KNOWLES: And one of those residents at Terrace Gardens is Ms Numamurdirdi.

DR HANSEN-KNARHOI: Yes, that's correct.

MR KNOWLES: Yes. And she is one of the Elders and traditional owners in her community in Numbulwar.

DR HANSEN-KNARHOI: That's correct.

MR KNOWLES: Can you tell the Royal Commission a little bit about you know of Numbulwar.

DR HANSEN-KNARHOI: Well, I've never been to Numbulwar but it's a long way from here. It's around 800 kilometres and some of that is on a dirt road at the very end. It's quite distant. It's a small isolated but beautiful, apparently, community right on the sea in the Gulf of Carpentaria.

MR KNOWLES: What's the population of Numbulwar, to your knowledge?

DR HANSEN-KNARHOI: It's around 750 but Mildred will correct me but it can go up to 1500; it depends on what's happening in the community, events, funerals, football matches, that sort of thing.

MR KNOWLES: Yes. To your knowledge where is the nearest residential aged care facility to Numbulwar?

DR HANSEN-KNARHOI: So the nearest residential facility would be in Katherine but that's still a five/six hour drive and then otherwise it's here in Darwin.

MR KNOWLES: And can you tell the Royal Commission how Ms Numamurdirdi came to be in Terrace Gardens and when that occurred.

DR HANSEN-KNARHOI: Right. So I first met Mildred in March 2018 and I was informed when I visited Terrace Gardens that I had a new resident and Mildred had been admitted to permanent residential care at Terrace Gardens after a stint in hospital when she was unwell, having been flown out from her remote community prior to that.

MR KNOWLES: You've been her GP since then.

DR HANSEN-KNARHOI: Yes, that's correct.

MR KNOWLES: So far as you are aware she has not been able to return to Numbulwar since then.

DR HANSEN-KNARHOI: No, unfortunately despite exploring options, no.

MR KNOWLES: And from your observation, has Ms Numamurdirdi had difficulties in keeping in touch with her family in Numbulwar from time to time?

DR HANSEN-KNARHOI: It has been really quite difficult. We are dependent on a mobile phones and it took some months to sort out a mobile phone for Mildred that she could use because there is no phone, you know, there is no sort of service in the residential care, plus connection with Numbulwar, it all depends on seasons and times and other people having their mobile phone switched on, etcetera, but we have got that now sorted out.

MR KNOWLES: And on 25 June this year, you assisted Ms Numamurdirdi to prepare a video statement for the Royal Commission.

DR HANSEN-KNARHOI: Yes, that's correct.

MR KNOWLES: And can you describe for the Royal Commission where it was taken and who appears on the video with yourself.

DR HANSEN-KNARHOI: So the video was shot at Terrace Gardens in an outdoor area. There was myself, there was Mildred, there was also Sekala Hartri who is a Kriol interpreter – because I wanted to be very clear that everyone, particularly – well, Mildred understood the consent process for the Royal Commission. And then there was the camera crew, and a health practitioner that works with me.

MR KNOWLES: Yes. Commissioners, that video is at tab 64 of general tender bundle. It is document RCD.9999.0093.001. As you will know, the video is subject to your direction made on 3 July this year, direction D0006, and that is that it not be published without Ms Numamurdirdi's consent. Its ongoing publication is also subject to your direction. Dr Hansen-Knarhoir, before the video is played, can I ask you; you've referred to this a moment ago, whether you sought Ms Numamurdirdi's consent to making the video statement for the Royal Commission and having it shown today.

DR HANSEN-KNARHOI: Yes, that's correct.

MR KNOWLES: Now, I will now ask, if it pleases the Royal Commission, for the operator to play the substantive part of the video, omitting formal parts at the beginning and the end.

VIDEO SHOWN

DR HANSEN-KNARHOI: So Mildred, we're going to try and tell your story about how you came to be living here in this place.

MS NUMAMURDIRDI: Well, I was very sick. I had pneumonia at my home, Numbulwar, and I was sick. So they sent me to Royal Darwin Hospital. I was staying there and after a while – March – and I finish my hospital so they decide to send me to home. So I didn't know this Terrace Garden ..... Rocky Ridge but this place, I didn't know – this hospital. So they drive me, put me on the ambulance and they drive me and I didn't know this place. And I was crying for four weeks ..... sad for my family. So I couldn't stop until they came, visit me and it's too far for us - for me – my family travelling, my daughter and my two grandson. It's too far from Numbulwar, just to visit me. We don't want that way because lots of accident along the road. They drink and drive. That's why my daughter, she frightened to come in and out. So I told her not to come much because she ..... I got friends I told her. So they can come any time if I want to ..... can I ask for aged care in a remote community, please. We don't have aged care closer ..... in our community. I'm asking to build aged care in our community - ..... community, please.

DR HANSEN-KNARHOI: So, Mildred, right now is dry season so in community, what is happening in dry season? There's ceremony and stuff is happening.

MS NUMAMURDIRDI: Yes, we got ceremony there ..... at Numbulwar for time being. My daughter went there last week. She was here with me and she went there. And she didn't come Friday. Next week Friday she will be here because she went there for the ceremony. She important, my daughter. She ..... ceremony .....

DR HANSEN-KNARHOI: And if you were living in Numbulwar, where is your house in Numbulwar?

MS NUMAMURDIRDI: My house at Numbulwar, just in the middle of the – somewhere about there.

DR HANSEN-KNARHOI: And what do you do with your family when you are home?

MS NUMAMURDIRDI: My family never miss me. They used to come, surrounding me and sit with me and talk with me, laughing. They love me so much and I love them so much, my children and my grandkids. My daughter and my two grandson.

DR HANSEN-KNARHOI: What about the food that you eat on community; what do you like to eat?

MS NUMAMURDIRDI: We eat damper. We eat damper.

DR HANSEN-KNARHOI: Yes.

MS NUMAMURDIRDI: We - like they go out hunting. Turtle and dugong, fish, crab, whatever they got, they bring it up to us. We sharing, family sharing. The food and the meat. They all loves me and they all miss me. I'm here. Far away from them. Yes.

DR HANSEN-KNARHOI: And how does it make you feel when you talk to your family on the phone and they are a long way from you here?

MS NUMAMURDIRDI: I really - I make them sad and I myself sad. Yes, my heart is crying, yes. My heart is crying because I far away from my family. Yes. Because if I pass away here, I've got my spirit, my culture, my ceremony way back home at home and my family, they don't want that way, because we've got everything there in the home. And if we pass away, culture there, our spirit. That is my family, because I'm the eldest out of my family and that's my mother land Numbulwar. Yes, I'm the eldest out of my family and so they worry about ..... I tell doctor, she can help me ..... don't worry.

DR HANSEN-KNARHOI: Is there anything else you want to say to the Royal Commission mob?

MS NUMAMURDIRDI: .....

DR HANSEN-KNARHOI: That's okay.

MS NUMAMURDIRDI: Aged care.

DR HANSEN-KNARHOI: Yes, aged care, because before when you lived in Numbulwar you could go on the beach in your wheelchair, but you got very sick.

MS NUMAMURDIRDI: Yes.

DR HANSEN-KNARHOI: And that's why you end up here.

MS NUMAMURDIRDI: Yes.

DR HANSEN-KNARHOI: So there is – but what is there in Numbulwar because they might not know. What kind of clinic is there?

MS NUMAMURDIRDI: We've got new ..... and big one but .....

DR HANSEN-KNARHOI: And so the clinic, the nurses and health workers and doctors.

MS NUMAMURDIRDI: Yes, we got the – we got big clinic and dialysis, we got in Numbulwar. We didn't have before now, and when they built a new house, with clinic, now we've got dialysis.

DR HANSEN-KNARHOI: So when you get sick in Numbulwar where you have to go to?

MS NUMAMURDIRDI: ..... sometime to Gove Hospital or here in Darwin. So yes.

DR HANSEN-KNARHOI: A long way on a plane.

MS NUMAMURDIRDI: A long way. And from here driving, it's too far for us.

DR HANSEN-KNARHOI: Yes. It's 800 kilometres and some of those roads are unsealed and dangerous.

MS NUMAMURDIRDI: Yes. Yes.

DR HANSEN-KNARHOI: And Mildred, do you have any family in Darwin at all here?

MS NUMAMURDIRDI: I've got nobody here. I've got my two niece but they drinker. I don't want them to drink, they drink too much. And my sister and my brother-in-law, they ..... they studying to be a Minister and ..... my sister ..... they here but they never come visit.

DR HANSEN-KNARHOI: Yes. And Mildred, when you came to Darwin, where was your key card for your money?

MS NUMAMURDIRDI: I gave that at my daughter place.

DR HANSEN-KNARHOI: Yes. So when you came to Darwin for like six months, we had trouble sorting out your money; is that right?

MS NUMAMURDIRDI: I don't know.

DR HANSEN-KNARHOI: Yes. And we had to try and find your key card.

MS NUMAMURDIRDI: Yes. But she – then my key card at my daughter. She looking after my everything.

DR HANSEN-KNARHOI: Yes. That's good. That's good. All right. Do you want to say anything more, Mildred?

MS NUMAMURDIRDI: No, thank you.

DR HANSEN-KNARHOI: I think you've done an excellent job, yes.

MS NUMAMURDIRDI: Yes. I say thank you to .....

DR HANSEN-KNARHOI: All right. So thank you. Thank you.

MS NUMAMURDIRDI: Thank you.

DR HANSEN-KNARHOI: This has been helpful. It's the 25th of June and - - -

MR KNOWLES: Thank you begin Ms Numamurdirdi and Dr Hansen-Knarhoi. Can I just ask Ms Numamurdirdi, is there anything that you wish to say?

MS NUMAMURDIRDI: No, thank you.

DR HANSEN-KNARHOI: No, thank you.

MR KNOWLES: And Dr Hansen-Knarhoi, do you wish to say anything else to the Royal Commission today?

DR HANSEN-KNARHOI: No, I think it's pretty clear. Thank you.

MR KNOWLES: Commissioners, unless there's anything further that you wish to ask of either of the witnesses, that concludes this evidence.

COMMISSIONER TRACEY: I've just got one question, Doctor, and it's this: the reason, as you've explained, why it's necessary to have Mildred here in Darwin is that she requires a particular level of care that could not be provided on country. Is there another centre closer to her home town that might realistically be considered for the establishment of an equivalent facility closer to the remote areas?

DR HANSEN-KNARHOI: Realistically, no. The nearest is Rocky Ridge in Katherine. That's still a five to six hour drive from Numbulwar so there is no residential care closer, because once you get on that road and you keep going there's – that's basically the community at the end of the road. So there isn't realistically anywhere that Mildred could live in that's right on country for her.

COMMISSIONER TRACEY: Thank you. Thank you, Mildred, for giving us your evidence and particularly for coming here today. It has been wonderful not only to hear your evidence but to know of your interest in the proceedings of the Royal Commission and your evidence will be given our greatest consideration when we come to making our recommendations. And, Doctor, for your assistance, we thank you.

DR HANSEN-KNARHOI: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn for 15 minutes.

ADJOURNED **[11.24 am]**

RESUMED **[11.40 am]**

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Commissioners, I call our next witnesses, Ms Sarah Brown of Purple House and Ms Kim McRae of NPY Women's Council.

<KIM MARIE McRAE, AFFIRMED **[11.41 am]**

<SARAH LOUISE BROWN, AFFIRMED

MS HUTCHINS: Ms Brown, I'll start with you first. Have you made a statement for the Royal Commission?

MS BROWN: Yes, I have.

MS HUTCHINS: Operator, please bring up WIT.0254.0001.0001. Ms Brown, is that your statement dated 26 June 2019?

MS BROWN: Yes.

MS HUTCHINS: To the best of your knowledge and belief, are the contents of that statement true and correct?

MS BROWN: Yes.

MS HUTCHINS: Thank you. I tender that statement.

COMMISSIONER TRACEY: Yes, the witness statement of Sarah Louise Brown dated 26 June 2019 will be exhibit 6-3.

EXHIBIT #6.3 WITNESS STATEMENT OF SARAH LOUISE BROWN DATED 26/06/2019

MS HUTCHINS: And, Ms McRae, what is your full name?

MS McRAE: Kim Maree McRae.

MS HUTCHINS: And have you made a statement for the Royal Commission?

MS McRAE: Yes, I have.

MS HUTCHINS: Operator, please bring up WIT.0264.0001.0001. Ms McRae, is this a copy of your statement dated 27 June 2019?

MS McRAE: Yes, it is.

MS HUTCHINS: And to the best of your knowledge and belief, are the contents of that statement true and correct?

MS McRAE: Yes.

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

COMMISSIONER TRACEY: Yes, the witness statement of Kim Marie McRae dated 27 June 2019 will be exhibit 6-4.

EXHIBIT #6-4 WITNESS STATEMENT OF KIM MAREE MCRAE DATED 27/06/2019

MS HUTCHINS: Ms McRae, you are a team leader at NPY Women's Council. Please tell the Commission what NPY stands for.

MS McRAE: It's the three language groups of the area that we cover. So those language groups are Ngaanyatjarra, from the Ngaanyatjarra Lands in Western Australia, Pitjantjatjara from the APY Lands in South Australia, and Yankunytjatjara languages.

MS HUTCHINS: Thank you. And, Ms Brown, you're the CEO of Purple House.

MS BROWN: Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, which is why people call us the Purple House.

MS HUTCHINS: Thank you. Excuse me one moment. Thank you. I'll just have the screen moved so you can see.

MS BROWN: Bless you.

MS HUTCHINS: No problem. So what is the region that your services cover in Purple House?

MS BROWN: So it began as the Western Desert of the Northern Territory and WA, but today we're helping people from the Top End, from Arnhem Land, from NT,

WA and SA, so we've expanded significantly, but remote regions of the Northern Territory, WA and SA.

MS HUTCHINS: Thank you. And you are currently the CEO of Purple House?

MS BROWN: That's lovely. Thank you. Yes, I am.

MS HUTCHINS: Thank you. And how long have you been in this role for?

MS BROWN: Sixteen and a half years.

MS HUTCHINS: And what are your qualifications and background relevant to this role?

MS BROWN: I'm a registered nurse with a masters degree and graduate diplomas in Aboriginal education and health service management.

MS HUTCHINS: Thank you. And, Ms McRae, how long have you been in your current role as Tjungu team leader?

MS McRAE: I'm Tjungu team manager, and I've been in my roles for 15 years.

MS HUTCHINS: What does that role involve?

MS McRAE: I look after the aged care and disability and respite programs at NPY Women's Council.

MS HUTCHINS: And I understand that NPY Women's Council began in the Tri-State Central Desert Region. Please explain for the Commission why it was that the - why it started there and the needs that it seeks to address.

MS McRAE: Yes. The NPY Women's Council started in the 1980s and it was when women from the NPY region, which is the remote cross-border region of the Northern Territory, South Australia and WA - that's a 350,000 square kilometre area, and there are 26 remote Indigenous communities across that area. The women all got together and had a meeting and decided that they were concerned about old people not getting supports that they needed and people with disabilities and families with children, and so the council formed to try and lobby government in order to build those services out bush so that people could continue to live on country.

MS HUTCHINS: Yes, and prior to this role, you worked as a regional information and advocacy council in Shepparton, Victoria.

MS McRAE: That's correct.

MS HUTCHINS: What were your initial impressions when you moved to your new location about, I guess, the state of the services and the community that was available?

MS McRAE: Yes, I think initially I was surprised, if not a bit shocked, about the lack of services available to people in remote areas when - yes, when I started travelling around to the communities and saw that people had very few services, people with disabilities and old people were living with a minimal amount of supports and, yes, it felt a – yes, a little bit shocking.

MS HUTCHINS: And what are the aged care services that your organisation provides?

MS McRAE: Our organisation - we get funded through the Commonwealth support program, and we provide respite and we provide equipment, and we provide social support individual, social support group. Yes, those are the – kind of the main services.

MS HUTCHINS: And, Ms Brown, Purple House was founded in 2000. It's an Aboriginal community-controlled not-for-profit organisation; is that correct?

MS BROWN: Yes.

MS HUTCHINS: Yes. And could you please explain for the Commission why Purple House was started and what it is that it seeks to achieve?

MS BROWN: Sure. So it started because people from the Western Desert, so Kintore, which is seven hours drive west of Alice Springs, and Kiwirrkurra, which is over in Western Australia - I think it's Australia's - officially Australia's remotest community - were worried for their family members who were having – were getting a diagnosis of end stage renal failure and were having to leave their country, their family, their community, to come to Alice Springs to seek dialysis treatment three times a week. Some people were doing that. They'd never lived in a city before and they were really struggling around getting what they needed to stay well in – in the city and also having any sort of quality of life away from everything that was meaningful to them.

And so people from those communities said, "Well, why can't we have a dialysis machine in Kintore and we can look after people ourselves and we can get people home?" At the time, there was only dialysis in the hospital in Alice and Darwin, and so when they went and asked politicians for help, they were told there was no hope. And so they got together and they painted some beautiful paintings. They had an auction at the Art Gallery of New South Wales, with the help of Hetti Perkins and Sotheby's Auction House and their art centre, Papunya Tula artists. Roy and HG were the auctioneers, and they raised $1 million in one night, so $1 million of independent money with the aim of getting dialysis in remote – in a remote community. So that was the original aim – aim of the Purple House.

So we were incorporated in 2003 and started to do dialysis in Kintore and in Alice Springs in 2004 and then realised that - that to look after people really well, we needed other services as well. And so we have expanded by helping other communities get dialysis and get people home. But we've also expanded kind of organically the services that we offer, so around what people need to stay well on country.

MS HUTCHINS: Yes, and what are these other aged care services that you provide?

MS BROWN: So we provide social support. We help run a consumer group. We've got a bush medicine making social enterprise that values the cultural knowledge of bush medicines. We've got a volunteer program and we help get extra supports out to communities. We offer Commonwealth funded aged care services now in one remote community, Mount Liebig, and in Alice Springs, and then we have primary health care services, GP clinics, care coordination, lots of picnics and outings and cooking kangaroo tails on the fire. Just whatever people need to stay well. Allied health services. Nutrition services.

MS HUTCHINS: And in November of 2018, your model of dialysis treatment was recognised with the creation of a new Medicare item number, which is for dialysis treatment performed in a very remote community by a nurse or an Aboriginal health practitioner. What does the creation of this Medicare item number mean in terms of your ability to better service the people that you are able to service?

MS BROWN: It's – it's huge. It's a game changer for us. Up until this time, we didn't fit. If we went to the states and territory governments to ask for support for our model, they'd say that all our – that - that all the funding for dialysis was going into the hospital system, and then when we went to talk to the Commonwealth, they said that they didn't fund dialysis, which is seen as hospital business. This means that for us now the borders have disappeared because the Medicare item number doesn't care if you're in the NT or South Australia or WA, and also it's sustainable funding. It's money for each dialysis that we do in a remote community. And so if there's high demand, we can look at more resources to get more dialysis and get more people home. And also, significantly, it doesn't change with – a Medicare number doesn't disappear when a government changes, and so it really is some surety for people and communities into the future, and also, it's for the whole of remote Australia. It's not just for our community. So we – we've got lots of plans to help other communities to get people home.

MS HUTCHINS: And, Ms McRae, I'd like to discuss with you next the types of people that access your services. What are the general age of your aged care clients that you service?

MS McRAE: Currently we have clients aged between the age of 50 up to about 95.

MS HUTCHINS: And how many clients do you currently service?

MS McRAE: Aged care clients - we service about 110 people.

MS HUTCHINS: And is there a range of languages spoken across your clientele?

MS McRAE: Yes, the – there is three languages for - the NPY languages, but also there are people all around the region. We - this is a highly mobile group of people and so often we have people with other language groups living in our region as well.

MS HUTCHINS: And do you have access to translating services?

MS McRAE: We have a model of service provision. We call it Malparara Way, and it's non-Aboriginal staff working with local Aboriginal people who have the expertise in language and culture and they understand family structures, and they give us not only interpreting support but support around solutions for the issues that our clients and families might have.

MS HUTCHINS: And what are the challenges that your clients face in accessing aged care services?

MS McRAE: Yes. The challenges are related to there not being a lot of services available in remote areas, and so as the care needs of our clients increase, the opportunity to keep supporting them out on community lessens, and there - there are pressures to bring people into aged care services in urban centres because there are a lack of aged care services out in communities.

MS HUTCHINS: And how do your staff find using the aged care system?

MS McRAE: We have found My Aged Care pretty accessible for remote people but we're in a kind of - a unique position that we also do the home support assessments for people to get them into My Aged Care, so we're able to now directly do the assessments while we're out in community and put people into the system. I mean, generally speaking, our clients don't use the internet at all. So they're not using the My Aged Care portal. They don't ring up the contact centre. They rely on staff and communities to be able to support them to access My Aged Care.

MS HUTCHINS: Through face-to-face - - -

MS McRAE: That's correct.

MS HUTCHINS: Yes. And, Ms Brown, in a similar vein, we'd like to understand better the nature of the clientele that you service. How many clients do you currently service?

MS BROWN: So all up - so not all our clients are old people.

MS HUTCHINS: Yes, sorry. I should have been more specific.

MS BROWN: No, that's okay.

MS HUTCHINS: In relation to aged care services.

MS BROWN: Aged care.

MS HUTCHINS: Yes.

MS BROWN: Okay. Probably about - we've got about 40 people who we've got Commonwealth funded aged care for, but we're actually supporting about 150 people who – who are old.

MS HUTCHINS: And what would you say is the approximate age range of the aged care support clients?

MS BROWN: Yes. So from 50 to about 85.

MS HUTCHINS: And do you have a range of languages spoken across your clients as well?

MS BROWN: Yes, we do. There's probably about six, mainly.

MS HUTCHINS: Six languages. And how do you find access to translating services?

MS BROWN: It can be quite difficult and so we've - we do a couple of things. We have a role, particularly in the Top End, called patient preceptor educator role, who are people who are interpreter trained but are also dialysis patients, and they've got two main jobs. One is to help people to navigate the system and the other role is to help stupid whitefellas to learn how to do things the right way. And then we also - the patients are very excited. They've been working on a language translation app which we are launching on Friday which is a real-time Pintupi-Luritja translation app on a - it will be a phone. It's on a computer. So the patients have had a lot of fun teaching that. But we certainly recognise the importance of first language in negotiating care and providing good care.

MS HUTCHINS: And what percentage of your staff are Aboriginal or Aboriginal and Torres Strait Islanders and what type of positions do they hold? Ms McRae, if I could start with you.

MS McRAE: In Women's Council broadly, we - about 60 per cent of our staff are Aboriginal and Torres Strait Islander background.

MS HUTCHINS: And what are the types of positions that they hold?

MS McRAE: They hold positions supporting project officers to go out and do a range of supports for people out in communities. So they do everything from day-to-

day personal care to giving advice around writing submissions, to providing interpreting and translating, to attending meetings and representing Aboriginal people, to - yes, just across the board.

MS HUTCHINS: And do you find that there's barriers to increasing the numbers of Aboriginal and Torres Strait Islanders that you can employ?

MS McRAE: Yes, we've done some project work in that area over the last couple of years, looking at what are the barriers to – to people getting into jobs in aged care and in disability support, and out of a project that we did, the list is that there are - limited English literacy skills is – is a big problem. A lot of people leave school at a young age and have lower levels of English literacy. There's a lack of work experience and readiness. There can be a lack of aspiration and people not knowing what is possible. Often, people are very shy and lack confidence.

There is a reluctance to engage in work due to previous poor experiences. There's no acculturation into mainstream employment models. People need case management and there are no wraparound support services to help people get into and keep a job. There's a lack of succession planning into the current jobs that are available out in communities. Lots of people don't have current driver's licences and this can be a big issue. They have ongoing family responsibilities. They have not got the support required to obtain criminal history and working with children checks. This can be a really big barrier to people getting into employment.

There - a lot of people reported that there were mental health issues and little or no support coupled with high marijuana usage, limiting people's ability to undertake work duties and there are also high levels of mobility which make it very difficult for people to commit to long-term work in a specific location.

MS HUTCHINS: Thank you. Ms Brown, what percentage of your workforce is Aboriginal or Torres Strait Islander?

MS BROWN: So across our organisation it sits at around 30 per cent and that's primarily because a big bulk of our workforce are dialysis nurses, and there's not many Aboriginal dialysis nurses in Australia, and even fewer in Central Australia. However, across our aged care workforce, it sits at around 80 per cent.

MS HUTCHINS: And I note in relation to your workforce generally that Purple House, I guess, bucks the workforce trend in remote communities insofar that you have waiting lists for nurses that want to work with you, even though there's an international shortage in this area as well. Why do you think that this is happening?

MS BROWN: I think we work really hard; we try and suck people into the story of this being an Aboriginal community-controlled organisation where people raise their own money and came up with their own model of care, which is quite different from the standard hospital role of a dialysis nurse. And then we provide lots of cultural safety training and mentoring, lots of support. We've never refused anyone's annual

leave. We put a lot of effort into helping non-Indigenous employees from other places to have a really great experience and build up strong relationships with people.

And then in terms of our Indigenous workforce, we work really hard to be as flexible as we can to encourage people to come, even if they've got other carer and family responsibilities. And so really flexible casual contracts that recognise people's strengths and create job descriptions around those people, and what they want to be doing with their lives.

MS HUTCHINS: Thank you . The Commission has received a lot of evidence already, and undoubtedly there will be more to follow, about the challenges and difficulties that remote service providers are experiencing. Do you have some observations that you could make about the benefits of being a remote service provider?

MS BROWN: Yes. There are all those problems with, you know, how far to your nearest haircut or cappuccino and, you know, I think it attracts particular people who are after – there's potential there to provide really good care. There's – there's no big institutions. For us, our focus is on getting people back to country, helping people to have a good life and doing things the right way, and that's the right way culturally; it's the right way for communities and their future and for patients and staff and for everyone. So there's really the potential to be – live and share – share your life in a beautiful part of the country with people who have a really strong focus on looking after each other and on how important it is to pass on cultural heritage, where the opportunities to be innovative and creative are incredible and with a bit of extra determination, you are able to create things that are the envy of the rest of Australia in many respects.

MS HUTCHINS: Ms McRae, would you have anything to add?

MS McRAE: That was a pretty comprehensive answer, Sarah. All I would add to it is I think that in the retention of staff at Women's Council a lot of it has got to do with the relationships that you build with your clients, with those families, with the women. Those relationships are incredibly rewarding. They involve sharing of culture. The women are, yes, amazingly generous in trying to educate new people who come out to communities. So for me, learning about Aboriginal culture, coming to understand all the things that I have in common with the ladies that I work with, understanding the importance of supporting people to continue living on country and what that means to people on a really deep level, has – has been one of the things that has kept me in my job for 15 years.

MS HUTCHINS: Thank you.

MS BROWN: That's a much better answer than mine.

MS HUTCHINS: Now, Ms McRae, NPY Women's Council performs home support assessments; what are some of the challenges or difficulties that your organisation experiences when you are doing this work?

MS McRAE: Yes, we've kind of had to - we all did the standard training to become home support assessors but we've had to change the assessment tool a little bit to make it more culturally appropriate because some of the questions and the way that the questions were asked was not going to work out in communities. And we have to work Malparara Way so we always work with a local Aboriginal person helping to do those assessments to ensure understanding, to do interpreting and to help us understand the responses that we get from the clients and families.

MS HUTCHINS: Are you able to provide an example of the types of changes?

MS McRAE: We've had to simplify it. I think initially when I did the training in 2015, it was a huge document. It was something like about 15 pages of questions. We've just had to really simplify it to reflect what life is like out in communities. So yes, without having the document in front of me, it's hard for me to give you an example because I haven't done an assessment for a little while but we've just had to look at how people live out there and make sure that those questions are framed in a way that reflects that and that they're going to understand and is going to be valid in that context.

MS HUTCHINS: Your statement notes a number of current health problems that affect your clients. Which are the most common health problems that you see?

MS McRAE: Diabetes, I think would be the most common, followed closely by renal failure. But people have really complex health issues. Most of our clients have a very long list of health issues. I mean one of the things that's always amazed me is how people continue to be resilient in the face of very high levels of health issues, yes.

MS HUTCHINS: And what are the types of measures taken by your organisation to try to support these types of clients?

MS McRAE: Yes, I mean the biggest thing, I think, is nutrition and making sure that people are getting regular meals. That can be a big issue for a range of reasons. Some of it is about the fact that poverty is a huge issue out on communities. Most people are dependent on Centrelink benefits. There is an obligation to share and support your family, and sometimes the end result of all of those things can mean that old people aren't getting enough to eat because they're making sure their grandkids are eating before they're looking after themselves. So making sure that people get access to the meals program, that they are getting regular nutritious food can make a huge difference to someone's life.

Also, being able to access laundry services, being able to – because most people don't have a washing machine in their house. So being able to wash bedding,

blankets, clothing, particularly if incontinence is an issue is really important in terms of maintaining people's health. So those sort of really basic supports are very, very important to ensure that people can continue to live on country.

MS HUTCHINS: Yes. When you mentioned the access to the meals program, what program is that?

MS McRAE: Through the Commonwealth Home Support Program people can be referred in for meals if they're eligible and so that's probably the major work of our home support assessors is referrals for meals.

MS HUTCHINS: Yes. And do you find that the scope of areas that those meals can be provided covers the areas that you provide services to?

MS McRAE: People can get meals in most of the communities that we go to but the quality of the meals can sometimes vary quite a lot. Sometimes it's, it's something that has been frozen and is given out to the family. It's not a fresh meal being cooked on the day or it might be just a sandwich from the store or in some communities there are really good meals available where they've got reliable staff and they've got access to healthy food and people get better quality meals.

MS HUTCHINS: In instances where it's the frozen meals, what are the types of food?

MS McRAE: It can vary. I mean, I've seen some examples of people saying to me that they were offered a frozen meat pie to put in a microwave. I've seen other examples with a really good nutritionally balanced meal.

MS HUTCHINS: And Ms Brown, you identify in your statement similar health problems to that expressed by Ms McRae. You also note that your clients include end stage renal failure requiring three times a week dialysis. What are some of the other major problems that you are seeing in your clients?

MS BROWN: So the bulk of our clients across our organisation are referred to us because they require dialysis. But often people will have diabetes, high blood pressure, dementia. Often when people have been on dialysis for a few years, they become frail quite quickly. It's part of the process of – dialysis is never going to be as good as your kidneys, and so people are losing calcium from their bones, so falls risks is quite high for elderly people sometimes. So a variety of chronic health conditions and then dementias and cancers and the usual things that you would see in older people.

MS HUTCHINS: Is food security an issue for your clients also?

MS BROWN: Yes. And it's very much that issue of communities living in poverty, often people not having access to even Centrelink because they've been breached. And people – it's like you need – to look after old people you've got to try and build

the health of the whole community because old people are an important part of that and I think that Aboriginal communities have a lot to teach us in terms of valuing older people and their cultural knowledge that isn't the experience of non-Indigenous communities. But at the same time, you're right, people are going to share their food and resources and so what has been allocated as aged care resources or NDIS resources is going to become family resources.

So, in Mount Liebig where we are the aged care provider, we also have now taken on the school nutrition program. So we are feeding all the old people and the people with disabilities in that community, but we're also feeding all the school kids every day, and making sure that all the leftovers go back out to community. And that's a great thing because all the people who come into work for that service learn about nutrition and take that knowledge back to their families. And we're ensuring that all the school kids get a healthy diet, too. And we've seen a real increase in the food security of that community because we are providing a lot of that food.

MS HUTCHINS: Thank you. Ms McRae, you mentioned that your organisation supports your clients' desire to live on country. What are some of the primary health supports that aren't available when someone is on country that would be available if they're in town?

MS McRAE: In most communities there's Aboriginal medical services and people do get a lot of help and support through the Aboriginal Medical Service and the Aboriginal Medical Service plays a big role in kind of monitoring the health of older people in communities. But as - Sarah's organisation was set up because of people needing dialysis and, of course, if you need dialysis you're going to have to eventually end up living in an urban centre unless there's a dialysis machine in your community. That's the main one. But also dementia, we find that we've got examples of where older people have – we've endeavoured for many years to keep them out on country but you get to a point where they're so demented that they're putting themselves at risk.

They might be wandering off into the bush, yes. In that case, people do have to come into Alice Springs or another urban centre because they can't get the level of support they need out on community. But generally, as I mentioned before, because people are incredibly resilient, sometimes they will stay living out on community despite their increasing care needs, because they will make that choice. They will make a conscious choice knowing that they would get better care if they came and lived in town. They will still choose to live on country and they will be very, very aware of the consequences of the choice.

MS HUTCHINS: Yes, and what role do you see for your organisation in explaining that friction between someone's dignity of choice to live where they may want to live and, I guess, the deficiencies or, you know, shortcomings they might receive in their care while they are on country.

MS McRAE: Yes, I mean, we do a lot of advocacy for people around their desire to continue living on country. At times that puts us a little bit at odds with other service providers who may feel that it would be more appropriate for someone to live in town and get additional supports. We support what the client and their family wants, and sometimes, yes, that can cause some conflict but that's okay. We still say that people should have a choice. They shouldn't be forced to live in town. We try to build as much of the support that they need. It might be that the family can be trained to provide some additional care. It may be that there are services around who can be engaged in supporting that client. We look at providing regular respite because that can be a way to maintain the care in the community, is to actually bring the client into town for a while and give the family a break from their caring role. We look at all the ways we can continue to support a person to live on country.

MS HUTCHINS: And what are some of the difficulties that you face operating in the current system to enable people to make their own decision in that regard?

MS McRAE: Yes, the difficulty is the threshold around where someone's care needs have increased and yet they're still saying they want to continue to live on country. You get to – there's a tipping point, I guess, where perhaps the medical service is starting to be concerned about that person. Their health is starting to decline. Family might be dealing with a whole lot of other pressures. And yes, those are the – that's the point where you've got to sort of look really hard at what's best for the client and for their family, and sit down and have more family meetings. Sit down and talk to services in the community and look at whether or not the ongoing caring community is going to be available.

MS HUTCHINS: And if a client does need to be in town, what measures would you support in terms of enhancing their cultural and spiritual and emotional needs?

MS McRAE: Yes. The - I think return to country is – is really critical to people's emotional and social wellbeing. So what we find is when people are in – they've had to come in to aged care because their care needs have increased beyond the capacity of the family and the community to look after them. They get stranded in town, and sometimes they're thousands of kilometres away from family. There is important cultural business goes on and people want to return to community. There are funerals. Those senior people often have really critical cultural knowledge that they need to be passing on to younger people in the community. They play a really important role in their community, and when they're removed from the community, there's a huge breach. There's a huge hole.

And it's very difficult. People need to have funding to return to community. All their money is tied up. Once they're in aged care, they've often got nothing left so they can return home. And we look at ways to support people to return to country, support family to come into town and see that person regularly. Yes, those are really important issues in terms of keeping people mentally well and still engaged with their community and still passing on their important knowledge.

MS HUTCHINS: How are you able to fund those return to countries or bringing family into town?

MS McRAE: Yes, fairly creatively. Sometimes it's because we are doing business out in those communities so we can pop someone in a car with us and take them out when we're going. Sometimes there will be an event where there might be a festival going on or something, and we will be able to, again, pop people in a car with us and go out bush with them. But actually finding specific funding for that to occur is getting harder and harder.

MS HUTCHINS: And, Ms Brown, I'd like to ask you about the interface between your services and other allied health services or hospital services. How do you find the process of looking after particular clients throughout the transitioning between different services?

MS BROWN: Okay. So we're – we're in a situation, too, where the - in some of the communities we are with, there are Aboriginal community-controlled health services, but in others there's Territory Government health services in communities, and then we've got the regional hospitals. I think there's – there's a shortage of aged care residential beds in Alice Springs, and so often people are coming into town requiring aged care support and end up being in the continuous care ward of the hospital and may actually be there for 12 months, 18 months or longer. May actually die in hospital, which is a big issue. Lots of very miserable people who have – have access to very few services or social supports and are basically living in the hospital for extended period of time.

In terms of our – we have shared care of dialysis patients with the hospital, and now we're a major dialysis provider. So we work really well with the hospital around being able to take people out of the mainstream system and get them home. And we have some, not as much as we'd like, access to occupational therapists, physios - that ongoing support. It tends to be fairly patchy out bush, so we try to make sure that when physios and people are – are visiting a community that they pass on what needs to be done regularly for people to our staff and to their families so that we can keep that up, because if you only get a physio visiting a community every three months, then you've got to be doing things yourselves in between time. So we've got a good working relationship with the Territory Health Department, and as our outcomes get shown as being better and better, they're asking us to do more, because they know that it's better for people if they get – people have support and get a chance to go home.

MS HUTCHINS: Ms McRae, in relation to continence, as a clinical care issue, is incontinence an issue that faces – that's affecting many of your clients?

MS McRAE: Yes. Yes, it is.

MS HUTCHINS: And how is that managed on country versus, you know, in the town environment, are there particular challenges in managing continence issues with these communities?

MS McRAE: Yes. Yes, there are. I mean, some of the challenges are around people feeling a lot of shame around continence issues and not wanting necessarily to engage with a continence nurse adviser or might be embarrassed about using aids - continence aids, might have trouble getting on to the continence aids scheme. Because people are very mobile travelling around that whole 350,000 square kilometre area all the time, you cannot always predict where someone is going to be and make sure there's going to be continence aids there for them. Yes, it is a complex issue, and it's one of the big issues that - one of those tipping points that ends up with people in town can often be related to continence because that's something that other people very quickly become aware of and start raising it and being concerned about it and – yes, so continence is a huge, big issue.

MS HUTCHINS: And as - you know, as a practical illustration, what are the types of measures that you would put into place if someone does return to town with continence issues?

MS McRAE: We try to get them in to see a continence nurse while they are in town. We try to get them on to the scheme. We try to support them to have continence aids with them wherever they go or work with the local Aboriginal medical service or the clinic to make sure that people have access to continence aids when they're travelling around communities.

MS HUTCHINS: And, Ms Brown, is continence an issue you've noticed affecting many of your clients?

MS BROWN: So generally, people with end stage renal failure don't wee, so they're great to take on a long road trip because they don't have to stop. But more generally, same sort of issues, but we do have a fantastic continence adviser nurse in Alice Springs who's a complete legend. She has a huge workload, but she's a really experienced nurse who's lived out bush for a long time and bends over backwards to help support people. So that's great. One thing, too, that I talked about in my statement is I think there's a lot of unofficial aged care that happens out bush, and I think community art centres are a site of real support and care for older people.

And I often worry for those young art centre coordinators who've done an arts degree in the capital city and have got a job running an art centre out bush, build really strong relationships with older people who are painting these magnificent paintings, but those people are at the art centre all day and requiring care that's not necessarily easily available in the community. So certainly in that situation, you've got young untrained people with their heart in the right place who are dealing with a lot of care needs for older people without the skills or experience or the networking ability to be able to provide those skills.

MS HUTCHINS: So what services do you think they'd be most greatly assisted by having access to?

MS BROWN: So I think it's a bit like, you know, how it takes a village to raise a child. I think that old people in remote communities are really important, and so we – and services are scarce in little communities, so we need to build up everyone with – with their training and their support to look after old people, including aged - art centre coordinators. So basic instruction on lifting people or personal care needs so that they feel confident that they're doing the right things for people, I think, would be a really easy way to improve the health of old people in remote communities because that's the place that they're going and hanging out. That's – that's where they spend their days.

MS HUTCHINS: In relation to training of your own staff within both of your organisations, do you find it difficult to attract highly trained and qualified staff in the first instance? I know the answer might be different for both of you.

MS BROWN: Go first.

MS McRAE: Yes, I think the short answer is yes, because not everybody wants to do remote work. There are a lot of – I mean, you have to also be able to do training in four-wheel driving. You have to drive into very remote areas. And there are challenges in communities sometimes that people find difficult. There's a bit of culture shock often, if you've come from working in Melbourne or Sydney to working out in a remote community. Some people find that situation really difficult, and need a lot of support to be able to be retained. Yes, it is difficult and it's difficult getting people with the right – the right attitude, I guess, because an immediate response to needs out in community might be to say, well, that person is going to be better off living in an aged care, in an urban centre.

Whereas, in fact, what we know is that people choose to continue living on country. That's where they want to be. That's where everything that's important to them is, and so yes, it's very difficult for new people to be seeing the care needs of people out in communities without saying, "Well, why aren't they living in an aged care?" So, yes, it's quite difficult to get people with the right attitude is probably the hardest bit.

MS BROWN: So we will actually go look for people with the right attitude and then build the aged care skills after that. And also for people who have some skills in supporting Indigenous workforce, I can say this because I'm a nurse, but nurses tend to want to rush in and get everything done. And that will often send local workforce running for the hills because, you know, "They're right, they're bossing me around and they're telling me the way to do things, and they've been here five minutes". So I think often we're looking for the people with the right twinkle in their eye and the right experience in terms of community and then building in the aged care skills after that and doing it the other way.

MS HUTCHINS: Do your organisations receive funding for training of your staff?

MS McRAE: Every now and then we get a little bit of funding that is specifically for training. But it's not very often. We've got some applications out at the moment hoping to get more funding around that area but, no.

MS BROWN: And for aged care services in our region, there's an allocation by the Commonwealth training provider who goes out to communities and offers training. We find that quite difficult because it's fly-out – fly-in fly-out, people coming from Brisbane and places to deliver a set course on a particular day. We think it would be much better if we had an allocated lump of resources and we could work with people about their training needs were and work alongside people on an ongoing process rather than these drop everything, you're going to sit in a classroom for a couple of days. So I think – I think there's some things that could be improved so that it's not training for training's sake. And that it's really tailored to the communities and the workers that you've got and it's really strength-based rather than tick a box training.

MS HUTCHINS: Yes. And Ms McRae, what are some issues that you see as affecting, you know, the health of the people that you service, you know, clinical-type issues that you would like to be able to address through the provision of the availability to provide extra services?

MS McRAE: Probably the first thing that jumps to my mind is palliative care and the need for culturally appropriate palliative care. Again, really, the importance of returning to country, if someone knows that they have a life-shortening illness, being able to build supports around that person and their family, letting – providing supports for people to go home and die on country is probably a really big issue that we hear about again and again. People get really unwell and can't return home, being able to bring family in when that's the case so that people have family around them when they pass away. Yes, being able to access supports for people to return to country is a matter of really high importance to our families.

MS HUTCHINS: And, Ms Brown, do you have a further particular issue that you would like to highlight?

MS BROWN: No, I think – I would agree with all of that. I mean, I guess for us, we've still got lots of communities where there's no dialysis and nurses and people are desperate to get home to spend what time they've got left in community with their families. I don't think you can underplay the importance – we've got senior – senior people with the cultural knowledge of particular bits of land of Australia that has been passed on to them, and they're away from their country. If they don't get an opportunity to return to teach their kids and their grandkids their cultural heritage, it's lost not only for those families but the whole community. And the whole of Australia loses that knowledge.

And so it's just absolutely critical not just for remote communities that people get a chance to live well on country but I think Australia will lose something if we don't all make those opportunities to help people to do that. And so certainly we work on

a policy of no regrets, that we can absolutely say we've done everything we can possibly do to help people to have the best life they can.

MS HUTCHINS: Thank you. Commissioners, there's no further questions.

COMMISSIONER TRACEY: The provision of aged care services to Aboriginal people living in remote communities is a matter of great concern to the Commission and we have needed assistance which you have both provided to us today in understanding the sorts of problems that confront services for people in remote communities and what work is being done to assist them. And we're very grateful to you both for coming and sharing your expertise with us. Thank you very much.

MS BROWN: Thank you, yes.

<THE WITNESSES WITHDREW [12.37 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 1.30.

ADJOURNED [12.38 pm]

RESUMED [1.35 pm]

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Good afternoon, Commissioners. The next witnesses, as the Commissioners will see, are a panel of four, two from Darwin, two from Alice Springs. If I could ask that the panel members please be sworn.

<JOHN BOFFA, SWORN [1.35 pm]

<DONNA AH CHEE, AFFIRMED

<OLGA HAVNEN, AFFIRMED

<SARAH RUTH GILES, SWORN

MR ROZEN: Thank you. Ms Ah Chee, if I could start with you, please, could you confirm for the transcript that your full name is Donna Ah Chee.

MS AH CHEE: Yes, it is.

MR ROZEN: Spelt A-h C-h-e-e. And, Ms Ah Chee, you have been the chief executive since 2012 of the Central Australian Aboriginal Congress.

MS AH CHEE: That's correct.

MR ROZEN: Known, I think, generally as Congress.

MS AH CHEE: Yes.

MR ROZEN: All right. That's how I'll refer to it. It is an Aboriginal controlled primary health care service; is that right?

MS AH CHEE: Yes it is.

MR ROZEN: And Congress employs over 400 staff who are involved in delivering primary health care services in Alice Springs and also some nearby remote communities.

MS AH CHEE: That's correct.

MR ROZEN: Personally, you are a Bundjalung woman from New South Wales.

MS AH CHEE: That's right.

MR ROZEN: You've lived in Alice Springs for some 30 years where you are married and have a family.

MS AH CHEE: That's right, on beautiful Arrernte country.

MR ROZEN: I'm sorry?

MS AH CHEE: On beautiful Arrernte country.

MR ROZEN: And in your statement - I won't go through them – you've set out a number of qualifications that you have. They're all set out in paragraph 5 of your statement. And you also have extensive involvement holding leadership positions in Aboriginal organisations.

MS AH CHEE: That's right.

MR ROZEN: And we see that once again set out in paragraph 7 of your statement. I don't need to go through each of those, but I would like to highlight a couple of the

current positions you hold. You are a director of the National Aboriginal Community Controlled Health Organisation.

MS AH CHEE: That's correct.

MR ROZEN: NACCHO, I think, is the acronym.

MS AH CHEE: That's correct.

MR ROZEN: And what does NACCHO do?

MS AH CHEE: NACCHO is our national peak body - - -

MR ROZEN: Yes.

MS AH CHEE: - - - that represents all the Aboriginal community controlled primary health care services across the country.

MR ROZEN: How many are there in Australia; do you know?

MS AH CHEE: About 140.

MR ROZEN: Of those, how many are in the Territory? Know that I'm probably testing the limits of your knowledge.

MS AH CHEE: Yes, I think we'd be up around 20, 23 - - -

MS .....: 27.

MS AH CHEE: 27.

MR ROZEN: Thank you. You're also an expert member of the National Aboriginal and Torres Strait Islander Health Implementation Plan Advisory Group.

MS AH CHEE: That's right.

MR ROZEN: Right. And is that a longstanding advisory group?

MS AH CHEE: It's been in place for the last couple of years, and I'm on there as an expert in early childhood.

MR ROZEN: Yes.

MS AH CHEE: And it's an advisory committee to the head of the – the Commonwealth Health Department - - -

MR ROZEN: Yes.

MS AH CHEE: - - - and then advice through to the Minister for Health.

MR ROZEN: Thank you. Last but certainly not least, in 2016, you were jointly awarded the Australian Medical Association award for excellence in health care.

MS AH CHEE: Yes, pleasantly.

MR ROZEN: Together with the gentleman to your left.

MS AH CHEE: That's right.

MR ROZEN: Who we'll now – I'll turn to in a moment. Before I do that, though, you, together with Dr Boffa, have made a statement for the Royal Commission dated 4 July 2019.

MS AH CHEE: That's correct.

MR ROZEN: It's WIT.0265.0001.0001. Is there a small amendment that you would like to make on page 8 of that statement, Ms Ah Chee, specifically in the middle of the page? So paragraph 36(a).

MS AH CHEE: Yes.

MR ROZEN: You'll see that paragraph in the middle which starts:

> *A key system reform.*

MS AH CHEE: Yes.

MR ROZEN: I think it's about eight lines down – sorry, five lines down, is a sentence that starts:

> *The aged care services people received under both aged care packages and HACC are often critical to the maintenance of health and wellbeing and should –*

and then the word "not" should be after the word "should"; is that right?

MS AH CHEE: That's correct.

MR ROZEN: So "should not be seen as completely separate to the role of providing health care", if that's correct reading.

MS AH CHEE: That's correct.

MR ROZEN: We'll come back to that interrelationship between the two in a moment. With that change being made to the statement, are you satisfied that the contents of the statement are true and correct?

MS AH CHEE: Yes.

MR ROZEN: All right. I'll tender that in a moment, Commissioners, once Dr Boffa has had an opportunity to indicate his assent to the proposition. Turning to you, Dr Boffa, you are the chief medical officer of public health at Congress?

DR BOFFA: Yes, I am.

MR ROZEN: And that's a position you have held since 2000.

DR BOFFA: Yes, it is.

MR ROZEN: What were you doing - you were working for Congress before that?

DR BOFFA: Yes, I was.

MR ROZEN: In what capacity?

DR BOFFA: So I was a senior medical officer, which was basically in charge of all of the medical services and other doctors as well as public health.

MR ROZEN: Yes.

DR BOFFA: So we split that position into two and we created a senior general practitioner coordinator - - -

MR ROZEN: Yes.

DR BOFFA: - - - which is now called the medical director, and my role, which is primarily in public health.

MR ROZEN: Okay. And what's the broad distinction between those two senior roles? The other one is more clinically involved. Is that - - -

DR BOFFA: Yes, the medical director is focusing on clinical - excellence in clinical services.

MR ROZEN: Yes.

DR BOFFA: Manages and supervise all the doctors. There's – currently, we've got, you know, more than 25 GPs - - -

MR ROZEN: Yes.

DR BOFFA: - - - and all the clinical staff, all the clinics. There's 14 clinics. They're all under the medical director. So my – and – and I'm part of the executive, so my role is to advise on - I'm responsible for continuous quality improvement, research, health policy, health promotion and - yes, that's the public health side of what we do.

MR ROZEN: Turning to your qualifications, Doctor, you have a Bachelor of Medicine and a Bachelor of Surgery from Monash University.

DR BOFFA: Yes, that's right.

MR ROZEN: And you graduated in 1985.

DR BOFFA: Yes.

MR ROZEN: With first class honours, I think you said.

DR BOFFA: Yes, that's right.

MR ROZEN: That's what it says. And you have a range of other qualifications which I won't go through but they are set out at paragraph 16 of the statement, if you could just confirm that for us. You don't need to look at it. I - - -

DR BOFFA: Yes. No, that's fine. Yes, I've got it in front of me.

MR ROZEN: - - - ask you to take my word for it.

DR BOFFA: Yes.

MR ROZEN: And in your current role, you answer directly to the CEO, Ms Ah Chee.

DR BOFFA: That's right.

MR ROZEN: And, as you've already told us, you have responsibility for health policy, research, health promotion and continuous quality improvement.

DR BOFFA: Yes, very much in partnership and collaboration with Aboriginal leadership and management through the CEO.

MR ROZEN: Yes, yes. And you jointly made the statement dated 4 July 2019 which is the one that's up on the screen.

DR BOFFA: Yes, I did.

MR ROZEN: Yes. And have you had a chance to read through that before giving your evidence?

DR BOFFA: Yes, I have.

MR ROZEN: Are you satisfied with the change that has been made?

DR BOFFA: Yes.

MR ROZEN: That it's correct?

DR BOFFA: That's a very important change .....

MR ROZEN: I tender that statement. It's formally made by Donna Ah Chee and it's dated 4 July 2019, Commissioners.

COMMISSIONER TRACEY: Yes, well, how do you want me to deal with it? As a statement of Ms Ah Chee that Dr Boffa concurs in or - - -

MR ROZEN: That's probably the most accurate description of it, so if that's - - -

COMMISSIONER TRACEY: Yes. All right. Well, the statement of Ms Donna Ah Chee dated 4 July 2019 in respect of which Dr Boffa has expressed his concurrence will be Exhibit 6-5.

EXHIBIT #6-5 STATEMENT OF MS DONNA AH CHEE IN RESPECT OF WHICH DR BOFFA HAS EXPRESSED HIS CONCURRENCE DATED 04/07/2019

MR ROZEN: Pleases. If I can turn to you, Ms Havnen, please, you are the CEO of Danila Dilba Health Service?

MS HAVNEN: Correct.

MR ROZEN: And you've held that role since 2013.

MS HAVNEN: Yes.

MR ROZEN: Can you tell us – we've heard a little bit about Danila Dilba earlier this morning, of course, but from the perspective of the CEO, can you give us a brief description of what you do here in Darwin?

MS HAVNEN: We're the only Aboriginal health service provider in Darwin. We provide health services across Darwin and Palmerston and the, sort of, surrounding rural area. We have seven clinics and about 180 staff. So the - the nature of our services is providing comprehensive primary health care, which includes - besides, you know, regular GP services, includes things like drug and alcohol, social and

emotional wellbeing programs and so on. We also provide services in Don Dale with the youth support program.

MR ROZEN: Yes.

MS HAVNEN: And we're about to provide the health care services in Don Dale as well.

MR ROZEN: In the statement which I'll ask you about in a moment, you indicate in the financial year 2017/2018, Danila Dilba provided 55,000 episodes – or a bit over 55,000 episodes of care and you had nearly 8000 regular clients.

MS HAVNEN: Correct.

MR ROZEN: And as is explained in the statement, Danila Dilba takes a whole-of-life approach to its services. Can you just explain to us what that means in a practical sense? You probably just alluded to it a moment ago, I suspect.

MS HAVNEN: That's correct. I mean, so maternal and child health right through to aged care services that we provide as an outreach service.

MR ROZEN: Yes.

MS HAVNEN: As well as more specialised services - you know, dedicated women's clinic and a dedicated men's clinic.

MR ROZEN: You also have a very long history of involvement in Aboriginal organisations, which you've set out in an annexure to your statement, and for the purpose of the Royal Commission, you've jointly, with Dr Giles, to your right, made a statement for the Royal Commission dated 4 July 2019.

MS HAVNEN: Correct.

MR ROZEN: Is it correct that - that's WIT.0263.0001.0001 - you have incorporated into the statement the views of Dr Giles, who's the clinical director of Danila Dilba?

MS HAVNEN: Yes.

MR ROZEN: And so far as you're concerned, you've read through the statement before giving evidence today. Is there anything you wish to change?

MS HAVNEN: No, that's fine, thank you.

MR ROZEN: All right. And I'll tender that in a moment on the same basis, Commissioners. Lastly, Dr Giles, your full name is Sarah Giles?

DR GILES: Sarah Ruth Giles.

MR ROZEN: Sarah Ruth Giles. Thank you. And you have set out your relevant experience in Annexure 2 to the statement, and I don't need to take you to that in detail, but you are a member of the Royal Australian College of General Practitioners.

DR GILES: Yes.

MR ROZEN: And your current job title is?

MS GILES: I'm clinical director of Danila Dilba Health Service.

MR ROZEN: And you're responsible for the delivery of clinical services to Aboriginal and Torres Strait Islander people in the greater Darwin area.

DR GILES: Yes.

MR ROZEN: And you also have a role in relation to clinical safety and quality.

DR GILES: Yes.

MR ROZEN: And is that a similar oversight role, or how would you describe it?

DR GILES: It's a similar oversight role, yes. It's safety, including cultural safety, and quality. I report to the CEO in relation to those areas.

MR ROZEN: Right. And you previously held the position of senior medical officer at Danila Dilba.

DR GILES: Yes.

MR ROZEN: And what's the difference between that previous role and the current one that you have?

DR GILES: After several restructures of having senior medical officer, we restructured to have a senior medical - safety and quality ..... workforce. That was then combined again into a clinical director role with overall management as well as quality and safety roles.

MR ROZEN: And you've personally provided clinical services to clients in aged care settings.

DR GILES: Prior to being senior medical officer, I worked for Danila Dilba. In the year 2016, I provided aged care services for Danila Dilba to three - at that time four aged care facilities.

MR ROZEN: Okay. I'll ask you a little bit more about that in a moment, but do those that you in are supervisory role - are they performing that role now? Is that the - - -

DR GILES: Yes.

MR ROZEN: That's the structure.

DR GILES: That's right. The GPs who are employed in local clinics provide services to the aged care facilities in their local area.

MR ROZEN: Yes.

MS GILES: So from the Palmerston clinic, there's a GP allocated to provide GP services from there.

MR ROZEN: All right.

MS GILES: Rapid Creek - I mean, Bagot Community Clinic provide services to Juninga.

MR ROZEN: Yes.

MS GILES: And we have one other service that Malak Clinic provides a service to.

MR ROZEN: All right. I'll ask you a bit more about those in a moment. For the moment, if I could just tender the statement of Olga Havnen dated 4 July 2019, Commissioners, perhaps on the same basis as the previous Exhibit was marked.

COMMISSIONER TRACEY: Concurred in by Dr Giles.

MR ROZEN: By Dr Giles.

COMMISSIONER TRACEY: Yes.

MR ROZEN: Thank you.

COMMISSIONER TRACEY: The witness statement of Olga Havnen concurred in by Dr Giles dated 4 July 2019 will be exhibit 6-6.

EXHIBIT #6-6 WITNESS STATEMENT OF OLGA HAVNEN CONCURRED IN BY DR GILES DATED 04/07/2019 (WIT.0263.0001.0001)

MR ROZEN: If I could come back to you, Ms Ah Chee, please, and ask you just a little bit more about Congress. You refer in your statement to Congress being the

largest Aboriginal community-controlled health service in the Territory. Measured on what basis: number of staff, number of clients, geographical area; what are we using as a measure for that?

MS AH CHEE: A combination of all those things. We were established in 1973, Initially as a – more of an advocacy service for the rights of Aboriginal people in Central Australia. It wasn't until 1975 that Congress started its journey of the provision of a medical service with the employment of a GP, a bus driver and a medical receptionist. So we've, you know, expanded from a team of three back in 1975 to now in 2019 having an employment of over 400 people, of which around at the moment, around 43 - 42 per cent of those are Aboriginal staff. We have a target of 60 per cent and the highest we have got to is 51 per cent. We have an episodes of care, on the latest data, at around - is it 170,000, Dr Boffa, in the latest 12-month report. So it's – it's both in terms of, you know, the activity of care and the breadth of services and programs of which Olga mentioned earlier in relation to Danila Dilba.

We also provide programs that range from antenatal care right through, you know, early childhood, youth services, detection and screening and management of chronic disease, you know, through to frail aged and disabled program including mental health. We are a provider of one of the, you know, first Headspace services that's part of a national program across the country. So it's a combination of those things, both geographic boundaries; we go as far as south to Uluru to Mutitjulu community which is around 500 kilometres south of Alice Springs. We go as far west of Alice Springs of around over 200 kilometres to a small community called Utju, or Areyonga.

MR ROZEN: That's still in the Territory, isn't it?

MS AH CHEE: Still in the Territory, that's right. And we go as far east, which is around 80 kilometres, to a place called Santa Teresa, Ltyentye Apurte is the Aboriginal name for that community. And in between we've got Amoonguna as well, which is about 22 kilometres out of Alice. And we are also in partnership with the Northern Territory government in the provision of - they run a clinic at Ntaria and Wallace Rockhole which is about 80 kilometres out of Alice – west of Alice, and we provide GP and maternal and child health services.

MR ROZEN: Could I ask you little bit about something you mentioned which is the proportion of staff that you employ from Aboriginal and Torres Strait Islander backgrounds. It probably goes without saying, given the service that you are providing but nonetheless, that goal of 60 per cent; why has that been set? Why is it seen as a desirable thing for the organisation to be employing staff of Aboriginal or Torres Strait Islander backgrounds?

MS AH CHEE: Well, I think the first thing is that it's in line with the UN Declaration on the Rights of Indigenous People to control their own destiny. And in doing so, being an Aboriginal community-controlled primary health care service, it's

important that – I mean, ideally, our board would love, including management, would love 100 per cent Aboriginal staff but given the nature of the service which we provide, you know, we've sort of looking at 60 as the appropriate target.

MR ROZEN: Yes.

MS AH CHEE: Of course we want to see more Aboriginal doctors, more Aboriginal nurses, more psychologists. We employ psychologists. We are the only, I think, service in the Northern Territory that employs two neuropsychologists. So it's the nature of the high quality service that we provide that dictates to some extent the proportion of Aboriginal staff based on the necessary qualifications that are required to deliver the service.

MR ROZEN: Perhaps if I could bring you in at that point, Dr Boffa, if I could. The ability to attract Aboriginal people with professional health qualifications, I think has been suggested as presents as a challenge to the organisation. Are there initiatives that have been taken to try and increase the number of Aboriginal doctors, Aboriginal nurses and so on, that are working for the organisation?

DR BOFFA: Yes, firstly, we monitor data in all aspects of the organisation, including HR. So we can say that seven per cent of degree qualified health professionals are Aboriginal people. 61 per cent of all other positions including degree qualified non-health professionals are Aboriginal people. So the big challenge is getting Aboriginal doctors, nurses, psychologists in that group. So Congress has done a whole range of things to try and assist people through traineeships, scholarships, a range of things to support people going to uni and to come back and work for us. But they're all long-term strategies, and, you know, we are getting more Aboriginal staff all the time but in that category of health professionals, we're still heavily reliant on non-Aboriginal health professionals and any national workforce strategy has to do both. We have to commit to getting a lot more Aboriginal people in all those health professional groups but at the same time we have to get non-Aboriginal people working in Aboriginal communities.

If it's one or the other, we are in trouble because we need both for now. And maybe well into the future we are going to need both. So there are a range of things that have been successful in getting Aboriginal people, but also if you go back to 1995, Congress had three full-time GPs in 1995, providing 24/7 on call, servicing the prison, servicing the nursing home, you know, that was it. So now we have got 19.1 FTE permanent GPs and about 14 FTE GP registrars. So we've been able to actually significantly address some of the challenges around GP recruitment and retention and if we learnt some of those lessons and applied those to other health professionals we would be doing a lot better across the board. But we can recruit. You know this saying – this myth that we don't want to fund something because we can't recruit to positions; I think it's defeatist.

I mean, we've been able to show even in the most remote communities we have got GPs, we've got nurses, we've got other staff living and working there. You've got to

have houses, you've got to have a lot of infrastructure. You've got to have an effective health service, you've got to have good remuneration, a good team, good support. People won't go if they're isolated and they're out of their depth. They've got to be part of a team. GPs have to be part of that team. Nurses and health workers on their own is not enough and you have enormous turnover in clinics that are run primarily by nurses. Recent figures in the department we're looking at 147 per cent per year turnover amongst remote area nurses.

We have around 48 per cent turnover among remote area nurses which is much lower than the department. I think that's partly because they're much better supported in a multidisciplinary team, with general practitioners, with Aboriginal health workers, with drivers, with psychologists, with social workers, with pharmacists; the whole team working together can make a difference and people are more likely to stay.

MR ROZEN: Dr Giles, can I bring you in on that question because it is matter of considerable interest to this Commission and the Commission heard quite a bit of evidence in its hearings in Broome a few weeks ago about the challenges of attracting and retaining staff to work in remote areas and the particular challenges associated with attracting significant numbers of staff with Aboriginal backgrounds. Is that something you can assist us with from your experience? Is there anything you can add to what we have heard from your colleagues?

DR GILES: Firstly, we are not remote, we are Darwin. And depending who asks we don't classify as remote. Olga can probably speak better to our strategies in terms of Aboriginal employment. If you are talking specifically about professional people you are talking about training programs only just starting to attract Aboriginal people into medicine and nursing and some of those professional groups – well, not just only ..... it has been relatively recent and the numbers aren't there, that we have a pool of people that we can employ Aboriginal staff from. On the other hand, we try and mitigate some of that risk to cultural safety by the employment of Indigenous outreach workers and outreach workers from clinic. So as part of the team that John refers to is non-Aboriginal staff don't work alone, and this is reflected in our services into aged care facilities. But Olga – I don't know whether Olga would like to speak to the overall employment strategy which we have, again, have had some success in the face of the challenges that we all face.

MR ROZEN: I think you've got no choice now, Ms Havnen you've got to jump in.

MS HAVNEN: Look, some years ago, yes, we did have challenges in recruiting and retaining staff. I think because of the kind of professional development and recruitment and retention strategies that we have adopted we no longer have those problems and fortunately we are able to recruit and attract across the board so that's good. The thing that we have also been able to do is reduce our turnover rate so turnover in employment here in the Territory is incredibly high, probably 30 to 40 per cent on average for most sectors. Our recent data suggests that we have got less than a 20 per cent turnover rate.

MR ROZEN: What's the magic trick there, just being a desirable place to work?

MS HAVNEN: Pretty much. We developed a campaign about being an employer of choice, and certainly in terms of providing career pathways and other training and development opportunities internally, but giving people an option to move from one particular part of the organisation into another sort of work, different types of jobs, different clinics and so on. So giving people that kind of flexibility. We have also, I think, really worked very hard at retaining Aboriginal staff. So, for example, overall employment stats for us is about 60 per cent and our management team likewise, 60 per cent Indigenous. So really investing in our people, building that skill and capability and certainly to move people out of clinical roles into management roles, if you like.

MR ROZEN: Thank you very much. Ms Ah Chee, can I change tack slightly and ask you a little bit about the advocacy role that you speak of as being performed by the organisation; what's the importance of that? I know you told us it started as an advocacy organisation, and has morphed into one directly providing health care services but I understand from your statement that the advocacy role still is a very significant part of the service provider. Can you expand on that for us, please.

MS AH CHEE: Yes, absolutely. Advocacy is actually a core element of comprehensive primary health care. So we are very familiar with putting submissions to inquiries, to giving evidence like we are today, sitting on national committees as well as doing the necessary, you know, social media and media advocacy where we need to; if we do need to go public, then we will. So we've done a number of, you know, areas around ensuring that, you know, equitable access to primary health care for Aboriginal people; that's one of our key platforms of advocacy that we do. When you look at the – this morning we heard the issue of high rates of diabetes. So one of the policy platform positions of Congress is that we support a 20 per cent gluco tax so that that is hypothecated into ensuring that we get affordable, healthy fruit and vegies, particularly in remote communities.

So, you know, the advocacy part of it is really about complementing, putting policy into practice and vice versa. So advocacy is actually – is absolutely a key element of comprehensive primary health care. We wouldn't be doing our job properly if we were not doing the advocacy that we need to do.

MR ROZEN: Dr Boffa, if I could turn to you on a related topic. In your statement, there is discussion of the importance of provision of primary health care to Aboriginal people in the context of care and respect for Aboriginal culture. Once again, it probably goes without saying but nonetheless could you explain why that is such an important feature of the service provision model that Congress has.

DR BOFFA: Well, there's a pretty significant history of racism in the health system in the Northern Territory, and that starts with the founder of the Royal Flying Doctor Service set up the first hospital in Central Australia in the 1920s; it was only for non-Aboriginal people and even though ministers in his own church said that was

racist at the time. John Flynn didn't listen to that. The Commonwealth government offered funding to build a new hospital as long as it was open to everybody; the town and John Flynn rejected that. So the first hospital for a decade wasn't for Aboriginal people even though Aboriginal people were already much sicker than non-Aboriginal people.

Eventually changes happened. The money was accepted; a second hospital was built. The new hospital became for Aboriginal people – for non-Aboriginal people and the old little hospital Aboriginal people got. Complete segregation until the 1950s, then Aboriginal people were allowed onto the verandas of the main hospital. It wasn't until 1969 that the hospital in Alice Springs was desegregated, and the hospital was the main institution that removed the children. So if you had a half caste baby who was sick, you didn't go to hospital until the child was nearly did because you knew if you did, the doctors would tell the native welfare branch they had just seen this child, a half caste, here are the parents, here is where the child lived. So the infant mortality rate when Congress started was 200 deaths per 1000 live births, which is still a national shame if you think about it. It has improved down to about 10 deaths per 1000 live births.

So Congress got going in an area where cultural safety was the absolute paramount; if you wanted people to come and see you, you had to demonstrate that you were different. You weren't part of that previous health system. You were different. You could empathise with people. You understood their culture, you understood the importance of language, the importance of traditions that had been around a very long time, to gain respect, to gain trust, and you've got to stay a while to do that. So if you want people to come and see you when they are sick and particularly if you want them to come and see you when they are well, which we do, we want people to come and see us for health screening, they are not going to do that if they don't have absolute – that's what community-controlled health service has achieved: Aboriginal people setting up their own health services, employing their own staff.

I mean when I went to Tennant Creek, there was no doctor in 1988. The previous doctor was sacked three weeks earlier. I didn't find out why until I had been there a while because it was a major mistake that doctor made in ceremony, which should never have happened. So they were able to sack that doctor, though. That's power; when you've got someone culturally incompetent - not just culturally incompetent but culturally dangerous, and having control means you can get rid of those people and get other people to come and work for you who are going to be able to work cross-culturally and in appropriate ways. So I think it's one of the great successes of Aboriginal people setting up their own health service. They are able to then employ their own staff, ensure they are given proper training and if they're not able to work in a way that's consistent with that, they can then say, "Well you're not suitable for us. We will get others".

And, you know, unfortunately with workforce shortages, sometimes you end up having to - particularly in the earlier years, you know, we had to work with people that we really shouldn't have had to work with, overseas doctors. You know, one I

remember was from Geordie, north England, ended up being terribly alcohol dependent. We didn't know that for a while. But you know, we've had – but not now. We have got more choice now so we can actually make sure we can employ good staff. But Donna's point - the point being made about why you need Aboriginal staff, Aboriginal staff almost by their very nature are culturally appropriate. You know, you don't have to retrain Aboriginal staff, they understand the people that they're working for.

Non-Aboriginal staff, you've got to do a lot more work to make sure people know how they have to practice in a way that shows empathy, compassion and trauma-informed care is a catch phrase now, a common term, I mean, but for many years it just means you've got to understand people's history. You've got to understand – to have empathy, you've got to know what has led to the way people are, otherwise you victim blame and anyone who victim blames shouldn't work in Aboriginal health.

MR ROZEN: Thank you. Dr Giles, can I pick you up on something you said earlier about the challenges of, that are presented by having non-Aboriginal staff working, say, in an aged care setting, if we can move to that, providing health care services for Aboriginal clients. What are the challenges in having non-Aboriginal staff performing that work in a way that is culturally safe?

DR GILES: Are you talking about visiting clinical private health care services?

MR ROZEN: Yes.

DR GILES: John has given an excellent background setting to what we're talking about in the residential care service. There are a couple of issues. One is that although we work very hard at ensuring that our staff are culturally competent, it's very difficult to understand the range of cultures and the range of things that people - clients present with in residential facilities in Darwin. In Darwin people come 50 per cent from outside Darwin, from a variety of communities in the Top End and so we're talking about over 40 language groups and over 40 different settings.

MR ROZEN: We had a very good example of that just this morning of someone travelling a great distance to Darwin.

DR GILES: That's right. So there are lots of different languages, lots of different cultures, lots of different nuances and stories. We work on the model of knowing our clients, knowing their health and working with them, and the way that we provide services is to have GPs visiting services with Aboriginal health practitioners, who serve the function of helping to ensure cultural safety, of actually knowing community and knowing a bit beyond even Darwin. We can't always get it perfect but there's just that extra breadth that's added to that service, and also to draw attention of non-Aboriginal staff to where things aren't right. So it adds extra value to that. I think we work quite hard at getting culturally competent staff and senior staff are the ones that we usually we send into aged care facilities because they have been with Danila Dilba for a long time and know the environment better.

MR ROZEN: Just in relation to the services provided to residential aged care facilities, if I could just ask you a little bit more about that. That's a service that has increased in recent years by the organisation?

DR GILES: When I was doing the aged care facility job in 2016, I would visit - I visited in fact four aged care facilities in a day. We have expanded that to three days a week working from local clinics, as I say. So we have three senior GPs and AHPs going out weekly to three different aged care facilities at the moment.

MR ROZEN: And can I just ask you at little bit about the arrangements. So is there some contractual relationship between the aged care facilities and Danila Dilba or how does that work?

DR GILES: There's not. We have started - we have a quality improvement project going on at the moment that we started probably about 18 months ago now when all the issues of whether people can be – doctors can be called out of hours and some of those sort of things had reached a bit of a peak. So we have tried to improve communication with the three facilities that we are working with. Juninga we visited for many, many years and have very good relationships with and understand how both the services work. It's more difficult in the other two facilities because our clients are the minority, they are very large facilities so finding the right people to talk to on the day is a challenge. Actually trying to engage at an MOU level we haven't quite got to that stage yet.

For DD to enter into an MOU are we dealing with the facility or are we dealing with a very large organisation; they're the challenges of trying to have a formal arrangement. So the relationships are very much built on relationships with management. Because we provide stability of staffing to those services, we generally have very good relations with management in all of those facilities and can raise issues directly with them, with a fair chance of them getting dealt with. Occasionally we have had to escalate them through the CEO to higher levels of management but that's where we are at the moment.

MR ROZEN: Okay. The reason I'm exploring these issues is, of course, the Commission has travelled around Australia, and one of the themes we have heard is the unwillingness of GPs to attend residential aged care facilities. Just as a general proposition. That's a theme in the evidence, a decline in the preparedness and willingness of GPs to attend at residential aged care facilities. You've said that the service that's provided – it's obviously only for the Aboriginal clients who happen to reside in the facilities, and as a proportion of the numbers in the facilities, it's a minority, is it, that - - -

DR GILES: We provide service to our clients, clients who are enrolled with our service in the facilities. So Juninga has an entirely Aboriginal – at the moment, Aboriginal and Torres Strait Islander resident population - - -

MR ROZEN: And how many - - -

DR GILES: And there are about 33 in that facility.

MR ROZEN: Thank you.

DR GILES: Terrace Gardens has a total population of 80. Of - of the 33 Aboriginal clients, we have 21 of those that are our clients.

MR ROZEN: Yes.

DR GILES: So they have 33 residents. 21 of those. And in Tiwi Regis, I'm not sure how large they are but they're – they're large. We have 10 clients there.

MR ROZEN: Right. One of the other themes that's emerged through the evidence we've heard elsewhere in the Commission's hearings is the sometimes fraught relationship between GPs and the care staff, in the sense of the GPs occasionally being unwilling, for example, to prescribe, you know, particular sorts of painkiller, Schedule 8 medications, out of a concern that the care staff might not have the skills and competence to be able to properly administer those drugs. And I was just wondering if that - from your experience, if anything like that arises in the context of the work that's being done, because by definition, the doctors are reliant on the staff once they leave to administer medication that's prescribed, for example. Is that an issue in your experience?

DR GILES: I don't think it's a significant issue. Whether – I - can I extend it beyond medications.

MR ROZEN: Yes, of course.

DR GILES: I think the medication systems, although they are complex and we have to prescribe in our system, prescribe in their system and have them dispensed in a – in a - pardon me - dispensed in a pharmacy system - so you've got three different organisations, but I know you've got experts speaking on that subject so I won't go further on that. But there's – we - I don't think that we have problems with management plans in relation to medicines being implemented. There have been issues with management plans in relation to other aspects of care, access to allied health, pressure sores - some of those sorts of things have, from time to time, been issues.

MR ROZEN: Right. Wound care - is that something that you - - -

DR GILES: I can't think of specific examples, but I would include it in that bucket, yes.

MR ROZEN: Right. I see you're nodding, Ms Havnen. Is there anything you want to add to those?

MS HAVNEN: I was just thinking about the example with the optometrist because it – that's a classic - - -

DR GILES: ..... the - we have a client who requires optometrist's appointment.

MR ROZEN: Yes.

DR GILES: The ophthalmologist won't see them until they have had an optometrist appointment. They may well have a preventable cause of diminishing vision.

MR ROZEN: Yes.

DR GILES: And it will cost the client $200 to see an optometrist, $50 for the taxi there and back - no, $50 - $25 there, $25 back.

MR ROZEN: $25 – yes.

DR GILES: And – and $200 for a carer to – $150 for the carer to go with them. So this has been a - is it six weeks or six months?

MS HAVNEN: Six weeks, I think.

DR GILES: Anyway, by now it would certainly be up to two months of not – of that client not being - that resident not being able to access that care in order for the management plan to progress.

MR ROZEN: Right. Whilst I've got you talking about the experience in aged care facilities, an issue that jumped out in your statement concerns the availability of interpreter services in - particularly in relation to residential aged care facilities, and if it helps you, this is paragraph 54 of your statement. If I might perhaps ask that to be brought up on the screen. It's page .0012 of the Danila Dilba statement by Ms Havnen. And you talk about the importance of communication generally, but particularly in cases where one is trying to make assessments about diminished cognition. For obvious reasons, that ability to communicate is very important, and you make a point about the availability of interpreters for - interpreting from English to Aboriginal languages.

DR GILES: And back.

MR ROZEN: And back, indeed. What's the issue there, in your experience?

DR GILES: There are - certainly when – when residents first come, they will often come with a - with an assessment that has already been by ACAT, by aged care services, and all this sort of stuff. How well they use interpreter services is an issue I'll leave to the side.

MR ROZEN: Yes.

DR GILES: In terms of providing day-to-day care, let alone medical care, understanding people's needs, language is obviously very important to that, and we're talking about older people for whom English is often their - at least their second and sometimes their fourth language.

MR ROZEN: Yes.

DR GILES: When - so it goes both ways, both in understanding what the rules are and how our facility works for them, but also about what care needs they have - is imperative. With people who have cognitive impairment and require - 50 per cent of clients are in facilities with dementia.

MR ROZEN: Yes.

DR GILES: Often they won't use English any more but - but use first language.

MR ROZEN: Yes.

DR GILES: The barriers to using first language are very – are complex in the Northern Territory. The interpreter services are originally funded to the - for the legal service. Health services don't use them that well. In Royal Darwin Hospital, mental health services use them better than most other areas, but they're still not used very well. Even in primary health care, it's difficult to access interpreter services, and certainly in aged care facilities, it's – it's often not heard of. There are a couple of barriers. One of them is who pays. It's a user-paid service. Does that mean the client pays? Does that mean the facility pays? Does that mean the primary health care service pays? But often it's about not acknowledging that an interpreter is actually needed. The assumption is that people speak English. Language is not well-recorded in people's records and their understanding of them as a person.

MR ROZEN: Yes.

DR GILES: I will give the example this morning of when I was - we were trying to find the language. The interpreter language was Creole. Gave that to the interpreter service. They came in and said, "Which Creole?" I didn't know there was more than one Creole. So our knowledge level in relation to use of language is not as it should be.

MR ROZEN: Yes. Can I come back to you, Ms Ah Chee, if I could, please. The Congress experience in relation to the provision of primary health care in aged care setting is more related to home care than it is to residential care; is that right, or is there a combination of the two?

MS AH CHEE: It's mainly in relation to residential care. So we've been providing GP medical services into two aged care facilities in Alice Springs, in Hetti Perkins and Old Timers - - -

MR ROZEN: Yes.

MS AH CHEE: - - - for many, many years. And it also includes 24/7 on call. At the moment, there are around 120 Aboriginal patients in total of which 60 are in either of those two aged care facilities, and we provide GP services, medical services, one day per week - - -

MR ROZEN: Yes.

MS AH CHEE: - - - with additional registrar - GP registrar support to - one day per week each to those two aged care facilities.

MR ROZEN: So the GPs are effectively doing a clinic when they are at the premises on those days. Is that - - -

MS AH CHEE: Absolutely, yes.

MR ROZEN: Yes. And those 60 - approximately 60 in each, do they make up a majority of the residents in those facilities, or what proportion of the overall number in those facilities would be - - -

MS AH CHEE: I'm sorry, I couldn't - - -

MR ROZEN: You don't know.

MS AH CHEE: I couldn't answer that question.

MR ROZEN: Okay.

MS AH CHEE: Dr Boffa might be able to.

DR BOFFA: So Hetti Perkins is virtually 100 per cent Aboriginal people. Old Timers, it's about half.

MR ROZEN: Right. And the challenges that present themselves to providing those facilities - is there anything you can - providing those services in those facilities - is there anything you can add to what we've heard from Dr Giles about their experience? Is it pretty similar?

MS AH CHEE: I think – I think the - the issues of access to interpreters, as - as well as, in addition to that, we would propose the employment of cultural workers in the residential aged care facility as a way of ensuring culturally responsive practices.

MR ROZEN: Yes.

MS AH CHEE: And also making sure that staff, where there is a higher proportion of Aboriginal aged care patients, are undergoing mandated cross-cultural safety training.

MR ROZEN: Dr Boffa, is there anything you'd like to add there?

DR BOFFA: Just to add, that comment you made before about GPs - whether they trust the nurses depends on – historically, at one point in time, nearly 20 years ago, one of the aged care facilities went down to having no registered nurses on staff. Now, that same facility has five registered nurses on staff. If there's five registered nurses on staff, doctors will trust. If there's no registered - medications are incredibly complex for these people. They have multiple chronic conditions, so they have very complex medication regimes. If you don't have a certain number of registered nurses in the facility, then medication dispensing is unsafe. The complexities of prescribing - doctors prescribe on one system, then there's chronic – there's medication charts that the facilities have to use. Who transfers the information? There's a lot of problems you will hear from – that's a national issue. That has to be sorted so there has to be one system for medications, not two separate systems.

So - but the trust depends on - as long as there's an adequate number of registered nurses, then things work and errors are kept to a minimum. But you need a certain number to make sure that the facility is safe and, as Donna said, that's not even – that's clinical safety. Then there's cultural safety.

MR ROZEN: Yes.

DR BOFFA: And rather than - the interpreter service you've got to book a week in advance. It works for the three-month reviews. You can book them. But for the current problems - and there are a lot of those, and people get sick on the day - you can't even book the interpreter service because you can't book a week in advance for an acute illness. So you've got to have staff that speak language as part of the workforce in areas where there's a high proportion of Aboriginal residents, and in a remote area where no one speaks English, like Mutitjulu, you've got to have Aboriginal – you've got to have people speak Pitjatjantara, Yankunytjatjara, otherwise you – you can't communicate at all.

So I think the interpreter service is only one part of the solution. You've got to have people on staff to ensure cultural safety. And clinical safety has improved a lot, I think, in recent years. Some of the Medicare reforms have helped with, you know, care planning and some of the other things that - but yes, if you don't have enough registered nurses, then the system is unsafe.

MR ROZEN: I've asked all of you about proportion of Aboriginal workers in your own organisations. What about - if I can start with you, Dr Boffa, what about in the residential aged care facilities that the staff are visiting? Are there - the care workers and the nurses, do they have Aboriginal backgrounds, in your experience?

DR BOFFA: I think they really, really - because as we probably all know, the nurses in aged care facilities are about the lowest paid in the country.

MR ROZEN: Yes.

DR BOFFA: Their capacity to recruit is – is more difficult than virtually any other sector. So they don't have much choice. So if you're an Aboriginal person graduating from nursing, you could pick where you wanted to work. And so I think very few Aboriginal nurses are choosing to work in aged care facilities. They'll take jobs in primary health care. We are always looking for Aboriginal nurses. We've got exciting programs like the nurse home visitation program. There's varied roles across all our services for newly graduated Aboriginal nurses. So I think nursing homes don't have the luxury of being able to even begin to Aboriginalise their nursing workforce. They're struggling to get and retain enough registered nurses to do the work that's required. So there's issues around their level of pay, the level of support they have - like you said, medical support.

MR ROZEN: Yes.

DR BOFFA: As I said before, if you've got nurses working in ..... with adequate medical support, it makes the whole job so much harder. You get higher turnover. And as you said nationally, a lot of nursing homes struggle to get GPs, and even when they do, if they're fee-for-service only GPs, they'll only do so much, whereas if you have got salaried GPs working in nursing homes like we have, then they can do more than just Medicare. They can help the nursing home deal with other issues, with quality and improvement issues, with other issues.

MR ROZEN: Yes.

DR BOFFA: They're not totally reliant on a transactional payment at the point of service. They can do other things, and I think the benefits of that are very significant when it comes to ensuring good quality medical care working alongside the nursing staff.

MR ROZEN: Can I ask you a little bit more about that - and I will come to you, Dr Giles, with a similar question to give you time to prepare the answer. You've touched on the idea of skills transfer by GPs, for example, attending at residential aged care facilities. Is that done on a purely, sort of, incidental ad hoc basis or is it part of the model of primary health care that you utilise?

DR BOFFA: No, I think it's done more on an ad hoc basis, but we have – you know, we've - the one GP service the nursing homes in Alice for about a decade, so that GP gets to know nurses - - -

MR ROZEN: Yes.

DR BOFFA: - - - and in that context can transfer skills, transfer knowledge. But it is pretty much done on an ad hoc basis, not formalised in any real way. And I don't think - you know, I don't know what the nurses in the nursing homes do for their professional development. We've got 45 nurses across Congress, but I don't think we've ever had a joint session, PD session with the nurses in the nursing home. So there's probably opportunities for that to be further explored as professional development, professional support because they can feel quite isolated in these institutions because there's only a few of them - - -

MR ROZEN: Yes.

DR BOFFA: - - - in each of those institutions, whereas if you're in an employer where there's a lot of nurses or a lot of any health professionals, they support each other.

MR ROZEN: Yes. Just before leaving that topic, you raised something which I think is probably quite significant, that is, that the residential aged care facility that's looking to employ a nurse, particularly a nurse of Aboriginal background, they're competing directly with you, I suppose, in terms of being able to attract such a recent graduate, for example.

DR BOFFA: Yes, they are, and they should be able to offer the same - they should be funded to a level where they can offer the same level of remuneration as nurses working in general practices, as nurses working in Aboriginal community controlled health services. That's important, as well as the funding models needs a loading for cultural safety.

MR ROZEN: Yes.

DR BOFFA: Which is - there's precedents for that. One classical example of that is general practitioner training, when NTGPE was set up, which is the Northern Territory general practice training organisation, the standard funding model didn't fund the complexities of training GPs in cross-cultural contexts in the Northern Territory. Eventually, after years of arguing, a loading was added to the funding model for that, so it becomes part of the standard funding that if you're in an area where there's a high proportion of Aboriginal people, you get additional resources so you can employ automatically Aboriginal workers to ensure cultural safety. So I think that plus having a level of remuneration so the nurses can get the same amount of funding as other nurses is quite important. But then we do need more nurses overall in primary health care.

MR ROZEN: Yes.

DR BOFFA: And so we are – we - we find it hard to recruit nurses as well. It's getting harder, not easier, and we're heading towards a nursing shortage. We've got many - we don't have a medical shortage. We have a maldistribution of doctors, a severe one, but we don't have a shortage. But nursing, we're heading towards an

absolute shortage, and in that environment, the nursing homes are going to find it harder into the future.

MR ROZEN: Yes. Yes. Dr Giles, from your experience, can you - are you able to add anything to those issues that we have been discussing about the potential for skills transfer by medical staff to residential aged care facilities and that issue of competition for new staff, particularly nurses? Is that a - does that resonate for you in the Darwin setting?

DR GILES: Absolutely. I think that if you asked us about the employment levels of Aboriginal people in residential care - - -

MR ROZEN: Yes.

DR GILES: - - - although it's very difficult to - to say, we think it's very, very low in Darwin.

MR ROZEN: Yes.

DR GILES: But whether we want residential care facilities to duplicate an Aboriginal workforce or whether we want to work on integration models where primary health care plays a greater role - - -

MR ROZEN: Yes.

DR GILES: - - - I think is open - open for discussion. Certainly, when you talk about transfer of skills and things like that, a recent example was when a residential care facility asked us for advice in relation to a – to a space they were developing and its cultural safety, and let alone clinical safety, we were able to direct them where to best get that advice. To expect facilities to get to the level that they're required in a hurry, I think, is ambitious.

MR ROZEN: Yes.

DR GILES: But I think that we, certainly in Darwin, have a very strong integrated model where the relationships, particularly with a service like Juninga, where we've been working with them for many years and where they provide services entirely to Aboriginal people, it's a good model. When you're talking about other facilities, how you - if you're talking about facilities that provide to both Aboriginal and non-Aboriginal clients, whether you expect the same level of staffing or whether there's another model, I think, is - is really important to consider.

MR ROZEN: Ms Havnen, is there anything you wanted to add to that? No?

MS HAVNEN: No.

MR ROZEN: Ms Ah Chee, can I come back to you and pick up on a couple of challenges that are identified in your statement. This is at paragraph 36 on page 8 of the statement. There's a couple of areas that are identified and there's a bit of discussion there. The first is the top of that page, paragraph 36, a shortage of home care packages and a lack of transparency and accountability on the services being provided for a given level of package. Could you expand on that in the context of the experience in Central Australia?

MS AH CHEE: Yes. Just as recently in the last couple of weeks we've tried to, you know, getting access for our patients to a level 4 home care package, we've been told that that person would have to wait 12 months or more. For a level 2, it's nine – at least nine months. So there's definitely an issue of shortage of the availability of these packages. And I think there needs to be some consideration given to lifting the cap that – similarly to what Purple House talked about as a major significant policy development in relation to renal dialysis, accessible through MBS, not that I'm suggesting - that's not my sort of area of expertise but the main point being is that the issue of having a cap that then prevents the much needed aged care support services to be available in community really does need to be addressed.

MR ROZEN: It's probably no consolation to you but those waiting times are consistent with what the Commission has heard is the case elsewhere in Australia. But it doesn't make it any better of course and it presents a particular challenge. There's a related issue that is also dealt with in the following paragraph on that page in the statement, and that concerns the need for better linkages between the assessment process and primary health care networks. Can you or perhaps Dr Boffa, whichever one is more comfortable, explain to us what that means in a practical situation. Why is that an issue, practically speaking, that lack of, the lack of linkages between the two processes, aged care assessments and primary health delivery.

MS AH CHEE: Yes, well we have had examples where we don't know that our, you know, a patient is actually has received a health care package.

MR ROZEN: An aged care package?

MS AH CHEE: Yes, a home care package, sorry, and it isn't until we have gone through, you know, a process. We had a very, very complex patient and once we looked at referring for an assessment, found that, well, you can't actually double-dip with that assessment because of the National Disability Insurance Scheme which is what we were originally looking at for this patient but found that, in fact, she had been on a home care package that we didn't know about. Is that right?

DR BOFFA: Yes.

MS AH CHEE: So the way in which we're proposing to deal with that is the, in a practical sense, is that we need to know as a primary health care service who of our patients are actually on a home care package so that we can ensure and assist that client with ensuring they're getting access to the appropriate service in relation to

that package. And a way in which we're proposing that be done is either the Commonwealth advises the Aboriginal Health Service when that package is awarded, or alternatively - and perhaps this is the best approach, would be to put that information and upload it on to the shared electronic record.

So it's that eligibility, knowing who is on it for our clients is really important and it's a two-way, I guess, accountability. It allows the service to ensure that the appropriate aged care services are being provided but it also is a two-way accountability process for the aged care service to ensuring that we are providing the appropriate medical care to that patient.

MR ROZEN: Yes. It sounds – maybe this is a naive question, I don't know, but it sounds like what you're seeking wouldn't necessarily be that expensive. It just requires coordination between different agencies, which can often be challenging itself but requires perhaps a will to do that rather than any great expenditure of money. Is that a fair observation?

MS AH CHEE: I think this is more about access of data more so than coordination, that it is about accessing information and there is a simple way in the provision of that information that I wouldn't suspect would cost a lot of money by uploading who are on health care packages on to their shared electronic record.

DR BOFFA: But we have to militate the Privacy Act because we have been trying to do this now for a couple of years and we have been told the Privacy Act forbids it. But what we're talking about is a public health benefit overcoming this concern about privacy, and particularly if you've got people that aren't all that well educated, that are marginalised, and they're on packages, they don't even know what services they are entitled to. A level 4 package means nothing to a lot of people. And if they're not getting the service they don't know they are not getting it.

When you've got a system like that, you can't just rely on individual people to complain, particularly if those people don't even know they're not getting the service they're entitled to. So you've got to have checks and balances in the system and the health services can be that on behalf of people, and we've had an experience where a sister service in Queensland IUIH who got control of the assessment process, started assessing, they did this a couple of years ago, started assessing all the Aboriginal people in their area and there's 35,000 people in that south-west – south-east Brisbane - - -

MR ROZEN: Is this is Mr Moore, Matthew Moore in Queensland?

DR BOFFA: Yes, he works – Adrian Carson is the CEO, but he works - when they started assessing people they'd find this person is eligible for a level 4 package. They'd write off to the Commonwealth, and the Commonwealth would come back and say they have already got a level 4 package and the provider is X. And they'd say, well, this person is not getting any services. So they started to - by doing the assessment, they started to uncover the fact that providers were being funded but

services weren't being provided to clients. Now, that's happening, I think, all over the country, and there aren't enough checks and balances in the system. So one of them is what Donna suggested; if it went up on the shared record any GP would know, you know, and then we have to educate our staff so they know a level 4 package, this is how much it is, this is what they're entitled to.

A level 2, this is what people are entitled to. What's a HACC service compared to this. You know, these are things that health professionals need to know because it's essential to people's health care. These services mean more to people's health care half the time than, well, maybe than their medicines. I mean, medicines are important but also having food, having access to personal care and support in the home, having someone make sure people are taking the right medications that are not going to inadvertently end up in hospital because of a medication error with a complex medication regime, having complex dressings well cared for in the home. But they are not things that are done well in the current system.

MR ROZEN: Dr Giles, Ms Havnen, anything you wanted to add to that topic?

DR GILES: We probably feel slightly strongly about the Privacy Act but otherwise we totally concur.

MR ROZEN: The last topic I really want to touch on is this: in both the statements there's a recognition of the challenges of geography which, you know, obviously are ever present in a large area such as the Northern Territory, with low population density, small remote communities and the like and, of course, we saw a very graphic example of that morning with Mildred and the challenges presented to her and so eloquently described by her. Does technology provide at least a partial answer to the challenges of geography. And I'm thinking of telehealth for example which is touched on in both of the statements.

Maybe I could start with you, Dr Boffa. It's part of our terms of reference to look at technology. It's not something that has had a lot of air time in the hearings to date but seems to be a possible answer here.

DR BOFFA: Well, telehealth is not going to answer the issues of a person with a level of dependency that Mildred has and a need for high level nursing home care. So one thing we wanted to point out about that is, as Donna said, we service Mutitjulu which is a community of 500 Aboriginal people. It has a residential aged care facility that can take people as dependent as Mildred was. That's a community of 500 people. She came from Numbulwar which is a community of 750 people, so we need to think about at what population level should people have a nursing home or have a number of nursing home beds as well as hostel beds, down to what level. You can recruit. This issue that you can't recruit needs to be thrown out. We have got to have the facilities in remote communities and in the Top End there's very large communities that don't have residential aged care or hostel-type facilities.

MR ROZEN: Does this pick up on the question Commissioner Tracey asked earlier about the possibility of having more facilities in remote areas?

DR BOFFA: Absolutely, and we've – in primary health care, we've for many years looked at population ratios for GPs, nurses, health workers, you know, a GP of 400 people in remote plus nurses to 250. We've looked at all that and we've planned around it. Similar planning needs to happen with aged care facilities. A community of a certain size should - and we have just heard - add to that the cultural imperatives of keeping people on country for the sake of their spirit and everything else. But even without that Australia as a nation should be able to afford - we have had 28 years of sustained economic growth and we can't even make sure that old people can be cared for close to home in communities of very considerable size. Others might want to add to that.

MR ROZEN: Ms Havnen.

MS HAVNEN: I just wanted to highlight, I suppose, the unique characteristics of the Northern Territory. We're actually as a jurisdiction quite different to other states, that is, we have a large number of discrete Aboriginal communities. We've got over 600 discrete communities, most of those are the smaller ones sort of from the middle of the Territory south. But I think it's worth noting that there are probably 13 communities across the Top End that you would call substantial sized towns. You know, they have populations of 1200, 1500 people and more if you include the surrounding outstations and catchment areas.

I cannot believe that you would find similar size towns anywhere else in this country that would not have a residential aged care service. It is simply shocking that a town like Nhulunbuy for years have been told and promised, yes, you will get an aged care facility, and I can remember consultations going back as far as 2007 and we still don't have an aged care service there. The point I really want to emphasize is that Aboriginal people have by far the most complex health conditions, complex level of needs and who actually receive the least level of service, and these things are not new. We have talked about it for decades as Donna and Dr Boffa have said. You know, we have done a lot of the research. I simply do not understand how we can still face such inequity. And I get it that, you know, there are competing economic and other sort of priorities but it's like when the hell do Aboriginal people's needs get met. Sorry.

MR ROZEN: That's all right. I asked the question.

MS HAVNEN: You know, it's just - - -

MR ROZEN: Can I just explore one aspect of that, and that is in the statements it's apparent that Aboriginal populations can be quite mobile. They move around for cultural reasons, related to sporting events and so on. Is it feasible to address the issues you've identified in the context of shifting communities and different - communities where the sizes might change over time; is it relevant, is it a concern?

MS HAVNEN: Look, I think the pattern of mobility needs to be understood in the context that generally tends to be according to season and other sorts of priorities but by and large these are permanent populations who have lived there permanently, and will continue to do so. The Aboriginal freehold land in the Northern Territory comprises about 45 per cent of the total land mass, and Aboriginal rights extend around 80 per cent of the coastline. Aboriginal people aren't going anywhere. This is home, this is permanent residence, and the other point I would make is despite the fact that we have nearly 30 per cent of Aboriginal people as the Territory's population, 80 per cent of that population live in remote or very remote areas. So the people who actually live in town in regional centres like Darwin, Katherine or Alice Springs are in fact the minority.

So I think governments have to get perhaps a little more serious about planning for the long-term future and accepting that those communities are going to be viable in one way or another, maybe not necessarily economically but they are viable in terms of Aboriginal people's aspirations and right to be on land. So I think we need to think about how do we accommodate and meet some of those needs. I accept that there are real challenges when you've got such a dispersed population over a large geographic area but I think we could do things far better.

MR ROZEN: Dr Boffa, can I just pick you up on something you said a moment ago and see if I can get some clarification. You talked about - this is the context of the - and Ms Ah Chee, you were talking about this too, the shared electronic record and sharing of information. Just to clarify; the shared record you are talking about, is it the Northern Territory community care information system or is it the more general My Health Record that you have in mind?

MS AH CHEE: The federal one.

DR BOFFA: The My Health Record.

MR ROZEN: Thank you for that. And the other matter that I just wish to explore briefly with you, I think this might be another issue for Dr Boffa, the home nursing question. You talk about in the statement, the decline in the home nursing or the availability of home nursing. What's the significance of that in your mind?

DR BOFFA: Do you want to take that first?

MS AH CHEE: Well, I think that the issue of home nursing like the level 4 packages, that the medical component, because of the, you know, level of complexity entailed in level 4 packages, we argue that those nurses should be employed within a primary health care service, because they can then be supported by a GP and other, you know, clinically oriented workforce and support, and as well as support of management from a clinical governance perspective as well. In relation to the first point, I think I will hand that over to you, Dr Boff, about the decline.

DR BOFFA: Yes, so, you know, traditionally, it was called domiciliary nursing, Latin word for home nursing, done by the state. Once the HACC program came in 1988 and then later came what was called CATP packages had now become home care packages, there has been a gradual decline in that, particularly for Aboriginal people. It's stopped. You know, they don't go to town camps, for instance, still in Alice Springs. So that was meant to be picked up gradually by the high level home care packages. But the problem with that is the packages fund little bits of home nursing. It's a complex thing. As Donna said, it needs to be supported by GP's. And in a holistic - it's now really clear from the evidence that providing nurses home visiting to older people with multiple chronic diseases prevents hospitalisation.

So there's a medical imperative to visit as well as an aged care imperative to support medications, complex dressings. They'd be for people who need their medications given to them which is where the CATP providers often draw a line. They will watch someone take their tablets but they won't actually hand them to them unless they are medically trained or medically supervised so those grey areas go away if a health service employs - if the home nursing comes from a health service, it will be holistic home nursing. It will be helping with chronic disease management as well as the aged care components and then the other services can come from specific aged care providers and then the two have to work together.

But at the moment, I think the home nursing component is difficult to recruit to. It's in little bits. It's not salaried nurses that are working full-time on this role, supported within multidisciplinary teams. They're on their own. They're often like a shag on a rock in an aged care provider. They might be the only nurse inside a service that doesn't employ nurses, has never employed – the nurse doesn't know about health care but has to meet this demand in a level 4 package. So it would be much better for the nursing component of aged care to be provided from health services at least, and I think that's where we would like to see that move in the future and that could be a grant-funded program because particularly in remote areas, the individual package system has to be pooled to get economies of scale to get a good service.

COMMISSIONER BRIGGS: Can I pick up on that Dr Boffa, please. This is a story that's not dissimilar to one we've heard in other places, a general decline in domiciliary nursing care, the suggestion that packages aren't providing for nursing care more generally, even at those higher levels of packages 3 and 4, is it the experience of you and perhaps Dr Giles or the other members of the panel that that is the case more generally and then I might follow up.

DR BOFFA: Yes, I think if you look on the website it's absolutely provided at level 4 but if you look in the community which is better than the website, often it's not provided at all but when it's provided it's very ad hoc. They can't retain the providers even if they do get a nurse for a while and can't retain them. They are not well supported. So we have seen a really serious decline in this service. It used to be much better when it was provided by the state. And CAP, the packages have not been able to meet the demand and take up this service. So we have seen a loss – and that's a really serious issue when it comes to the prevention of institutional care

because that is the service that keeps people at home, without having them to go into a nursing home or without them having to go to hospital because either way it's a failure of the system and it's very poorly – and so we are suggesting in our submission a whole new approach which is a grant funded program to fund that component properly.

The states have withdrawn - by and large states have withdrawn from that service and transferred to the Commonwealth through aged care funding but it's not happening at anything like the level it needs to happen. Then it falls back on - what ends up happening these people end up being picked up, brought into a health service to have their complex dressings rather than having it at home which is where they should have it. The health service is left picking up the pieces because that health service is not being provided.

COMMISSIONER BRIGGS: So if I can try and unpack that a little bit, I hear what you are saying about the services should be provided either by the Territory government or the State Governments. Might it also be possible to have those services provided by an Aboriginal-controlled health service or medical service?

DR BOFFA: Absolutely.

MS HAVNEN: That's what we are proposing, absolutely.

COMMISSIONER BRIGGS: And similarly, would you see Aboriginal – what's the word – control extending to aged care services more generally?

MS HAVNEN: There are a number of - sorry if I could respond to that one. I know from the urban, the Institute of Urban Indigenous Health in Brisbane, IUIH, they run and provide a whole range of aged care services including residential care. So I think that's a really good example and a model and that's certainly something that has grown over more recent years and I think certainly, you know, the bigger health services would have that capacity to do that work.

COMMISSIONER BRIGGS: Yes, it's something that has been suggested to us in one of our roundtable discussions on this matter. So I'm quite interested in what you're saying, Dr Giles.

DR GILES: One of our cautions is that Aboriginal community-controlled health organisations are increasingly asked to do more and more with no funding increases.

COMMISSIONER BRIGGS: Indeed.

DR BOFFA: But if there's one - Aboriginal control, yes, in terms of what health services should absolutely do, we're saying it's home nursing should absolutely be with the health services. Other aspects of aged care, other Aboriginal organisations can do that and it doesn't have to be with a community-controlled health service. But Aboriginal control over all of these services is very important for Aboriginal

communities. And that has been - that is what is happening. A lot of the aged care services to Aboriginal communities are provided by Aboriginal organisations, not the health services. But even the community – the shire councils do a lot of this work in remote areas as well and they've got Aboriginal boards so Aboriginal-controlled organisations, how would you describe the Shires?

MS HAVNEN: That's debatable.

DR BOFFA: That's a bit of a grey area but, yes, Aboriginal control, yes. But the sine qua non for the health services is the home nursing component which has to be – which really needs to be within the health services.

COMMISSIONER BRIGGS: I hear you.

MS HAVNEN: Like with like.

DR BOFFA: Yes.

MR ROZEN: That actually concludes the questions that I had for the panel, Commissioners.

COMMISSIONER TRACEY: Yes, thank you, Mr Rozen. You may have been here this morning when I thanked the earlier witnesses who have provided us with insights into what we regard as a very important area and that is the proper care for Aboriginal people, aged people, in remote parts of the country, and with the earlier evidence, plus what you have assisted us with, we're certainly much better informed than we earlier were and we thank you very much for sharing your expertise with us.

<THE WITNESSES WITHDREW [2.58 pm]

COMMISSIONER TRACEY: The Commission will temporarily adjourn.

ADJOURNED [2.58 pm]

RESUMED [3.15 pm]

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. I call Michelle Lillian McKay. She is presently seated in the witness box.

<MICHELLE LILLIAN McKAY, AFFIRMED [3.15 pm]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Operator, please display WIT.0235.0001.0001. Ms McKay, is your full name Michelle Lillian McKay?

MS McKAY: That's correct.

MR GRAY: Have you made a witness statement for the Royal Commission giving your name as Michelle McKay without your middle name?

MS McKAY: I have.

MR GRAY: And that's dated 4 July 2019.

MS McKAY: Yes, it is.

MR GRAY: Please look at the screen. Do you recognise that as your statement?

MS McKAY: Yes, I do.

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

MS McKAY: Yes, they are.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The witness statement of Michelle McKay dated 4 July 2019 will be exhibit 6-7.

EXHIBIT #6-7 WITNESS STATEMENT OF MICHELLE MCKAY DATED 04/07/2019

MR GRAY: Ms McKay, were there a number of attachments to your witness statement? Commissioners, those are to be found at tabs 55 through to 63 of the general tender bundle index. You identified a number of statements in your - - -

MS McKAY: Yes.

MR GRAY: I beg your pardon. A number of attachments in your witness statement.

MS McKAY: Attachments.

MR GRAY: Thank you.

MS McKAY: Yes.

MR GRAY: Ms McKay, you're the chief operating officer of Top End Health Service; is that correct?

MS McKAY: That's correct.

MR GRAY: Please explain to the Commissioners what is Top End Health Service with reference to NT Health, the Department of Health in the Northern Territory, and with reference to its sister health service.

MS McKAY: Certainly. So NT Health comprises of the Department of Health, which is largely the system manager for health in the Territory and also responsible for a strategy and policy, and there are two health services: the Top End Health Service, of which I'm the chief operating officer, and Central Australian Health Service. Largely, the services are split by a line, if you were to draw it on a map, below Katherine.

MR GRAY: Thank you. So Top End Health Service covers more of the population of the Northern Territory; is that right?

MS McKAY: It does, yes.

MR GRAY: Can you give the Commission an indication of roughly what the breakdown is by reference to paragraph 5 of your statement?

MS McKAY: Certainly. So Top End Health Service covers about 35 per cent of the geography of the Territory and has approaching 80 per cent of the total population.

MR GRAY: Thank you. If we go to the next page, please, operator, Ms McKay, what services does Top End Health Service provide in the community?

MS McKAY: So perhaps if I describe the breadth of Top End Health Service might – it might more easily describe that. So there are four acute hospitals within Top End Health Service. The Royal Darwin is the only tertiary hospital within the Territory, and there are also hospitals located at Palmerston, Gove and in Katherine. In addition to that, Top End Health Service also is responsible for a large mental health service provision for the population, as well as some mental health service into Central Australia. And Top End Health Service also has responsibility for a range of primary health care services across that – that geography. Top End Health Service also is responsible in an aged care sense for the ACAT, the Aged Care Assessment Team service, and also has responsibility for some Commonwealth Home Support program funding, largely around equipment and allied health.

MR GRAY: And when you say Top End Health Service has responsibility for some Commonwealth health support program funding, do you mean that Top End Health Service receives funding in return for the provision of equipment?

MS McKAY: Correct. Correct.

MR GRAY: Thank you. And in the community, in terms of community services, is there a community allied health team?

MS McKAY: There is. That service is actually in the process of transitioning from the department to come under the responsibility of Top End Health Service, but it provides allied health services into the region of the Top End Health Service currently. It consists of a range of allied health professionals, and those individuals also do the ACAT assessments when they're visiting community.

MR GRAY: Thank you. And is there anybody else in the Territory providing ACAT services?

MS McKAY: No, we're the – we're the provider of the ACAT assessment service, yes.

MR GRAY: And in terms of the actual health services you mentioned a short time ago, they're Territory owned and operated health services, are they?

MS McKAY: The primary health services you're referring to?

MR GRAY: Yes.

MS McKAY: That's right. So there are some different providers of primary health services in the Territory, and we've heard today from some of the Aboriginal community controlled health organisations. Top End Health Service provides some primary services into remote and urban communities, and we also have, within the larger centres, more traditional GP service provision.

MR GRAY: So taking remote communities, there are, as I understand it, a number of remote communities which have a territory owned and operated health service.

MS McKAY: Correct. So within Top End Health Service, that's - that number is about 30 communities.

MR GRAY: Thank you. And there's a process of transition in certain communities; is that right?

MS McKAY: That's right. So the NT Government has a policy of transitioning primary health care services to Aboriginal community control, where there's an organisation able to deliver that service and a community that is engaged in that process, and that's an ongoing process. In fact, as at last week, 1 July, we

transitioned some services to Aboriginal community control in the east Arnhem region.

MR GRAY: Thank you. What about the memory service? Can you tell the Commissioners what that is?

MS McKAY: Yes, so the memory service is provided for people across the Top End and consists of a small number of staff who provide clinic services and consultant advice for people who are suffering from dementia.

MR GRAY: Is that available as outreach or inreach, depending on your perspective, into aged care facilities?

MS McKAY: It can be, but largely there are also other mechanisms for residential aged care services to access dementia-specific consultant advice, so we would perhaps be one provider in that sense.

MR GRAY: And you mentioned the mental health service. Is that given the acronym TEMHS?

MS McKAY: That's correct, yes.

MR GRAY: And a little more specifically, what are the services available from that service?

MS McKAY: Well, the mental health service offers a breadth of service from child and youth-specific services, adult services through to forensic mental health services. We have an inpatient unit within the Darwin area for adults and youth, and the service is provided both as an outpatient setting, an inpatient setting and also inreach to the prisons.

MR GRAY: Is there any inreach into residential aged care facilities?

MS McKAY: There are no psychogeriatric specific residential ages care services in the Territory, so that tends not to be the case. We do have a psychogeriatric service with a clinician based in Melbourne who provides some support to - to individuals.

MR GRAY: By telephone, I take it, or telehealth.

MS McKAY: By telehealth and telephone, yes.

MR GRAY: Thank you. In Ms Havnen's witness statement at paragraphs 45 and 46, she refers to - and this is also Dr Boffa's witness statement - she refers to Danila Dilba's clients commonly coming to aged care – I beg your pardon. I withdraw that. In Ms Olga Havnen's witness statement, paragraphs 45 and 46, she refers to Danila Dilba's clients commonly coming to aged care through ACAT assessment at

hospital. Is that consistent with your understanding of the typical way in which the ACAT service provided by Top End Health Service comes to be provided?

MS McKAY: Well, Danila Dilba is an Aboriginal community health controlled organisation in Darwin. So given the bulk of the population is here, it would make sense that a number of their clients would be having ACAT assessments as a result of being in hospital, yes.

MR GRAY: In the next paragraph, she refers to one of the issues reported by Danila Dilba's staff as being that in terms of transport between residential aged care facilities and hospital, some residential aged care facilities provide transport and others do not. Is this a matter that NT Health has any role in, to your knowledge?

MS McKAY: So I think the particular issue highlighted at paragraph 47 was discussed in a little bit more detail in that evidence earlier, and that was specifically about accessing a visit at an optometrist before the patient resident could then be seen by an ophthalmologist. So that – that is a question around residential aged care service transport. But usually, of course, a not infrequent transport need for people who are in residential aged care services if their health deteriorates and they need to come to hospital, in which case, that is, of course, via the ambulance which is grant funded through NT Health.

MR GRAY: Yes. Did I refer to paragraph 47? I meant to refer to paragraph 46.

MS McKAY: My apologies. 47 popped up.

MR GRAY: If you could call out paragraph 46, please, operator.

MS McKAY: Yes, so what the statement is saying is some aged care facilities provide client transport and others do not. We also provide client transport in – in a range of circumstances, should there - there be a need. It would dependent on the particular requirement and the particular facility for residents.

MR GRAY: I want to ask you about the discharge summary procedure when a patient who may need to then become a resident of a residential aged care facility is leaving a hospital. It's at tab 56 of the tender bundle, please, operator. And do you recognise this to be one of the attachments to your statement, Ms McKay?

MS McKAY: Yes, it is.

MR GRAY: And going on its title, it's the procedure that is laid down by Top End Health Service in respect of discharges from one of those four hospitals you mentioned; is that right?

MS McKAY: Correct. That's right.

MR GRAY: And if we go, please, operator, to page .0014, near the top of the page - if you go to the preceding page, please, operator. It's two pages before that page, please, operator. Thank you. We see there, Ms McKay, under the heading Transfer to a Residential Aged Care Facility, the procedure that applies in respect of those transfers.

MS McKAY: Yes.

MR GRAY: And in addition to the matters noted there, is transport also arranged or are there some circumstances in which transport isn't arranged?

MS McKAY: Well, it would – it would absolutely depend, so you're talking about the circumstance of someone leaving hospital for their first admission into a residential aged care facility. It would depend on the particular circumstances of that person. Some people will need to be transferred by ambulance because that's the only appropriate transport mechanism. Some may choose - may prefer to go with family, and we would have a transport option as well, as we have a Top End patient transport service. So it would really depend on the individual needs and wants of the person concerned.

MR GRAY: There's a reference to documentation that – or other forms of record communication that should be completed, including medication information, and there's a reference in the third-last line to, therefore, enter discharge medications in EMMA or manually enter on the CWS document. Are those information systems?

MS McKAY: Yes. So the EMMA is the in-hospital electronic medication system. CWS will be the documentation that accompanies the resident. We did hear earlier that medication management in residential aged care services is reliant on a number of different systems, but this actual reference to an electronic system is concerning the hospital's electronic system, so that the record of what the resident was discharged with is clearly captured there for our purposes.

MR GRAY: In the Territory, is there any form of electronic platform that is interconnected between the hospitals on the one hand and the residential aged care facilities on the other?

MS McKAY: No. No, there isn't.

MR GRAY: I want to ask you about paragraph 6 of your statement, Ms McKay, concerning palliative services provided by Territory Palliative Care. Is Territory Palliative Care a service that's provided by each of Top End and the sister health service? Is that - - -

MS McKAY: Yes, there are teams located in both, but the - the two teams do work closely together.

MR GRAY: And could you tell the Commissioners a bit about the palliative care services.

MS McKAY: Yes, so I'll talk about the - the Top End one. So we have a hospice located on the site of the Royal Darwin Hospital, a 12-bed hospice. That's one aspect of palliative care. There's consultant services for inpatients and – and there are some community-based services within that mix of palliative care services.

MR GRAY: If we go to paragraph 22 of your statement, amongst the matters you address, you refer to - and I'll find it in a minute - but I believe you refer to palliative care being an area for some improvement in that – I beg your pardon. I do beg your pardon, Ms McKay. It's Ms Havnen's statement in paragraph 22. She states that palliative care doesn't recognise cultural differences amongst Aboriginal people. In your statement, at paragraph 6 is where I should have asked you to look. You refer to there being some key challenges, including finding successful approaches to people being able to die on country and that requiring significant planning and family and community acceptance and support. Could you expand on that, please.

MS McKAY: Yes. So I will be quite generalised in my response, but I think I will just say at the outset, of course, it's very dependent on the patient's individual needs in terms of what level of care is required. So – so we would agree with the points made earlier about the importance of people being able to die on country. But arranging that can, at times, provide a series of challenges. So a family is able and – and willing to accept having someone who is dying at home. Not - not all families – and this is across all cultural groups – not all families are comfortable with that or able to support the level of care required. Does the home in which the person will be going to - can it support having someone with high care needs? So some of those things can be challenging to resolve. Symptom management often will require provision of very serious medication, so we need to make sure people are able to do that. But I would – I would agree that we would – would absolutely endorse the view that we should all be trying to facilitate that as much as is possible, but on occasion it can be quite challenging to arrange.

MR GRAY: And in amongst the matters that you're considering in that regard, do you include cultural safety, cultural - - -

MS McKAY: Absolutely. Yes, that's absolutely right. In fact, it's one of the prime drivers to try and support people who are at the palliative stage of an illness being able to be returned to country, most definitely.

MR GRAY: I want to ask, with reference to paragraph 7 of your statement, about a community nursing service provided by Top End Health Service and how it is managed. A little earlier there was evidence from the panel, in particular from Dr Boffa and Ms Ah Chee from Congress, concerning a decline in the availability of domiciliary nursing services. Are you able to speak to that issue and explain what, if any, role NT Health has in that equation?

MS McKAY: Sure. So the aged care system has gone through some significant reforms over the last couple of decades, and one of those was a change where the Commonwealth Government became responsible for aged care services. Prior to that, states and territories had also provided some aged care services. So responsibility for that shifted to the Commonwealth, and most aged care clients who would be in need of domiciliary or what was then called domiciliary nursing services would access that, now usually via level 4 packages or perhaps 3, but certainly at the high end or, of course, in residential aged care services.

I think the evidence that was heard earlier was - was quite interesting in terms of whether access has dropped over time. The Aboriginal community health controlled organisations that spoke are long-term organisations within the Territory. I think their assessment of the situation would, of course, be very sound, but - but the reference was to those nursing services that would largely sit in those high-level home care packages largely. I would say that I think the proposal made about alternate funding mechanisms for that, such that it encourages nurses to be part of a health service in the way described earlier, was a very sound proposal.

MR GRAY: And picking up that point, the proposal that the clinical element of care in the home could be provided more readily by local community health services, what, if any, role does NT Health have in that equation? Is that a case of considering whether the community in question has a territory owned and operated primary health service or not?

MS McKAY: Well, it could be. Currently, for the communities that we are the primary care provider in, we will have nurses associated with our - as part of our services. The differential here is whether the client is an aged care client in receipt of an aged care funding package. That's really the distinction. Our – our nurses, in providing primary care, just as is the case with the ..... who spoke earlier, are providing a range of nursing services, but the particular discussion point was around people in receipt of home care packages with nursing as a component.

MR GRAY: The direct aged care services that are currently provided by Top End Health Services are limited to those ACAT services and the equipment.

MS McKAY: ACAT equipment largely, yes, that's right.

MR GRAY: So Top End Health Service isn't currently providing home care package funded or CHSP funded - - -

MS McKAY: No. No. The - - -

MR GRAY: - - - home nursing services?

MS McKAY: No, the Top End Health Service and the NT Health as a whole is not an approved provider of aged care services. In communities where there is no aged care service provider, it would absolutely be the case that our primary care services

would be providing care, of course, to individuals who live in that community. But we are not a provider in the sense of home care packages or, indeed, residential care.

MR GRAY: Thank you. Ms Ah Chee and Dr Boffa of Congress, in their joint witness statement at paragraph 36, after referring to this domiciliary nursing point, at a point prior to the introduction of the HACC and community aged care packages, they proposed – this is in paragraph (d) – a solution or a requirement that aged care providers have MOUs, memorandums of understanding, with their local health care services to meet a lack of integration. Do you have any comment on that proposal?

MS McKAY: I think that the comment I would make is probably to reference, as I – as I mentioned earlier, the different providers of primary care within the Territory. So we've heard from Aboriginal community controlled organisations who largely have primary care coverage for Aboriginal clients in those services but not full coverage. Some individuals will, of course, have a GP of their choice, who's been their GP provider prior to their entry to residential aged care. So I do think we just need to - to recognise that nuance. But - but in remote communities where there is an Aboriginal community controlled health organisation or, indeed, one of our primary service providers, it's – it's a concept that is worth exploring, largely, I think, for the reason given earlier about the clinical staff being part of a clinical service, in terms of their professional clinical governance and professional support - was a point well made earlier.

MR GRAY: And what about the related point concerning the uploading of information as to the grant or assignment of home care packages and presumably other aged care related entitlements to My Health Record, to enable any primary health provider to understand what's being provided or any other community support service to understand what a person's entitlement might be?

MS McKAY: So I think that, as a sort of first point, I would say the more information sharing that can occur about a person across a multiplicity of providers, if they have them, is, of course, beneficial. Some of the issues, though, that present, sit around privacy, consent, where a person has given consent for others to have access to – to information. Increasingly, of course, technology itself is becoming less and less an issue. It's much more tied up with – with that information being made available, which I think was the point being made earlier as well. But as a principle, the more information that can be shared, the better, would be my view.

MR GRAY: I'll come back to that point a little later, if I may, and ask you about the Territory's own information system.

MS McKAY: Yes, certainly.

MR GRAY: At paragraph 8 of your statement, you refer to a psychogeriatric service that was the subject of a 2013 review that demonstrated reduction in acute admissions, and if I could just ask you to expand on that, and I might take you to the evaluation of the effectiveness of the service.

MS McKAY: Yes, so would you like me to make some comments? So the evaluation document that is contained within the attachments is from a period of about five years ago.

MR GRAY: Yes.

MS McKAY: So I just make that point. Some of the dollar values, etcetera, in it are probably no longer valid, but the general finding of that evaluation is that people with very complex needs, which is certainly the group who are in need of psychogeriatric services, benefit greatly from – from access to those services I think would be the salient finding, and they benefit by needing less hospitalisation and - and we would have to assume that is then better coordinated and – and better care. I think I touched on earlier the breadth of the current psychogeriatric services in the Territory.

MR GRAY: You mentioned access to the psychogeriatrician who's located in Melbourne.

MS McKAY: Yes.

MR GRAY: This is the same program. Is - - -

MS McKAY: Yes, that's correct.

MR GRAY: You note - - -

MS McKAY: That is the psychogeriatric service. That's correct.

MR GRAY: Thank you. In 2013, was it the same methodology?

MS McKAY: That is my - - -

MR GRAY: The same process?

MS McKAY: Yes. That is my understanding. I – I wasn't here in 2013, but I understand that that's the case.

MR GRAY: And I'll just ask you to identify the attachment. It's at tab 55. It appears to be, and I think you've described it as, an excerpt of the evaluation of the program in 2013. Is that the attachment in question?

MS McKAY: Yes, that's right.

MR GRAY: And if we go to the second page, .0002, it appears to have involved assessing the indicative costs in terms of time incurred multiplied by cost factors for the psychogeriatric service and for the acute system, that is, hospital costs for a number of case studies. And then on page 0003, there's a tabulated analysis and

comparison of the costs and a conclusion in the middle of the page to the effect that where the client's case was managed by the psychogeriatric service, there was a lowering of costs to the acute sector of a factor of about 2.4.

MS McKAY: That's the finding of that evaluation from five years ago. I have no reason to doubt its veracity.

MR GRAY: And you don't know of any material reason why circumstances would be materially different now in a way that would affect - - -

MS McKAY: I wouldn't have thought so. I wouldn't have thought so.

MR GRAY: Now, I want to ask you, with reference to paragraph 9 of your statement, about the serious matter of the low level of residential aged care places. Perhaps the best entry point for this is to go to the most recent quarterly performance report of the Top End Health Service's provision of ACAT services under the aged care assessment program. In fact, it may not be limited to Top End. It may also cover central.

MS McKAY: Yes, that's right.

MR GRAY: Operator, please go to tab 59, which is NTH.0001.0003.0093. And if we go to 00098, at the foot of the page under the heading Additional Input, is this input that NT Health wish to bring to the attention of the Commonwealth in this report across the ACAT services provided by both sister health services?

MS McKAY: Yes, this – that is the purpose of this section of the report. That's right.

MR GRAY: Yes. And - - -

MS McKAY: Just a reminder, it is just the one ACAT service that does the whole territory, just to - - -

MR GRAY: Thank you. Thank you. So with respect to the ACAT service across the whole territory, reading from the third-last line, there's a statement that:

> *Prior to the changes in 2017, the Northern Territory had over 1188 home care packages assigned to providers.*

And, in effect, what's said here is there's been a halving of the number of assigned home care packages since that time. Is that true?

MS McKAY: Yes. So probably just to put some context around that, prior to the reform changes in, I believe, 2017, that timeframe, home care packages were assigned to providers and then providers would offer those to clients. The reform introduced at that time was a national process so home care packages were no longer

assigned to providers. They were kept on a national list and individuals who needed to access packages went on to a national wait list. So that has been the impact for the Territory as a result of that move to a national wait-listed process as opposed to providers controlling the packages.

MR GRAY: Thank you. If we go back now to paragraph 9 of your statement, you've provided some more information about the decline in numbers of activated packages at the bottom of the page. That's a similar point, from the bottom of the page, since policy changes introduced by the Commonwealth in February 2017.

MS McKAY: Yes, that is largely the same point, yes.

MR GRAY: Yes. Now, just above that point you've made a point that there are proportionally fewer residential aged care places in the Territory and you've given us some of the raw figures, and it seems that there's an allocation of 720 but only 569 places are activated by residential aged care providers; is that right?

MS McKAY: That's correct.

MR GRAY: So do you have any explanation to offer from your observation on the ground as to why there seems to be this lack of activation, given that the Territory has proportionally fewer residential aged care places to begin with, and this is compounded by a halving of the number of assigned home care packages since 2017. What are the drivers of these phenomena?

MS McKAY: Yes, so if I go to the residential aged care beds first, the process is through the ACAR round generally once a year. Providers can submit application to get more licences, which means, of course, they can then have more beds. For the most recent ACAR round, the number of licences that had been allocated to the Territory, not the total number, was submitted for by providers and then subsequent to that, providers don't necessarily then build and activate those new places that they have won quickly, and so you end up with this sort of arrangement where there are more allocated places than there are in fact activated places.

MR GRAY: And what about the driver of the halving of assigned home care packages since 2017; do you have any comments on that?

MS McKAY: Yes, so that seems to be totally related to moving to the national wait list arrangements. So home care packages go to people through a national waiting process as opposed to a state or territory-based waiting process.

MR GRAY: Thank you. Do you have any other comments on other implications of the move to consumer-directed care in home care package administration? So this is a question that really goes to a point after there has been assignment. Assuming one gets through the waiting list on the national priority system, however long that might take, is there then an issue about the impact of consumer-directed care on utilisation of those home care packages, in your view.

MS McKAY: Well, I think – and, again, I would make the distinction between clients in rural and remote areas as opposed to more urban areas, so the concept of consumer-directed care is that individuals can choose how they want to use the resources within their package, what sort of supports they want. Informed by the ACAT assessment process, of course. And then it assumes that the consumer will decide where they want to purchase those various services from, but in a place like the Territory and particularly rural and remote areas in the Territory where there is a thin or non-existent market, it doesn't work that way. And, in fact, what we instead see is benefit when those funding streams are pooled to enable better service provision. So it's quite a different arrangement. So I think the philosophy of consumer-directed care, of people having choice and control is of course a good one but it assumes that you've got a market that you're working within.

MR GRAY: Operator, please go to the next page, and we will just show Ms McKay's paragraph 10. You make this point, do you, in the last paragraph under question 10, and you highlight the National Aboriginal and Torres Strait Islander Flexible Aged Care Program as having advantages because it's block-funded.

MS McKAY: It's both block-funded but it's also pool-funded. So I think earlier today in the opening remarks we heard how much more this particular program is a feature of the Territory's aged care service landscape than it is anywhere else, and it's because it does enable relatively small communities to have a mix of residential beds and home care package care for the people in that community by pooling that funding and then block funding it so there's certainty of funding for the provider.

MR GRAY: Thank you. In the paragraph, the very short paragraph just above it, you refer to the Commonwealth Home Support program and also the transition care program and you say they work effectively in the Northern Territory. Do you wish to expand on that?

MS McKAY: Yes, so Commonwealth Home Support program is of course targeted to lower level needs, if that's a way to describe it. Transition care is about giving people a bit more intensive support as a mechanism to try and have a situation where people can remain in their own homes as opposed to needing residential aged care or a higher level of home care package. So it's across the spectrum of the whole aged care arena. Those are effective programs, as the note says.

MR GRAY: Thank you. Ms McKay, you've explained to the Commissioners your observations about the limitations on residential aged care places and the halving of the amount of assigned home care packages. You also made other observations about the other programs that have some advantages over those, subject to the availability of services and the depth of the market. I just want to ask you now about the flow-on impacts of the scarcities of aged care service provision you've been speaking about and in particular those flow-on impacts for NT Health for the system that is administered by NT Health. If we start with paragraph 12 of your statement beginning at the foot of page 11, the main text goes over the page; do you wish to

expand on the impact of the long waiting times that the Commission has been hearing about concerning HCPs?

MS McKAY: Yes. So if a person has been assessed as needing a level 4 home care package, that's indicative of them needing quite a significant level of support to remain at home, and if you need to wait 12 to 18 months to access that support, it is more likely that you will continue to deteriorate during that time and, in fact, be more likely to then need residential aged care. By the time you factor in, as you've noted, difficulties in accessing residential aged care, it can be the case that individuals in this situation actually need to be in hospital because it is the only place able to care for their high level needs.

MR GRAY: And presumably by reference, amongst other things to that evaluation of the psychogeriatric service, it's clear that that's going to be a more costly outcome for the system as a whole?

MS McKAY: Correct. Correct.

MR GRAY: Could I ask you, with reference to paragraph 15 of your statement, to give an opinion about, to the extent you can, the impact of restrictions imposed on take-up of residential care places, perhaps by analogy with the freezing sanction; that is, the freezing that was placed on a particular approved provider from taking on new residents for a time until it had complied with a timetable of improvements. What was NT Health's and Top End Health Service's experience of the impact of that on the hospital system?

MS McKAY: So the result of that is, of course, it reduces access to beds for a time. So further compounding the relatively low number to start with. And feedback from people who were here at the time, I wasn't personally, was that in addition to that, if you like, hard instance where the provider is unable to accept new admissions for a time, it can have a flow-on effect into members of the community more broadly, being concerned about accessing residential aged care as a general statement, not necessarily even that provider - those concerns. So it has a flow backward effect on to the hospitals where a number of people who are accessing residential aged care will come from hospitals. So if we have a reduction in the number of beds that are available that obviously has a flow-on effect. Similarly, though, for individuals who are at home awaiting access. So that largely was the impact on that occasion.

MR GRAY: Thank you. You refer in paragraph 14 to a long stay patient working group. What's the work of that group?

MS McKAY: So this group meet regularly to work through options for how people who have been in hospital for a long time, awaiting residential aged care might be able to access residential aged care beds. Some of the issues are very complex. If the particular environment that that person needs is not available in the Territory aged care facilities and how that might be managed, and sometimes it's about if particular individuals have behaviours of concern, that need a management approach

to enable them to transition into a residential aged care service. So the purpose of that group is to meet regularly and work through those issues in a desire to move people to a more appropriate setting.

MR GRAY: So is it the case that the working group is to provide ongoing facilitation rather than coming up with a set of recommendations as a sort of end destination?

MS McKAY: It's more based on a patient-by-patient review. So probably more the former, from what you're saying, yes.

MR GRAY: Thank you. Just skipping, really, to the conclusion which you perhaps – putting words into your mouth – identify as the root cause of some of these matters. You say in paragraph 24, don't you, that access is the prime issue for aged care in the Northern Territory?

MS McKAY: Yes, and I think that some of that hard data we talked about shows that, but equally some of the evidence we've heard earlier today about remote community service provision, so access is the issue within the Territory.

MR GRAY: And you give a variety of issues as particulars for that in your paragraph 24. You refer to the wait listing and rationing and you've already spoken about those matters.

MS McKAY: Yes.

MR GRAY: You say that revised eligibility and entitlement provisions should be considered and more alternatives to the market-based approach to aged care services are required. Have you covered that in the answers you have already given or do you wish to elaborate on that?

MS McKAY: I think I touched earlier on opportunities around pooled funding and different ways that that's managed and we talked specifically in terms of nursing care provision in high level home care packages. I think it is looking, for those communities which is a lot of the Territory's geography, where there is no market, how you can design appropriate models, both funding and staff provision, that actually work for those communities.

MR GRAY: Thank you. You identify the need to consider a mix of staff and improved access to allied health resources including - well, and in addition, specialist psychogeriatric support. Now, you speak about the need to consider funding mechanisms in that regard, to provide presumably additional incentives to whatever incentives might already exist. Do you care to elaborate.

MS McKAY: Yes. That's right. So a number of years ago, the Aged Care Funding Instrument which is the mechanism by which residential aged care services receive funding for care was altered to pay particular emphasis on physiotherapy service

provision and that did result in much higher access to physiotherapy services in residential aged care services. The proposal is that consideration be given in a similar sort of way to other allied health services. We heard quite a bit earlier today, for example, around food and nutrition. So there may well be other ways within the current funding frameworks to look at how some of those services could almost be incentivised.

MR GRAY: And you're not limiting that to having permanent staff. You say that it could extend to specialist services through in-reach models, for example in the area of palliative care.

MS McKAY: Correct. I mean, there would be any number of different ways that - or different aspects that could be looked at. Again, I just say that we need to think about how that works in remote communities as well as urban centres, for whom there might, you know, might not be the volume of work for some of the allied health specialties, for example.

MR GRAY: You've identified what you must consider to be a trend of residential providers not accepting individuals with complex behaviour needs; please elaborate on that.

MS McKAY: Yes. I think that that's a finding being seen right across the sector, that providers are less keen to take residents who have challenging or difficult behaviours. And so consequently that tends to be the cohort of potential residents who are in our acute hospitals, which isn't the ideal environment at all, of course. And that is a difficulty, particularly if you look at the growth of the prevalence of dementia over time, how, again, we look at the current models at various funding opportunities to ensure that that group are getting appropriate service. I've touched on already, of course, there are no psychiatric – psychogeriatric, sorry, service, residential services in the Territory as an example.

MR GRAY: If we go back to the evaluation of the psychogeriatric services provided by telehealth from Melbourne and facilitated by NT Health, which is tab 55, and we look at the case studies on page 0002 please, operator. If we take, for example, case B, we seem to see here - if you could call out the text under Overview of Case - in this particular case study, we seem to see the psychogeriatric service working successfully to move a patient who is in hospital for a reasonably extended period through ACAT assessment into a transitional care program, and ultimately into a settled life in an RACF. Is that an example of what you're speaking about?

MS McKAY: Yes, exactly. And so how, you know, that provides support to the provider in that situation where they're getting very specialist advice around that particular individual's needs and I think that those sorts of models I would have thought enables providers to feel more confident to have residents with some of those very difficult behaviours.

MR GRAY: Thank you. Another point in your package of suggestions for reform in paragraph 24 is the pooled funding arrangement. You've already spoken about that. I don't think you need to add anything, do you Ms McKay?

MS McKAY: No.

MR GRAY: And you then refer to design of a streamlined assessment workforce to consider remote locations as different from what urban locations may need. Can you please expand on that.

MS McKAY: Yes. So when the regional assessment services, which assess people for the lower end of aged care services came into being they were very purposely designed to be separate to the ACAT services and separate from the provider services. So for somewhere like the Territory, where the volume of people needing assessment is relatively low in numbers but hugely dispersed in geography, you might end up with only a very small – you know, funding for a very small number of actual assessors. Being able to then multi-skill people to do that assessment, an ACAT assessment, perhaps even and NDIS assessment, as well as their other work when they're visiting remote communities does have the opportunity to create a far more sustainable workforce model, and, in fact, enable people to get assessment more quickly than waiting for the particular person to visit community who happens to be funded by that specific funding stream. So I think there's opportunity to look at how that can be more effectively streamlined.

MR GRAY: Thank you. Just a couple of final questions. Going back to that example of the sanctions that had those, in effect, chilling effects on the desirability of residential aged care and also that had that practical effect of putting pressure on the hospitals, from that, it sounds like sanctions imposed in the aged care space in the Northern Territory can result in stressors on the health care system in at least those two ways, by deterring people from taking up residential care generally and by specifically displacing people who'd been in residential care and leaving them in the acute care system. Do you have any suggestions how those .....

MS McKAY: Yes, it's very ..... the other aspect was, I think, in your opening remarks you talked about the fact that the Northern Territory occupancy rate for residential aged care is, in fact, higher than it is in other states, so you end up with a situation where a couple of beds not being able to be accessed can make a really big difference. I think it's quite a vexed scenario because, equally, if you have a situation where providers are not providing a safe or appropriate service, then you don't want more residents going into that service until it has reached a level of quality and safety provision that is acceptable. I make the point that the same happens somewhat, in my experience, even when providers have non-compliances. So not - not necessarily at the sanction end but at the non-compliance end, because often providers will self-limit new admissions while they focus on improving whatever the aspect of their service is that has - has been found wanting.

So - so I think it is a really – it's very difficult because we want open transparency across the system. As - as individuals, we - we want to know that services are safe and appropriate. So the – the concept of that information being made public is obviously sound, but it does definitely have a flow-on effect across the rest of the system, and I think more pronounced here because of the – a whole range of the different aspects that we have touched on today in terms of limited access, to begin with.

MR GRAY: Thank you. I just want to conclude by asking you about that information sharing system, and could you please explain to the Commissioners the attributes of the Territory's own community information or - I beg your pardon - community care information system, CCIS, and whether you have any remarks to make about the efficacy of that system in providing a platform for health care and community care related information to be universally available, albeit within the Territory.

MS McKAY: Yes. So we do have currently a Territory-wide information primary care information system for – for those services where we are the provider. So what that means is that the – the data held in that system is accessible to all of our primary care services. So if individuals move from community to community, their health care record can be accessed across the board. We'll have one doctor who is on call 24/7. They're able to dial up the health record of anybody who is in those remote communities or the urban community primary health care services that we operate. So that's – that's great.

But the Territory is moving and is in the process of implementing an integrated health record that will go right across our service provision, so not just primary care, but also hospital care. One aspect of that that we're exploring or beginning to explore now is access for other providers concerning that admission. It's important to note that it's not just a repository - or the – the new one, I should say, isn't just intended to be a repository of information. So it's not – it's not quite like at the moment you might upload a document to My Health Record, for example. It's also the - it will be the system that clinicians are actually putting information into real time when you're in hospital.

So all of that will be encapsulated in an integrated health system. It's a five-year program of work that we're approaching the sort of second and third year of doing, and most of that has been around design to this stage. The first hospital and health clinics are intended to go live next year.

MR GRAY: And I think a minute ago you might have said this, but is it accepted that it will be available for other providers to link in, not just Territory owned and operated providers?

MS McKAY: Yes, so it's one of the things we're exploring now. As I touched on earlier, issues around the Privacy Act and who – who has a right to that information

and who doesn't, who should be able to see it and who can't. These are things to be worked through. But – but that is what we are – we are currently working through.

MR GRAY: Commissioners, those are the questions I have for Ms McKay.

COMMISSIONER TRACEY: Thank you, Mr Gray. Ms McKay, you've heard the evidence today from a number of witnesses about the importance which elderly Aboriginal people place on being on country for as long as possible and the difficulties associated with the fact that when they get to the point where they do need institutional care, they have to travel enormous distances, generally off country, to obtain those services. Does the department have any plans for expanding the number of residential care facilities beyond the major centres where they're available at the moment?

MS McKAY: So it is, of course, important to note it's the Commonwealth Government, not the Territory, that has responsibility for aged care provision. What we would say is that the - the NATSIFlex program is a really good mechanism for the Territory. It enables communities to have residential aged care for their community at a bed number far fewer than what is required to actually run a viable residential aged care service. So I think we heard mention today of the residential aged care facilities in the Territory largely through the discussion around the numbers of Aboriginal clients in those services. And the - the viable ones are running at, sort of, 80 to 100 beds.

Many of the remote communities, of course, do not have a population that would be able to support 80 to 100 beds, so the - the NATSIFlex program is a really good option for those communities. The Territory Government doesn't - isn't financially funding those. We don't do that; the Commonwealth Government do. But I think we see it as an effective mechanism for the provision of support. We certainly recognise and would share - you know, we heard some powerful testimony earlier about the - the issues of older people coming off country for residential aged care and the real difficulty and impacts of that. We would completely endorse that view. And so - so that would be my comments.

COMMISSIONER TRACEY: And is that an approach you have urged upon your Commonwealth colleagues?

MS McKAY: Yes. You know, there are a number of remote communities that have this model and run very effective facilities and services for those communities. I think the point made earlier about the fact that some of our bigger communities don't have it is probably a point well made. But I think it would be – it is really coming to the only way that we can keep Elders on country who need that level of care, who really need a residential option.

MR GRAY: Commissioner, if I may?

COMMISSIONER TRACEY: Yes, of course. Anything arising?

MR GRAY: Yes. Thank you, Commissioner.

COMMISSIONER TRACEY: Yes, please.

MR GRAY: Ms McKay, just with reference to what you've said in answer to Commissioner Tracey's question and also with reference to what you said earlier about the Northern Territory only providing – that is the Northern Territory Department of Health through the health services – only providing ACAT services and equipment, whether that's through the health services or from the department or some other form.

MS McKAY: Sure.

MR GRAY: Outside ACAT services and equipment, the Northern Territory government is not currently providing any Commonwealth funded aged care services; is that right?

MS McKAY: That's right. The Northern Territory government is not an approved provider of aged care services.

MR GRAY: Has the Northern Territory government any intention, to the best of your knowledge, of entering that space and becoming an approved provider of aged care services?

MS McKAY: Not at this time to my knowledge.

MR GRAY: To the best of your knowledge has the Northern Territory government advocated to the Commonwealth Government for either the granting of funds to others to support capital investment for the construction of residential aged care facilities in other communities or for increases in NATSIFlex funding for that, for a similar purpose albeit not for the erection of residential aged care facilities in formal terms.

MS McKAY: I don't know that they have very specifically. I do know, though, that the Northern Territory government has raised the issues that we have talked about here in terms of access to residential aged care packages, home care pages, etcetera, and is keen to continue to work with Commonwealth colleagues on how – how that might be addressed.

MR GRAY: Commissioner, the staff of the Commission may take that up administratively in order to determine what those communications have been.

COMMISSIONER TRACEY: Thank you, Mr Gray. Ms McKay, thank you very much for your very helpful evidence. We greatly appreciate the time you have taken away from your no doubt very busy duties to come and enlighten us about how things work up here in the Top End. Thank you very much.

MS McKAY: Thank you.

COMMISSIONER TRACEY: 10 o'clock?

MR GRAY: Yes. Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until 10 am tomorrow morning.

<THE WITNESS WITHDREW [4.22 pm]

MATTER ADJOURNED at 4.23 pm UNTIL TUESDAY, 9 JULY 2019

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