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TRANSCRIPT OF PROCEEDINGS

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

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

CANBERRA

10.02 AM, MONDAY, 9 DECEMBER 2019

Continued from 15.11.19

DAY 69

MR P.R.D. GRAY QC, counsel assisting, appears with MR R. KNOWLES SC and MS B. HUTCHINS
MS A MITCHELMORE SC appears with MR B. DIGHTON for the Commonwealth of Australia

COMMISSIONER PAGONE: We would like to start by acknowledging the traditional custodians of the land on which we meet today, the Ngunnawal people. We should also like to pay our respects to their elders, past, present and emerging and extend that respect to other Aboriginal and Torres Strait Island people who are present. Mr Gray.

MR GRAY: Thank you, Commissioners. I appear with Mr Knowles SC and Ms Hutchins. I too would like to begin by acknowledging the traditional custodians of the land on which we meet, the Ngunnawal and the Ngambri people, and I pay my respects to their elders, past present and emerging. I would like to extend that respect to all Aboriginal and Torres Strait Islander people present here today. The theme of this hearing is the interface between the health care system and the aged care system with a particular focus on residential aged care. The funding, management and delivery of health care services all differ markedly from the equivalent aspects of aged care, yet health care is vital to safe and high quality aged care.

All people receiving aged care should have access to health care services commensurate with their needs on an equitable basis with the access to health care enjoyed by other Australians. This applies to all tiers of health care, including primary health care, care delivered by specialists and acute care of the kind delivered in hospital settings. As I will outline shortly the evidence is clear that this is not happening. Access to health service is perhaps best described as a patchwork quilt, where the pieces don't join particularly well. In some areas with an active primary health network or local hospital network, older people in aged care receive excellent services. In other areas, access is much more limited.

This week, we will explore ways in which these instances of good practices can be systematised so that all Australians in aged care are provided with the health care they need and are entitled to receive. On Friday, 6 December 2019 the Royal Commission published consultation paper one, Program Design in Aged Care. Depending on the conclusions ultimately reached on the matters raised in that paper, Commissioners, certain aspects of the system interfaces addressed in this hearing may have to be revisited but the fundamentals of what we intend to cover in this hearing will remain relevant.

The focus on interfaces touches on many of the Royal Commission's terms of reference, including those related to the quality and safety of care provided in aged care and what the Australian government and aged care providers can do to strengthen the system. Paragraph (L) of the terms of reference also directs you to have regard to:

> *The interface with other services accessed by people receiving aged care services including primary health care services, acute care and disability services, and relevant regulatory systems. This should take into account how people transition from other care environments or between aged care settings.*

Throughout the last year the Royal Commission has explored some aspects of this term of reference, for example, in Melbourne hearing one, the Royal Commission looked into the interface of the aged care and disability sectors in the context of younger people with disabilities in residential aged care. In Melbourne hearing two, the interface between the Department of Veterans Affairs and aged care was examined. In Mudgee, the Royal Commission considered multipurpose services which are located in State hospitals. People receiving aged care services are highly likely to have poor health. People's health generally deteriorates with age and the subset of the population assessed as requiring aged care services because of their frailty or difficulty in managing the activities of daily living is likely to have worse health than the aged population generally.

As a result, people receiving aged care will have chronic and complex health care needs, quite often. It's thus important that the interface between the aged care and health systems works well to ensure the health needs of aged care recipients are met. The evidence is clear that while Australia prides itself on having a universal health care scheme aged care recipients are often denied practical access to this health care. At the Sydney hearing, Professor Joseph Ibrahim discussing residential aged care residents outlined his view of the underlying problem in the terms that follow:

> *It's the truth that residents are stateless. They're citizens of the state but the State doesn't provide care because the Federal Government is supposed to. The Federal Government doesn't provide care because the States are supposed to. The provider has no responsibility over the clinicians. The clinicians who provide the care have no obligation to the provider.*

Commissioners, this is not a new problem. Multiple previous reports and inquiries have raised concerns about the interface between aged care and health care. As recently as last year, the aged care workforce strategy task force chaired by Professor John Pollaers included in its report a strategic action to strengthen the interface between aged care and primary/acute care. Four witnesses representing government health agencies in this hearing in Queensland, New South Wales, Victoria and South Australia in their statements have agreed that access to at least some health services by aged care recipients is inadequate. The public, too, are concerned about the poor care older people receive as a result of perceived inadequacies at the interface between the aged care and health care systems.

As at 2 December 2019, more than 500 public submissions to the Royal Commission raised issues related to the interface between aged care and health care. The staff of the Royal Commission have analysed these submissions and they raise concerns about access to primary health care services, specialist services, allied health care, State and Territory funded rehabilitation and restorative care and palliative care services, as well as transitions between hospitals and aged care. You will hear from people who made submissions to the Royal Commission about the interface between aged care and health care during this hearing. Aged care providers also agree that there are significant issues related to the interface between the aged care and health care systems.

Just over 500 providers responded to the Royal Commission's provider survey questions regarding the difficulties faced in accessing health care for care recipients. Analysis of the responses to this survey shows providers regularly identify problems caused by, first, a lack of access to health services including GPs, specialists, in-reach clinical support and telehealth. Next, poor service integration, information sharing, record keeping and communication processes between various professionals, including GPs, residential aged care providers, registered nurses, hospitals and ambulance services. And, finally, poor hospital transfer discharge practices and follow-up care.

The staff of the Royal Commission have undertaken an analysis of Commonwealth, State and Territory health data to attempt to understand the extent of the interface problem in quantitative terms. I must caution that this data is indicative only and I will return to that qualification shortly but there are some startling results. Firstly, in 2016 to 2017, the financial year 2016/17, I should say, almost 70 per cent of permanent aged care residents did not see a medical specialist outside hospital settings. This is much worse than the comparative figure in the community. About 40 per cent of similarly aged people living in the community did not see a medical specialist in that financial year. Also, those residents who did receive at least one specialist service received fewer such services than people in the community.

Next, eight per cent of permanent resident did not see a general practitioner in that financial year compared with two per cent of home care recipients that didn't see a GP that that financial year. Next, 46 per cent of GPs are not delivering any services to aged care residents which suggests that when an older person transitions from community living into residential aged care they're nearly as likely to have to change their general practitioner as they are to keep the same one. For people in residential care who receive at least one GP service they are likely to receive roughly double the number of services compared with a person in the community who receives at least one service. In both the 75 to 84 year old age group and the 85 and above age group, that figure holds true.

However, one of the limitations of any analysis of service delivery is, in spite of those figures I've just quoted there's no unambiguous measure of the need for the services represented by those figures so while aged care residents who are seen by a GP receive a higher number of services of people of the same age living in the community we do not know whether this level of access is commensurate with their need. There's evidence that people have very high degrees of frailty when entering permanent residential aged care, suggesting that the need for primary health services in residential aged care is significantly greater than it is in the community. There's also evidence that the average level of frailty on admission significantly increased between 1998 and 2016.

Over five years to financial year 2017/18 the increase in the number of residents with high needs in the ACFI complex health care domain exceeded the increase in general practitioner services for aged care residents. This leaves us with no confidence that the data demonstrating higher numbers of GP visits for those people who receive at

least one service in residential care demonstrates sufficient access to those GPs for those people in residential aged care. When it comes to access to specialists the data is far clearer and it paints a picture of very poor access. The fact that in 2016/17 only 32 per cent of aged care residents saw a specialist outside a hospital setting is of enormous concern. Remember, that these people are the most vulnerable in the aged care system and have the most complex chronic conditions. That's why they need residential care.

However, they are less than half as likely to have seen a specialist as a person who's on a home care package; in the same year 74 per cent on a home care package saw a specialist. And they're nearly half as likely to have seen a specialist as similarly aged people in the general community of whom 58 per cent had seen a specialist. The secretary of the Commonwealth Department of Health has said in her statement that:

> *The data would tend to suggest there may be an issue with access.*

We agree and put it more strongly. There is very poor access to specialists and this needs urgent attention. Professor Len Gray, who we will hear from later in the week, states that:

> *There should be an expectation that residents have access to an array of specialists comparable to the level of access that they would enjoy if they were community dwellers able to travel.*

This expectation is reasonable and needs to be met. We will also hear later in the week from Professor Leon Flicker who will explain that in order to design a system that meets the health care needs of people in aged care we need to know what their needs are and what appropriate benchmarks of service provision should be. There needs to be far better data collection in the States and Territories, a requirement that may inform the recommendations you make in the final report, Commissioners. During this hearing our focus will be on potential solutions. And we will be testing propositions that may in due course help to inform the recommendations you might consider making in the final report.

Those propositions include mechanisms and processes directed to improving the effectiveness and consistency of the interface between the aged care and health systems. We will be addressing five main themes going to systemic issues at this interface and testing a number of propositions relevant to each theme. The five themes are, first, improving access to and integration with primary health care services particularly, general practitioners, nurse practitioners and primary care nurses. Secondly, improving access to and integration with secondary and tertiary or subacute and acute health care services. This theme will pay particular attention to specialists such as geriatricians, psychogeriatricians, palliative care specialists and rehabilitation specialists. We will not consider mental health services in this hearing but this important topic will be considered separately next year.

The third theme, and perhaps related to the second theme, but worthy of its own particular focus, is improving access to and integration with palliative care services. The fourth theme is improving the transfer of older people in residential aged care to and from hospital, including ambulance transfer, and appropriate rehabilitation and transition care. The last theme is improving key mechanisms and processes needed for an integrated and coordinated interface between the aged care and health care systems and that includes data. Some of the propositions we raise will require intergovernmental cooperation. Where access to secondary health care services is concerned, joint action between the Australian Government and State and Territory Government assist required.

Other propositions are within the remit of the Australian Government alone, for example, it is the Australian Government that can take action to reform how primary care for aged care recipients is funded, and it is the Australian Government that can clarify the responsibilities of aged care providers for the delivery of health care services. I will now address the question of access to secondary health care services in a little more detail. Our principal thesis is that all people in residential aged care should have access to State and Territory local hospital network and outreach services. These services, we suggest, should reach into residential aged care facilities or people's homes and provide services in situ wherever possible.

We've heard on numerous occasions that hospitals are distressing for older people, particularly for those with dementia and that they are particularly at risk of iatrogenic harm. In addition, the degree of frailty of many people in residential aged care means that taking them to hospital is a difficult and a costly task. Our proposition is that recurrent funding should be provided for the system-wide implementation of multidisciplinary outreach health services for people with high needs in aged care. This these would include 24/7 advice and triage services, and teams of registered nurses and nurse practitioners and others specialising in acute care level with access to a core team of specialists.

This proposition is consistent with recommendation 9.5 of the 2011 Productivity Commission report Caring For Older Australians. In the years since 2011 there have been hopeful developments along these lines in some jurisdictions and within some local hospital networks but nothing that is specifically funded by the Australian Government to be implemented on a system-wide basis across the country. There is now a framework for intergovernmental agreement to be reached on such a program. The joint funding mechanism used in the National Health Reform Agreement could be used to cover these services and to determine the relative contributions of the Australian Government on the one hand and the relevant State or Territory on the other.

Some points of terminology here. Under the National Health Reform Agreement the States and Territories undertook to establish local hospital networks or LHNs. These are geographically based groups of State-managed public hospitals. In some States they're called local health districts, local health networks, hospital and health services, or health services. These entities are to be distinguished from two other

geographical units which are relevant to health care and to aged care, both of which are generally larger and both of which are the responsibility of the Australian Government. The geographical unit of most relevance to aged care planning is the aged care planning region of which there are 73 across the country.

The geographical unit relevant to planning of primary health care delivery is the primary health network. There are 31 of these across the country and many encompass more than one LHN. In some states there's an alignment of boundaries between the State-managed hospital areas and districts and the primary health areas, but not always. The boundaries of aged care planning regions are different again. In previous hearings, the Royal Commission has heard of examples of local hospital network run outreach hospital care services intended to improve the health care available to aged care recipients while keeping them out of hospital where possible. As best we can tell from the available evidence, whether or not services of this kind are established in a particular place is presently a decision for each particular local hospital network, depending on resources, and appears to depend on leadership by individual health care workers to advocate for and implement such services and the availability of ad hoc funding. As a result, the degree of access to publicly funded secondary health care for older persons receiving aged care across Australia is largely determined by whether they reside in a local hospital network area which happens to provide such a service. We will be propounding that these services should be expanded nationally to guarantee governing and consistency. This will require regular and reliable funding which, as I have indicated earlier, could be achieved by expanding the national heads reform agreement to include aged care outreach services as an additional activity stream.

We will also propose that any future funding agreement should contain an explicit acknowledgement by the States and Territories of the rights of aged care recipients to access all State and Territory funded health care services. In future, aged care outreach services should be structured to focus on the needs of people in aged care. One of the issues is whether or to what extent such outreach services as already exist as are provided by local hospital networks are designed around the goal of achieving savings through supposed reductions in hospitalisations or reduced length of stay in hospital. To what extent should outreach services be designed to react to crises rather than proactively address health needs and improve the quality of care in aged care per se.

The Royal Commission has also heard of the importance of multidisciplinary care for the complex and interrelated health problems frail residents are likely to have. These outreach teams need access to the expertise of a range of health professions which are usually all found in a local hospital network, such as nurse practitioners, registered nurses, palliative care experts, physiotherapists and occupational therapists. They also need to be able to engage primary health practitioners who are responsible for the ongoing care of residents. This leads me to our second major thesis which is that the system of funding primary care for aged care recipients through fee for service under the Medicare Benefits Schedule or MBS needs reform. While many general practitioners are providing excellent care under this regime and

some specialist are emerging, fee for service does not encourage holistic care or continuity of care.

During the hearing will we test propositions for implementing blended payment arrangements, under which a general practitioner enrolling an aged care recipient would receive, for example, an annual payment based on the recipient's health needs, fee for service payments for complex or after-hours attendances and performance payments based on factors such as immunisation rates or diabetes management plan. Our final major thesis is that the role of aged care providers needs to be expanded and clarified to support people to receive the health care they need and to ensure there are no gaps in responsibility for providing that care. To this end, in one of our propositions we suggest that individual care recipients should have a care coordinator with the skills and training to ensure that the health care needs of individual older people are identified and addressed. We will test whether this role should be undertaken by the care provider organisation or whether it should be filled by independent services.

Finally, we advance a proposition that the subordinate legislation which sets out the care and services that should or may be provided by aged care providers needs clarification. It's not clear what "obligations to provide assistance" – that's a quote - in obtaining health practitioner services or access to specialised services or rehabilitation services means in practice. I turn now to the place where we're holding this hearing. We meet here today in Canberra in the Australian Capital Territory. The Australian Capital Territory is about 2,300 square kilometres in size. It does not have any outer regional or remote or very remote areas and most people live in the city of Canberra. Across the Territory there are 25 residential aged care facilities which provide services to people occupying 2585 allocated places. The occupancy rate of these facilities is 91 per cent. In addition there are 67 home support outlets and 44 home care providers. There's also one transition care service which provides 58 restorative care places and two short term restorative care services which provide 20 restorative care services – I should say 20 restorative care places.

Commissioners, I turn now to the witnesses. We will hear from three groups of witnesses in this haring. We will hearing from a number of family members of aged care residents who will describe the experiences of residents in accessing health care or in transitioning between the health and aged care systems. We will also hear evidence from a number of health care providers and academics and a group of aged care facility managers. We will be asking the health care providers about their experiences in delivering care, and then turning to the factors that affect their service delivery models. We will be asking how negative factors can be addressed and whether changes to the policy environment would enhance their ability to deliver appropriate and timely care.

We will be asking two distinguished academics, Professors Len Gray and Leon Flicker, for their perspectives on the shortfalls in the current system and how these might be addressed, and we will be asking facility managers about their experiences in arranging health care for residents, the problems they face and the impacts of

possible solutions. On Thursday and Friday we will be calling witnesses representing the State and Territory health departments as well as the Commonwealth Department of Health. We will be asking them for their views on possible solutions. Operator, please display the general tender bundle index. Commissioners, I tender the Canberra hearing general tender bundle in accordance with the index that's now being displayed. It consists of 67 documents listed in the index.

COMMISSIONER PAGONE: The General Tender Bundle will be exhibit 14-1.

EXHIBIT #14-1 CANBERRA HEARING GENERAL TENDER BUNDLE

MR GRAY: Thank you, Commissioner. Mr Knowles will now address you about a witness statement we seek to tender without calling its author, Associate Professor Jason Bendall, and after doing so, Mr Knowles will call our first witness.

COMMISSIONER PAGONE: Yes, Mr Knowles.

MR KNOWLES: Morning, Commissioners. As Mr Gray has indicated, before calling the first witness we seek to tender a statement of Associate Professor Jason Bendall who is presently overseas and unable to attend the hearing this week. His statement is dated 4 December 2019 and it bears the document identification number of WIT.1300.0001.0001. Professor Bendall has extensive experience in paramedicine. He worked for New South Wales Ambulance Service from 1995 until 2012, much of that time as an active paramedic. Since 2016 we understand he has been a director and commissioner of St John Ambulance New South Wales. In his statement Professor Bendall describes the role of paramedics at the interface between the aged care and health systems. Among other things he refers to the extended care paramedic programs which provide additional training to paramedics to assess and manage less acute conditions with a view to avoiding unnecessary hospitalisations. Having regard to the nature of the evidence that he gives, we do seek to tender the statement of Associate Professor Jason Bendall dated 4 December 2019.

COMMISSIONER PAGONE: Yes, Mr Knowles. As a matter of process, was the professor the subject of a notice to give evidence?

MR KNOWLES: I will need to seek some instructions in relation to that, Commissioner.

COMMISSIONER PAGONE: Well, you might need to seek instructions about that and also if he needs to be excused from the onerous compulsion to attend to give evidence, including whether there needs to be filed something that will justify the excusal. So make those inquiries, please.

MR KNOWLES: Yes, I understand that in the case of Professor Bendall, he's only been served with a notice to produce and the notice to produce only extended to the statement which has actually been given to the Royal Commission.

COMMISSIONER PAGONE: Thank you.

MR KNOWLES: So there is nothing beyond the requirement vis-à-vis his statement that presently stands.

COMMISSIONER PAGONE: All right. Well, the statement of Professor Bendall will be exhibit 14-2.

EXHIBIT #14-2 STATEMENT OF JASON BENDALL DATED 04/12/2019

MR KNOWLES: Thank you, Commissioner. I now turn to the first witness and that is Ms Rhonda McIntosh. She'll give evidence to the Royal Commission about difficulties experienced by her father, Mr Allan Sheldon, in accessing proper medical care as a resident in a aged care facility. She will refer specifically to two incidents, one in which he had a heart attack at the facility and another when, due to his diabetes, he experienced a hyperglycaemic attack at the facility. I now call Ms Rhonda McIntosh.

COMMISSIONER PAGONE: Yes. Thank you.

<RHONDA FAYE McINTOSH, AFFIRMED [10.32 am]

<EXAMINATION BY MR KNOWLES

MR KNOWLES: Ms McIntosh, can you tell the Royal Commission your full name.

MS R.F. McINTOSH: My name is Rhonda Faye McIntosh.

MR KNOWLES: And you've prepared a statement dated 29 November 2019 for the Royal Commission.

MS McINTOSH: I have.

MR KNOWLES: Yes, and that bears, you will see on its front page as displayed with the screen before you, the document identification number WIT.1307.0001.0001.

MS McINTOSH: Yes.

MR KNOWLES: Now, can I ask you, have you read your statement lately.

MS McINTOSH: I have.

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

MS McINTOSH: There is at point 46 in the last sentence.

MR KNOWLES: Yes. Point – sorry, point - - -

MS McINTOSH: It should read - - -

MR KNOWLES: Sorry, point did you say point 46; is that - - -

MS McINTOSH: 46.

MR KNOWLES: Yes, thank you.

MS McINTOSH: In the last sentence instead of "but I" it should say "was", "But was overheard", and then the word "her" should be removed.

MR KNOWLES: And can you just tell the Commission was overheard by whom?

MS McINTOSH: That was my daughter, Jordan.

MR KNOWLES: And did she then relay that to you.

MS McINTOSH: Yes, straight after.

MR KNOWLES: Yes. Now, subject to that change to paragraph 46 in the last sentence, are there any other changes that you wish to make to your statement?

MS McINTOSH: No.

MR KNOWLES: And are the contents of your statement subject to that change otherwise true to the best of your knowledge and belief?

MS McINTOSH: Yes.

MR KNOWLES: Yes. I seek to tender the statement of Ms Rhonda McIntosh dated 29 November 2019 subject obviously to that change.

COMMISSIONER PAGONE: Yes, the statement of Ms McIntosh will be exhibit 14-3.

EXHIBIT #14-3 STATEMENT OF RHONDA MCINTOSH DATED 29/11/2019

MR KNOWLES: Thank you, Commissioner.

Now, Ms McIntosh, your father is a resident at an aged care facility in a suburb of Melbourne.

MS McINTOSH: Correct.

MR KNOWLES: Yes, and you provided some pictures of him to the Royal Commission which we'll now display on the screen before you. Can you, starting with the picture on the left, just say who is in that picture and when it was taken.

MS McINTOSH: That's myself and my parents, Allan and Lynette Sheldon, and that would have been taken in about 1968.

MR KNOWLES: Yes.

MS McINTOSH: Possibly in Rosebud, which is a suburb in Victoria.

MR KNOWLES: And in terms of the photograph on the right, that's also a picture of your father. When was that taken?

MS McINTOSH: That was taken last Sunday.

MR KNOWLES: All right. Thank you. Now, can you tell the Royal Commission a little bit about your father.

MS McINTOSH: Dad's 83 years - - -

MR KNOWLES: How old is he?

MS McINTOSH: 83.

MR KNOWLES: Yes.

MS McINTOSH: And he lives in an aged care facility. He was an engineer all his life for the same company, at one stage for about 40 years. He's been married with my Mum - they're still married - for 59-odd years. He was active when he was younger but, you know, he played lawn bowls and when he was younger again he raced a pushbike and things, played squash, things like that, but he's quite – he's quite, sort of, sedentary now.

MR KNOWLES: Yes. And in that regard, what history does he have in terms of health conditions?

MS McINTOSH: Before he entered aged care he did have some health concerns, he had a heart attack some 25 years ago. He also had diabetes and an incidence with some prostate cancer but that was successfully treated.

MR KNOWLES: Yes. And he moved into an aged care facility in 2017; is that right?

MS McINTOSH: Yes. That's right, yes.

MR KNOWLES: And why did that come to pass?

MS McINTOSH: Mum wasn't coping with him at home. She was caring for him and it became too difficult for her to continue to care for him. His care needs just exceeded what she could provide and she was becoming very tired and more and more frail herself and we just – we couldn't allow it to continue. She was becoming quite unwell and Dad wasn't getting the care that he needed either.

MR KNOWLES: What care did he need at that time in 2017 that he was unable to get at home?

MS McINTOSH: He'd become incontinent by that stage and Mum couldn't manage that. She also had trouble managing his medications on time and getting those to him and that type of thing. Showering him as well became difficult.

MR KNOWLES: Yes. And so he ended up moving into a residential aged care facility in May, was it, of 2017?

MS McINTOSH: Yes. Yes, it was, yes.

MR KNOWLES: How was that facility chosen?

MS McINTOSH: That was chosen – it wasn't his first choice.

MR KNOWLES: Yes.

MS McINTOSH: In fact, it ended up being my choice because his choice, we put him on the waiting list there and he just stayed on the waiting list. We never got a call; we never got him into that facility, so we had to search further afield and get him into a facility that had available space for him at that time.

MR KNOWLES: And once he was in the residential aged care facility, would you visit him and do you still visit him and how often?

MS McINTOSH: Weekly, myself, but he's also visited by both my adult children. My Mum still visits him, my husband visits him, other family members as well. So yeah, he does have quite a lot of visitors in, where he lives now, yes.

MR KNOWLES: When he first moved in the new to residential aged care who was his general practitioner?

MS McINTOSH: When he first moved in the new - - -

MR KNOWLES: Yes, when he first moved into residential aged care. Was he - - -

MS McINTOSH: It was the GP that was assigned to the facility, so - - -

MR KNOWLES: How was that choice made to use that general practitioner?

MS McINTOSH: We didn't make a choice as such. He went into the facility and we were told that the GP visits on a Thursday, I think it was, at that stage. We were told the GP's name and that he came on a Thursday and visited a number of residents at the same time.

MR KNOWLES: Was the GP able to visit at other times after-hours or - - -

MS McINTOSH: Not that I'm aware of, no. At other times they would call a locum.

MR KNOWLES: Yes.

MS McINTOSH: There was some sort of service that they would call and then they would try and get the locum to attend if it was after-hours or even on a day other than when the standard GP came.

MR KNOWLES: That is the Thursday that you referred to on a weekly basis?

MS McINTOSH: Yes.

MR KNOWLES: And were you satisfied with the facility's GP?

MS McINTOSH: No.

MR KNOWLES: Why not?

MS McINTOSH: Sometimes something would happen like Dad had a rash or at one stage he had a little growth on the back of his hand and I'd say to him, you know, "What does the GP say about the rash or the condition?" And he would say, "Oh, I haven't seen the GP." So I'd ask for him to be put on the list to see the GP for the following Thursday and then I'd follow-up with Dad and say, "What did the GP say about your rash?" And he'd say, "Oh, I still didn't see him." And sometimes he'd say he stuck his head in the door and said, "How you going? You're okay. You're good." And, you know, Dad said he didn't even come into the room sometimes; he just saw him from the car doorway. Whether or not that was a consultation or just a

hello, I'm not sure. But, you know, often he wouldn't see the GP and I'd have to keep following up.

MR KNOWLES: You decided to change your father's GP eventually; is that right?

MS McINTOSH: Yes, because we weren't satisfied, so - - -

MR KNOWLES: And when was that?

MS McINTOSH: That was in 2017, I think.

MR KNOWLES: Did you tell any – I think – did you tell any of the staff at the residential - - -

MS McINTOSH: I did, I - - -

MR KNOWLES: - - - aged care facility of your intention to change GPs?

MS McINTOSH: Yes. Yes, I mentioned to one of the staff that I wasn't happy and I was going to change GP and she said, "Oh, I don't blame you." She was not surprised at all and I was - - -

MR KNOWLES: Did she elaborate on why she said that?

MS McINTOSH: No, not really and I was, sort of, taken aback by it. And I thought, well, you know, if everybody knows that - that, you know, it's not a good sort of service, I wish she had told me before and I didn't have to come to that realisation by myself but - - -

MR KNOWLES: How did you regard, just in general terms, your father's access to GPs in residential aged care at that first facility?

MS McINTOSH: It was poor.

MR KNOWLES: And why do you say that?

MS McINTOSH: Because it shouldn't be a once a week thing, you know. You should be able to access a GP when you're sick or when you're – you need to or when you feel that you want to, not wait for, you know, a day into the future and then even when you put your name down on the list to be seen by the GP for that not always to happen and then have to wait for the following week till the GP returns on the next scheduled visit. So that's why we ultimately changed GPs.

MR KNOWLES: And what about specialists? Did your father need to see specialists while he was in residential aged care?

MS McINTOSH: He did see a dermatologist at one stage and a referral to the dermatologist was left for me at reception for my next visit, and I was given that – that referral and told that I needed to follow that up and make an appointment and make sure that Dad got to that specialist.

MR KNOWLES: So that was something that was left to you. Was there any assistance provided - - -

MS McINTOSH: No.

MR KNOWLES: - - - by the people at the residential aged care facility with that?

MS McINTOSH: No, no. That was up to us, the family to make appointments and get Dad to and from the visit, wherever it would be, and organise that ourselves.

MR KNOWLES: What about dental care, in terms of the access that your father had to dental care at the time?

MS McINTOSH: He didn't really have access to dental care. I remember an incidence where the facility rang me and said that Dad - in the morning the care staff had noticed that he had some blood in his mouth and somebody looked in his mouth and saw that he had a decayed tooth, and they suggested to me that I needed to take him to a dentist, which I subsequently did. I asked them, what would happen if I was unable to take him? And they said that in the past they had volunteers that used to do that but they don't do that anymore. So it was up to me to take him to the dentist which was difficult because at that time he was in a wheelchair, so we had to call a disabled taxi to get him there. And I'd never pushed a wheelchair before. Well, actually I have one other time but only in the context of caring for Dad and it's more difficult than you may think.

MR KNOWLES: Now, can I turn to events that occurred at the facility earlier this year. You've said in your statement that you had a conversation with your son - - -

MS McINTOSH: Yes.

MR KNOWLES: - - - on 8 January this year about his visit to see your father that day.

MS McINTOSH: Yes.

MR KNOWLES: What did your son tell you at that time?

MS McINTOSH: That Dad was having chest pains, that he'd felt like he was having a heart attack and that he'd been telling the nurses and the care staff that he felt that he was having a heart attack.

MR KNOWLES: And did your son tell you that he had spoken with staff at the residential aged care facility about that?

MS McINTOSH: Yes, so Nick - Nick was alarmed and he went and saw the staff and they assured him that Dad was fine and that there was nothing to worry about.

MR KNOWLES: And I take it from that response that, so far as he was aware and you were aware, at that time no doctor or ambulance was called.

MS McINTOSH: No. No doctor or ambulance was called and this went on for some time.

MR KNOWLES: Yes. Well, you say that your mother visited on 10 January, two days later.

MS McINTOSH: Yes. Yes.

MR KNOWLES: And she spoke with you about that visit on that day.

MS McINTOSH: Yes.

MR KNOWLES: What did she tell you?

MS McINTOSH: He was still having chest pains on that day and he said he'd been having them pretty much consistently for two days or so by that time. And Mum reported it to me and I was alarmed, and then I subsequently made an appointment to go down to the facility to see the manager.

MR KNOWLES: Yes. And when did that appointment occur?

MS McINTOSH: I went down to see the manager on the 11 January.

MR KNOWLES: So that's the next day after the conversation with your mother.

MS McINTOSH: Yes. I went to see Dad before the meeting.

MR KNOWLES: Yes, and what did he say to you when you saw him.

MS McINTOSH: He said, "I'm - I'm having a heart attack." He said, "I'm having chest pains. I'm telling everybody who" - I said, "Who are you telling, Dad? Are you telling the nurses?" He said, "I'm telling everybody. I'm telling everybody who will come in, everybody who will see - anybody I can tell, I'm telling them."

MR KNOWLES: You said earlier your father had previously had a heart attack - - -

MS McINTOSH: Yes.

MR KNOWLES: - - - some 25 years ago.

MS McINTOSH: Yes.

MR KNOWLES: Had he mentioned anything about that - - -

MS McINTOSH: Yes, he - - -

MR KNOWLES: - - - to the staff at the facility?

MS McINTOSH: Yes, he told the staff he knows what a heart attack feels like because he's had one before and he said it was the same feeling, so - - -

MR KNOWLES: What was the response that he told you he had received from staff in relation to his complaints about chest pains?

MS McINTOSH: They were assuring him that he was not having a heart attack and that he was anxious and paranoid. And they checked his blood pressure and they assured him that because his blood pressure was in his normal range then that means you can't be having a heart attack.

MR KNOWLES: What treatment had been proposed for your father at that time? Had anybody suggested that a doctor or ambulance ought to be called?

MS McINTOSH: Nobody suggested that. They gave him Panadol to help with the pain.

MR KNOWLES: Anything other than Panadol?

MS McINTOSH: No.

MR KNOWLES: So after speaking with your father you then went to speak with the facility manager; is that right?

MS McINTOSH: That's right.

MR KNOWLES: And was there anybody else with you when you spoke with the facility manager?

MS McINTOSH: Yes, Mum came with me at that stage because she was as concerned as the rest of us were.

MR KNOWLES: And do you remember what day of the week it was when you were having this meeting?

MS McINTOSH: Friday.

MR KNOWLES: It was a Friday. And what time of the day was it that you were speaking with the facility manager?

MS McINTOSH: It was around the middle of the day, I think.

MR KNOWLES: Yes, and what did you say to the facility manager at the meeting.

MS McINTOSH: I said that I was concerned that Dad was having a heart attack and that I wanted him to be seen by a doctor and I wanted him to be seen that day, because it had been dragging on by this stage and Dad had just, minutes earlier, told me he was still having chest pain. So I insisted that he be seen by a doctor that day.

MR KNOWLES: And what was the response that you received from the facility manager?

MS McINTOSH: She said that she was unaware that Dad was having any chest pain or any difficulties at all, and she left the meeting and she came back and she then admitted that other staff were aware that he had been reporting the chest pains, but that nothing had been done.

MR KNOWLES: And so you say you told her that you wanted - - -

MS McINTOSH: Yes.

MR KNOWLES: - - - your father to be seen by a GP.

MS McINTOSH: Yes.

MR KNOWLES: Did she agree to that?

MS McINTOSH: She did agree to that.

MR KNOWLES: What did she say that she or staff at the facility would do?

MS McINTOSH: She said they would ring a locum doctor and that once they had a time for that doctor to attend they would ring me back and let me know. So I had plans on attending that appointment. They rang me later and said that the locum wasn't coming.

MR KNOWLES: So were you given any reason why the doctor wasn't coming?

MS McINTOSH: No, they said that the doctor wasn't coming and because it was a Friday night the doctor couldn't come the next day either, and that if that was a problem I could arrange a doctor myself. It was 7 o'clock at night by this stage.

MR KNOWLES: And this is on a Friday night?

MS McINTOSH: Yes.

MR KNOWLES: What did you do?

MS McINTOSH: Well, I said, "Well, how is he now? How is he feeling right now?" And they said "Well, he's saying he's okay now. He doesn't have any chest pains right this minute". And I really didn't know what to do at that stage. So Mum said, Well, we'll go and check on him in the morning, see if the pains have come back and we'll take it from there." So that's what we subsequently did.

MR KNOWLES: And what happened the next morning?

MS McINTOSH: Mum went to visit him and he reported to her that he'd been having really bad pains all night. So she approached the staff and she said, "Something has to be done". And they said to Mum, "Well, look, we could call an ambulance but they probably won't come".

MR KNOWLES: Did you ask why they said that?

MS McINTOSH: I asked Mum why they said that, and she said, "I don't know". Mum was panicky by that stage. She – she couldn't get them – she felt she couldn't get them to call the ambulance because they'd said that they won't come. So then she rang me and said, "We have to do something".

MR KNOWLES: And what did you do?

MS McINTOSH: So then I sat down and rang many GP clinics in the town where we live to try and get him in immediately. You know, it's pretty hard to get a GP visit on the spot. I probably rang, I don't know, 10 maybe, different places. And finally I found a clinic that would see him straightaway. So I went to the facility and I took Dad myself to the GP clinic.

MR KNOWLES: Did they, at the facility, assist with his transfer in any way?

MS McINTOSH: No.

MR KNOWLES: Did they provide you with any clinical records relating to your father?

MS McINTOSH: I asked for the records. I said, "Can you give me the - photocopies or whatever of what you've been doing so that I've got something to take with me to the GP". And they did give me some photocopies of some clinical notes of the preceding few days where Dad had been complaining of pain and they'd given him Panadol. But they didn't give me a medication list or anything like that. It was nothing that was really helpful for the GP once we arrived.

MR KNOWLES: Yes. Now, once you did arrive at the GPs - - -

MS McINTOSH: Yes.

MR KNOWLES: - - - and I take it this was not a usual GP that your father had seen.

MS McINTOSH: No, he'd never been there before.

MR KNOWLES: Right. The GP conducted an electrocardiogram.

MS McINTOSH: Yes.

MR KNOWLES: And that detected that your father had suffered a heart attack.

MS McINTOSH: And was continuing to have a heart attack.

MR KNOWLES: What happened then?

MS McINTOSH: The GP immediately called the ambulance and the ambulance was there - I would say it was no more than six or seven minutes that the ambulance arrived, and they were there immediately. They did another test on him. They'd brought some equipment with them, and they did another test and they said, "Yes, we're off, we're going". So they loaded him in the ambulance but enroute they transferred him to a different ambulance to a MICA ambulance alongside of the highway, apparently. And then they took him - - -

MR KNOWLES: That's an intensive care ambulance; is that right?

MS McINTOSH: Mobile intensive care ambulance. Yes.

MR KNOWLES: And he was transferred into that ambulance and then taken to an emergency department of a nearby hospital.

MS McINTOSH: Yes, correct.

MR KNOWLES: Now, on presenting at the hospital, what was his diagnosis? How was his condition regarded by the doctors there?

MS McINTOSH: Well, he was having a heart attack still.

MR KNOWLES: Yes.

MS McINTOSH: And he was dehydrated.

MR KNOWLES: Yes.

MS McINTOSH: And they tested him and did blood tests and everything and they said that they needed to do a procedure to open up one of the arteries that was blocked and that was what was causing the pain, causing the heart attack, in fact, this

narrowing have an artery, that they had to then subsequently place a stent into to open it up and that was successful.

MR KNOWLES: Yes. How did you regard the care at this time that your father had received at the residential aged care facility?

MS McINTOSH: We were – we were appalled. We – we don't know why the – the nurses at the facility would say that if you call an ambulance they won't come. That's never been our experience and, in fact, the ambulance officers said, "You must always call an ambulance; we'll let you know if we need to come. We'll ask you questions on the phone, we'll make that decision and then we'll arrive and then we'll assess you and then we'll decide if you need to be transferred to hospital or not".

MR KNOWLES: Did anyone at the hospital comment on the care provided at the residential aged care facility in terms of the assessment of your father's condition?

MS McINTOSH: They did. I mentioned to them that Dad's blood pressure was normal throughout the episode and they – and that we'd been told that that meant that you weren't having a heart attack. And they said that doesn't mean you are not having a heart attack. You can have a heart attack with a normal blood pressure reading and, in fact, anybody with any, you know, relevant nursing experience should know that.

MR KNOWLES: How long was your father in hospital on this occasion?

MS McINTOSH: It was about three or four days, I think, at that stage, yes.

MR KNOWLES: And he was subsequently readmitted to hospital - - -

MS McINTOSH: He was.

MR KNOWLES: - - - after a couple more days - - -

MS McINTOSH: Yes.

MR KNOWLES: - - - of having returned to the residential aged care facility.

MS McINTOSH: Yes.

MR KNOWLES: Why was that?

MS McINTOSH: Because his blood – his heart beat rate dropped too low and it was dangerously low, so they – that time they called an ambulance and he was readmitted back to the same hospital, yes.

MR KNOWLES: How long was he in on that second occasion in the hospital?

MS McINTOSH: He was in a little bit longer that time and the doctor there said that they felt that he'd been discharged back to the nursing home too soon, and that there may have been a medication error at the nursing home because the medications, if they've been taken correctly, his heart rate shouldn't have dropped that low. And so they stabilised his medication again on that second visit - hospitalisation.

MR KNOWLES: And on being discharged on that second occasion, were you aware of what the discharge instructions from the hospital to staff at the residential aged care facility were?

MS McINTOSH: After the first one?

MR KNOWLES: Well, perhaps let's go back a step. After the first one were you aware of what instructions were given?

MS McINTOSH: Yes, they were told that if he's ever having any other sort of heart symptoms or pains or he's asking for an ambulance, that they're to call an ambulance.

MR KNOWLES: What about after the second occasion of his discharge?

MS McINTOSH: After the second occasion he went to a rehab facility.

MR KNOWLES: Yes.

MS McINTOSH: He was there for two weeks at the rehab facility.

MR KNOWLES: Now – and was he – were there instructions for his care upon discharge from the rehab facility to the residential aged care facility, that you can recall?

MS McINTOSH: Yes, because he'd had the heart attacks and he'd been mobile, he wasn't walking as well as he should be. He was quite infirm and he was having a lot of physio, and they wanted that to continue when he went back to the aged care home so that he could at least get back the movement that he had before he was hospitalised with the heart attack.

MR KNOWLES: And to your knowledge did that physiotherapy continue upon his return to the residential aged care facility?

MS McINTOSH: I think he was seen by a physio once, and he was given a pamphlet on some exercises, but I expected that he would have been seen more often than that, but he wasn't.

MR KNOWLES: Did you follow-up with about the residential aged care facility about the lack of ongoing physiotherapy?

MS McINTOSH: No, I don't recall.

MR KNOWLES: Now, when he returned to the facility you've said that the GP that was treating him there started to reduce his diabetes medication.

MS McINTOSH: Yes.

MR KNOWLES: Why was that?

MS McINTOSH: He was having a few side effects with it, or that they attributed to the diabetes medication. I don't believe that it was a diabetes medication but they started to reduce it to see if these and other problems that he was having was the side effect of the diabetes medications.

MR KNOWLES: And was the regularity with which his blood sugar levels were checked changed in some way?

MS McINTOSH: Yes, they went from testing it daily to testing it every three months which is a different type of test. It's more a baseline measurement, as I understand it, rather than the daily tests that they'd previously been doing. They said that that was sufficient now with the new medication regime that they'd put him on since they reduced it.

MR KNOWLES: Can I turn now to events in July of this year.

MS McINTOSH: Yes.

MR KNOWLES: Ms McIntosh, you've said in your statement that your father had a series of falls - - -

MS McINTOSH: Yes.

MR KNOWLES: - - - at the residential aged care facility at that time.

MS McINTOSH: Yes.

MR KNOWLES: Were you telephoned by staff at the facility after the first fall?

MS McINTOSH: Yes.

MR KNOWLES: What did they say to you that they would do?

MS McINTOSH: They said that they would – I asked them well, what's happened and they said, "Well, we'll call a GP if you like" and they did. But then they later told me that the GP couldn't come, couldn't attend.

MR KNOWLES: Did they explain why the GP - - -

MS McINTOSH: No, no.

MR KNOWLES: And you've said that you were also telephoned after your father had had a third fall within a week.

MS McINTOSH: Yes.

MR KNOWLES: What did you do after receiving that call from staff at the facility?

MS McINTOSH: I went directly to the facility.

MR KNOWLES: And when you got there, what state did you find your father in?

MS McINTOSH: Dad was in his room in his chair like he always was but he was completely incoherent. He was – he didn't know where he was, he was talking about things that weren't there. He was completely delirious.

MR KNOWLES: What was his physical presentation like?

MS McINTOSH: He was sitting in his chair, but I encouraged him to have a drink but he couldn't hold the cup. His hands were jerking wildly and the cup was – as he got it to his face, it was banging against his glasses and spilling down the front of him. He couldn't drink the water and he couldn't hold anything.

MR KNOWLES: What did you do then?

MS McINTOSH: I went directly to the manager's office and I went in and I said "Something's wrong with Dad. Have you seen him today?", you know.

MR KNOWLES: What did she say?

MS McINTOSH: She said he's fine, he's, you know, he's good, and she said, you know, you have to understand that when people are coming to the end of their life they start to become a little bit, you know, less coherent and, you know, these are things we have to accept and, you know, she assured me that this was a natural part of ageing and dying, I guess.

MR KNOWLES: Was she suggesting to you that your father was dying, is that what you're saying?

MS McINTOSH: I think that she was. I think that she was suggesting to me that this was a natural progression and that he was becoming more and more infirm and that it was natural, the way he was acting.

MR KNOWLES: What did you do in response to that?

MS McINTOSH: I didn't accept that and I went back to his room and I decided to call my daughter because she'd seen him most recently. She'd seen him a day or so before. And I called her and I told her what had happened and she said, "I'll be right there". So she came as well and she walked in. By that stage I was back in the room with Dad. She walked in and spoke to him and she said "No, he wasn't like this a day or so ago. Something has happened". In fact, I thought he'd had a stroke. That's what I thought. I thought he'd had a stroke. And my daughter said "No, this is not normal and we need to call an ambulance, we need to do something".

MR KNOWLES: And was that conveyed to the facility manager?

MS McINTOSH: So the facility manager was then asked to call an ambulance, and she was reluctant to do so. She continued to assure us that he was okay and that we didn't need her to call an ambulance. Eventually we convinced her to call an ambulance but she was overheard by my daughter saying on the phone to the ambulance that it was non-urgent.

MR KNOWLES: So after that call for an ambulance, how long was it before the ambulance arrived?

MS McINTOSH: It was about an hour and a half.

MR KNOWLES: And what happened when the ambulance paramedics arrived and saw your father?

MS McINTOSH: They walked in and they assessed him and very quickly they said to each other and to us that it looked like his blood sugar levels were too high, that he was hyperglycaemic because that would account for his jerking hand movements, his delirium and the fall that he'd had over the preceding week.

MR KNOWLES: And were attempts made to measure his blood sugar levels at the facility at that time?

MS McINTOSH: They asked the nurse who came in what his blood sugar was. They did a test and the machine that they used, it only goes to 30, that's the highest reading that it will take, and his – we didn't get an accurate reading because his reading was higher than that. So it was at least 30.

MR KNOWLES: And was his blood sugar level on that scale eventually measured at the hospital?

MS McINTOSH: Yes, it was 50.

MR KNOWLES: It was 50.

MS McINTOSH: Yes.

MR KNOWLES: Now, the paramedics, they decided to take your father to hospital.

MS McINTOSH: They did, yes.

MR KNOWLES: Yes. And what happened there?

MS McINTOSH: When he was admitted?

MR KNOWLES: Yes.

MS McINTOSH: Well, they tested his blood, they saw that it was at 50 and they gave him insulin to get it down because it can be fatal to have a blood sugar reading that high over a period of time, that can – that can result in death. So - - -

MR KNOWLES: Was your father dependent on insulin before this time?

MS McINTOSH: No.

MR KNOWLES: So although he had diabetes he hadn't been using insulin; is that correct?

MS McINTOSH: No, he'd been using medication to control it, tablets. But then he'd weaned off the tablets and that resulted in his very high reading, this hyperglycaemic condition, and then when he came out of hospital he was then on an insulin regimen.

MR KNOWLES: Did the hospital provide any directions in respect of the regularity with which his blood sugar levels needed to be tested at the facility?

MS McINTOSH: Yes. Yes, daily, and before dinner in the evening.

MR KNOWLES: Right. And did you and your family observe him before dinner in the evening and observe that testing his blood sugar levels taking place?

MS McINTOSH: No, not always. My son was nearly always with him on a Sunday in the lead-up to his dinner and often – Dad often took dinner in his room and his dinner would be delivered to him and his blood sugar hadn't been tested. And it was important that it was because that's how they can tell how much medication that he needed. That's what the reading was for. So often, you know, Nick would be there and his dinner would arrive and he would say, "Aren't you supposed to have a blood test before your dinner?" and he'd "That doesn't always happen". And I had that experience too. I had been there on different days in the lead-up for dinner and his blood sugar wasn't tested before his dinner like it should be.

MR KNOWLES: Did you inquire of staff at the facility about his blood sugar levels and the testing of them?

MS McINTOSH: Every time I went to the facility after he came out of hospital after this I would ask about his blood sugar levels so, you know, the first person I saw who was on the floor who was looking after him, I would say "What's his levels today?" and they would give me a figure and it was always an acceptable figure, like, you know, it's 8 or it's 6.9, you know, 8. And then later that same hour or two that I was there visiting, another nurse would come in with the actual chart and I'd say to them, What was the reading?", and then they'd look at it and say it was 12.2 or some other number. So I felt that in the first instance when I'd asked about it they just told me an acceptable number because that would keep me happy and I'd be on my way.

MR KNOWLES: And how were you feeling about the standard of care that was being given to your father at this particular residential aged care facility at this time?

MS McINTOSH: By then we knew that we had to move him.

MR KNOWLES: And did that occur?

MS McINTOSH: Yes.

MR KNOWLES: Yes. And when did he move and where to?

MS McINTOSH: He moved in about September, I think.

MR KNOWLES: That's of this year?

MS McINTOSH: Yes, this year. We moved him to another aged care facility.

MR KNOWLES: Yes. And how is your father's health now?

MS McINTOSH: He's very frail. Every hospitalisation that he had, he became more frail, but in the facility he's in now his care is much improved; the staff are much better, they're much more proactive and we're quite happy with it, actually. We feel that he gets the care that he needs there, and the – it's chalk and cheese, actually, the difference between the two facilities.

MR KNOWLES: And can you just ask you in relation to the photographs that are up on the screen; the photograph on the right.

MS McINTOSH: Yes.

MR KNOWLES: When and where was that taken?

MS McINTOSH: That's in the second aged care facility last Sunday.

MR KNOWLES: Where he presently resides?

MS McINTOSH: Yes.

MR KNOWLES: When was that photograph taken?

MS McINTOSH: Last Sunday.

MR KNOWLES: Now, what would you like to see change, Ms McIntosh, to avoid the circumstances that were experienced by your father?

MS McINTOSH: I think, you know, Dad's still an Australian; he's still entitled to Medicare like we all are. He still should be able to see a doctor when he wants to or when he needs to. He shouldn't have to beg staff for it, or he shouldn't have wait until we're able to advocate for him. We put him in the aged care facility because he needed complex care and we thought that he would get it there, but it appears that is they just - really just house you and feed you, and any type of care that you need is the family's responsibility. And I think I realised that a little bit too late, that it was my responsibility, because I would have done a much better job had I known that. I wouldn't have relied on them the way I did and trusted them. I would have taken on his primary care myself if I had known that the care was so poor.

MR KNOWLES: And is there anything else that you wish to say to the Royal Commission in terms of changes that you might wish to see?

MS McINTOSH: Yes, I – I hope that we can get improvement for older people. You know, recently I found a newspaper in my daughter's bedroom. It was from 1997. I kept the newspaper because it was from the day she was born and on the front page of the newspaper it said:

Nine out of 10 aged care facilities fail standards.

And that was 22 years ago. And it seems to me as though not a lot has changed.

MR KNOWLES: I don't have any further questions for Ms McIntosh, Commissioners.

COMMISSIONER PAGONE: Ms McIntosh, thank you for coming to give us your evidence and experience and it helps the Commission a great deal to have - - -

MS McINTOSH: Thank you.

COMMISSIONER PAGONE: - - - information like that.

MS McINTOSH: Thank you.

<THE WITNESS WITHDREW [11.12 am]

MR KNOWLES: I understand that there is scheduled to be a brief adjournment.

COMMISSIONER PAGONE: Yes, we will have a brief adjournment until 11.30 am.

ADJOURNED **[11.12 am]**

RESUMED **[11.30 am]**

MS HUTCHINS: Commissioners, before I call the next witness, there are some appearances to be made.

COMMISSIONER PAGONE: Yes.

MS A. MITCHELMORE SC: May it price the Commission, Mitchelmore is my name and I appear with MR DIGHTON for the Commonwealth.

COMMISSIONER PAGONE: Yes. Thank you, Ms Mitchelmore.

MS HUTCHINS: Thank you, Commissioners. The next witness to give evidence before the Commission will be Ms Kristine Stevens who will give evidence regarding the experience of her mother and father who both live in residential aged care facilities in New South Wales. Her evidence is illustrative of personal and clinical care issues that may be consequence of inadequate clinical competence, inadequate access to specialist care, and a lack of understanding about who is responsible for determination and management of health care needs of residents. Should it suit the Commission, I call our next witness, Ms Kristine Stevens.

COMMISSIONER PAGONE: Yes. Thank you.

<KRISTINE GAIL STEVENS, AFFIRMED **[11.31 am]**

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Ms Stevens, what is your full name.

MS STEVENS: Kristine Gail Stevens.

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

MS STEVENS: Yes.

MS HUTCHINS: Operator, please call WIT.1308.0001.0001. Is this a copy of your statement dated 26 November 2019?

MS STEVENS: Yes.

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

MS STEVENS: Yes.

MS HUTCHINS: Sorry, read it lately. And are there any changes that you wish to make?

MS STEVENS: Paragraph 10, I've stated that my Dad had a diagnosis of Parkinson's and Lewy body dementia in 2012. It was actually November 2011, which I didn't realise until I looked back through the medical records.

MS HUTCHINS: No problem. So correct 2012 in paragraph 10 to read 2011. And otherwise, are the contents true and correct to the best - accurate to the best of your knowledge and belief?

MS STEVENS: Yes.

MS HUTCHINS: Thank you. I tender that statement.

COMMISSIONER PAGONE: Yes, the statement of Ms Stevens will be exhibit 14-4.

EXHIBIT #14-4 STATEMENT OF KRISTINE STEVENS DATED 26/11/2019

MS HUTCHINS: Operator, please bring up RCD.000- sorry - 49.0271.0002 and also RCD.0271.0001.0001. Thank you. Who are these people displayed with the screen?

MS STEVENS: So that's my mum, Nina Stevens, and my dad, Albert Stevens.

MS HUTCHINS: And how old are they now?

MS STEVENS: My Mum is 81 and my Dad is 84.

MS HUTCHINS: And they both live in the same residential aged care facility in Dubbo.

MS STEVENS: Yes, they do.

MS HUTCHINS: And how long have they lived in Dubbo for?

MS STEVENS: My Mum was born and raised in Dubbo. My Dad moved to Dubbo as a young man and he was about 19 years of age when he moved there.

MS HUTCHINS: And do you live in Dubbo also?

MS STEVENS: I do now, yes.

MS HUTCHINS: And this is the third residential aged care facility that your father has lived in and the second that your mother has lived in; is that correct?

MS STEVENS: Yes, that's correct.

MS HUTCHINS: And you are one of three children; is that right?

MS STEVENS: Yes.

MS HUTCHINS: And are you the only one of the three children that live in Dubbo?

MS STEVENS: Yes.

MS HUTCHINS: Yes. And would you say you have a big part in visiting and caring for your parents?

MS STEVENS: Yes, I do. I'm actually the only member of the immediate family that lives in Dubbo. So the responsibility is actually mine.

MS HUTCHINS: And in 2010 your father had a heart attack and that's when you moved to Dubbo from Newcastle where you were living at the time.

MS STEVENS: Yes.

MS HUTCHINS: And why was it that you felt you needed to move?

MS STEVENS: Well, my Mum is not that much younger than my Dad and I just felt that if Dad was becoming more incapacitated and possibly in need of care, then Mum would need my assistance. So I moved back to Dubbo.

MS HUTCHINS: And from 2011, your father was diagnosed with Parkinson's disease and Lewy body dementia. From that time, how was his health? Was he able to remain living independently in the community?

MS STEVENS: Yes, he was. My Mum became his full-time carer and they lived independently in the family home until we sold the family home, and they moved into an independent living villa, like a community, in 2016.

MS HUTCHINS: Yes. So in January 2016 your parents moved into that villa.

MS STEVENS: Yes.

MS HUTCHINS: It was some months later in May 2016 that your father needed to move into residential aged care.

MS STEVENS: Yes, I moved them into the villa because I thought that that might assist them in staying together for longer and there were less trip hazards and all sorts of reasons why it was better for them both to be in the village. And the village was adjacent to an aged care facility, so I envisaged that as Dad transitioned into aged care, Mum would be living adjacent to the facility that he moved into and it would be better for them.

MS HUTCHINS: What were your father's care needs at that time which required his need to move into the residential aged care facility?

MS STEVENS: He was using a walker to assist his mobility. He was actually needing assistance with bathing and we did have in-home care, so he'd been assessed, had an ACAT assessment and we had a home care package to assist my mum in caring for my dad. So that's how they were able to stay together for as long as they did.

MS HUTCHINS: When your father moved into the residential aged care facility, he was placed in a locked dementia ward.

MS STEVENS: Yes.

MS HUTCHINS: Were you concerned he was a flight risk?

MS STEVENS: No, he was definitely not a flight risk and – but he had the beginnings of dementia; the Lewy body syndrome is a dementia that's associated with Parkinson's, and he was placed in this ward that was locked with a number of other - in fact, 20 - there were 20 residents in this particular ward, and the door was locked and my Dad felt trapped. I felt that he was misplaced in that ward and it was distressful for him and for me and so distressful for my mum that she was reluctant to visit.

MS HUTCHINS: And during this time that your father was in his first facility, how was your mother's health during this time?

MS STEVENS: She became anxious and depressed and was sent to a psychologist and a psychiatrist and was actually placed on medication for her anxiety.

MS HUTCHINS: Yes.

MS STEVENS: And depression. So she became more incapacitated living - it was the first time she'd ever lived alone.

MS HUTCHINS: And so in July 2017 you made the decision to move your father from that first facility to a different facility.

MS STEVENS: Yes.

MS HUTCHINS: And also to admit your mother into residential aged care for the first time.

MS STEVENS: Yes, she went in - when I transferred Dad she went in initially just on respite and with the view to staying on a permanent basis if she felt comfortable in the – in that facility and, as it turned out, she did. And that was for me a blessing because I'd supported her for 12 months while she remained independent in the community but, in fact, was quite dependent on me, so - - -

MS HUTCHINS: And we can turn in some detail to the issues that you encountered during this – during your parents' time in the second facility shortly, but it became to be that by August this year you were unsatisfied with the level of care that they were receiving and you've moved them both now to a new facility where they're currently living.

MS STEVENS: That's correct, yes.

MS HUTCHINS: That's correct. And during the history of your parents' time across these three facilities, have they had the same general practitioner during this time?

MS STEVENS: Yes, they have.

MS HUTCHINS: And is that a general practitioner that they used to see historically?

MS STEVENS: Yes. Yes, they've had the same GP since I returned to Dubbo and I went back to Dubbo in 2010. So in all of that time they've remained with the one GP.

MS HUTCHINS: And how has your experienced been in terms of your parents' ability to receive care from that GP as and when they need him?

MS STEVENS: That GP is very popular. He's very thorough but he's also under the pump. So it's quite difficult to get an appointment with him and there are often times when you have to wait in order to see him. So the facility might call him and it might be 9 o'clock in the evening and it might be 10 am in the morning when they put the call through, but 9 o'clock at night when he finally gets there because he's had so many other people that he's had to treat.

MS HUTCHINS: Do you see the same GP yourself?

MS STEVENS: Yes.

MS HUTCHINS: Is it the same experience for you?

MS STEVENS: It's the same experience. If you need an appointment with that GP because you're not well, might have to wait two weeks to get in. So, you know, it's inadequate but it's the same for everyone in the community. There's a lack of GPs in regional areas.

MS HUTCHINS: And when it comes to arranging visits with the general practitioner, who would usually, you know, make sure that he was there if you needed to be, to see your parents .....

MS STEVENS: To see my parents? My expectation is he would come to the facility that they're in so I don't have to transport them. But if he is absolutely unavailable then they will send someone else from the same practice to the facility.

MS HUTCHINS: And at the various facilities where your parents have lived, has there been a private consulting room for the GP's visits or does that happen in your parents' rooms?

MS STEVENS: At the second facility, yes, there was consulting rooms that was part of that facility. That facility was incredibly well thought out. It was fabulous but under-resourced.

MS HUTCHINS: Yes. And so at the first facility when your father was in the - in the dementia ward, would he be seen in a private area or in a room with other residents?

MS STEVENS: Just in his room. But he was a lot healthier at that first facility then compared to what he is now, so the need for him to see a GP, you know, on a frequent basis wasn't really something that was one of my concerns at the time. It was more about his everyday living needs that were being met at the first facility.

MS HUTCHINS: Yes. And so in your statement you detail an incident that happened just before Christmas of 2017 where there was – where your mother experienced an undiagnosed urinary tract infection which ultimately ended up in her hospitalisation. Could you please describe to the Commission how it was that you first became aware of the issue with your Mum with her urinary tract at the time?

MS STEVENS: Well, she was just becoming a little confused, and over a period of five days she was observed by the staff at the facility, and on the fifth day the RN decided that Mum needed to be transported to hospital. She'd become delirious and was in a fairly bad state. So the facility called an ambulance and had Mum transported to hospital where she had to wait a period of about 24 hours in the accident and emergency department waiting for a bed. And when she was finally given a bed in the surgical ward at the hospital, one of the neurologists from the

hospital came along and suggested that Mum may have Parkinson's and Lewy body, which to me was a surprise because that was my dad's diagnosis and I felt that that couldn't possibly be correct. And he proceeded to prescribe a drug that my dad was actually taking for his illness and then went home for the weekend. It was a Saturday. And my Mum had an incredibly bad reaction to that drug and we were calling the family and asking them to come to Dubbo quickly, it was that bad, and eventually they dealt with it at the hospital, but I believe that she had a bad reaction to that Parkinson's drug and there was no specialist on hand at the time to observe her reaction to that, and she has never been the same since that incident.

MS HUTCHINS: Yes. And so when you say she hasn't been the same since, how was her health physically before this incident?

MS STEVENS: Well, she was walking and talking and interacting with other residents and participating in community events. After that, she became fragile, unsteady on her feet. Her capacity to communicate was diminished and she just continued. It was like she'd jumped off a cliff in terms of her wellbeing. She deteriorated so much.

MS HUTCHINS: And following this incident, was she still able to walk or was she predominantly bedridden?

MS STEVENS: Well, she was unsteady on her feet so she was sort of placed in a chair and because residents are often placed in chairs and then put in the corner of the room and left unattended they often try to get out of the chair because – in my mum's case she wasn't used to not being able to walk so she experienced a series of falls and the last of those falls resulted in a fairly severe gash to the back of her head and that's the one that really I believe was the last straw, basically, in terms of her being able to communicate and participate. She's been bed-bound or at least – she's not ambulant anymore. She has to sit in a comfort chair and that's about – and she doesn't communicate in the way she used to.

MS HUTCHINS: Yes. And following the stay in hospital, was it presented to you as an option that she might be able to go and receive rehabilitation services anywhere?

MS STEVENS: No. The second facility actually had a physiotherapist on site. So I was under the impression that they would work with my mum and try to get her on her feet and, you know, with the assistance of a walker at least being mobile, or, you know, even if it wasn't as mobile as she had been, I assumed that they would try and work with her to rehabilitate her, but that really didn't happen. And I guess my expectation was that the facility was going to deal with it. They had the professionals on site, but it didn't, and so – and then my dad had an incident as well, and I then took steps to hire a physiotherapist privately and have that physiotherapist come into the facility and work with my mum and my dad, and fortunately my dad was more receptive and more robust, and able to benefit from what – from these

sessions with the physio but my mum was too far beyond that, and really we had limited success with her.

MS HUTCHINS: Yes. And in terms of arranging that physiotherapist, is that something that you arranged independently and was financed by you or your family?

MS STEVENS: It was financed by ourselves, well, my mum and dad who have private health insurance but there was, of course, still a gap. I did ask the facility if it was okay for me to bring a physiotherapist in, and they were okay with that. I – I just felt that because the facility was so under-resourced there was no one available to actually work with my mum and dad on an individual basis to assist them to be rehabilitated after they became unable to walk.

MS HUTCHINS: And in terms of your general practitioner's involvement, you know, through these various health problems that they were experiencing, did you feel he was coordinating the care – the potential care needs or trying to facilitate access or anything like that?

MS STEVENS: No, I actually felt like the responsibility lay with me and the family, and because I'm the only representative in Dubbo it was sort of my responsibility to access allied health professionals and other health professionals.

MS HUTCHINS: Now, in October 2018 whilst in the second facility, your mother developed a pressure wound?

MS STEVENS: Yes, was it October? September. She moved into the facility in August. I relocated her to a third facility in August. When I relocated her – them both, my mum had a pressure wound on the base of her spine. I, not having a nursing background, was unaware of how serious that was, and at the time was not really aware of what state that wound was in. And she - - -

MS HUTCHINS: Sorry, just to go back a step, so you became aware of the pressure wound while your parents were still at the second facility?

MS STEVENS: Yes.

MS HUTCHINS: Yes. And how was it you became aware of the wound?

MS STEVENS: Initially, my mum, 12 months prior to me relocating them, had said to me that her bottom was sore, so I relayed that to the staff. The staff examined her and it turned out she had a little pressure wound at the base of her spine, which was very minor at the time.

MS HUTCHINS: Had you seen it yourself?

MS STEVENS: I actually didn't see it at that stage.

MS HUTCHINS: Yes. And so were you receiving updates about how care for the pressure wound was going through updates from staff members?

MS STEVENS: Yes, I would ask.

MS HUTCHINS: You would ask. How often were you visiting the facility at this time?

MS STEVENS: Well, I was trying to visit the facility every day but I work full time. So I'm a bit stretched, and – but mostly I get there on a daily basis because my feeling was that my mum and dad were often dehydrated, and there were other reasons why you just needed to touch base and check and make sure they were both okay.

MS HUTCHINS: And during this period, you know, from the time you first heard about the pressure wound through to when your parents moved facilities, what was your overall impression about whether it was being adequately cared for or - - -

MS STEVENS: I thought it was being managed. I didn't think it was deteriorating, and I just thought – it developed because my mum lost the capacity to walk, so she was in a comfort chair. She had very little opportunity to get out of that comfort chair so she developed this wound on the base of her spine, and I felt that they were managing it. But I became acutely aware of the fact that it wasn't being managed well after she moved to the third facility and it caught them unawares because I hadn't actually mentioned it when I transfer – I – I gathered as many documents as I could from the second facility because the onus was on me again to communicate with the new facility as to what stage of care my parents were at.

MS HUTCHINS: Yes.

MS STEVENS: Or what they required of the new facility and so I was gathering their medications, their care plans and getting as much information as I could and taking it with me. But, of course, I didn't mention the pressure wound and I think they struggled, when my mum arrived, to cope with it.

MS HUTCHINS: What was the tenor of the conversation that staff at the new facility had with you about the state of the pressure wound?

MS STEVENS: Well, they really didn't say that much. And it was a period of weeks. It was only a matter of weeks since my mum had transferred in there, when I received a phone call from the GP one morning and I knew that this meant something was fairly serious because the GP had called me.

MS HUTCHINS: Had you spoken to the GP previously about the pressure wound?

MS STEVENS: Not about this particular – no. Not about this particular wound.

MS HUTCHINS: And so what did the GP say to you during that telephone call?

MS STEVENS: He said to me that my mum had a fairly serious pressure wound and that he was going to get the palliative care nurse to check on her the following day when she was scheduled to visit the facility. He was also going to prescribe a course of antibiotics and get her some pain relief.

MS HUTCHINS: When he refers to the palliative care nurse, is that someone that you had seen before?

MS STEVENS: No, and when he said palliative care I thought, well, that doesn't sound like we're going to try and deal with this, and see if we can heal this wound. It sounds like we're accepting that this wound is going to really result in the death of my mum. It sounded fairly serious to me.

MS HUTCHINS: Had you had any discussions previously with the GP about palliative care?

MS STEVENS: No, none at all. In fact, I'd had – he's my GP also, but I'd had very little conversations with palliative care in relation to my mum and dad.

MS HUTCHINS: And had you understood before this call that the seriousness of the condition was to the stage where it was time to be having a discussion about palliative care?

MS STEVENS: Well, I sort of was alarmed when he called me, and that's why I decided that I had to go over there and actually view the wound or at least take someone with me with some nursing expertise and have a look at the wound ourselves so that we could make some sort of determination as to what was the best way forward.

MS HUTCHINS: Yes. And so you took – you asked one of your friend's daughters who is a registered nurse to come with you to the facility?

MS STEVENS: Yes, and we went there that afternoon after I finished work, so yes.

MS HUTCHINS: What happened when you went to the facility with your friend's daughter.

MS STEVENS: We went straight into Mum's room and we looked at the dressing on the wound and my friend's daughter had "This needs to be changed. Let's just get the RN. Let's just buzz and get the RN or someone down here and let them know that this wound dressing needs to be changed." So we were actually reprimanded for buzzing because they were busy feeding other residents. So we were told we needed to wait and eventually the RN came down and I chose actually not to look at the wound because I was feeling like it was going to be confronting, and it was. And as

soon as she saw that, she came over to me and she said "We need to call an ambulance now", and she was really alarmed and I valued her opinion.

So we asked the RN that was on duty at the facility to call an ambulance. There was no way my mum should have been asked to wait for a palliative care nurse the following day. We just needed to get her in an ambulance and get her to the hospital.

MS HUTCHINS: Had the doctor prescribed some pain relief?

MS STEVENS: That was still sort of happening but it hadn't happened. She still had no pain relief.

MS HUTCHINS: So your mother was transferred to hospital by ambulance?

MS STEVENS: Yes.

MS HUTCHINS: What was the reaction of the hospital staff when they saw your mother's pressure wound?

MS STEVENS: They were shocked, and they couldn't understand why she hadn't been sent to a hospital much earlier than she had.

MS HUTCHINS: Who was your mother seen by when she was at the hospital?

MS STEVENS: Just the registrar that, like - the doctors and nurses that were on duty in the accident and emergency ward at the hospital.

MS HUTCHINS: And she was admitted?

MS STEVENS: Yes, it took about – again, it takes a while to get a bed in regional hospitals and she waited overnight and they gave her a bed in the surgical ward and moved her on to the ward, yes.

MS HUTCHINS: When your mother was in hospital, was she seen by a wound specialist?

MS STEVENS: A clinical nurse specialist, yes.

MS HUTCHINS: And what was your impression of the care provided in the hospital compared to the level of care she was receiving in the facility?

MS STEVENS: Well, the level of care she was receiving in the facility wasn't working and the wound had deteriorated so much that it actually was life-threatening.

MS HUTCHINS: Yes.

MS STEVENS: So once she got to the hospital and we had people that knew how to deal with these type of wounds, looking after her, then I felt reassured in that we were going to work through it, but I was advised by the surgeon that this wound may never heal in my mum's life time, is what they actually said to me.

MS HUTCHINS: Yes. And how long was your mother in hospital before she was ready to leave?

MS STEVENS: I actually don't think she was ready to leave but they needed the bed so she was in for about a week and that was only because I pushed back on having her discharged because I wanted to make sure that everything was in place after her discharge.

MS HUTCHINS: So after the week you were told by hospital staff that they required the bed back; is that correct?

MS STEVENS: It was probably on the Friday. Mum, I think, was transported into hospital on the Monday and by the Friday they were going, "Well, we really need that bed" and they were looking for other options for where my mum could be relocated to.

MS HUTCHINS: What were the other options that were suggested?

MS STEVENS: Well, the options were to send her to Narromine or Wellington which are a minimum of half an hour drive from Dubbo to keep her in the public hospital system because without being in the public hospital system she had no access to the clinical nurse specialist who was looking after her wound. If she was to return to her home, the aged care facility, her access to the people that knew how to look after her wound was going to cease. So that was the issue.

MS HUTCHINS: Yes, and you note in your statement that it was offered to you that you could bring your mother back to the hospital to be able to see the specialist at the hospital.

MS STEVENS: Yes.

MS HUTCHINS: Why was that a difficult – what was the difficulty in being able to do that?

MS STEVENS: Well, yes, they did suggest that I could bring Mum to a wound clinic once a week at the base hospital, however, in order to get my mother to that wound clinic, I would need to transport her on a stretcher because the wound was on the base of her spine and she was not able to sit up. So she had to be transported in a stretcher, and I was told that the ambulance would not be the right mode of transport or would be unavailable. And I asked if we could access patient transport from the public hospital and they said no. And in Dubbo there are no taxis with the capacity

to take a stretcher. So my Mum's access to the wound clinic was going to be nil, basically, after she moved back into the aged care facility.

MS HUTCHINS: And did you make inquiries as to whether the wound specialist could visit your mother at the facility?

MS STEVENS: I did and I was told that that wasn't possible, and I'm not sure why it wasn't possible, whether it was to do with funding or whether it was to do with just the rules that surround aged care, but they are able to visit elderly people in their own homes but they're not allowed to visit elderly people in aged care facilities.

MS HUTCHINS: Yes. Correct. And your statement – in your statement you outline that the hospital has, in effect, made an exception for you where your mother is currently able to receive services from the hospital wound care specialist via video.

MS STEVENS: Video link.

MS HUTCHINS: Video link.

MS STEVENS: Yes, and that's because the facility that she now resides in had a clinical wound specialist that was offsite and was available for video link to all of those facilities that I think are probably nation-wide, but she subsequently resigned so they now have no wound specialist available to them. So they've negotiated with the hospital to do these video hook-ups, and yes, the - - -

MS HUTCHINS: And has the facility since this visit been assisted by the guidance of the wound specialist?

MS STEVENS: Yes, absolutely, and I think that they are now managing it. They – the wound specialist was actually employed by the facility. I don't really want to mention the facilities, right, but the third facility had a wound specialist, the one that was offsite. When my Mum initially moved into that facility she was on annual leave and they had no one to replace her. So their access to expertise in my mum's first three weeks at the new facility was nil, and that's why the wound deteriorated to such a state, I believe, yes.

MS HUTCHINS: And when it came to putting these arrangements in place for you to be able to use the hospital's services, was that – did someone assist you in making those arrangements? Was the GP involved at all or someone from the facility?

MS STEVENS: The facility – the facility has actually had a change in care managers since my Mum first moved in as well, and it's the current care manager at the facility that has put all of these things in place. And, you know, I have great faith in her capacity to make sure that my Mum's wound is cared for adequately and that she gets the level of care that she needs.

MS HUTCHINS: In your experience over the years between the various facilities, how has the information exchange been between, say, the facilities and the hospital or the GP and hospitals or yourself or the various people involved in your parents' care? How have you found that information sharing to be?

MS STEVENS: I think it's inadequate. I – particularly when you're transferring from one facility to another, there's no communication between the facilities to assist in providing the level of care that's required for the residents. I think it's sort of on a needs to know basis and there's often a lack of communication between the health care professionals and the families of the residents. I also found it quite difficult to actually get to speak to the right person because the carers that actually do most of the manual work and caring, hands on caring in these facilities have no clinical skills. So communicating with them about something that concerns you because you're unable to access the one registered nurse that's looking after 70 residents is quite difficult, you know, so I think communication, there needs to be a focus on communication and how you actually communicate effectively and efficiently so that the residents are not – so that it's to the benefit of the residents, than rather the detriment.

MS HUTCHINS: Yes. You note in your statement that at the time your parents transferred from the second facility to their current facility, you had a lot of difficulties obtaining the information and the records that you required. One such example you gave is that your parents had advanced care plans in place which the second facility couldn't locate; is that correct?

MS STEVENS: Yes.

MS HUTCHINS: Yes. And so when had those advanced care plans initially been made?

MS STEVENS: Well, when my mum and dad first moved into the second facility, we sat with the GP and my mum and dad, because my mum was still able to have those sorts of discussions at that time, and we came up with an advanced care plan directive, and then that was documented and signed and everything and the facility, I presumed, had those, wherever they kept them, so that they could be enacted if necessary. And when my mum and dad were moving, I wanted to access those documents so that I could take them with me to the new facility and we wouldn't have to redo them, especially since my parents had been involved in actually creating those documents but the facility – the second facility was unable to locate them. So what happened was I had to then recreate those documents on my own without the assistance of the GP or my parents. So that was quite a difficult process to have to go through, but it's been done now. So they have advanced care directives in place, but the ones that I created, not the one that they did.

MS HUTCHINS: Yes. But you hold the power of attorney for your parents.

MS STEVENS: And enduring ..... along with my two siblings, however they're not on-site and we're all able to act independently of one another, so the responsibility lies with me.

MS HUTCHINS: And was your GP involved in the handover that was involved when your parents were moving from the second facility to the third facility?

MS STEVENS: No, not really. I got a list of medications. I've liaised with the new pharmacy because most facilities deal with a particular pharmacy. So when you relocate a resident, they have to go and start dealing with another pharmacy. So I had to communicate with the pharmacy and I had to communicate with the new facility as to what sort of care plan had been in place for my mum and dad, what their medications were. The GP actually wasn't really involved, only that he had to come to the new facility and sign off on their medications or some documentation that would allow the staff at the new facility to administer the medications.

MS HUTCHINS: Yes.

MS STEVENS: Even though we all knew what they were and we had the scripts.

MS HUTCHINS: In your statement you note there was a lag between when the medications were required and when the GP was able to come to sign off on the scripts. So what does that mean that you were required to do?

MS STEVENS: Well, the staff at the new facility said, okay - I had already been to the pharmacy and we had the drugs and everything organised but the staff weren't allowed to administer them. So they said to me, "You'll have to come back at 6 o'clock and you'll have to give your parents their medication." And I said that's fine, and then, "You'll have to come at 6 tomorrow morning and you'll have to do the medications again." And so I was all prepared to do that until the GP was able to come and sign the paperwork and fortunately he arrived at about 9 o'clock that night. So I only had to do the evening medication and I was not required to go in at 6 am and do the morning medication.

MS HUTCHINS: Reflecting - - -

COMMISSIONER BRIGGS: So can I just ask, does that mean there was no registered nurse who was able to give the medications?

MS STEVENS: There was a registered nurse but, unfortunately, they're not - for whatever reason, I didn't question it - not allowed to administer drugs unless a GP has signed some sort of documentation that allows them to do so.

COMMISSIONER BRIGGS: Okay. Thank you.

MS HUTCHINS: Reflecting on the experience that you've had with your parents across these various facilities, has the level of involvement that you have had in

ensuring their care needs have been met, does that reflect what you would have understood or thought the position would be when you were first putting your parents into residential aged care?

MS STEVENS: I felt like I was going to be able to relax slightly and be reassured that my parents were being well cared for. But my experience has been that unless people who can't speak on their own behalf have someone to advocate for them, then they'll be overlooked and basically neglected because of insufficient staffing levels. And, well, as I said before, my father indicated that he had a toothache at one stage and so I arranged to take both my parents to the dentist, and then I asked the dentist to write a report which – to take back to the facility, which indicated that they had very poor oral hygiene. So that's another thing that's overlooked because there's a lack of staffing levels. You know, there's inadequate staffing levels to look after high needs people.

MS HUTCHINS: Do you have a sense of who's responsible for overseeing the needs of your parents, their care needs?

MS STEVENS: Well, I would think the care manager who then has a registered nurse reporting to them, and then there's a multitude of caring staff but the caring staff don't have clinical skills, and they're the ones giving the hands-on care. So they lack the training and expertise to make decisions when they observe things as they're caring for the residents.

MS HUTCHINS: You note in your statement that you think the injuries that your mother has suffered were preventable.

MS STEVENS: They absolutely were preventable. They are a result of neglect and that neglect is directly related to staffing levels. The fact that they don't have time, the caring staff don't have time to spend any more than a few minutes with each resident every day, and facilities are reluctant to tell family members what the staffing ratios are. They actually can't tell you what the staffing ratios are, so you don't know.

MS HUTCHINS: Thank you. I have further questions, Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Ms Hutchins. Thank you for coming and giving your evidence and for your insights and experiences. It's very important the Commission and the public hears these things and I know it can be very difficult. Thank you very much.

MS STEVENS: Thank you. Thank you for the opportunity.

<THE WITNESS WITHDREW [12.11 pm]

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Our next witnesses are adjunct Professor Dr Paresh Dawda, Dr Troye Wallett and Ms Susan Irvine. I call those witnesses to the witness box now. Perhaps if the oath or affirmations can be administered and then I will introduce the panel.

<PARESH DAWDA, AFFIRMED [12.12 pm]

<TROYE WALLETT, AFFIRMED [12.13 pm]

<SUSAN IRVINE, AFFIRMED [12.13 pm]

<EXAMINATION BY MR GRAY

MR GRAY: Thank you. Professor Dawda, what is your full name?

DR DAWDA: My name's Paresh Dawda.

MR GRAY: Thank you. I'll ask the operator to display your witness statement on the screen, Professor Dawda, WIT.0618.0001.0001. Is that your statement made for the Royal Commission dated 22 November 2019?

DR DAWDA: Yes, it is.

MR GRAY: Are you able to see it on that screen there as well?

DR DAWDA: Yes, I can.

MR GRAY: Do you wish to make any amendments to your statement.

DR DAWDA: No.

MR GRAY: To the best of your knowledge and belief, are the facts and opinions true and correct and are the opinions in it opinions that you sincerely hold?

DR DAWDA: Yes, they are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The statement of Dr Dawda will be exhibit 14-5.

EXHIBIT #14-5 STATEMENT OF DR DAWDA DATED 22/11/2019 (WIT.0618.0001.0001)

MR GRAY: Dr Wallett, what's your full name?

DR WALLETT: Dr Troye Stuart Wallett. I'll ask that the operator display your witness statements on the screen. We'll start with your statement dated 26 November 2019; it's WIT.0617.0001.0001. For the record, I note that there's a document associated with your statement, GenWise Care Pathway at tab 43 of the general tender bundle as well. Dr Wallett, do you wish to make any – I should ask you do you recognise the document with the code I just read out on the screen to be your statement dated 26 November 2019 which you've made for the Royal Commission.

DR WALLETT: I recognise it, yes.

MR GRAY: Do you wish to make any amendments to the statement?

DR WALLETT: No, thank you.

MR GRAY: Are its contents, so far as they're factual, true and correct and to the extent that they're opinions, are they opinions that you sincerely hold?

DR WALLETT: They are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. The statement of Dr Wallett will be exhibit 14-6.

EXHIBIT #14.6 STATEMENT OF DR WALLETT DATED 26/11/2019 (WIT.0617.0001.0001)

MR GRAY: Dr Wallett, you've made a supplementary statement referring to testing of the market for demand for general practitioners to provide services in residential aged care facilities, that testing having taken place this year, initially early in the year and then later at the Royal Commission's request. You have produced a document recording that information; is that correct?

DR WALLETT: That's correct.

MR GRAY: I will ask the operator to display the supplementary statement which is dated 9 December 2019. Document ID, WIT.0617.0002.0001. Do you see the document on the screen in front of you now?

DR WALLETT: I do.

MR GRAY: Is that the supplementary statement that you've made for the Royal Commission dated 9 December 2019?

DR WALLETT: It is.

MR GRAY: Do you wish to make any amendments to it?

DR WALLETT: No, thank you.

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

DR WALLETT: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The supplementary statement of Dr Wallett will be exhibit 14-7.

EXHIBIT #14-7 SUPPLEMENTARY STATEMENT OF DR WALLETT DATED 09/12/2019 (WIT.0617.0002.0001)

MR GRAY: For the record, it refers, at tab 52 of the general tender bundle, to a spreadsheet which has been prepared dated 5 December 2019 summarising those data; that's correct, isn't it, Dr Wallett?

DR WALLETT: I believe so.

MR GRAY: Ms Irvine, could I ask you about your statement. You've made a statement for the Royal Commission dated 22 November 2019. I will ask that it be displayed for you, WIT.0621.0001.0001. Do you recognise the document on the screen in front of you - - -

MS IRVINE: Yes, I do.

MR GRAY: - - - to be your statement?

MS IRVINE: Yes, I do.

MR GRAY: Do you wish to make any amendments to it?

MS IRVINE: No, I don't.

MR GRAY: To the best of your knowledge and belief are its factual contents true and correct, and are the opinions stated in it opinions which you sincerely hold?

MS IRVINE: Yes, they are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The statement of Ms Irvine will be exhibit 14-8.

EXHIBIT #14-8 STATEMENT OF MS IRVINE DATED 22/11/2019 (WIT.0621.0001.0001)

MR GRAY: Thank you, Commissioner. For the record, general tender bundle tab 42 is a report from the Nurse Practitioner Reference Group to the MBS review taskforce referred to in Ms Irvine's statement. Dr Dawda, I will begin with some introductory comments about your career and expertise, it won't do justice to all the things that are – you have done that are relevant to general practice and the aged care space, but at any rate, if you just confirm their accuracy once I've completed reading this out. You're a general medical practitioner, you're an academic and a researcher with expertise in clinical leadership quality and patient safety improvement, you're the director at Prestantia Health which provides primary care services exclusively to people living in residential aged care facilities, and that operates here in the ACT.

DR DAWDA: That's right.

MR GRAY: It's an outreach primary care service to those with complex chronic conditions unable to access the usual forms of general practice or at least unable to do so readily and it provides services to people in residential aged care facilities, disability homes and services to housebound people; is that correct?

DR DAWDA: That's correct.

MR GRAY: A significant element of the work of Prestantia Health includes palliative care; is that right?

DR DAWDA: That's correct.

MR GRAY: You're a member of the primary care advisory committee for Australian Commission for Safety and Quality in Health Care, and a member of the Royal Australian College of General Practitioners national standing committee on quality care; that's so, isn't it?

DR DAWDA: I'm no longer on the Australian Commission for Quality and Safety's primary care committee. That term finished in June last year.

MR GRAY: Thank you. You're an adjunct professor at the University of Canberra.

DR DAWDA: That's correct.

MR GRAY: Are you still an associate professor at ANU?

DR DAWDA: I am.

MR GRAY: And you've had, previously, 13 years practice as a general practitioner in the United Kingdom and some knowledge of delivery of general practice primary health care services into aged care settings.

DR DAWDA: That's correct.

MR GRAY: Dr Wallett, you're a general practitioner and the co-founder of GenWise.

DR WALLETT: I am, yes.

MR GRAY: GenWise was the Telstra 2017 Business of the Year.

DR WALLETT: It was, yes.

MR GRAY: It's an aged care general practice which supports health professionals to work in residential aged care facilities.

DR WALLETT: Yes.

MR GRAY: It operates in a number of States. You're on the Federal Government's Aged Care Clinical Advisory Committee and you're a contributing member of the Royal Australian College of General Practitioners Aged Care Book; is that the silver book?

DR WALLETT: It's the silver book, that's right.

MR GRAY: Expert advisory committee.

DR WALLETT: Yes.

MR GRAY: Thank you. Ms Irvine, you're the general manager of Home Nurse Services.

MS IRVINE: Correct.

MR GRAY: Home Nurse Services is the largest private employer of nurse practitioners in Australia.

MS IRVINE: It is.

MR GRAY: Nurse practitioners are a particular group of registered nurses with enhanced clinical expertise.

MS IRVINE: That's correct.

MR GRAY: And a broader scope of practice.

MS IRVINE: That's correct.

MR GRAY: Home Nurse Services has 35 nurse practitioners operating across most States and Territories in Australia.

MS IRVINE: Yes. Correct.

MR GRAY: And its stated purpose is to provide enhanced collaborative clinical care to customers who cannot otherwise access appropriate health services, including those in their homes and those within residential aged care.

MS IRVINE: That's correct.

MR GRAY: Thank you. Members of the panel, the process we will adopt is that I will raise a particular topic for discussion and then I'll invite each of you in turn to comment on it. With respect to one or two of the topics there's in effect a general practitioner emphasis and it may be that, Ms Irvine, I might not direct a question on those to you. But for the first topic, I will just give a brief introduction. The current model for giving primary health care to people in the aged care system rests on a relationship between a patient and a general practitioner where the practitioner is remunerated on a fee for service basis through Medicare. That's the primary funding model. It appears that model is under strain in aged care settings.

Now, each of you have described in your statements different models of giving or facilitating the provision of primary health care for people in aged care. Starting with you, Dr Dawda, I want to ask you what would be your ideal funding model or models for improving access to and the quality of primary health care provided to people in aged care, and I want to just note that the Commission, through counsel assisting, at least is exploring the proposition that there should be blended payment arrangements which is a matter referred to in your statement. Blended payment arrangements might involve a general practice treating an aged care recipient or a group of them and receiving in return an annual payment based on the recipient's or the group's health needs with fee for service payments for complex or after-hours attendances and perhaps a performance element, performance payments based on factors such as immunisation rates or diabetes management planning built into the funding model.

Would such a model support improved primary health care for aged care recipients and what features would you like to see in such a model?

DR DAWDA: Thank you for the question. It's my view - and my view is formed both on the basis of my practical experience in providing aged care services, but I was also commissioned a few years ago to write a paper for the Australian Hospitals and Healthcare Association on the role of bundled payments in primary health care, so it's informed through my sort of academic work as well. And when we look at the payment models for doctors in general, there's various facets to payment models. Each of those facets, each of those components have certain advantages and certain disadvantages. So the first sort of facet really is along a spectrum between a variable payment model such as fee for service at one end of the spectrum, and then at the other end of the spectrum is a more fixed payment model which sometimes is described as "capitation".

MR GRAY: I will ask the operator to bring up pages 16 and 17 of your statement, beginning at paragraph 13.2.

DR DAWDA: Thank you. Now, fee for service as a payment model has certain advantages which are, for example, improving access to care. On the other hand, it has certain disadvantages such as appropriateness of care, allowing and supporting a team-based care delivery model and disincentivising, really, innovation in service delivery. On the other hand, capitation has some of those advantages. The disadvantage of capitation is the potential risk of under-servicing. So, you know, there's no payment model that's, on its own, truly fit for purpose and therefore a blend, a blended payment model which makes most of the advantages of the different models and tries to minimise the disadvantages is perhaps the way to go in my opinion.

With both of those models, they can be sort of topped and tailed, if you like, with various mechanisms such as capping for fee for service to restrict the amounts of payments people can make or, if you want to enhance quality through some sort of quality incentive payment or quality incentive mechanism, and so that's a third mix that can be introduced into a blend to try and get that ideal balance between appropriateness of care, prevention and coordination of care, access to care but also high quality care.

MR GRAY: Thank you. If we look at paragraph 13.6 of your statement you refer to the UK model. Can you explain a little more about the UK example where you've mentioned there a shift away from activity-based funding to whole of population budgets coupled with payment equality.

DR DAWDA: Certainly. So the UK over the last few years has looking at alternative models of provision for aged care and across the country have been set up so what I've described as vanguards, and they include within them an enhanced form of primary care. That enhanced form of primary care is really being supported by an alternative funding mechanism. And the idea of this alternative funding mechanism

is to say, well, actually if you fund people in silos, if you fund general practice here and so we fund community services here and we fund hospital services here, the issue with that is you often get some duplication.

You get a lack of coordination and communication between those silos which sort of operate independently and autonomously, and so the model the UK is going down the route of and, actually, the US as well, is what's often described as a value-based model which is to say, here's a population that needs looking after, here's a pot of money that will fund their health care in its entirety, now let's let the health system work out what the mix of the health service needs to be, the balance between general practice community and acute care to best deliver the care for that person. And within that are elements of risk sharing that have to be negotiated but also there's a built-in incentive there around if they are efficiencies of scale that are achieved and savings realised and agreements around how those savings could be utilised, for example, a case for investing potential savings in further enhanced service offering is not uncommon.

MR GRAY: Dr Dawda, in your statement you mention in a number of places a shift towards an integrated practice unit approach. Is there a connection between the funding approach you've just described and the notion of integrated practice units?

DR DAWDA: Absolutely. So the integrated practice unit sort of model comes from a concept, initially developed in the US around value-based health care, that is, delivering the outcomes that matter to patients, and cost as a denominator. So it's really a balance between getting good outcomes but at a sustainable cost.

MR GRAY: You mention in your statement Health Care Homes, a pilot program being conducted by the Australian Government's Department of Health but you say, I think, that it doesn't include residential aged care facilities?

DR DAWDA: That's correct, so the Commonwealth Government are undertaking a pilot program across 10 PHN areas across Australia which is experimenting with a different model of care and a different funding mechanism as part of that model of care. And then that's a bundle of payments. It's grouping elements of chronic care together into a quarterly payment. However, in that pilot that's going on at the moment, residents within aged care facilities are specifically not part of that program.

MR GRAY: In your opinion, should there be a funding program providing for a blended remuneration model for supporting the provision of primary health care into residential aged care facilities?

DR DAWDA: Absolutely. When I look at the complexity of care that's required within residential aged care, the need for team based care, the need for prevention, the need for comprehensive care, the need for coordination, there's no doubt in my mind that a blended funding model is the fit for purpose funding model that can help deliver some of those requirements where we need them in aged care.

MR GRAY: Thank you, I'll move to Dr Wallett. Dr Wallett, I want to just ask you again about the information that you've provided to the Royal Commission in your supplementary statement, exhibit 14-7. At page 1, paragraph 6, you refer to market testing for interrogation of need for GP's services that you, through GenWise, conducted early in 2019. So this is document WIT.06 – yes. Thank you, operator. And could you just confirm, what was the issue that you saw when you co-founded GenWise and how are you attempting to address it?

DR WALLETT: So I founded GenWise in February 2014. Basically we recognised a need for GPs to work in aged care facilities. As a GP working in an aged care facility, we engaged with the local RACFs in the area and realised that there was a large need for GPs. Most of them were crying out for it. And then going on from there, once we founded GenWise we'd get phone calls from aged care facilities requesting us to find them GPs and this was borne out in that data we collected in the beginning of 2019 confirming our thoughts.

MR GRAY: Thank you. And it's really quite startling when you look at the definition that you've given in your supplementary statement of urgent need, that means – this is paragraph 8 – the facility needs a GP today.

DR WALLETT: Yes.

MR GRAY: And immediate need is defined as one as soon as possible. Now, you refreshed that information, this is at paragraph 10 on page 2, and paragraph 11, just the other day by reference to the data that was available in September 2019, and you found, again, quite startling figures; out of 102 facilities on your database, more than half have an immediate need and just under half have an urgent need?

DR WALLETT: Yes. Yes, we contact aged care facilities regularly because we have GPs that come – that require work in aged care facilities that need work and the matching of those is challenging, so we call them and look for work for our GPs in the nursing homes or the RACFs around the country.

MR GRAY: You've said in your statement that you see remuneration as the greatest barrier for attracting GPs to this environment. What's the ideal funding model for primary care that would support a replication of the GenWise model for providing primary health care into aged care settings?

DR WALLETT: That's correct, I spoke to a GP three weeks ago and I spent half an hour with them or 45 minutes talking about the remuneration around aged care facilities and this particular GP was trying to work out if it was worthwhile for him to move from his practice into aged care. And in the end he concluded it wasn't. It wasn't financially viable for him to do the work in aged care despite the fact that he wanted to do so. So it is definitely a barrier to entry for GPs to move into aged care and GPs do altruistic care and they do work in aged care facilities but that, of course, is very limited as you can imagine.

The reasons why it is challenging and we – and they were highlighted in the previous testimony by Ms Stevens, was that GPs do a lot of work unremunerated in aged care. Two of the things that she – that was highlighted in that previous statement was that the handover between one practice and another would require the GP to do work that was unremunerated. The coordination of care was talked about in quite some detail and she had to do a whole lot of work that was required to look after her parents and the GP would need to be doing a lot of that work unremunerated as well. So there are various different things that a GP does in aged care that's required their work but is not remunerated.

The MBS structures don't make provision for working in aged care facilities. They do slightly but often it feels like the numbers, the item numbers are wedged into aged care and they are difficult to make sense of and understand what you are able to bill for and what you're not able to bill for. Again this story of that GP arriving at 9 o'clock at night-time to write a medication chart, that's not remunerated under Medicare at the moment. You have to see the patient and do a consult to be remunerated. So coming in and writing up a drug chart and signing for it is unremunerated work and I – and I acknowledge that, I mean, I'd like to just pay my respects to that GP who did do the work at 9 o'clock at night-time.

The other thing that MBS does at the moment with all the item numbers and – is it incentivises acute care over proactive care, and Dr Dawda mentioned a whole lot of ways that could be solved in what he was talking about, but having more provision for proactive care is very important. And the last thing about MBS and us incentivising, it needs to be considered that we not only incentive GPs to do the work but also incentivise practices to set up the systems to make the work easier and to lower the barriers of entry and make that work easier. So two of the suggestions that I was considering was doing – was considering something like at the moment that the diabetes cycle of care that is used in general practice and possibly using or developing something like an aged care cycle of care that would have certain criteria set up that the GP needs to tick the boxes and be able to be billed from that. But I think the complexity of billing is immense and lots of people have lots of different ideas. We need to consider the second order consequences of – of setting up the funding, as was - I mentioned previously. So I think that a Medicare - an MBS review with the interested parties that I understand how it works would be warranted.

MR GRAY: So, Dr Wallett, should the Royal Commission recommend at least the availability of a blended model?

DR WALLETT: I think so, yes. I think it would be a good idea.

MR GRAY: The Commission, through its staff at least, is also exploring the potential for amendment to MBS items related to comprehensive health assessment to support comprehensive assessment and team care more often, every six months or as needed. Do you support that?

DR WALLETT: I do and I think it would help solve problems we've heard about before, about bringing families together, communicating with families and coordinating the care. At the moment there's no provision for a team care kind of arrangement in aged care facilities.

MR GRAY: Should nurse practitioners be involved in comprehensive health assessments?

DR WALLETT: Definitely.

MR GRAY: Ms Irvine, that's a good segue to you. Staff at the Royal Commission are considering propositions that measures are warranted to increase the numbers of nurse practitioners generally in Australia and in the aged care workforce in particular. What's your position on that general proposition?

MS IRVINE: Look, we would support any recommendation that increases the potential to grow the nurse practitioner workforce in Australia.

MR GRAY: Specifically a proposition that we're testing in this hearing is whether there should be Commonwealth funding for a scholarship program with return of service obligations into aged care settings and perhaps particularly into rural settings. What do you say about that?

MS IRVINE: Absolutely. Myself and Home Nurse Services, we estimate an additional 600 nurse practitioners nationally to support aged medical care in Australia, and certainly a scholarship program would go a long way to supporting that growth of that workforce.

MR GRAY: In your statement you've identified a very simple funding solution, I'm not sure the extent to which it's on your position the entire solution, but it's $1 per day per resident funding stream to be paid through residential aged care facilities to nurse practitioners, in essence, for the retention of nurse practitioners to provide the necessary high level clinical nursing support that you speak of in your statement. Could I just ask you, you also mention in paragraph 10, a mentoring role and an upskilling role, an upskilling effect that presence of nurse practitioners seem to have on the staff of residential aged care facilities. Do you envisage that the $1 per resident per day funding stream would be sufficient to cover that mentoring role or is it more directed at non-MBS clinical attendances?

MS IRVINE: Look, the dollar a day that we're proposing would supplement the non-billable items that nurse practitioners do within the facility, similar to doctors, we believe. So that goes some way to supporting that upskilling and mentoring that the nurse practitioners do within the facility and we estimate that for every consultation or review that the nurse practitioner is doing with the resident, that it's anywhere - as a minimum it's probably 10 minutes per practitioner that nurse practitioners are communicating and educating the staff in that facility.

MR GRAY: What about home care, people on home care packages particularly with high level needs who may benefit from a nurse practitioner? What's the funding solution you have in mind there? The $1 per day per resident clearly doesn't apply to them.

MS IRVINE: That doesn't work, no, we would estimate that at least $100 per consultation would need to be done to do that. But having said that, I think that in the community care sector, the people accessing or requiring medical support or more complex care, they're a lot more – there's a lot more ability to access those types of support services. So the nurse practitioner in that model would probably be most beneficial would be in assisting in coordination and liaising and coordinating that high level clinical support with the doctor services like Paresh Dawda. I'm not sure what you do in the community sector, whether it's just residential aged care, I think. But I know the work that Dr Dawda is doing in the community. You know, there's certainly a lot more support in the community sector. But for nurse practitioners to provide a regular home visit, certainly the current MBS items don't support that model.

MR GRAY: And in your statement, I think it's fair to say, you also make it clear that you're supporting an increase in scope of access to rebatable items under MBS if the services are provided under nurse practitioners. So in effect, are you advocating a blended funding model as well?

MS IRVINE: Look, yes. Certainly, look, with the dollar – rough a dollar a day that we've said, we see that that would fund one day of a nurse practitioner once a week, which is what our current model is for a 100 bed facility. Obviously with additional residents in the facility, if it's a larger facility, we would have – we'd have access to more nurse practitioner time. But I think that, concurrently to that, the MBS items especially for nurse practitioners would need to include the health assessments and the chronic disease management plans which need to be accessible to all residents in aged care, because they're not at the moment, and including nurse practitioner access to mental health care plans which they currently don't have access to.

MR GRAY: I want to move now to our next topic, which is moving up the tiers of health care needs to the specialist area, and I know, of course, that general practitioners are, in a sense, specialists but I mean specialists, those practitioners providing health care beyond the primary care tier. Data available to the Royal Commission indicates that access via MBS fees at least for service to specialists for people in residential aged care is poor.

All three of your respective practices involve at some level an element of multidisciplinary teamwork, I think that's a correct summary; or at least your models work very closely with other disciplines. How important is that collaboration and teamwork to multidisciplinary work – this is the topic I'm developing, I'm going to ask each of you about that in a second – and could you please bear in mind this question: in making recommendations should the Royal Commissioners be looking to facilitate more of this collaborative teamwork involving specialists?

Should it involve perhaps a program of multidisciplinary outreach involving specialists with expertise in common conditions that can lead to hospitalisations of people in aged care, and particularly in residential care with a view to saving, perhaps, some of those hospitalisations. Ms Irvine, I will start with you. Should the Royal Commission make a recommendation for system-wide implementation of multidisciplinary teams with dedicated funding for such a program?

MS IRVINE: Look, I think it would help. One of the things that I raise in my statement generally is that over last 30 years the complexity of care in aged care has significantly increased and most people entering residential aged care in particular with significant comorbidities but a lot of people with dementia and challenging behaviours, mental health and psychoses. With the ageing disability sector we're getting a lot more complex people with disabilities in general, ageing. And then palliation and end of life management. So I think that that multidisciplinary specialty model is critical to managing the medical care needs of residents in aged care and that advanced clinical practice.

MR GRAY: Thank you. Dr Dawda, you were involved at the conceptual stage in the genesis of the Geriatric Rapid Acute Care Evaluation program, GRACE, about which the Royal Commission is going to hear more about later in the week. That is in substance a version of a multidisciplinary outreach team, is it not?

DR DAWDA: I guess it's an extension. When I think about multidisciplinary teams I kind of think of it as the layers of an onion in some ways. So, you know, within primary care there's a multidisciplinary team. So in our practice, for example, we've got a GP, a nurse practitioner, a pharmacist as well as enrolled nurses and registered nurses. Then there's an extended team around that, and I would say the GRACE model fits in that layer, so the GRACE model is registered nurses, particularly with a skill set that's around the assessment of deteriorating patients who can provide a rapid response to assess somebody who may be deteriorating or potential deteriorating. In addition to that assessment they also support the transition, either from residential aged care to the hospital, or back including some form of case management and coordination across that.

Although the GRACE model itself doesn't have any direct medical support, it looks back to general practice as providing that medical support, and then the sort of third layer of the onion is perhaps the broader specialist that you were talking about earlier. So that may well include geriatricians, psychogeriatricians and physicians and surgeons and, you know, there's a fourth layer which, I guess, is sort of the broader system, and may well include elements of social care and community nursing services and so on.

MR GRAY: What's your position on the proposal or the proposition that the Royal Commission might make a recommendation for system-wide implementation through dedicated funding, there can be local variation in exactly what form the team might take but for dedicated funding for the implementation of multidisciplinary teams to provide outreach services to residential aged care.

DR DAWDA: So I would be very keen and supportive of that, and in some ways it lends itself to a value-based payment model I was talking about earlier. It's perhaps an early iteration of that. The comment I would make is within the Australian health system, of course, we've got State-funded services and we've got Commonwealth-funded services and there's a split there. The vehicle through which that funding is distributed, I think it's important that it lends itself to integration between the two elements of the health system and so I would strongly urge the Commission to consider not only having it go through local hospital districts but also primary health networks and think about a sort of co-commissioning type of model, and that way it puts an emphasis on multidisciplinary teams in an integrated way rather than in a siloed way.

MR GRAY: Thank you. And you're quite right; the proposition that we've been developing suggests that, while there would be joint Commonwealth and State and Territory funding, the delivery or the commissioning would be through the hospital networks, those State administrative units, but thank you for that insight. Dr Wallett, I will go to you now. Do you agree with Dr Dawda on that last point and then I will ask you more generally whether you support the propositions about multidisciplinary outreach teams involving access to specialist expertise?

DR WALLETT: I do agree with Dr Dawda. I think that a multi – a funded multidisciplinary team is important because the people in aged care facilities require the expertise from multiple different people.

MR GRAY: And the idea of co-commissioning, not only through the State administrative unit, the local hospital network, by whatever name that goes, but also having involvement of the Commonwealth administrative unit, the primary health network in that co-commissioning process.

DR WALLETT: It's a little bit outside of my range of expertise but it sounds reasonable.

MS IRVINE: Could I just make one more comment.

MR GRAY: Yes, Ms Irvine.

MS IRVINE: One of the, I think, whilst those services are particularly good and they provide a very valuable service, at this point in time I think in any model going forward, we – it would need a little bit more thought around it, because currently it's more around - the design of those services are around hospital avoidance and admission or hospital in the home-type services. And whilst that's very good it's still very much a bandaid solution and I don't think in those models there's much about the proactive management around those specialty needs in aged care. So that's just an additional comment I'd like to make.

MR GRAY: Can I just take that point and ask, perhaps, first, Dr Dawda, what's the way in which you would see a multidisciplinary team of the kind you've been

outlining cooperating and collaborating with the primary health care practitioner? How does that work and does that go some way toward meeting the point that Ms Irvine has raised?

DR DAWDA: So I'd like to make two comments. One is around how I see it, but I think the other one is around process. The way I see it is there's, again, a real need for integration and when we think about integration, if we can sort of think about integration in – with a number of elements, you know, the first element is perhaps around functional integration, so shared record systems. If we're going to have two different teams sorts of looking after the same person, it's important we have a shared record system and a way of communicating securely around that. The second is around professional integration. These are people we're looking after with very similar need and we bring different levels of expertise.

For a team to work efficiently and effectively requires a number of factors; it requires a shared purpose, it requires trust, it requires communication. A mechanism of building that trust, that communication is to have some clear roles and responsibilities through shared education activities and professional activities around that. But the third is sort of around clinical integration and how the service sort of fits together around who does what, when, where the roles and responsibilities lie and being really clear about that, because otherwise things can get quite muddied and I think that presents a risk to patients. So, you know, I think that – I would see it working with those sort of three elements to begin with, at least, being looked at and explored and solutions put in place around that.

I'd like to go back to process though, and I think, you know, it was mentioned that different localities, different areas will have different needs and so what's really important as we understand that the context varies across the country. This is a very heterogeneous situation. We know, for example, through primary health networks that one of their first and foremost functions is around assessing the needs of a population, and then commissioning services where there's gaps. A commissioning role can also be around enhancing existing services and improving the quality. And it's around the process – I think it's again using that footprint of local hospital districts, primary health networks which are often – which are no coterminous and then using the sort of co-design, co-production type of methodology to design a fit for purpose local solution. It's an important part of the process.

So I think whatever is agreed and implemented at a Commonwealth level or a State level I think it is important that the process of how this service is actually designed and delivered is a bottom-up approach through using co-design and co-production methodologies.

MR GRAY: So is this a fair summary, that if one takes an integrated care unit model, that should really address the point Ms Irvine has made about resort to specialists to avoid hospitalisations being a bandaid measure because the focus will be suitably on preventative health and primary health with more flexible resort to specialists - - -

DR DAWDA: Absolutely.

MR GRAY: - - - in the overall interests of quality of care?

DR DAWDA: Yes. Absolutely. Particularly if it's complemented by a blended payment mechanism which ultimately is designed to do that. It's just trying to get the balance right.

MR GRAY: I think we're coming up to lunch but I've just got time for a quick supplementary question for you, Dr Wallett. Perhaps as an alternative to the kind of interdisciplinary teams that you've been – you've all been addressing over the last 15 minutes or so, is there a need for financial incentives to encourage medical specialists in the core disciplines to be more ready to accept referrals from general practitioners to provide medical services in situ in aged care settings? Do you see any utility in increasing MBS items, perhaps extending MBS items for telehealth consultations with specialists or anything of that kind?

DR WALLETT: It is very challenging as a general practitioner looking after our residents when we do need that specialist input. The options often are to look around to see if somebody will attend, and that's very rare. The palliative care specialists and the geriatricians are the only two that I find are able to come into aged care facilities, but if you're finding – but if your resident is not able to be transported, a dermatologist won't come in, there's no incentives there. So changing the incentives to allow for specialists to attend aged care facilities, I think would make a big difference. We've heard about it as a wound care specialist, etcetera. Those things would help a lot if we could implement them.

MR GRAY: Is that a convenient time, Commissioners?

COMMISSIONER PAGONE: Yes. 2.15.

ADJOURNED **[12.59 pm]**

RESUMED **[2.16 pm]**

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner.

Ms Irvine, before leaving the multidisciplinary team topic, I understand you wished to raise a point that you feel has been omitted in the discussion so far.

MS IRVINE: I did. And it was around including in those teams the importance of the residential aged care staff as part of that, so not only the carers, the RNs, the care

managers and the facility managers because they obviously are integral of the whole on the ground care services, and I think that, too, in any model we are going forward in they should be considered and included and that's one of the things that we said about our dollar a day with a nurse practitioner is designed around supporting that clinical need within that design of that team. So I just want to make that point.

MR GRAY: Thank you. I wish to go now to a new topic. It relates to aspects of the Royal Australian College of General Practitioners standards for general practices, fifth edition, and to a draft document which the College has produced for discussion relating to the requirements that the College would like to see imposed on residential aged care facilities or, at any rate, adopted by residential aged care facilities to support general practice and visitation by general practitioners at those facilities. I'll direct these questions to yourselves, Dr Dawda and Dr Wallett.

The fifth edition of the standards for general practices require general practices to service an entire demographic range of their relevant community and to have a physical presence at which certain essential equipment is to be maintained in order for that general practice to achieve accreditation with the College. That is, accreditation with the authorities that administer accreditation – the accreditation regime. Now, it's been suggested that these matters can stand in the way of development of innovative mobile or virtual general practices which specialise in providing primary health care to older Australians in their own homes or in aged care facilities, and that this in turn means that specialised general practices of that kind might have difficulty accessing practice incentive payments designed to be an incentive to general practitioners to visit aged care facilities or to look after older Australians in their homes.

So Dr Dawda, starting with yourself, what's your response to a proposition that the College should amend the accreditation standard to allow general practices which practice exclusively in providing primary health care to aged care recipients in facilities and in their own homes to be accredited?

DR DAWDA: I would wholeheartedly support that proposition. Certainly we have experienced difficulties seeking accreditation for those reasons and it seems to me a little bit of a paradox when our whole service is designed to cater for people who can't get into practice, that we can't be accredited just because we've haven't got a height adjustable bed, for example, so I would wholeheartedly support that.

MR GRAY: Thank you. And Dr Wallett, what's your position?

DR WALLETT: Yes, I would also support it. I think if we look at accreditation standards as supporting the GPs that are doing the kind of work that is required in aged care facilities, standards are set up; they're not viewed as a set of rules but rather guidance towards the GPs. It might even encourage GPs to work in aged care facilities in a supported manner.

MR GRAY: I will now ask you a question, Dr Wallett, about the draft document which I mentioned a minute ago which is not, as I understand it, intended to be standards directed to what GPs should do when they visit residential aged care but rather is a list of things that the College considers facilities should do to support GPs. In your statement you've referred to those on page 0007 at around paragraph 41. You've also listed a number of things that facilities can do to support general practitioners visiting facilities. You've referred to the importance of internet access, access to residential notes, facilities to print documents and you've otherwise referred to that draft documents – that draft document I mentioned a minute ago. Dr Wallett, what's the importance of these matters you've referred to in your statement? Would you go so far as to say that the Royal Commissioners should recommend that requirements be imposed on residential aged care facilities to afford the support that you've listed in your statement?

DR WALLETT: It's a fairly challenging question in that every aged care facility is very different and the GPs that work there work in different ways as well. So I think that having some guidelines or some requirements that that engagement is discussed and possibly laid out would be – would be very good. The GP, the minimum requirements that I've laid out here which I think makes it very difficult, without these the GP's life is very difficult and encompasses all of the facilities at which I've worked and the GPs I've worked with have worked. So it's basic internet access, basic access to printers, access to the facility's notes to continue on with the clinical communication between the residents. So those are generally sort of minimum requirements that my GPs that I work with need. And anything more than that, I think, would be open to discussion, understanding that and maintaining that level of uniqueness that needs to be brought up between the aged care facility and the GP.

MR GRAY: In the draft document that the College has produced for discussion, there's another order of requirements that are mooted in that document along the lines of quite an extensive list of mandatory equipment, almost equipping the facility as if it were a medical clinic, at least a primary care medical clinic and also a suggested requirement for a consulting room. What is your position on those items?

DR WALLETT: My understanding is that talking to one of the members of the committee that wrote the standards is that these are – some of these are requirements that they're bringing forward, some of them are a wish list. This would be ideal but this is – these things are mandatory. So I think this is why it's in a draft form at the moment is they're getting lots of feedback on it and I think it will change going forward to make that idea a whole lot more clear. I think some GPs that come into aged care facilities will require a clinic room with everything set up there for them. Some GPs would be very happy to walk in with their computer and their own equipment and deal with residents that way. So I think one needs to be cautious of mandating things that some that might not fit into both the GP or the RACF.

MR GRAY: Dr Dawda, can I now come back to you on those supports that are mentioned in the draft College document and I noted in your statement that you referred to an aged care provider saying something to the effect that there's a heavy

burden on aged care providers at present in dealing with fluid situation. What's your view about the - - -

DR DAWDA: That's right.

MR GRAY: - - - about those supports recommended by the College?

DR DAWDA: So I think those standards for aged care facilities from the College about how they might work better with general practice, I think they're absolutely really well intentioned, but they are voluntary. And in my conversations with directors of nursing, for example, at residential aged care facilities, I think I've quoted one of them in my statement which was along the lines of, you know, "Please don't give us anything more to do. We just can't cope." I think there's a real risk of unintended consequences.

I certainly agree with Troye around some of the basic needs, you know, having good broadband internet access, having the ability to print documents, being able to access a computer, etcetera. I have gone to facilities and visited facilities where there's been the option of having a consulting room and what I've found is, whilst the concept sounds good, in practice, actually having staff bring residents down to the room has been a utilisation of staff time which could be better deployed doing something else. So I think that, you know, it needs – it needs careful thought about how it would actually operate because many residents within residential aged care facility will still need support to walk down or be brought in a wheelchair and that's taking a staff member away from other duties they could be doing.

DR WALLETT: I agree.

MR GRAY: Thank you, Dr Wallett. Ms Irvine?

MS IRVINE: I'd just like to make a comment and I think - and I've had a look at those draft standards as well from the RACGP. I agree, I think that the unintended consequences potentially for aged care providers and when you talk about, you know, as Troye said, aged care facilities across the country in different locations, rural, remote, even some regional areas, access to internet is problematic anyway and that would be an unnecessary burden. I also think one of the – I'd like to put a suggestion forward as part of this, is that basic service agreements between visiting GPs and the aged care providers could address a lot of the individual requirements and that gives a sense, I think, one of the issues that I see from residential aged care providers is it's all very well and good where you've got good GP support but when you've got sub-optimal GP support within a facility there is a lack of accountability, I think, and that causes some great concerns in some – in a lot of instances. So I think a service agreement requirement between general practitioners and any other health professionals going in where it outlines mutual responsibility and accountability would be - will go a long way to assuaging some of the concerns of GPs visiting but also concerns of aged care providers.

MR GRAY: Thank you, Ms Irvine. That's actually a very convenient segue into the next topic I wish to raise for the panel's consideration.

COMMISSIONER PAGONE: Just before you segue, Mr Gray, what would the – how do you envisage the agreement to look like? Would it be just a matter of each of the aged care facilities being more or less required to guarantee that they would make available something for GPs visiting? Is that what you had in mind?

MS IRVINE: No, I think on an individual basis, so a mutual conversation, as Troye suggested, between the – what the GP is thinking that they need to require, and don't forget we don't have to have one GP visiting an aged care facility and we visit one aged care service in South-East Queensland that has 55 GPs visiting that facility.

COMMISSIONER PAGONE: Well, that's why I ask.

MS IRVINE: So I think the ideal is, is, you know, a conversation about the requirements from the GPs who visit, what they need, and everyone is different. And also as I said, the mutual obligation clauses would, I think, improve the situation markedly across residential aged care for residents and providers.

COMMISSIONER PAGONE: Dr Wallett, you seem to – you've put your hand up as you do at school.

DR WALLETT: Yes. Thank you, Commissioner. I – currently the way that it works as a GP, if I wanted to engage with an aged care facility as a GP I would walk in, talk to the clinical manager and say I'm available. They would communicate with me and start offering my services to residents and I would pick them up and see them as a GP, and that's the nature of the relationship between myself and the aged care facility, so having a service agreement which we may discuss further would allow us to formalise that arrangement to say these would be the expectations that the aged care facility requires from me, and these are the expectations that I as a GP would require from the facility. It allows for that uniqueness between the way that I work and the aged care facility works. So I would agree that a service agreement sounds like a good idea.

COMMISSIONER PAGONE: So that would be a service agreement which would be a kind of memorandum of understanding, as it were, between the GP and the facility in a sense upon the assumption that there's a patient out there who may or may not need the GP services, but what about where the GP is the patient's GP, and the idea is that the resident/patient, wants the GP to come in? Are you envisaging that there would be a service agreement – that the service agreement would apply to that GP as well or would there be a different kind of model for the relationship between the facility and the GP?

DR WALLETT: I would think that - - -

MS IRVINE: After you.

DR WALLETT: I would think that it's vital that people are able to maintain their relationship with their GP and any restrictions that prevent that from happening I would think would not be ideal. The service agreement I would see would be – would still apply. The aged care facility would be able to hand that to the GP. The GP would say this is what I – this is what you can expect from me, and the RACF would say this is what you can expect from us. And so - because of the fluid nature of my consideration and others would work, it would still allow for those GPs to engage with the aged care facility but still have that memorandum of understanding.

COMMISSIONER PAGONE: So at one level the relationship between the patient/resident and that person's GP could simply be on the basis that any resident should have access to his or her GP without being impeded, full stop. That as a concept, I understand. But I thought what was going suggested was some more formalised arrangement where GPs could expect that the facility would make available some things, whatever they might be, and that it be formalised in some form of agreement. If the GP whose presence there is governed by the relationship the GP has with the patient/resident, rather than the formalised agreement, it looks at that level like a two-tier GP arrangement which doesn't sound optimal.

MS IRVINE: I think what it does, Commissioner, is provide a level of understanding both for the resident and their family and the aged care facility of what they can expect. So a GP may say formally, I will visit the aged care facility when needed, you can ring me any day of the week between 8 am and 8 pm and I will deal with the situation. You may have other GPs who say I'll only come in once a fortnight, but then everyone is very clear about what's expected and perhaps, if it's particularly articulated for each GP, what the arrangements are if they're not available. So everyone has got that understanding and that's not clearly articulated in the current models in most instances.

COMMISSIONER PAGONE: Is it what you would like us, the Commissioners to contemplate, is to recommend and possibly draft a model of what GPs could – should be able to expect from any facility they might visit, whether they might do so in an ongoing relationship with the facility or on the basis of visiting on behalf of a patient/resident?

MS IRVINE: I would, but at the same time I would like a mutual obligation clause in there because at the moment that's the bit that's missing.

COMMISSIONER PAGONE: And what would the GP be agreeing to from the other side.

MS IRVINE: I think, as Troye said, there are some things that aged care providers would like their GPs to assist with, so some of the things that they're required to have in regards to good clinical governance as well as accreditation requirements. So around medication charts, you know, how they respond to an acute or deteriorating resident and some of the things that we've talked about, some of these outreach services, I think that we would get a better level of understanding of what's

expected. And most relationships that you have, you have an understanding of what your rights and responsibilities and obligations are in a relationship.

COMMISSIONER PAGONE: And is there any possibility that the GP of a patient/resident might say no, that goes beyond what I have to do for my patient?

MS IRVINE: Yes, and I think it happens now anyway. I mean, we've just got an example of a facility that we support in Sydney where three GPs have over 75 per cent of the residents in that facility, and two of those GPs have just gone on leave without providing adequate backup service to that facility, which has left everybody quite challenged and that facility in particular, and those residents in that facility.

COMMISSIONER PAGONE: I see that Dr Dawda is tentatively raising his hand.

DR DAWDA: I am, I thought I would follow Troye's lead. Thank you, Commissioner. I have a – I completely understand the intent being described. I do have a slight difference of opinion though, and I come back to what I was talking about earlier around the integration agenda, and when I talk about this, I talk about it again as a GP but also one of my other roles which we haven't mentioned before is I am the editor-in-chief of a journal on integrated health care, so it's informed by some of that knowledge. What we know about integrated health care is it's really dependent on relationships and good relationships. I worry about having service level agreements, as it becomes a transactional, rather than a transformational system.

I think where integrated care works well is when those relationships are being built and developed and nurtured and then they are formalised through an agreement, or an MOU. My worry with just having an MOU and a recommendation around that is it becomes very transactional. There's no teeth for either party if the contract isn't - you know, if the MOU or the SLA isn't followed. You know, there's no teeth so what happens in that eventuality And ultimately the relationship here is between the patient and the GP. And so I worry by introducing a third party which is, you know, with the purpose of clarifying accountabilities where there's no – no exchange of moneys, for example, between the two parties, could potentially be detrimental and may actually put some GPs off providing services to residential aged care, so I think, again, there's a risk of an unintended consequence.

COMMISSIONER PAGONE: Well, it's really because of those kinds of considerations that I ask these questions on this topic. During the session we've heard lots of things which as somebody who doesn't have much background in aged care or, indeed, care generally, sound like a good idea and one is tempted to say, well, that's a good idea, we will recommend that. But when you look at these, that sounds like a good idea ideas, they seem to have problems. What should we do?

DR WALLETT: I think that – I am a GP, not a lawyer, and so the nature of the terminology, I don't have a good handle on. But the way that I see this is there's a relationship between the GP and the patient that is – and sometimes there's

documents that are signed around that when you start with practices and that sort of – there's understanding on that level. And then there's also the relationship between the GP and the aged care facility. At the moment that's a very informal - and so much so that there could be misunderstandings as to, I'm - as a GP, I'm going to deliver these services on these days, and I can just rock up and basically do as I please.

And in some way recommending that there is some kind of agreement and I wouldn't – I would think it more as a relationship agreement rather than a legal entity, and I think memorandum of understanding is what I think that sounds like, and it would basically be saying, as an aged care facility this is how we practice and this is how we look after our people, and as the GP you would say, yes, and this is what I am intending to do, and so that there is some kind of communication between those two parties. Because at the moment it's very informal and different GPs do different things and expect different things and if you can start off a relationship knowing what is available, I think it will lead to better outcomes to the residents.

COMMISSIONER PAGONE: Well, one aspect of what you described – and I'm not even being remotely critical of this description but just to pare it down to its most elemental aspects, one aspect of what you describe could be seen as an arrangement with a – a doctor's arrangement with a facility for the doctor to conduct practice from the facility and it is simply an arrangement between the two so that the GP will say look, I'll be here on such and such a day, and there are all sorts of models all over the world where you have itinerant travelling professionals, you know, the book fairs that turn up amongst the barristers they're probably familiar with, the tailors who arrive from Hong Kong to take up their orders for the season, and it's – I'm not saying it critically in any way, it makes perfect sense that you might have an arrangement with the facility whereby the doctor says I will turn up and as it were, conduct practice from this facility during this period of time.

But that doesn't deal with the other situation, does it, where the GP has a relationship with the resident independently of that. The GP is outside of that system, and what should we be doing about that aspect of it?

MS IRVINE: One of the things that I mention in my submission is the fact that whether traditional general practice is actually the right model of care - and my learned colleagues on the right of me might have a view of that, but I think that - I've been around working in the aged care sector for 27 years and over that time, with this increasing complexity of residents, we need a model which is designed around supporting those complex conditions that residents in aged care have, so from that, you know, as I said before, you know, the dementia behaviours and management, depression and mental health issues and psychoses, the ageing of the disability sector and palliative and end of life care. So it's a very different model that you might see in traditional general practice. It's not what you see. You see more primary health care. It's becoming a different model of care and I think that we're trying to at times fit a round peg into a square or vice versa.

COMMISSIONER PAGONE: And is that because some residents have conditions - if I can use that description, in the hope it doesn't get misunderstood – that isn't really the same thing as a transient illness?

MS IRVINE: Exactly.

COMMISSIONER PAGONE: So that a doctor might be able to be of help if it's a transient thing but if it's a condition that you've got either permanently or degrading that you need a completely different kind of treatment; is that what you're getting at?

MS IRVINE: It's a different holistic way of looking at it. And aged care specialist GPs, like Paresh and Troye, get that there's that complexity but there's a lot of other GPs that don't necessarily do that. And I think, going back to my team approach and one of the issues of residential aged care is the fact that we've talked about it and your other witnesses have said, is about the lack of clinical experience of the registered staff and the care staff in the facilities, and I can – we could spend another session talking about that from my perspective. But I think that, you know, from our model with the nurse practitioners providing that higher level of clinical oversight, advanced practice which is what – that's the layer that's missing in residential aged care at the moment.

And that's where that team approach needs to be with specialist aged care general practitioners, other specialists, gerontologists and others and this advanced practice clinical support for residential aged care and then we would solve many of the issues that your witnesses, like earlier this morning were talking about, they would be addressed.

COMMISSIONER PAGONE: Just getting back then to – we'll just call it an MOU, just for want of a better word, at the moment I'm having difficulties contemplating what the irreducible minimum terms would look like, because it would seem to me to be so GP and context specific, it may just be – and indeed it may just be whatever the facility can afford to whatever the market might encourage them to pay more for.

MS IRVINE: Or individuals themselves.

COMMISSIONER PAGONE: Or individuals themselves.

MS IRVINE: Yes.

COMMISSIONER PAGONE: If you've got some ideas, now is a good time to tell me.

DR WALLETT: When I've worked, I was speaking to a clinical manager on Friday and the overwhelming view is looking after residents and looking after their people, and I think having some recommendation that the MOU is put into place but leaving it loose between the aged care facilities and the GPs, I think, would be – would be

fairly powerful in that – and I acknowledge that there are some aged care facilities where they are – I stated before, there are lots of them that are crying out for GPs and need GPs to work there, but there are some that say, well, in the metropolitan areas where they have 55 GPs and I think I would say that as a aged care facility you can recommend GPs. So leaving aside the GPs that follow their patients to an aged care facility, and those do happen and I believe that's sovereign, oftentimes there are GPs that will say - put their hands up, such as myself, if the residents doesn't have a GP, I'll take them on.

For me, the facility would hand me their service agreement that they have set up and say, "These are the minimum requirements that we have for our GPs and our facility. Are you able to achieve those? Are you able to attend your residents once a day?" It could be as simple as, "How do we communicate with you after-hours? How do we do these things", etcetera, etcetera. There are various different – we don't have to say a GP has to attend every week but we could say, "How often do you plan to attend? What is your after-hours contact details", etcetera, etcetera and again I could – I'm sure we could come up with a list of five or six or seven things that would be required on a MOU, not dictating the answer to them but at least the questions.

COMMISSIONER PAGONE: What would be the incentive from the doctors' point of view, putting your practice to one side - yours is different.

DR WALLETT: Yes.

COMMISSIONER PAGONE: But what would be the incentive more broadly?

DR WALLETT: I think a GP knowing how the – the RACF works would be incredibly valuable and having that agreement upfront would be really valuable because then I could say to them, here's my mobile number, for example, call me anytime until 7 o'clock and then after that call the after-hours service. And then I won't be receiving phone calls at 9 o'clock. So they understand – so we would have a working relationship that we've sat down and chatted about initially, rather than having to build that over the first couple of months as we're getting to know each other.

COMMISSIONER PAGONE: Would it be simply like creating a dedicated aged care locum arrangements?

MS IRVINE: That's actually been tried in Canberra. We had an in-hours GP aged care locum service a few years ago that was financed by the ACT Government and supported by GPs, and that worked particularly well, an in-hours locum service for GPs, and we got a lot of support for GPs visiting aged care. But I do go back to - and I'm worried that we've gone over time here, but I was – one of the things that I – we kept coming back to is that where the nurse practitioner and our model fits in, in supporting – again supporting GPs coming into aged care, and particularly for the aged care facilities where they have access to nurse practitioners and a funding model to support them to engage nurse practitioners, because there isn't at the

moment, is that that provides that complex clinical care that often also challenges GPs coming into aged care around managing family dynamics, those complex behaviours and those sorts of things.

COMMISSIONER PAGONE: And is the Canberra model still active?

MS IRVINE: No, it was defunded.

DR DAWDA: It was decommissioned in June 2016, I believe.

COMMISSIONER PAGONE: Because?

DR DAWDA: The funding arrangements for that were supported by Territory Government, so the ACT health system with billings being funded through MBS and I don't know the detail, but my understanding is it was felt not to be a financially viable service for the number of clients that were being seen during that daytime period.

COMMISSIONER PAGONE: But otherwise successful from a health point of view?

MS IRVINE: Absolutely.

DR DAWDA: So certainly when that service was decommissioned, I noticed in the four to five months afterwards, the number of patients that were coming over to our service increased predominantly because their previous GP was withdrawing doing any aged care as a consequence of that daytime service being suspended.

COMMISSIONER PAGONE: Has this been studied?

DR DAWDA: So I don't believe the evaluation of that service is publicly available. But I understand there was an evaluation of it which probably rests with the ACT Medicare local as it was at the time. I think the other thing in terms of the solution around this, and I come back to primary health networks, primary health networks have a role in making sure there's effectiveness and efficiency of primary health services within that patch. They also have a role in identifying service gaps and I think what we're highlighting is service gaps which are – which take very heterogeneous nature across the country and across localities, and so it seems to me, like, again, we have this footprint of primary health networks which we're under-utilising at the moment in the health system, and I think we could actually use that footprint to help us solve some of these problems.

COMMISSIONER PAGONE: If one wanted to get hold of this evaluation, who should one ask?

DR DAWDA: So the ACT Medicare local's successor organisation is Capital Health Network, which is the primary health network in the ACT. I would assume

that they would have access to that, and the ACT Government, I would have thought, would have access to that as well.

DR WALLETT: We've certainly looked at that as from a corporate point of you as launching a daytime locum service and density was the reason why we didn't. We didn't think we would have enough work for GPs to make it efficient. So that might give you some insight as to what may be a reason why that didn't work is the density issue.

COMMISSIONER PAGONE: Thank you.

MR GRAY: The next set of topics have been substantially covered but I will just round off on them and seek your conclusions on each of them. There are three interrelated propositions that staff of the Royal Commission are testing in this hearing. One is that there's a need for more precision and clarity about the extent of residential aged care providers' responsibilities to obtain primary health care for the people in their care. That is particularly accentuated now that there's a clinical governance framework perhaps. The proposal would be that the relevant subordinate legislation be amended to clarify exactly what it is that aged care providers are required to provide. It may be that, in the course of the discussion that's just been had, you've really answered that and the MOU idea seems to be the preferred idea because of its flexibility but I will just give each of you an opportunity to comment in a minute.

The next proposition is whether there should be a requirement on an aged care provider to itself engage the primary health care practitioner for the person in care. Now, this might be as part of a tripartite arrangement and it might have some relationship with the funding model evidence that the panel gave before lunch. I'd like to test your views on whether there's any support for a requirement that residential aged care providers themselves have a direct engagement relationship with primary health practitioners. Again, perhaps what's been said about the MOU might really supply some of the answer to that.

And finally there's a proposal that's under consideration that residents of residential aged care facilities should have a care coordinator to assist in them accessing appropriate health care to ensure that their health care plan is being implemented to liaise with general practitioners and to liaise with any outreach services, family and the rest of the facility. So starting with you, Dr Dawda, there are those three questions: should there be requirements imposed about the clarifications of roles of aged care providers to obtain primary health care; should they, in fact, be required themselves to engage the relevant primary health care; and what, if anything, is the role of a care coordinator?

DR DAWDA: I certainly think there should be clarification around the role. I think that's important so people know whose responsibility it is. I do have concerns about passing the responsibility on to the residential aged care facility to secure primary care for that resident. I think that could work well but it could be lots of unintended

consequences as well, and we've certainly seen examples where that's happened. I completely agree with the need for a care coordinator. My thoughts around where that care coordinator should sit are – I have some uncertainty around that. As I understand it at the moment, the proposition is that the care coordinator might either sit within the residential aged care facility or maybe, sort of, commission from part of that multidisciplinary team conversation we had earlier.

I have some concern that having a care coordinator who is sitting within general practice hasn't been considered and my main reason for – well, I have two reasons for this concern. Firstly, we know contemporary models of general practice are taking on a care coordination function so if we look at the Health Care Homes pilot, for example, that's to look at one of the goals is to look at care coordination. We've got examples from the DVA and the Coordinated Veterans' Care Program which is around coordination of care, with that sitting in general practice, and we could have some learnings from that around how we could do care coordination with it being embedded in general practice as opposed to outside general practice.

And finally I think, you know, whilst we're focusing on a population of residential aged care, there's all the older people that are in the community and what's being proposed at the moment doesn't necessarily support care coordination for those older people in the community. Which I think an exploration of how that could happen within general practice may actually fit both cases in community and residential aged care, so I think that's something that ought to be considered.

MR GRAY: Thank you. Dr Wallett, would you like me to repeat those three points?

DR WALLETT: No, I have – I have comments on the - I have got them written down. The requirement to engage primary health care practices, I agree, is problematic. I think that, again, it adds a burden to the aged care facilities which are overburdened already. However, it does worry me that aged care facilities are being built in remote and rural and sort of more distant areas without consideration to where they are going to receive primary health care. And so whether it's as a – so I suspect that it is a good proposition at a certain level and it possibly could be on a licensing level rather than on an operational level. Again, that's a little bit out of my expertise but it does concern me by adding up burden to these aged care facilities but it does worry me, yes. I'm repeating myself.

The care coordinator idea, I think, is very good. This is the first time I considered – I have heard the idea of basing them in general practice. I do like the idea of them being based in the aged care facilities because then they can then – they would have 100 or so residents to look after. And in a general practice, it increases the scope, so we can do home visits through them, but generally an aged care – a general practice will have fewer residents to look after. And then it brings up issues of how do you register your aged care facility patient with the care coordinator. So I do like the idea. To me it sounds like it needs some nutting out and thinking about to where that person sits and how that can sit and where and how that would work. But from a

working GP point of view I like the idea of being able to walk into a facility, finding the care coordinator who will tell me all about my residents, find the pressure wounds we heard about before, phone specialists and get them and do all that kind of thing, so I think it is a good idea.

MR GRAY: And on clarification of roles, rather than them being imposed through subordinate legislation, do we take it that your view is that the MOU approach is the appropriate approach?

DR WALLETT: Yes. After today's discussion I think there's a lot to think about but, yes, I think an MOU is important.

MR GRAY: Ms Irvine.

MS IRVINE: So I think as everyone has sort of suggested that there are potential unintended consequences around enforcing aged care providers to engage. I think that there's – we've seen it elsewhere and there are unintended consequences. I think the MOU model or something of that nature would be - I think it's something that needs fleshing out and talking about. In regards to the care coordinator, our model and our proposition would be that, you know, on a dollar a day for a nurse practitioner across aged care, across the country, where that money is allocated and quarantined specifically for the advanced clinical practice nurse practitioner, and that that particular skill set would be the ideal for the care coordination role.

It – I think it is slightly different within the community and I think Paresh's idea of that potentially being in and around general practice would work but I don't think it works particularly for residential aged care. I think a nurse practitioner style model is where that would sit best in residential care. They have the ability to, you know – they speak the same language as doctors, they can talk to the specialists, they can talk to all the aged care, they could talk to families. They have the time to talk to families and look at those issues.

MR GRAY: Are there sufficient numbers of nurse practitioners to achieve that at present?

MS IRVINE: Look, we've done some modelling and we will send you – I got a letter last night about - asking for us to submit something else, around our proposition, is that it would be – we said we've identified there probably needs another 600 nurse practitioners and based on current modelling of the number of nurse practitioners coming out and if there was a scholarship program we could probably get those numbers within five to six years.

MR GRAY: The final topic I wish to address, if that's all right with the Commissioners, given the time, thank you is - - -

COMMISSIONER PAGONE: Just a tick.

MR GRAY: Thank you.

COMMISSIONER BRIGGS: I think we will give you extra time, Mr Gray, because this is something that I'm interested in, and I'm sure it doesn't matter to the Commission if this is going to be going a little over.

COMMISSIONER PAGONE: Not at all.

COMMISSIONER BRIGGS: I've had many suggestions about who might have to manage care coordination over the years and it goes between geriatricians, GPs, nurse practitioners, RNs and so on, and what disturbs me about these model is that everyone loses sight of the person who should be getting care and there's a lot of argy-bargy that goes on between all different sides about who might need these arrangements, and so I want you to have a stab at telling us what you think would work best in all settings to begin with, and then if you can't do that specifically for in the home and then in a residential aged care arrangement.

MS IRVINE: Could you just repeat that last little bit?

COMMISSIONER BRIGGS: I'd like you to have a stab at putting aside your professional hats, which arrangement would look better for care coordination and does it necessarily have to have - is there an arrangement where teams can work leaderless but more importantly, if you can't envisage that, what would work best in both the community and in a facility or overall?

DR DAWDA: May I start, Commissioner?

COMMISSIONER PAGONE: But with a loud voice, please, because we can't hear you all the time.

DR DAWDA: I – my sense is the function of care coordination isn't necessarily correlated with any particular craft group. I think it's a function and I think the function can be fulfilled by a number of different craft groups. It could be a medical person, so it could be a GP, it could be a geriatrician, it could be a nurse practitioner, it could be a nurse, it could be a social worker. It could even be a very well-trained care worker. There are all sorts of models out there. I think we need to be responsive to what the local context is, what the local needs are, what the workforce issues are locally and availability of workforce, so, you know, that's the first thing I'd say about care coordination, is I don't think we should say it's a particular craft group. I think we should say it's a function that's required, and then the craft group that fulfils that function, subject to appropriate training and regulations and so on can vary.

In terms of where it sits, I think, again, the key element is around integration. A lot of the function of the care coordination is around having conversations with the different care providers involved in that person's care, the person and the family, sitting – and in my view, I feel from what I've seen of contemporary general practice

and models around high performing primary care around the world that function sitting within general practice is a very cost effective way of doing things, partly because we know clinical data sits within general practice systems. Collaboration with the general practice has perhaps been the medical home which is often what's talked about for patients, kind of helps leverage that.

I think although that function sits within general practice, it doesn't mean that they always have to be in the general practice. There's nothing to say that they can't go and spend a day within a residential aged care facility to have a conversation with the staff there around particular clients, particular patients. So, you know, my view is very much let's not tie it to a craft group, let's embed it within general practice because we know from high performing primary care from around the world that's where contemporary general practice is heading towards, and that's where the evidence is so why not go with the evidence.

DR WALLETT: I couldn't say that better. I think that it – I think that – yes, I think that's – there are a couple of things to add, and I'm very – first of all, I thank you for the question because the turf war arguments drive me crazy, excuse my colloquialism, and hides the real discussion about who's looking after the patient or the person. I think – and Australia is a unique and beautiful country in that our metropolitan areas are different to our more rural areas, just 100 kilometres out of a metropolitan area their resources are very different. So setting up a system that would work that's loose enough to work in both of those areas is important, rather than saying it's this group that's going to be in charge of that. All that said, I think the awareness that GPs are trained in multidisciplinary care coordination, I do some of the examination for the RACGP and every question has got "Who are you going to be involving in the care of this patient, the physiotherapist, the allied health professionals, the nurse practitioners, the specialists, so we are trained to coordinate care.

However, having the support of a nurse practitioner who's able to be in the facility, look at the patients a little bit more and help and guide that care I think is important as well. And specialists cover – it brings an expertise that is very necessary but they are stretched very, very thin. So I think looking at it as a collaboration and as a team approach, rather than we all want a little bit of this and a bit of that is important.

MS IRVINE: Thank you, Commissioner, for the question. Look, I think it goes back to – and whilst I do agree with the models that both Paresh and Troye are talking about, from a community perspective and around primary care and general practice but as in my previous comments I think aged care, residential aged care in particular is vastly different and where I see the – and we see across the 40-odd homes that we currently are in, is that level of clinical care coordination at that advanced practice nursing level is significantly missing, and I think that with a team approach where you've got a nurse practitioner coordinating and assisting the residential aged care and their residents and their families in conversations with the visiting GPs and making that a true team care-based approach is the most effective, cost effective and appropriate clinical model for residential aged care.

MR GRAY: Thank you, Commissioner.

COMMISSIONER PAGONE: Just before – Dr Wallett, before we leave those topics, you mentioned when we were talking about whether a memorandum of understanding would be the way to go, you mentioned, I think, twice the idea of a licensing arrangement and because I – because I am a lawyer, I do wonder what that would entail. Would there be – or in your experience has that resulted in the aged care facility saying, well, if you the doctor expects to have facilities here, then it will come at a cost because somebody has got to pay for the overheads that are associated with the kind of facilities that you need, or has that not yet arisen?

DR WALLETT: My understanding of the question is, I – when I suggested licensing, I was considering the idea of an aged care facility organisation deciding to build a facility in a remote area, without consideration of where they're going to get their primary care from. And so as part of the – I've no idea if this is true but I'm assuming that they would need some type of licensing or some type of – to register an aged care facility in a certain area, and at that level I would think as part of their request, having who's going to be supplying primary care to your residents is an important question that they could answer.

My thinking that they could then go to the local general practice and say we're going to build a 100 facility aged care facility in your area, will you be able to manage those residents and can you sign here; I feel like it will be as simple as that. And whether there's money exchanged for the signature or not, I'm not sure, but it does worry me that these facilities are built and I know lots of them, especially in the rural areas - - -

COMMISSIONER PAGONE: But one can imagine, though, that if a facility is being built with facilities or parts of facilities from which a GP might be conducting a practice, that the facility might then be tempted to ask the GP to contribute to that cost?

MS IRVINE: From my experience – aged care providers, that wouldn't happen. They may like to but they wouldn't do it, I don't think, not in this particular climate because they're just very grateful for any medical support that they can get into their facilities.

DR WALLETT: I think the practice would just say no, they won't contribute to the costs because for most general practises, having patients is not their problem. Most of the time it's actually having GPs sitting in their chairs that's the problem.

MR GRAY: Time permitting – I'm sorry, Commissioner.

COMMISSIONER BRIGGS: No, I've just got one more question, and I understand how you're talking about getting nurse practitioners into residential aged care. Is remuneration the only issue that Dr Wallett and Dr Dawda think is necessary, really, to get GPs into aged care?

DR DAWDA: No, I don't believe remuneration is the only issue. I think it's part of the issue. So I think it's also around the professional satisfaction. So one of the reasons I do it is not for the remuneration, because of the professional satisfaction it gives me so I think that's certainly an intrinsic motivator to tap into. I think what puts people off, what the barriers are is the huge volume of non-clinical administrative tasks, faxes toing and froing, messages sort of bouncing around. So I think if some of that non-clinical burden can be systemised and made more efficient and made to be less of a burden, then I think that would incentivise some GPs to do aged care.

COMMISSIONER BRIGGS: Dr Wallett?

DR WALLETT: I agree. The systems are a big barrier to entry. There's two other things that in my experience – and I speak to lots of GPs trying to get them into aged care. One of them is clinical mastery. In the general practice training, aged care is a big aspect of it, but there are far fewer GPs that actually attends aged care facilities as registrars, and so the training aspect of it is important. And then the – another one is inertia. If I'm a GP sitting in a general practice it takes a little bit of a push to get me out of my chair and into the community because it's very comfortable and easy and there's no reason for me to leave my chair. So it's just human inertia that stops people from – from moving into the aged care facility area and work.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: Finally, should the Royal Commissioners recommend that residential aged care facilities and possibly home care providers as well should have to have the ability to communicate their care plans up onto My Health Record? Would that assist in the provision of primary health care understand the models that you support, starting with you, Dr Dawda?

DR DAWDA: I was fortunate enough to be speaking to the chief medical officer for the Digital Health Agency this morning, and so I took the opportunity to ask how many aged care facilities are using My Health Record actively, and there's very few. I - it's my opinion, my belief that certainly utilising the original my health record should be done and should be encouraged. However, I don't think we should stop there. I think it's about secure information exchange with the plurality of providers that are involved in the resident's care, and so we should be looking at digital communication in a secure way with all those providers and certainly My Health Record should be a component of that. But I don't think my health record is a two-way communication tool, and therefore I don't think should limit ourselves just to My Health Record.

MR GRAY: That sounds complex. Would mandating My Health Record at least be a useful first step while the more complex digital interoperability solutions are pursued?

DR DAWDA: I think if you're going to do anything, yes, definitely a first, you know, as a stepping stone. That said, the Digital Health Agency has commissioned a framework for interoperability and in the fullness of the next year I would have thought that framework would be available. The technology – from a technical point of view, I don't think there's a technological barrier; it's not new technology. It's just about creating the market and making it happen. So I think it's - my opinion, it's low-hanging fruit.

MR GRAY: Thank you. Dr Wallett?

DR WALLETT: I don't have anything else to add. I agree with all those statements.

MR GRAY: Ms Irvine.

MS IRVINE: I think there's potential unintended consequences. We have many aged care providers across the country who still don't use digital systems at all, so they're still paper based in a lot of ways. I think one of the other big problems is the communication between residential care and hospitals. That's quite poor. And I think, you know, hospitals across the country have got their own problems from an integrated, you know, health care model, having personal experience in recent years where, you know, admission to one part of the hospital and they don't talk to the other part of the hospital. So I think there's – there could be some unintended consequences for making things mandatory at this stage.

COMMISSIONER BRIGGS: Would you agree, however, Ms Irvine, that ideally every aged care facility in the country should have access to digital systems?

MS IRVINE: Absolutely.

COMMISSIONER BRIGGS: Absolutely.

MS IRVINE: But we have some of the largest providers and listed companies in the country who are not.

COMMISSIONER BRIGGS: And that is surprising, so one would be expecting those providers to upskill in this area, do you imagine?

MS IRVINE: I would hope so.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: Commissioners, they exhaust the questions that I have for the panel and we can move directly to the next panel.

COMMISSIONER PAGONE: Good. Thank you. Thank you for sharing your expertise with us. We are better informed. Thank you.

MS IRVINE: Thank you.

MR GRAY: May the witnesses be excused.

COMMISSIONER PAGONE: Yes. And you're formally excused.

MS IRVINE: Thank you very much, Commissioners.

<THE WITNESSES WITHDREW [3.19 pm]

MR GRAY: Commissioners, the next witnesses are Dr Anthony Bartone and Associate Professor Mark Morgan. I call those witnesses to the witness box.

COMMISSIONER PAGONE: Yes. Thank you.

<ANTHONY BARTONE, SWORN [3.20 pm]

<MARK MORGAN, AFFIRMED

<EXAMINATION BY MR GRAY

MR GRAY: Thank you. Please take a seat. Dr Bartone, what's your full name?

DR BARTONE: Dr Anthony Bartone.

MR GRAY: I will ask that your most recent statement be displayed on the screen before you, WIT.1301.0001.0001. Dr Bartone, can you see there a copy of your statement dated 27 November 2019?

DR BARTONE: I certainly can.

MR GRAY: Do you wish to make any changes to the statement?

DR BARTONE: No, do I not.

MR GRAY: To the best of your knowledge and belief, are the facts in the statement true and correct and the opinions in it opinions that you sincerely hold?

DR BARTONE: I do.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The statement of Dr Bartone will be exhibit 14-9.

EXHIBIT #14-9 STATEMENT OF ANTHONY BARTONE DATED 27/11/2019

MR GRAY: Thank you, Commissioner. For the record, the statement refers to the AMA's submission of the Royal Commission which is to be found at general tender bundle tab 25. Professor Morgan, what is your full name.

ASSOC PROF MORGAN: Mark Morgan.

MR GRAY: I ask that your statement be displayed on the screen before you. It's WIT.1317.0001.0001. Do you see there a copy of the statement you've made for the Royal Commission dated 5 December 2019?

ASSOC PROF MORGAN: Yes.

MR GRAY: Do you wish to make any amendments?

ASSOC PROF MORGAN: No.

MR GRAY: Are the facts stated in the statement true and correct and are the opinions in it opinions that are held by the College or that are held by you personally?

ASSOC PROF MORGAN: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes, the statement of Professor Morgan will be exhibit 14-10.

EXHIBIT #14-10 STATEMENT OF MARK MORGAN DATED 05/12/2019

MR GRAY: Thank you. And that statement of Professor Morgan refers to the draft College standards to which reference has already been made at general tender bundle tab 46, also to two phases of the MBS review taskforce report of the GP and Primary Care Clinical Committee.

Dr Bartone, you're the President of the Australian Medical Association, the AMA. You were elected Federal President of the AMA in March 2018 having served as vice-president since May 2016. You're an experienced GP and a management

executive. Your principal specialty interests include men's health, mental health counselling, care coordination of patients with multiple chronic illnesses and aged care. Is that all correct?

DR BARTONE: Correct.

MR GRAY: Thank you. Professor Morgan, you're the chair of the Royal Australian College of General Practitioners Expert Committee on Quality Care, REC-QC; is that correct?

ASSOC PROF MORGAN: Yes.

MR GRAY: That's a role you've been in since October 2018.

ASSOC PROF MORGAN: Yes.

MR GRAY: The REC-QC advises on matters of clinical experience to the College and to general practice and produces a suite of clinical resources. You have it 22 years of experience as a general practitioner. Your current appointments or employment are as Associate Professor, Faculty of Health Sciences and Medicine at Bond University and general practitioner at Eastbrooke Family Clinic Burleigh Waters; is that correct?

ASSOC PROF MORGAN: Yes, that's correct.

MR GRAY: You hold a range of appointments which are detailed in a long list in the statement. I won't read them all.

ASSOC PROF MORGAN: Thank you.

MR GRAY: Dr Bartone and Dr Morgan, I'll just lead into the first topic I wish to raise for your comment. You may have received a document setting these out that will assist for the purpose of giving, probably best if I read that out and then I'll direct some specific questions to you. The material before the Royal Commission suggests that the current model for the provision of primary health care to people who are in the aged care system rests primarily on the relationship between patient and general practitioner, and primarily that's a service provision model which involves remuneration on a fee for service basis through Medicare. In addition there are practice incentive payments but primarily it relies on a fee for service approach.

It appears that this model is under strain in aged care settings. I refer in particular to the AMAs 2017 survey which you referred to in your material, Dr Bartone, including in your original statement in February, and that survey provides some evidence of the attitudes of medical practitioners about visitation of residential aged care facilities and it makes sobering reading. Also, the Royal Commission's staff analysis of unpublished AIHW data suggests that 46 per cent of general practitioners are not delivering services to aged care residents. So if one thinks about the principle of

continuity of care, a matter that's referred to in your statements, it seems that on the basis of those data, a person transitioning from living in the community to living in a residential aged care facility would probably have roughly an equal chance of having to change general practitioners upon that transition.

Now, each of the AMA and the College respectively supports increases in the level of Medicare rebates for consultations for general practitioners providing primary health care services to residents and to others in the aged care system. In this first topic, I want to explore both the AMAs and the college's views on the question of whether addressing MBS items and the levels of rebate is, in itself, a sufficient response or whether the model for delivering care and the way in which funding applies needs augmentation or even fundamental reform. If it does, what changes are needed?

Dr Bartone, would you like to address those topics first? Of course, you have - in the material the AMA has provided to the Royal Commission, including your statements identified in detail, arguments for the increase in MBS rebate levels and you've pointed out that the AMA has consistently, in recent times, been seeking high increases in those items. In addition and augmenting that matter, if we could to the question of the funding model. What's the AMAs position on whether the funding model needs to be fundamentally reformed to perhaps involve a base fee on a capitation model as an augmentation for fee for services?

DR BARTONE: So if we look at how primary care is to be funded into the future, what we're seeing now is an increased movement or an increased understanding that fee for service alone will not support the increase in chronicity of care, the increased complexity of care and the increase in non-face-to-face care. So that increasing non-face-to-face component needs to be funded in an alternative way to the fee for service model whereby the MBS moiety only rewards time spent in front of the patient. So, therefore, noncontact time with patient essentially, except very few occasions perhaps, is not remunerated.

So with – and we're looking at the increasing complexities, as I say, and the increasing amount of non-face-to-face care. So not only in aged care but right across the whole primary care spectrum, we're now looking at a blended payment of funding. More so than any of those other spectrums or any localities, aged care would really be a screaming example, in my opinion, of where that blended approach needs to be considered even more so. Notwithstanding that we already have an ineffectual blended payment model between the MBS and the PIP which is an incentive grant, you might call it, for – for the amount of work that you might do in an aged care facility but not directly rewarding face-to-face time, those two components together largely do not reward or completely remunerate in any way, shape or form the activity required. And so what we're saying is the principles are sound, the funding is woefully inadequate and needs to be reviewed and not only augmented but also improved in that relationship between the amount of work that really goes on, and I think if you go back to both my previous testimony to the Commission, the amount of work that happens after you've finished your visit at the

facility is significant if not substantial, and all of that occurs outside the envelope of the MBS fee for service and the PIP grant that currently exists.

MR GRAY: What would that blended funding model look like precisely? Does the AMA have a position on how the base component of that blended funding model would be constructed?

DR BARTONE: Certainly there is a significant amount of work being done at the moment in the primary care steering group by the Minister that is looking at a voluntary nomination payment for those – at this stage for those over 70 in the community that nominate a GP or a GP practice as their usual doctor. That kind of backbone could be – that kind of funding arrangement could be the backbone if appropriately funded to ensure that there was both that blended component but also a significant redress of that MBS item funding.

MR GRAY: So that's an enrolment model?

DR BARTONE: Enrolment is one part of that, yes, there is an enrolment process but essentially the patient or the resident would just nominate a doctor or a practice as being their regular practice or their regular doctor, and that would see those payments follow that period of nomination into the future.

MR GRAY: Would that be outcomes based?

DR BARTONE: No, that's at this stage the – the entire process is about a certain level of – what's the word I'm looking for – activity, not even activity, sort of addressing certain scopes or certain items of care ensuring that they were part of the everyday relationship between doctor and patient. In an aged care facility there would be, I would imagine, a different set of requirements but it wouldn't be – there's no scope at this stage for any outcomes based payment there.

MR GRAY: Right. Dr Morgan, I should say Associate Professor Morgan, what's your position or perhaps more precisely the College's position on this question of whether the funding model needs reform – fundamental reform and a move away from heavy reliance on a Medicare base fee for service.

ASSOC PROF MORGAN: The quantum of funding certainly needs some reform if we're going to shore up the struggling system. I think those points have been well made. It's worth, in addition to contemplating the amount of work that surrounds the face-to-face care provided to residents of aged care facilities, there's no funding module that drives quality improvement activities or the care coordination activities or – or audit and feedback, looking at patient's safety events or taking a population health approach, so being able to look at perhaps your antimicrobial – antibiotic prescribing rates or for the provision and collection of data or analysis of that data, so there's a lot of activities that you would think would be really valuable activities for the system and for patient care that are not covered under a strict fee for item of service model of payment.

So in terms of the College's position on blended models, a enrolment - voluntary enrolment scheme is something that the College is in favour of and that voluntary enrolment would come with some payment – in exchange for some payment, some responsibilities and there would need to be a balance between those aspects.

MR GRAY: When you referred to what the fee for service model does not do, in that it does not create incentives for a range of desirable outcomes - - -

ASSOC PROF MORGAN: Yes.

MR GRAY: - - - and then when you moved to the topic of what the College supports which is a blended model involving voluntary enrolment, you didn't mention whether any of those incentives towards those desirable outcomes would be built into the funding model that the College prefers involving voluntary enrolment. Does the College have a position on whether there would be any outcomes based incentives built into the base enrolment funding under the blended model?

ASSOC PROF MORGAN: If you wouldn't mind me just parking just a moment the outcomes based, the things I described are all process-based for improved quality, and continuous improved quality, improved patient safety and improved system performance. The College does not support a pay for performance or strict outcome based pay because it distorts clinical decision-making and leads to a number of unintended consequences. So what happens – what ends up happening in pay for performance model is that things that are easy to measure are the things that get measured and they're not always the most important or best things to be measuring and those are the things that get incentivised in a pay for performance model, leading to the unintended consequences that patients with more complex problems, the complexity is not addressed and clinical care is not provided in a patient-centred, patient-needs addressing way.

It gets distorted towards the incentives built into a pay for performance model. So the College does not support a pay for outcomes or pay for performance model.

MR GRAY: Well, if we consider the voluntary enrolment model that's been described, is there a safeguard built into the framework that the College supports against under-servicing?

ASSOC PROF MORGAN: So a blended model would have a component of fee for service but enhanced on what is currently existing because fee for service really does encourage access and adequate care provision blended with a voluntary enrolment scheme that provides some form of funding for the non-face-to-face care.

MR GRAY: Does the framework that the College supports include the incentives towards population health and better outcomes of the kind that you listed at the commencement of your evidence on this point?

ASSOC PROF MORGAN: So the College is supportive of schemes that encourage quality improvement. So that's a – a subtle difference from outcomes-based pay. It's about improving from where the situation is now and becoming a learning organisation to move on and get better, rather than reaching some threshold to achieve some payment.

MR GRAY: So staff at the Commission are considering a proposition that there should be blended payment arrangements under which a GP servicing aged care residents would receive an annual payment, say, based on the health needs of the resident or group of residents concerned coupled with or blended with fee for service payments for complex or after-hour attendances and moreover, performance payments based on factors such as immunisation rates or diabetes management planning. Would such a model support improved primary health care services for aged care recipients, in your opinion?

ASSOC PROF MORGAN: So the model you've just described has, I think, three components, and the component that I believe would not support improved outcomes would be the component that talks about immunisation rates or diabetes management because those things will be appropriate for some patients and not for other patients, and doesn't lead to individualised care. And in residential aged care patients tend to be more complex with more medical conditions, complex polypharmacy, some patients will be moving towards a palliative care approach and so it's really hard to conceive of any sensible measures of – that would support a pure outcomes based payment.

There is another way of providing some almost block funding by enhancing the value or – and content of things like comprehensive medical assessments so that they provide in some ways a fee for a comprehensive and detailed service including some forward care planning and care coordination. So that's an additional way to – rather than just payment for the time of face-to-face visits.

MR GRAY: Dr Morgan, just taking this concept of the funding model that seems optimal, and also considering the need to bring in specialist expertise at times when a health condition develops and requires expert clinical expertise, whether that be because of a very complex set of morbidities, pressure injuries, whether – whatever the reason may be, what is the – what is the best approach for getting that specialist expertise into the aged care settings? The data that's available to the Royal Commission staff suggests that outside hospital settings, access to specialist clinical expertise is very low for people in residential aged care. What is the solution the College would advocate for this problem?

ASSOC PROF MORGAN: So there's a number of solutions and I don't think it's easy to conceive of a one-size-fits-all solution that would work in rural, remote, outer urban and central urban areas, but certainly access to enhanced case conferencing where all of the relevant members of a wraparound service of multiple different specialties are funded to attend or to telephone into case conferencing is one way of enhancing care planning for non-urgent complex situations. Another way is to

conceive of models which have been tested where crisis intervention is available from hospital-based teams with specialist geriatric experience. And a third way is to enhance access to telehealth to cope with the tyranny of distance for rural and remote patients particularly.

I think what GPs need to support their care is high quality responsive staff within residential aged care facilities that are able to implement a plan and do so reliably and effectively, coupled with access to expertise where necessary and the right equipment to provide the levels of care that they can provide in their general practices, and those are things that are missing or lacking at the moment. It's very hard, in my experience, to arrange for patients to see specialist services in outpatients and so there's an overreliance on emergency departments which is not the right environment. It's also expensive for the patients and often requires their carers to provide the transport and logistic support for patients to attend specialist services so I think there's lots to be fixed there.

MR GRAY: I will return to that topic in just a moment and ask both of you further questions about it. Dr Bartone, the staff of the Commission are exploring a proposition that the MBS items related to comprehensive health assessment should be amended and liberalised to make comprehensive health assessment rebateable more frequently for residential aged care recipients and also for people in the complex or high needs categories in home care. What would you say to a recommendation that those comprehensive health assessments should be available every six months or as needed?

DR BARTONE: There would be no objection at all. The – let's understand that with aged care residents at the moment as a cohort, as a group, they are entering into facilities at a much later point in their life. They've stayed in the community for longer periods of time, supported with either their local GP and/or members of the local – local community care team. Because of that increasing complexity they are – it's the care that's required is becoming increasingly more complex and more nuanced. And so the – you know, anything that supports the comprehensive assessment on a more frequent basis and/or allow that to happen on a more frequent basis would be a good thing. And in essence that really – that whole issue underpins some of the questions that you already asked today and I know that's not what you're asking me right at this minute but it does need to be stressed that because of that increasing complexity we can't look at what can happen in the next six months or 12 months.

We need to take a really long-term approach but we do need to look at ensuring that continuity of care which underpins good clinical care is fostered. So whatever the framework is, it's got to recognise that whether it be through voluntary enrolment or nomination of some other process that blended payment model supports that the ongoing fee for service by the usual GP supported by a multidisciplinary care team and that's where the complexity arises and then that multidisciplinary care team would interact where there was a need to up – upregulate the care required and prevent admission to, as Professor Morgan was saying, to emergency departments

which is extremely – both – not only costly but costly in terms of time, wasted in terms of necessary intervention to clinical care.

It's very disruptive to the patient, very, very disconcerting to the patient if not – that the whole transfer procedure wastes time, wastes a lot of – fear and creates a lot of fear and concern by in family members and in the patient. And we need to support their care as long as possible in that facility and anything that allows that to happen has got to be a good thing.

MR GRAY: Can I ask you about the composition of such a multidisciplinary care team. Who would be on it?

DR BARTONE: Well, we would look at all the usual wraparound services that you would expect. Now, some of those will be provided by the facility and some won't. But anything that – either both in face-to-face or in a telehealth case conferencing-type environment that could in part or improve the patient's journey has got to be a good thing. So dietitians are not regularly available sometimes in some aged care facilities. Social - psychologists, psychiatrists, the whole breadth of the medical specialty treatment profession would be able to be brought in and wrapped around that as well. So it's about tailoring the care required to the individual resident's needs.

MR GRAY: And there would be utility, I suggest, in a team of that kind having access to specialised clinical expertise that's usually only available in the hospital setting, if that were called for and if there was a possibility of avoiding a hospitalisation as a result of that advice and assistance being provided in the aged care setting?

DR BARTONE: Certainly where the access and the availability of an outreach-type service is one type of model that I'm very familiar with, where you can bring in localised non-GP specialised care from the hospital environment into maintaining and managing that resident without having to transfer them to hospital is obviously a very good and very obvious clinical example of how that could work.

MR GRAY: I will ask you both about that in just a moment but before I move to that, would another member of the multidisciplinary team, subject to workforce supply issues, be nurse practitioners with specialty in caring for older Australians?

DR BARTONE: I'll make a couple of comments about that. First of all, the nurse practitioner model has a defined scope of practice, usually under supervision or delegation with a supervising medical practitioner. They work really well in acute clinical environments such as emergency departments or hospital departments where there are an abundance of other medical specialists professional present. And allow them to – to exercise their scope of practice to within their scope but at all times ensuring that their continuity and that they've done – that breadth of care is available in case of complex needs that progress outside that.

And that's what we've got to remember. As a model of care we need to remember that nurse practitioners cannot substitute entirely for an appropriately trained medical workforce. There by – but working with a supervising medical practitioner there is a role or a scope but usually within a designated formulary of medications that they are able to prescribe or tests that they're able to order or conditions that they – or a diagnosis they're allowed to perform.

MR GRAY: Should they have more liberal access to rebateable items under MBS? For example, should they be able to at least participate in or perhaps make comprehensive health assessments?

DR BARTONE: So I'm a bit confused as to what is – whether – what's the problem we're trying to solve? We're trying to solve access to an appropriately trained medical workforce to perform the duty. So if we're saying that that is not – no longer an option and we're looking to put in a – an alternative standard of care, then perhaps that, you know, your premise would be appropriate. But we've got to recognise that it's only in collaboration will this – will they really fully exert their benefit, their true worth. So having independent access to the MBS is only going to fragment care and increase duplication and increase unintended outcomes.

Working collaboratively as part of the one team therefore then we can really increase both the outcomes, both the care and both the immediacy of treatment provided.

MR GRAY: The next topic I want to raise for further comment, you've already begun to comment on it, is the idea of – that transition to – access to that specialist expertise that might most typically really only be available in a hospital setting for people in residential aged care, and it seems the data would seem to suggest that they're probably being transferred to hospital to access that specialist clinical expertise in more cases than might be warranted. Now - - -

COMMISSIONER PAGONE: Perhaps just before we do go to that, sorry to let you continue to the end of your description of the next topic, but I wanted to make sure that it wasn't going to be dealt with by what I was going to ask. Dr Bartone, and I suppose also Professor Morgan, there are all sorts of reasons why a medical profession may not be as actively involved in the aged care setting as one might like, and there are all sorts of ways in which one might encourage greater participation but if I'm understanding what's being said there's kind of an irreducible minimum that needs to be dealt with and that is that GPs or doctors, whether they're GPs or specialists doesn't really matter, need to be compensated for that non-remunerated proportion of the activity that currently is undertaken in the context of the aged care setting.

Assuming that is right, and please tell me if I'm not right, but assuming that is right, then can you see some mechanism of getting the irreducible minimum dealt with by identifying those elements of, say, the supervision of others or the travel time spent travelling, or the time spent on the telehealth service? Is that something that is something that's worth looking at from our point of view? I understand that each of

your organisations may have different positions but ours is not so limited. You can start, Dr Bartone; I did address you first.

DR BARTONE: Certainly the introduction of telehealth item numbers to – for aged care residents is something that could occur forthwith.

COMMISSIONER PAGONE: Immediately.

DR BARTONE: Immediately, absolutely. And could really ensure more effective and timely intervention and an assuredness by an increasing larger proportion of the general practitioner workforce. There's no doubt about that. In terms of having that delegation or that working in collaboration with teams, that would also then circumvent some of the travelling time and the repeat visitations required. Now, often you only just leave the facility or you've just got back to the – your practice premises and you receive a call about something that's occurred, and that ability to delegate that or to have either a telehealth option would immediately solve that problem and reduce the need to go back to the resident – aged care facility that night or the next morning.

That's what we need to encourage, more efficiency and more efficient ways of utilising the scarce resources that the GP has to his or her availability.

COMMISSIONER PAGONE: So just before I let Professor Morgan add to that, so we've thought of three examples where GPs could receive additional compensation for that part of the aged care service that isn't currently being met. One is to add to the Medicare items an item for telehealth which as you say could happen overnight, if somebody added it on the list. The second one is to delegate and presumably have some form of compensation to the doctor for that part of the care and responsibility that goes with supervision, I presume is the second area that you've looked at. The third is presumably to compensate for the travel and administrative time. Now, they're three. Have you got anything else to add to the list?

DR BARTONE: Those three certainly would form the basis of an easily and clearly targeted set of incentives to increase, but also things that increase the collaboration and the communication I think are things that I've already addressed, perhaps not as quickly, but certainly just by ensuring that the – there was more communication between the facility and the practice would certainly also increase that. But the last thing I'll add to that list is just a care coordinator for even the more - sickest or the more acute care requiring residents, working as part of that team. So perhaps another complexity to that care coordination model, or that care - multidisciplinary care team by having the ability to fund in the – an optionality of a care coordinator which could be upscaled or downscaled according to the resident's needs.

COMMISSIONER PAGONE: From the doctor's point of view that's really just one of the sub-items of care and responsibility for somebody else?

DR BARTONE: Well, presumably it could go with the facility but also sometimes the doctor's own multi – team of clinic staff could as part of that provide those services where they're not available and that could be compensated through the practice-based processes.

COMMISSIONER PAGONE: I see that Professor Morgan wants to say something so - - -

ASSOC PROF MORGAN: We're in furious agreement about those things. It's interesting because we've not collaborated about them before. I think the - - -

COMMISSIONER PAGONE: That's usually not a defence in .....

ASSOC PROF MORGAN: No. There's a lot of potential tasks that would be wrapped into those administrative tasks, but I think the things that make care inefficient and somewhat frustrating are the things that should be addressed because they're also barriers to increased participation by the medical – by GPs. So IT systems within aged care facilities are woeful where they exist at all, and are really designed for kind of ward-based processes, and not for clinical care of patients in an ongoing way that's searchable or useable. So the sorts of ingredients in the draft list of suggestions, requirement aspirations for residential aged care facilities to be suitable for their working with GPs, that – the things in that list are the things that would reduce the barriers to GPs being involved and allow them to do a much better job supporting patient care, which is where their passion and interest lays.

COMMISSIONER PAGONE: Yes. Thank you, Mr Gray.

MR GRAY: Thank you, Commissioner.

We've heard of various examples of outreach services throughout the hearings of the Royal Commission, such as RADAR and flying squads, and later this week we're going to be hearing about CARE-PACT which may be a model with which you're familiar. As we understand the evidence, these outreach services are primarily directed at acute and subacute service provision and have, at least as a – probably a primary motivator, hospital avoidance and we understand ad hoc funding is often provided for these outreach services out of hospital budgets. What's your view – I will ask each of you in turn, starting with you, Professor Morgan; what's your view about these hospital led outreach services? Do you think there is scope and utility in a dedicated stream of recurrent funding on a formalised basis involving intergovernmental agreement, perhaps on the funding split agreed in the national health reform agreement, for them to be scaled up, replicated and rolled out across Australia? Professor Morgan?

ASSOC PROF MORGAN: The short answer is yes. The more complex answer is that the models are tried in reasonably short-term boutique environments with strong clinical leadership and so the implementation might be problematic, particularly in areas where the hospital services themselves are very stretched. I think the evidence

that I've examined suggests that there are some things that have a limited effect, so something purely focussed on a hospital medication reviews have a limited effect, or specialist nurse outreach services have a limited effect, whereas a comprehensive service that has geriatric specialist input and crisis intervention that works closely with primary care are the ingredients of the successful models.

So I think there's a care – there's a concern over the patchy availability of flying squads or reach out services but also they need to work closely and not set up a parallel version of care from general practice care because it's the GPs that will be visiting on a regular basis providing follow-up care and adjustments to following the crisis intervention. So I think there are some essential ingredients and I think the review by Fan et al. in 2015 went some of the way to identifying what those essential ingredients are.

MR GRAY: Thank you. You mentioned working closely with primary care. How in practice does that look? What's the optimal way in which these outreach services which can draw on hospital based expertise how do they interface well with primary care practitioners?

ASSOC PROF MORGAN: Well, the way that primary care already interfaces with single organ specialists and specialist services is through a referral process or by telephone to speed up referral processes when there's an urgent need, and I think a triage process within residential aged care facility that can involve and engage the GP and the primary health care team would be the most suitable access point. And then the availability of rapid response when there's a call for it from the primary health care team would be the most efficient and effective way of making sure that the services are in lock step together and there's not a parallel provision by a specialist team looking after some patients and GPs looking after other residents.

MR GRAY: One of the witnesses on the panel earlier today, Dr Dawda, referred to a trend which he supports towards integrated care units, and as I understand his evidence, he is advocating for a greater level of integration than merely a referral process from a primary care practitioner to a specialist outreach service. Do you have any views on a greater level of integration than merely relying on a referral?

ASSOC PROF MORGAN: It much depends on what that integration looks like. I've seen examples where it had the unfortunate and unintended consequence of a specialist service changing treatments and giving instructions to residential aged care facilities to change management plans, which has not been adequately discussed with or involving the GP and that leads to fragmentation of care and problems of management plans seesawing from one version to a different version and back again. So I think integration really means where those services are working really closely together and on a needs basis. And I think it needs to be really recognised that the week by week care of residents is going to fall to primary care. There's no way to consider scaling up outreach services to provide that level of care. So very important that that's recognised in whatever model emerges.

MR GRAY: As a supplement or an alternative, should there be better financial incentives to encourage medical specialists in the core disciplines, geriatricians, psychogeriatricians, palliative care specialists, rehabilitation specialists to provide a minimum level of services into residential aged care in situ rather than there having to resort to hospitalisation?

ASSOC PROF MORGAN: My understanding is that the fee for service model is insufficient to encourage those services at the moment, so yes, more funding is required to incentivise or to pay for that increased level of service. But I think where specialist providers are a scarce resource, a consultation or liaison process where they're funded to provide advice and assistance might be more scaleable than funded to provide one-on-one care.

MR GRAY: Dr Bartone, I will ask the same range of questions of you. Do you wish me to go back to the first one about multidisciplinary outreach teams; should they be scaled up and replicated with sustained recurrent funding on the national health reform basis?

DR BARTONE: Certainly what is occurring at the moment is patchy, is haphazard, is subject to the local funding envelopes and availability of local hospitals. Yes, one of the drivers perhaps is to try and minimise unnecessary ED presentations and that might be the only driver for some, but clearly there is - if we need to remember whatever model we put in, it's about is -what does this mean for the resident, the patient, and making sure it's patient centred. So whatever the model that we implement, it's got to be patient centred. I agree that there should be some more systemic funding of this service, rather than just hospital by hospital or facility by facility. So there should be some more over-arching State or Territory support for that.

But clearly, what – whether it's an integrated model, whether it's a referral model or whether it's a hybrid of the two, there are three things that need to be remembered in that whole process. There needs to be someone in charge or someone loosely pointed to – you know, to look after the needs of coordinating all of those resources, and that 99 times out of 100 will be the patient's usual or the resident's usual GP. And that is a complex process, but whether it be by phone or whether it be by telehealth or whether it be by secure messaging, it's going to require significant coordination of all of that, including some face-to-face attendance. But then the facility and the staff, the trained staff at the facility will be brought to bear into that, as well as the outreach team, as well as the regular GP. So that whole process is a complicated and very, very skilled solution to even a more complex task, and that is of transferring the patient to the facility for care that could be easily – that could be delivered at the local aged care service. And I'm sorry, the next part of your question?

MR GRAY: Well, it was, there was – the next element was how does the interface with the primary health care practitioner work, but I think you've answered that. So you've advocated - - -

DR BARTONE: So, yes, and that's - - -

MR GRAY: - - - for the care coordination role to be - - -

DR BARTONE: And that – yes, and - - -

MR GRAY: - - - with that practitioner.

DR BARTONE: The centrality of the GP to that solution and to coordinating that is vital and paramount to ensuring both - no fragmentation or duplication or things just going through the cracks but that is a really elegant and very, very robustly resourced model of a much more upskilled solution to the problem.

MR GRAY: And finally, talking about specialists, particularly the specialist component in such teams, as a fallback or as a supplement, what's going to be the utility of looking at the MBS items available to them, including perhaps an expansion of the ability for them to provide rebatable services in the nature of telehealth advice?

DR BARTONE: All of those additional item numbers, including the telehealth item numbers for non-GP specialists would obviously improve and augment the envelope of services that you could provide to the resident during his or her time of need.

MR GRAY: I want to now go to a question that's specifically about publications of the College. So I really direct these questions - - -

COMMISSIONER BRIGGS: Could I just ask a question.

MR GRAY: Yes, I'm sorry, Commissioner.

COMMISSIONER BRIGGS: I'm sorry, my microphone is not quite working properly. I think I'm getting it now. The question of specialist doctors has been a cause of some discussion over today, and the sad reflection on this is that people in residential aged care have lower access to specialists, more generally, than anyone else in the community. And this is a shocking state of affairs. And it seems the only way they can access specialist services is to be hospitalised. Has either of your organisations - I suppose I should look directly at you, Dr Bartone, from the AMA side because you cover specialists; have you been thinking about what might specifically encourage specialists to act in this field or do we take it as a fait accompli that they aren't going to visit residential aged care facilities, so the people concerned either need to go to a hospital or they need to have transport that takes them to specialist offices to get the kind of investigatory and preventative care that other members of the community are entitled to?

DR BARTONE: In some parts of the country, some models where the "outpatient clinic", in inverted commas, from the local hospital for that said specialty was held in the aged care facility. Now, that could be a model which, if funded appropriately,

could work quite well. Certainly where there is a significant need or patient requirement. But the telehealth option is also a very valid way when working in collaboration with the usual regular GP to provide services well and above what is currently available, and certainly would minimise or obviate the need for any inappropriate transportation of patients to the hospital. And certainly it's only when things get exceedingly more complex that you have to actually look at that transport requirement.

COMMISSIONER BRIGGS: How common are the specialist outreach services that you speak of?

DR BARTONE: Obviously they vary between State and Territory as well as rural and regional as well as urban and semi – and semiurban. It comes down to the local facility and the – and the degree or the foresight that that clinical care team inside the facility has, I mean, at the hospital to provide that service and work with the community. It does require a liaison, a GP liaison-type arrangement by the facility with the local GPs, but that certainly isn't a reason why it can't occur but often is a reason why unfortunately, if we look at hospitals, they've become more and more isolated, more and more separated from the communities they serve, and they've become distanced from their primary care services that they, in terms both of communication and accessing and working with that. There is certainly no doubt in my mind that both the primary care team and the hospital could really work more cooperatively if allowed to provide services more at the point of care of the resident.

COMMISSIONER BRIGGS: Is there anything that would force that to occur; and I mean significantly incentivise it to occur?

DR BARTONE: The problem is, of course, that we have a federal and a State funder, so funding different sides of the equation. COAG and the COAG health processes through the Health Ministers' forum there is certainly a forum whereby all the people are around the table and it could be made to be a significant point of responsibility in addressing this area because it is about increasing patient care, patient outcomes and efficiency of scarce health resources.

COMMISSIONER BRIGGS: Thanks, Dr Bartone.

MR GRAY: Before I go to those College publications, I do want to follow up a couple of the points that have been raised in discussion around the team's topic and the coordination topic, and also the remuneration topic. Dr Bartone, I'll direct these questions principally to you and we will see if Dr Morgan wants to add anything or any different views. The first point is that there seems to be, in the evidence before the Royal Commission, a suggestion of a degree of disinterestedness on the part of primary health practitioners when it comes to visiting residential aged care facilities. It is not 100 per cent explicable just by reference to remuneration issues. That's the first point.

The second point is that in terms of the traditional role of the general practitioner being to coordinate all the care of the patient, whatever setting they may live in, that model seems to have come under strain and to have broken down in a number of situations that have been in evidence before the Royal Commission, perhaps because of confusion as to who really has the role in coordinating care; is it the GP, is it the facility? Perhaps for some other reason. Whatever the reason, is it now time to revisit who should be the coordinator of care and to open the debate up to the possibility that that role should be squarely placed on a designated person who may not necessarily be the general practitioner. What do you say to those points?

DR BARTONE: In response to your assertion that GPs are disinterested, I find that disappointing that that assertion has been made. The – the disinterest as you refer to is about the frustration, the lack of clinical satisfaction, the lack of due processes being available and being followed in terms of the care that's required to be expended or enveloped around that patient. It's about the – that everything takes a lot longer, takes a lot more effort and a lot more opportunities for things to go through the, you know, to go through to the keeper because unless you double down, triple down and ensure that you've exerted even more than what you would normally do, there is a, you know, there's something might have been overlooked, you need to – everything from communication at the moment to the – the record-keeping to the – having to print out additional scripts in that process, and then the recording of the IT incompatibility at the facility with your IT at the surgery, with the fact that you've only just left the facility and you get a phone call to go back.

They're the things that are frustrating and concerning and problematic in terms of ensuring that your expectations of the quality of care that you want to impart for your patient, for your resident that's in there, is why more and more doctors are deciding that no, this – I have a surgery full of patients that also require my attention. This is a much more efficient and a much more appropriate use of my time because there's the problem of when does – you know, you go to the facility, you think you're going to finish at 6, you're still there at 7, you ring up your home and say you're not going to be home before 8. You're about to get into your car at 8 and there's another – something else has happened and you're there still 9.

That story just happens far too frequently, far too often to be other than a reflection of the process failure that is currently occurring, and that underpins, not just the remuneration, because that can be addressed overnight but the remuneration aside will not address any of those other issues.

MR GRAY: Professor Morgan?

ASSOC PROF MORGAN: I would just like to point out that the AIHW statistics on visiting would suggest that a lot of GPs are not demonstrating that they're putting up with all those frustrations, but continue to provide a service against the odds really and at their own cost because we've worked out that they cost more to be seeing a patient in a nursing home compared to in your surgery. So the average person in 2016/17 I think it was 24 visits or 24 item numbers billed by GPs against a patient.

MR GRAY: For the 81 per cent or so of people who received at least one service.

ASSOC PROF MORGAN: The 92 per cent, yes.

MR GRAY: I beg your pardon, 92 per cent, yes.

ASSOC PROF MORGAN: That's a lot of work that is going on. So although there are frustrations, I wouldn't say it's gone as far as a disinterest. But it's a fragile situation and it wouldn't take a lot to collapse it. So I think we need to be very careful not to create disincentives as part of any change process. And the second part of your question related to?

MR GRAY: Care coordination.

ASSOC PROF MORGAN: Care coordination. I think care coordination has a mixed record. Where care coordinators are external to an organisation and have little power to change things within an organisation, the results have been disappointing of care coordination trials. So it seems like a good idea but the reality is often not as good as the idea appeared unless the care coordinators are deeply embedded either as part of the residential aged care facility or as a role of the primary health care. I think if you had a third organisation that was kind of put into that mix, it would be very easy for it to be a failed experiment.

MR GRAY: I'll now ask about the College publications I mentioned.

COMMISSIONER PAGONE: Just before you do, Mr Gray, Dr Bartone, forgive me for going back to your answer to Mr Gray a moment ago, but as you were giving it, about it wasn't a matter of compensation but frustration, I was trying to grapple with the content of the frustration and the content of the cause of the frustration. And some of the content I suppose I can work out by myself. Some of them I can't and if you're saying that it's not a frustration that can be helped by remuneration, what is the answer to the problem that otherwise sounds most uncaring?

DR BARTONE: To think that there is a one solution or a one lever that can be manipulated to fix this problem is really the point behind my answer. There are many, many things which need to be addressed. Over the fullness of time, processes which can be measured, which can be documented, researched, collated and data improvement – data used to quality improve the outcomes over a course of time. What I've – remuneration obviously would be welcome but that alone isn't going to create the robust increase in the workforce required to ensure that we have a fully skilled and appropriately trained workforce to deal with the increasing amount of aged care residents that are going to be in need of care.

So everything from the systems in the facilities to examine the patients in the facility, to the interoperability of IT systems, to the communication, to the remuneration, to the processes being coordinated and having that integration between not only just the practice and the facility but having the facility being part of the overall health system

because it isn't at the moment, is part of those, all those levers that need to be looked at.

COMMISSIONER PAGONE: I can understand that aspect of your answer and in a sense that runs throughout what we're required to do as Royal Commissioners but you remember what started the answer was Mr Gray's question about - the way he put it, was a lack of – or disinterestedness. Now, putting to one side whether that's the best description or not and whether your response would have been different had instead of "disinterested" he might have used the word "dispirited" or "frustrated" or that it seemed like too big an effort for the reward, that was the context in which you said, no, it's not money that causes this disinterest, but something else.

DR BARTONE: And – and I'm sorry if I've created a – a misunderstanding, but what I was trying to say was that I was taking exception to the word "disinterest".

COMMISSIONER PAGONE: I understand that.

DR BARTONE: And that, really, whatever adjective you want to put there, or description, you certainly need to understand that there are many reasons behind it and – but at the end of the day as Professor Morgan has already outlined, there are still an enormous number of GPs dedicating their time and their services to the care of their patients in aged care facilities, and will continue to do so, notwithstanding what happens in that remuneration space to a large degree in the immediate future. But how far can you stretch, you know, can you, you know, pull that lever and hope for the goodwill of the practitioner, especially as an ageing workforce which is the bulk of a lot of those medical practitioners visiting facilities reaches the age of retirement, and there's not the replacement coming through because of all the other reasons that we've outlined, including remuneration.

COMMISSIONER BRIGGS: Yes. I wondered if it's okay with you, Commissioner Pagone, have you finished your question?

COMMISSIONER PAGONE: I have, yes.

COMMISSIONER BRIGGS: I've been pondering for some time the issue you raised, Dr Bartone. I'm very conscious of what appears to be the case, namely, that there are quite a lot of older doctors who are attending to older people in residential aged care and marrying that with the issue about the increasing complexity of care and it does seem to have increased dramatically in the time. And we've even heard suggestions in some of the witness – in one of the witness statements today that formerly these people may have been in almost subacute settings in the seventies and eighties, for example.

So there's a real issue about the capability and the size of the medical workforce that supports these groups, and some of the suggestions we've had is that in medical training programs, young people should – young doctor trainees should have placements in aged care. I don't know whether that would work to increase the

interest, but there's the broader question of whether or not younger doctors with the experience they have, have the capabilities to deal with this kind of complexity of care need. Do you want to comment on that or let us know what you've been thinking these issues, and perhaps you too, Professor Morgan?

DR BARTONE: I might leave the training question to Professor Morgan.

COMMISSIONER BRIGGS: Yes.

DR BARTONE: Because that's actually the RACGP. But in terms of the – using the aged care facilities as training venues, I would suggest that that would be an excellent opportunity, both for some pilot programs or some scaled-up opportunities to have that kind of training. It seems to me that there is an enormous amount of clinical experiential learning that could occur in an aged care facility and would be only part of the rounded requirement around the training that would impact in the development of a young GP. We need to understand that – and Professor Morgan will speak further to this, no doubt, but the training that goes to produce the breadth of capability and skills required to be a GP are becoming wider and wider all the time, and so another venue such as an aged care setting would be an excellent opportunity to actually improve on the training capabilities.

ASSOC PROF MORGAN: I would certainly strongly agree with that description of the complexity. I think the – every clinical decision is a matter of weighing up pros and cons, nothing is black and white in people that are generally frail with multiple medical conditions and a very large number of medications. The College has tried to address things like the skills required to de-prescribe, the skills to manage multimorbidity. We produce guidelines but we're in the midst of a series of updating of guidelines of the silver book to give guidance to GPs that want to start off in, or continue working in residential aged care facilities.

So there are things there to help, but it does – it is clinically challenging work and to try and get it right requires a lot of dedication which is what is shown by those GPs that are visiting. And I think it pertains back to some extent to the skills mix and how you could not supplement or replace a GP with a nurse practitioner doing that level of clinical decision-making. It is actually very complex.

COMMISSIONER BRIGGS: Yes, I understand that. So I suppose what I'm thinking of is could the College, beyond the basic GP training and the education placement issue that we talked about a minute ago, could the College do more in terms of upskilling the existing practicing GPs in some of these complexities?

ASSOC PROF MORGAN: I think there's – there is no limit to how much we could do. It's a case of building the right – priorities because GPs look after 500 conditions reasonably frequently and so there's a need to – for the GPs to prioritise their own professional learning. As a profession, GPs tend to work out what their learning needs are and then seek out ways to address those learning needs. So they're available. I think the idea of an apprenticeship model encouraging GP registrars to

latch on and work with a GP that visits residential aged care facility, I think that's something that could be enhanced and made a very usual part of GP training.

COMMISSIONER BRIGGS: Perhaps the College and, indeed, the AMA might consider coming back to us to address this – the issues to address these needs specifically because fundamentally we are dealing with a much more complex health issue for elderly people than we have experienced before, because frankly they used to die earlier. I think that's fundamentally what's going on here. So the management of these complex conditions affects the health system, it affects the aged care system and it affects the community more generally with the downstream impacts on families who witness these concerns with considerable concern and in some cases frustration or horror that they can't seem to get the supports that people need. So we would welcome you coming back with further submissions in this regard.

COMMISSIONER PAGONE: And when you do, for the benefit of at least the – me who has no background in medical matters except my own ailments over time, you need to explain or make clear how it is that a deepening knowledge of medical practitioners in aged care is the relevant inquiry as distinct from the conditions which in old age one might have. Being old is not a medical condition. Dementia might be, or glaucoma might be or various forms of cancer might be. But how the College might do more in the context of perhaps additional training for practitioners entering into the aged care space is a particular kind of inquiry that is different from becoming an expert in dementia and the other conditions that are likely to be seen in that context.

ASSOC PROF MORGAN: I agree, and the particular skills that are important are the ability to trade off between disease-specific guidelines in the context of somebody with multiple conditions, to take a very patient-centred approach to what are the patient's priorities for their ongoing care and to tailor treatments towards those priorities. And I think there are some skills around that which in the most extreme end become the skills of providing palliative care, and then there is the complex pharmacology skills, so those are the areas that we are increasingly producing resources to address.

COMMISSIONER PAGONE: So I wasn't meaning to in any way minimise the breadth of the question that Commissioner Briggs asked you, on the contrary do so to the fullest extent, but as a subcategory at least, I wouldn't want you to say, well, we would need to have lessons in dementia and this and that and palliative care. By all means if that's what you want to answer, do, but in addition to that it's the specific question about the caring for the aged in – and how you see that component of the answer.

ASSOC PROF MORGAN: Yes, and we'll come back to you with a bit more information on possibilities around caring for the aged, but also the skills of working within and with residential aged care facility teams because I think that's a – that's another related skill.

COMMISSIONER PAGONE: And sorry to go on about this but bear in mind the critical focus is what is it that doctors can do to contribute to that process, because there are others who might be putting their hand up.

ASSOC PROF MORGAN: Certainly.

MR GRAY: Commissioners, when that's addressed and for general purposes, it wasn't my intention to suggest that all general practitioners or all primary health care practitioners were disinterested but merely that the trend - - -

COMMISSIONER PAGONE: I don't think anybody understood it that way.

COMMISSIONER BRIGGS: No, that's right.

MR GRAY: Now, we've run out of time.

COMMISSIONER PAGONE: But we've used the time effectively, Mr Gray.

MR GRAY: Indeed. And there is one question that I really need to direct - - -

COMMISSIONER PAGONE: One question, Mr Gray.

MR GRAY: And that is, would the College agree that in order to foster innovative mobile general practices which specialise in provision of primary health care to people in aged care, it would be appropriate to amend the fifth edition of the College's standards for general practices to facilitate the accreditation of such mobile services? There are aspects of the standards as they presently exist which in effect require a bricks and mortar presence and require servicing of the entire demographic of a relevant community. Could those elements of the standards be amended to allow accreditation of such services?

ASSOC PROF MORGAN: So I've been communicating with the expert committee within the College that produces standards and their intention is to be working in that direction early in 2020 to look at what the various stakeholders would require for accreditation. The underpinning reason, I think, for that question is access to the practice incentive payment, and I think in – those two don't have to be entangled so tightly. The purpose of standards is to maintain quality and safety, and there do need to be standards but you're quite right; if it's a mobile service they're not going to have a height adjustable bed in the back of the car so there are some requirements to talk to all the stakeholders about trying to make an appropriate set of standards for those newer and emerging models of care.

MR GRAY: Thank you. Commissioners, if that's a convenient time and if these witnesses could please be excused?

COMMISSIONER PAGONE: Yes. Thank you both for coming to assist the Commission. You more than most, or more than many anyway, I'm sure, understand

the significance of the work of the Commission and that your assistance in that regard has been very helpful, both to us and to the public as well as to your members, so thank you for coming and thank you for sharing your views.

<THE WITNESSES WITHDREW [4.40 pm]

COMMISSIONER PAGONE: 10 o'clock tomorrow, I think.

MATTER ADJOURNED at 4.40 pm UNTIL TUESDAY, 10 DECEMBER 2019

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