REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON THE PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

INQUIRY INTO THE PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Wednesday 28 April 2021

The Committee met at 10:00.

PRESENT

The Hon. Courtney Houssos (Chair)

The Hon. Greg Donnelly
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Taylor Martin
The Hon. Daniel Mookhey
The Hon. Mark Pearson

CORRECTED

The CHAIR: Good morning, this is the final hearing of the Select Committee on the Provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020. The inquiry is examining whether there is a need to have a registered nurse [RN] on duty at all times in nursing homes and aged-care facilities with residents who require a high level of care. In examining the bill we have looked more broadly at the need for further regulation, minimum standards of care and appropriate staffing levels in aged-care facilities, the potential for cost shifting onto other parts of the public health system and lessons from the COVID-19 pandemic. Before we commence, I acknowledge the Gadigal people who are the traditional custodians of this land and I pay respects to the Elders past, present and emerging of the Eora nation, and extend that respect to other Aboriginal people present today or who may be watching us online.

Today we will be hearing from a number of stakeholders including aged-care providers, aged-care and ageing associations and experts in geriatric medicine. I thank everyone for making the time to give evidence at this important inquiry. Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. The transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcast guidelines, media representatives must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today it does not apply to what witnesses may say outside of their evidence at this hearing. I therefore urge witnesses to be careful about any comments you may make to the media or to others after you complete your evidence.

Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If the witness is unable to answer a question today and requires more time to respond they can take a question on notice. Written answers to questions taken on notice are to be provided within seven days. If witnesses wish to hand up documents then they should do so through the Committee staff. In terms of audibility of the hearing today I remind both Committee members and witnesses to speak into the microphones.

As we have a number of witnesses in person and via videoconference it may be helpful for Committee members to identify themselves and to whom they direct their questions. For those with hearing difficulties who are present today please note that the room is fitted with induction loops compatible with hearing aid systems that have telecoil receivers. Finally, will everyone please turn off their mobile phones or set them to silent for the duration of the hearing.

CORRECTED

ANNA-MARIA WADE, State Manager (NSW & ACT) , Employee Relations Manager, Aged & Community Services Australia, affirmed and examined

SUE THOMPSON, member, Aged & Community Services Australia NSW & ACT Divisional Council, Chief Executive Officer, McLean Care Ltd, before the Committee via videoconference, affirmed and examined

The CHAIR: The witnesses do have the opportunity to make an opening statement. Would you like to do that, Ms Wade?

Ms WADE: We have a consolidated one.

The CHAIR: How efficient.

Ms WADE: Thank you very much for the opportunity to appear and speak to our submission. Aged & Community Services Australia [ACSA] is a leading aged-care peak body supporting church, charitable and community-based not-for-profit organisations throughout New South Wales and Australia. Not-for-profit organisations provide care and accommodation services to about one million older Australians. ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians. The proposed bill will amend the definition of "nursing home" in the NSW Public Health Act 2010. The intent of the proposed amendment is to ensure the requirement for a registered nurse to be on duty at all times is extended to a larger number of facilities covered by the new definition.

ACSA understands the intention is to improve the quality of care in residential aged-care facilities. However, our experience as an association representing not-for-profit providers is that this approach alone will not do that. We offer four reasons: First, we believe that staffing requirements in a residential aged-care facility need to be more flexible than simply mandating a minimum nursing staff level. Registered nurses play a key role in the care provided to aged-care residents. ACSA is supportive of 24-hour registered nurse coverage when and where this is needed. For example, in the instance of a resident who is at the end-of-life and requires a syringe driver to receive various medications, a registered nurse should be available to operate and monitor the syringe driver. This helps to ensure that the resident is as comfortable as possible at the end of their life. However, there are circumstances in which having a registered nurse on duty at all times is not necessary.

Registered nurses are a precious and scarce resource and to be required to roster them 24 hours a day would reduce the ability to allocate precious other staffing resources. Staffing in a residential aged-care facility comprises nurses, personal care workers, leisure and lifestyle staff, hotel and other support services. All of these roles contribute and are vital to the care and support of elderly residents. What is required is the flexibility to have the right staffing model which caters to the care needs and overall wellbeing of residents, noting that residents' needs change over time and the staffing mix needs to be flexible and adjust to meet these needs. Second, is the issue of funding. We all know not-for-profit organisations in our sector work on very thin margins and in reality are chronically underfunded. The Royal Commission into Aged Care Quality and Safety final report highlighted this and the fact that successive governments have failed to implement reforms and provide the funding that is required.

The royal commission made a number of recommendations offering both short and long term proposals to increase funding to the system. As a comparison, the OECD average for expenditure on aged-care services is 2.5 per cent of GDP. In Australia we spend around 1.4 per cent. This means that providers are operating on the back foot. According to the StewartBrown sector report 64 per cent of residential aged-care homes are operating at a loss and that figure goes up to 78 per cent in rural, regional and remote Australia. Providers work to meet all of the requirements and needs that an older person might have. About 70- to 75 per cent of all of our costs are workforce related. We would like to have more staff but the reality is the system is not currently funded to deliver that. So, our members are juggling that in an underfunded system. They cannot pay for more staff if the funding is not equal to the cost of delivering the service.

Third, ACSA's ongoing consultation and engagement with aged-care providers consistently identifies workforce availability as one of the most significant challenges they face. Our members advise us that there is very real potential that they would not be able to meet a 24-hour registered nurse requirement should the bill be enacted. Primarily due to the restricted availability of registered nurses in their communities. I note that in the 24 hours prior to 8.30 this morning on one job aboard alone there were 50 vacant positions listed for registered nurses in aged care in New South Wales. They were vacancies posted within the last 24 hours. This is particularly apparent in regional, rural and remote New South Wales. Even if the funding issue were resolved, the availability of staff issue would still be prohibitive.

The fourth, and last, point is that the final report of the Royal Commission into Aged Care Quality and Safety made a comprehensive number of aged-care workforce recommendations. These are addressed in chapter 12 of the report and include:

> Recommendation 86: Minimum staff time standard for residential care
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> 2. From 1 July 2022, the minimum staff time standard should require approved providers to engage registered nurses, enrolled nurses, and personal care workers for at least 200 minutes per resident per day for the average resident, with at least 40 minutes of that staff time provided by a registered nurse.
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> 3. In addition, from 1 July 2022, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility for the morning and afternoon shifts (16 hours per day).
>
> 4. From 1 July 2024, the minimum staff time standard should increase to require approved providers to engage registered nurses, enrolled nurses, and personal care workers for the average resident for at least 215 minutes per resident per day for the average resident, with at least 44 minutes of that staff time provided by a registered nurse.
>
> 5. In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times.

We can see that a similar recommendation to the key component of this bill is made by the royal commission and proposed to take effect by 2024. We await the Commonwealth's response to the final report, to be addressed in the 2021 Commonwealth budget, and the full response by 31 May.

Whilst we recognise the sovereign power of States to pass laws relevant to their jurisdictions, we respectfully argue that, in a national industry where responsibility for funding and regulation lay primarily at the Commonwealth level and in which we have seen a two-year and 148-recommendation royal commission, we believe that arrangements relating to staffing levels in facilities must be national. It makes no sense that there should be different rules relating to staffing arrangements between similar facilities in Boorowa, Broadmeadow, Beenleigh or Burnie. To summarise our position, registered nurses are an important part of aged-care staffing models. With the right levels of funding and workforce availability, we want to be able to roster them around the clock. But short of that we need a more flexible approach to staffing which allows us to meet the needs of residents when they are most needed within current resourcing constraints. Thank you. We are prepared to take questions.

The CHAIR: Ms Wade, you said in your submission and then also in your opening statement that you need the flexibility of when and where registered nurses are needed. What is the clinical oversight of those decisions?

Ms WADE: I will defer to my colleague, Sue, who actually is CEO and registered nurse.

Ms THOMSON: I can use McLean Care's experience to demonstrate that. McLean Care operates two models: a model where we have registered nurses 24/7—and that is largely on our large sites that are governed by the Public Health Act where we are required to have a registered nurse 24/7—and the other model we operate is in our smaller facilities that that particular piece of legislation has never applied to. I will speak to those sites regarding our staffing arrangements. In those sites we all mostly, where it is possible, have a facility manager that is a registered nurse. On a site of 32 beds, a decision around how that flexibility occurs is primarily either made by that facility manager or the executive director of operations, who is a registered nurse. So if there is a resident that is palliating and requires the services of a registered nurse 24/7 then the decision is made at those levels to deploy a registered nurse where possible to support a palliating resident and particularly in the case of where a syringe driver is required.

The CHAIR: Is it the specific stage or medication requirements that usually then dictate the decision to then engage an RN 24/7? Is that right?

Ms THOMSON: No. It is a multitude of clinical needs. All of those needs are assessed and then a decision is made based on those clinical needs. So a person that is palliating may not necessarily require a syringe driver, in which case it could still mean that a registered nurse is required to continually assess that particular resident. So it is not the sole determinant.

The CHAIR: We have heard consistently over our previous two days of hearings and through our submissions about the increasing fragility of residents with complex comorbidities entering aged care, and that it is not like it was perhaps several decades ago where it was like a retirement village or a lifestyle decision. Often people are entering aged care as a last resort after they have exhausted all of their other home-care options. Would that be your experience, either Ms Wade or Ms Thomson?

Ms WADE: Sue, you can speak to that because you are on the ground.

Ms THOMSON: What we are also seeing is that same trend, where people are coming to us later in the stages of their comorbidities where they are requiring increasing complex care. We certainly look to our individual services as to whether we can meet the needs of those people that are coming to us and we undertake a thorough assessment process prior to admission. Now if that person is assessed as being able to be managed appropriately and safely on a site where there is not a registered nurse 24/7, then we will take those people into those services, bearing in mind that most of our smaller services operate registered nurses throughout days, seven days a week. So there is always a registered nurse accessible and even supported by a qualified registered nurse that has oversight of all those residential facilities.

The Hon. MARK PEARSON: Putting aside the cost issues and that burden, if we just put all that aside and look at what we believe is the primary service for our aged citizens, and considering, as the Chair has pointed out, we are now in a sense reaching a crisis in many ways because we have got a medical system that is about keeping us alive as long as possible with all of the various treatments but in a sense we are not evolving to live this long so this burden is now building up onto nursing homes—but putting aside, as I said earlier, the funding issue, would you say the ideal and most responsible standard of care for our aged citizens would be to have a registered nurse onsite 24/7?

Ms WADE: In principle, yes. In the ideal world where we did not have to worry about availability as well of workforce and the funding, then, yes, we would welcome that. But they are a reality.

The Hon. MARK PEARSON: Why would you welcome that?

Ms WADE: To have a registered nurse—you know, you have got somebody available. You are not relying on somebody on call. You have got them there onsite. But, saying that, having people on call does work. It would be great to have the body on the ground, but the system can work without that person there.

The Hon. MARK PEARSON: Is it ever the case that the registered nurse on call is up to 50, 100 or 200 kilometres away from the facility or further?

Ms WADE: I do not know the answer to that question. Sue might.

The Hon. MARK PEARSON: Ms Thomson?

Ms THOMSON: From McLean Care's experience we operate several different methods of an on-call arrangement and certainly that distance is not the case. The maximum distance, if it was that we did not have the resource available to us, would be around about 100 kilometres and we use a telehealth mechanism, where a registered nurse is essentially able to videoconference with a staff to assess a resident that requires assessment, bearing in mind that that does not occur very often.

The Hon. GREG DONNELLY: I will just direct you to page 5 of the submission if I could please, and specifically the paragraph at the top of the page. This is specifically in reference to schedule 8 medications and tying into this matter of palliation and end-of-life treatment. We have had Palliative Care Nurses Australia organisation provide a submission to this inquiry and also evidence as well as providing some answers to some supplementary questions that have been directed to them. Their evidence was that—I can perhaps wrap it up in these simple terms—as far as palliative care in our nursing and aged homes go, there is a long way for us to go in terms of getting it up to the point of being the desired standards that we would like. Obviously some facilities do it quite well; others less so.

The evidence that we received from them and other witnesses is the sort of general reference to the need to have a registered nurse to deal with the syringe drivers for the delivering of the actual medication to deal with pain. But palliative care and specifically end-of-life care are a lot more than making sure the syringe driver is operating properly or effectively. Would you agree that there is a general sense amongst your members that we can do a lot better as far as palliation and palliative care go in nursing homes in Australia?

Ms WADE: I do not have conversations with members about this every day, but I do hear in some instances that that would be the case. In some instances—

The Hon. GREG DONNELLY: Before you go any further, people dying in nursing homes and the like is happening every day. It is a matter of many people go into these facilities and that is where they pass.

Ms WADE: That is right.

The Hon. GREG DONNELLY: So surely it is something that gets discussed with you a fair bit, not just from time to time, the issue of dying and death and how it is managed?

Ms WADE: And people want a good death, that is exactly right. But it is not just the RN that is responsible for that, it is the whole care team. There are personal care workers who are on the front line all day, every day, assisting those residents. It is not just the RN, those personal care workers are critical to that process as well.

The Hon. GREG DONNELLY: But the management of the medication—and I am talking beyond the syringe driver, I mean the delivery of high-quality palliative care under the supervision of a palliative care specialist doctor—goes way beyond just simply delivering pain relief through a syringe driver. It is very sophisticated, as you know. Would that be your assessment? Would you agree with that?

Ms WADE: I am not a palliative care expert either. I am not on the ground in a nursing home. My colleague would be better—

The Hon. GREG DONNELLY: Well perhaps directed to the other witness, just on the issue of the delivery of palliative care in these facilities and how we have got some way to go.

Ms THOMSON: I can speak to, again, the McLean Care experience. We, operating in a regional and rural area, do not have the benefit of having a palliative care team oversighting palliating residents and nor do we have a doctor apart from the resident's GP oversighting palliative care residents. I would agree that there is much more—

The Hon. GREG DONNELLY: Sorry, can I just interrupt you? Before you go any further, in terms of your facilities—and I am not reflecting on you, I am just clarifying a statement of fact—how many facilities are we talking about here?

Ms THOMSON: McLean Care operates a facility in Inverell, Guyra, Gunnedah, Oakey in Queensland and Yallambee is located in Millmerran in Queensland.

The Hon. GREG DONNELLY: Let us just talk about the New South Wales ones. Your evidence, as I understand it, was that there are no specialist teams in place in these facilities to deal with palliative care. There is no reference to or availability of a palliative care specialist doctor to provide advice with respect to the palliation of residents who are close to death. But what you do have is access to a general practitioner and the advice and care that he or she may be able to provide. Is that your evidence?

Ms THOMSON: Yes, we do; we have access to a GP. If it was even plausible or possible we could potentially access a palliative care team via phone from, you know, I guess wherever the centres are that they are located in. Generally we do come across times when we would seek the advice of a palliative care team, but quite often they are not available to us at the time we need them.

The Hon. GREG DONNELLY: So is it fair to say—and, once again, this is not reflecting but just stating things as a matter of fact—that, with respect to the palliation of residents, the basic palliation is the syringe driver providing morphine at the end of life? Is that really the sum total of it?

Ms THOMSON: No, palliation is much more about not only just the medication administration but also about tending to the residents in terms of making sure that they are turned regularly to prevent pressure areas, attending to continence issues, attending to—

The Hon. GREG DONNELLY: I am talking about, specifically, pain relief. I understand what you have said in terms of pressure sores and related matters, that is something pretty clearly understood as basic and necessary end-of-life care. But in terms of pain relief and the delivery of pain relief medications at a sophisticated level, I do not just mean matters of a morphine injection, that is generally not available? It is just the basic syringe driver of morphine, is that what is available?

Ms THOMSON: No. McLean Care offers palliative care pain management via medication by our registered nurse, as authorised by a general practitioner.

The Hon. GREG DONNELLY: Okay. I might have to leave it there for the moment. Thank you very much for that evidence.

The CHAIR: I will just pass to the Government.

The Hon. WES FANG: Thank you very much for appearing before us today. I have got a general focus on rural regional care. I noted in your opening statement, Ms Wade, that you talked about the number of registered nurse job advertisements that were posted overnight, for example. I guess there are concerns that should a requirement like this come in there will be many rural regional health care and nursing home areas that will be fighting, whether it be the hospital and the aged-care facility, for the one resource. Do you have a view on that?

Also, Ms Thomson, as a provider in a rural regional setting, I am keen on your views and opinions on this and what on-ground experience you might have around this area and thoughts on how it may affect yourselves and others.

Ms WADE: I commenced my career in regional rural New South Wales in aged care as an HR manager for a standalone aged-care provider in the Central West. That is 11 years ago and even then we struggled to get registered nurses, but since I have been with Aged & Community Services Australia it is definitely getting worse. We are getting accounts from the city as well that providers in metro Sydney are struggling to secure registered nurses. There have been sponsorship possibilities, so bringing people in from overseas, which is certainly something that we did when I was working in provider land. That worked really well. However, over the last 12 to 18 months, with restrictions on immigration, we cannot tap into that skilled migrant worker system and providers are really, really struggling. That is across the board. I am dealing with people in the Riverina, Murrumbidgee, New England, the Central West, Far West, all day, every day and workforce is the major issue.

The Hon. TAYLOR MARTIN: If I can just pick up on that line of questioning for a moment. What is your understanding of what situation might arise should you be in a situation like you have just described? Should this legislation pass and providers, as you said in your opening statement, advertise along with many other providers and other services and local hospitals and local health districts for registered nurses, what might be the situation? What is your understanding if you could not actually hire someone?

Ms WADE: They will close. If they cannot comply with a 24/7 requirement—they are a 10-bed facility in rural New South Wales or even remote and they cannot get a registered nurse—they will close.

The Hon. TAYLOR MARTIN: That is not good at all for—

Ms WADE: No, it has knock-on effects in the community. Oftentimes aged-care facilities are the one, two, three biggest payroll in town. You take that away and then that has got ramifications on the town and the general area, definitely.

The Hon. WES FANG: Continuing on with that, if that was to happen what would happen to the residents?

Ms WADE: They would have to secure alternative accommodation, which means that they may have to relocate, in some instances hundreds of kilometres away from their families.

The Hon. WES FANG: But they are typically there because that is where their family are and that is where they want to be.

Ms WADE: That is where they have lived all their lives. They have farmed, they have worked, they have been the banker and they have a right to grow old in their own community and to be cared for by people in the community. If a home was to close then that is taken away.

The Hon. WES FANG: That would have a very detrimental effect on their wellbeing, their state of mind and their family?

Ms WADE: Social dislocation, yes, their mental wellbeing, their families. Then there would be the travel for families to get to see them. So they might not be seeing them every day, they might be every week. Yes, that is very real.

The Hon. WES FANG: Right. That is of great concern, is it not?

Ms WADE: Definitely.

The Hon. WES FANG: The other aspect around this bill that I think will affect rural and regional communities, in particular, is the increased cost. There is no doubt that putting a registered nurse on 24/7 would have an increased cost to the facility as the employer of the person. In your experience, do you know where that cost would normally be passed to? Is it absorbed by the organisation or is it usually passed on to the residents?

Ms WADE: We represent not-for-profit members. Any surplus that they have, which is a scarcity at the moment, goes back into their organisations, into their residents, into their staffs and into their general environs. They would absorb the cost as much as they can but there comes a point where you cannot absorb any more.

The Hon. WES FANG: So that is likely to be passed on to the residents, is it?

Ms WADE: I could not comment. Ms Thomson?

Ms THOMSON: No, under the current Commonwealth funding system that is not allowable and that is not what would happen. Essentially, business would operate at a loss until such time as that business became unsustainable.

The Hon. WES FANG: So that could also then force a business to close if it became unsustainable.

Ms WADE: Yes.

Ms THOMSON: Correct.

The Hon. WES FANG: My final question is with the view that you have got a risk of closure through not being able to satisfy the requirements of the bill, because there is a lack of resource and there is the increase in cost as well. What do you see as a better way to move forward: the adoption of something like this now, or would you see that harmonising our system with what is proposed through the Federal report that was recently released? Would that be a better way to adopt a 24-hour nurse coverage approach, with the harmonisation across the country with all nursing homes having the same requirements funded potentially by the Federal Government?

Ms WADE: Yes, the Federal Government is the governor and the regulator of aged care, and the funder. They also, through the quality and safety standards prescribed, have staffing requirements. You need to have the right people, right place and right time to provide quality care to the people in your care. The royal commission has made those recommendations, around 2022 and 2024, so they are sitting there and we are waiting for the Commonwealth's response by 31 May.

The Hon. WES FANG: Potentially what we are doing now could put more risk to those smaller homes and communities than just waiting for the Federal Government to—

Ms WADE: Yes.

The Hon. DANIEL MOOKHEY: Thank you for your appearance today. Can I just pick up on some of the lines of questioning that have been raised by my colleagues Mr Donnelly, the Chair and Mr Fang. Could we just talk about the workplace planning issues that you made mention of. These were first flagged in your sector 20 or 30 years ago. Is that correct? Would that be fair?

Ms WADE: In the last 20 years, yes.

The Hon. DANIEL MOOKHEY: So it is not like this is a new issue about a shortage of registered nurses. You would agree?

Ms WADE: It has become more prevalent.

The Hon. DANIEL MOOKHEY: So what steps are you taking? What steps is your association sponsoring in terms of how we would improve workforce planning around the skilling of more registered nurses?

Ms WADE: We have graduate nurse program. We have a workforce and industry development unit that is specific to aged care and we promote that across the country. We have got a particular interest in regional Australia.

The Hon. DANIEL MOOKHEY: What does it do?

Ms WADE: It skills up staff. It is not just registered nurses but personal care workers, looking at hospitality aspect as well, but aiming to bring in more registered nurses into the sector.

The Hon. DANIEL MOOKHEY: How many of your centres participate in that program?

Ms WADE: I do not know. I would have to take that on notice.

The Hon. DANIEL MOOKHEY: How many people have gone through it?

Ms WADE: I do not know. I would have to take that on notice.

The Hon. DANIEL MOOKHEY: How many of them are care and personal workers?

Ms WADE: That would be the graduate nurse program so they are nurses, not personal care workers.

The Hon. DANIEL MOOKHEY: What is the budget?

Ms WADE: That I will have to take on notice.

The Hon. DANIEL MOOKHEY: If you could that would be helpful. If you have got any further suggestions around workforce planning, that would be helpful too. Secondly, just arising from this point that I think Mr Fang raised, which is a good point, about what the introduction would do, is it not the case then that,

in terms of anyone who has advanced an argument for the introduction of registered nurses 24 hours—or probably the way I should put this is that people who have come before this Committee and advanced that argument—any such requirement would have to be phased? Would you agree with that?

Ms WADE: Yes.

The Hon. DANIEL MOOKHEY: And you would agree that such phasing should be structured according, effectively, to the availability of regional nurses' particular geography?

Ms WADE: Sorry, could you repeat that, please?

The Hon. DANIEL MOOKHEY: That is, the way in which we should phase it in is according to whether or not it is capable of being complied with by geography, as in there are enough registered nurses in the particular area, and the areas in which there are should perhaps—

Ms WADE: I think that would have to be considered, yes.

The Hon. DANIEL MOOKHEY: You would not disagree with that idea that we should really tie the phasing according to the availability of registered nurses in a particular place?

Ms WADE: No, I would not disagree.

The Hon. DANIEL MOOKHEY: Great, thank you. Can we talk about the personal care workers side of the industry. Do you agree that those people are underpaid?

Ms WADE: ACSA is on the record for saying that we believe that personal care workers or aged-care workers need to be remunerated better but that is contingent upon funding.

The Hon. DANIEL MOOKHEY: So your issue here is, effectively, that there is not enough money.

Ms WADE: That is right.

The Hon. DANIEL MOOKHEY: You would agree that the responsibility is primarily with the Commonwealth, yes?

Ms WADE: Yes.

The Hon. DANIEL MOOKHEY: Can I just tease out one aspect of your opening statement in which you said that you have a preference for there to be a consistent set of national regulations—that is, we should have one set of rules applying across all facilities. Have you raised that with the Commonwealth—not the royal commission, but the actual Commonwealth Government?

Ms WADE: That I do not know the answer to but I will take it on notice.

The Hon. DANIEL MOOKHEY: Have you had any indication from the Commonwealth as to whether they are committed to that in principle?

Ms WADE: Not that I know of but I can take it on notice.

The Hon. DANIEL MOOKHEY: Have you had any indication from the Commonwealth as to whether they have a timetable to introduce such a national regulation?

The Hon. WES FANG: Point of order: Given the answers to the first two of those questions in sequence, it is likely that the witness will not have an answer because she said she is unaware. Mr Mookhey might be better to—

The CHAIR: We have very limited time, Mr Fang. Mr Mookhey is entitled to pose the questions how he sees fit.

The Hon. DANIEL MOOKHEY: The witness is doing very well. She can just answer, "No."

The CHAIR: I think the witness is very capable of providing an answer and has been quite informative for the Committee this morning so I think we will allow this to continue.

The Hon. DANIEL MOOKHEY: The question was, have you had an indication from the Commonwealth as to a timetable to introduce such a regulation?

Ms WADE: I am not aware of one but I can find out.

The Hon. DANIEL MOOKHEY: Thank you. Do you agree that New South Wales has more people in aged care than any other State?

Ms WADE: I believe so, yes.

The Hon. DANIEL MOOKHEY: So why should we, as a State, be waiting for the Commonwealth to act when there is no indication that they are willing to?

Ms WADE: The Commonwealth is the regulator. They govern the system and they fund the system. It is overseen by the Commonwealth Government.

The Hon. DANIEL MOOKHEY: But we have had multiple evidence to us as well as to the royal commission that, to really put it plainly, the Commonwealth is doing a pretty bad job. And every day the Commonwealth is left to do a bad job is another day that New South Wales residents are left at risk. So why should not we be acting? Why should we be deferring given we retain constitutional prerogatives in this area and have not ceded our powers?

Ms WADE: The royal commission has made the recommendations and there are 148 of them and we are waiting for the Government's response, which is at the end of next month.

The Hon. DANIEL MOOKHEY: So your view is that the royal commission is enough of an event changer to cause us to have a lot more faith in the Commonwealth?

Ms WADE: They have made recommendations and we need to wait to see what the Commonwealth is going to say.

The Hon. DANIEL MOOKHEY: I accept the proposition and you are not the first person to make the point. I am not suggesting that you are alone in this view. But I have raised this with other persons before who have given us evidence, which is that we carry more of the risk; more of the residents are here; we are not Tasmania or some of the smaller States that have smaller populations; we are the biggest State here. Why should we be waiting for the Commonwealth when we are at more of a disproportionate advantage and inertia costs New South Wales more than it cost other States.

Ms WADE: I really cannot answer that question other than that it is a Commonwealth-regulated system.

Ms CATE FAEHRMANN: Most of my questions have been asked. But just looking at the workforce issue again, which you have both obviously raised quite emphatically and which is clearly a big issue, are there any of your organisations that do not have registered nurses on at any time because you cannot find them to employ them? Is that happening in any of your services?

Ms WADE: Ms Thomson, have you got experience with that?

Ms THOMSON: We, as McLean Care, do employ registered nurses on all of our sites but I do know anecdotally that there are facilities—very small facilities—that are unable to find registered nurses to provide any length of service. Some are able to access registered nurses a couple of hours a day, maybe a couple of days a week. I do hear of one particular site that is in the Upper Hunter that has an arrangement with the local hospital to provide registered nurse services; so providers do, I believe, look to alternative resources to ensure that the residents they have are able to access the most appropriate clinical services.

Ms CATE FAEHRMANN: Do you receive any complaints or concerns, whether it is from the workforce themselves, from management or from patients, in relation to the lack of registered nurses in some of those areas that you mentioned—the Upper Hunter, for example?

Ms THOMSON: I cannot speak to the actual providers' complaints data. I only anecdotally know from conversations about the issues of accessing registered nurses.

Ms CATE FAEHRMANN: When you say you cannot speak to the complaints data that the providers would have, is that because you yourself, in your position, do not see summaries of that? Or it just stops at the providers if people make complaints about—for example, patients' families may require or suggest that more time and more hours of registered nurses be at certain places. You would not hear of that. Is that the situation? It does not come up to you?

Ms THOMSON: I am a separate provider to the provider I am actually talking about, so they have no responsibility to my organisation or to report to me in any way, shape or form. They are their own individual entity and it is only through collegial conversations that this information that I have is known to me.

The CHAIR: Thanks very much. Mr Pearson, I do have a couple of questions as well.

The Hon. MARK PEARSON: I will be brief. Just for clarification, when you referred to the fact that because of COVID obviously immigration has shut down, was it the case that if somebody came from an overseas

country and decided to train in nursing, one of the requirements was that they were to work in a regional area for a given period as part of their application as a permanent or temporary resident?

Ms WADE: I understand the arrangement is something like that, yes.

The Hon. MARK PEARSON: Did that increase the number of registered nurses' availability in regional and rural areas?

Ms WADE: It increased it somewhat, in my experience. In speaking with members and going out to visit members in regional, rural and remote New South Wales, I am seeing an increased mix in the registered nurse population—people who have come from overseas, yes.

The Hon. MARK PEARSON: I understand one of the major issues for elderly people in aged-care facilities is the problem of falls. If there is a fall, it can be quite complex because of the lack of strength of the bone, et cetera. Can a registered nurse, via a video link or via a phone, assess a resident if they have fallen as to whether there could be a complication of a fracture or breakage requiring hospitalisation, or could that only be done by an assessment face to face?

Ms THOMSON: I am happy to take that question, Ms Wade.

Ms WADE: Thanks, Ms Thomson.

Ms THOMSON: Fundamentally, falls are a complex assessment process. And so, the most appropriate person, if available, to assess a resident who has fallen is a physiotherapist or alternatively an occupational therapist. If facilities employ those particular allied health specialists, then they are the most appropriate people to assess it.

The Hon. MARK PEARSON: But that is not going to happen at two o'clock in the morning, is it, Ms Thomson?

Ms THOMSON: Correct, correct. On a site where there is not a registered nurse 24/7, the way McLean Care would operate in that situation is that an on-call registered nurse would be called and the registered nurse would go through an assessment process similar to the Situation, Background, Assessment, Recommendation process that is used in acute care facilities. And then, they would make a clinical decision to attend the site or to organise an ambulance to come to the facility and transfer the resident to a hospital.

The Hon. MARK PEARSON: If that is the case and we are talking about quality of care for our aged community in their most familiar environment—knowing people, everything is familiar, less stress. But if a decision has to be made for a resident to go to hospital which would not have been made if a registered nurse was on site, does that not strike at the whole issue of doing the very best for our residents in causing the least stress? By putting them in an ambulance, carting them off to a hospital, lying around in an emergency ward not knowing anybody—in the balance, in the interest of the wellbeing of the resident, is it not better for that assessment to be done face to face, to avoid such a trauma to the resident?

Ms THOMSON: I would just like to make a couple of points with those comments. A registered nurse can assess a resident via a telehealth mechanism because what we are assessing for is pain and displacement, both of which are viewable via a telehealth process. Clearly there is also assessable injury such as bruising or bleeding; they can also be done via a video link, per se. Notwithstanding, a registered nurse could also attend the site if they were on call, as well, if there was any concern about whether the person potentially has a fracture or another injury that does require medical assessment.

That is the basis of a registered nurse's assessment, so that can happen. There are also other ways around, and virtual programs that physiotherapists have developed where you can use a Shadow simulator to look to making sure that there is no displacement available. So, there are other ways that assessment can take place. In fact, I think the way forward in the future is to look to developing technological solutions to a workforce dilemma—not to replace the registered nurses but to support registered nurses that are currently in place and to support care workers to make better clinical decisions for residents, to get the best possible outcomes.

The Hon. MARK PEARSON: Would you say at the moment that that standard of education for the assistants in nursing or equivalent is not of that standard to be able to fill that gap if a registered nurse is not on the floor?

Ms THOMSON: I can only speak to McLean Care's experience. McLean Care would either deploy a registered nurse to the site if the resident had fallen. If they were concerned, after using a telehealth mechanism, that the resident potentially may have a fracture, they would then attend the site before making a call to the ambulance to transfer to hospital. We all agree that transferring residents to hospital is not what we want to do.

We want to keep our residents at home. We only ever transfer when it is absolutely necessary or when the resident's family, regardless of the clinical assessment, requests the transfer, as we have to honour those wishes as well.

The CHAIR: I am mindful of time, sorry. I have a couple of final questions and I know we started a few minutes late. Obviously the thrust of your testimony today, Ms Wade and Ms Thomson, has been that there is simply not the money for the nurses. There is not the money and there is not the availability. I wanted to ask you whether you have undertaken any modelling on what level of funding would be required in order to fund a registered nurse 24/7?

Ms WADE: I am not down to the exact detail of that. Ms Thomson would be much more on top of the cost.

Ms THOMSON: We know it costs between $600,000 and $700,000, depending on the length of service of a registered nurse, to employ per annum. And so, if our sites that do not currently have a registered nurse were to require a registered nurse 24/7, we would have to undertake a full business review as to whether that service was viable ongoing if we did not receive the appropriate funding to cover the costs of a registered nurse. One of the important things to also understand is that there is very little modelling from a national perspective on how much it actually costs to deliver services to older people.

The CHAIR: Yes, I wanted to ask you about this. The lack of transparency is an issue that has been spoken about consistently in the media and you said in your submission that what is required is transparency and reporting against resident acuity. Would you be prepared to accept an increased level of transparency for an increased level of funding?

Ms WADE: I do not think that would be unreasonable. Yes.

The Hon. DANIEL MOOKHEY: Just before you go on, from either of the witnesses on notice, can we get that $600,000 per nurse per annum broken down by what it would cost per patient or per resident?

The CHAIR: That is exactly what I was about to ask. That is a good question because there have been public figures that providers currently receive over $88,000, about $66,500 per resident in government funding and roughly about $22,000 in resident fees. I appreciate that changes. Perhaps I can just attach this to Mr Mookhey's question to take on notice: Is that enough? If it is not, how much would be required?

Ms WADE: I can say it is not enough but we will take it on notice as to what is enough, yes.

The CHAIR: We might have some more questions on notice on this issue because I am mindful that it is 10.50 a.m. and our next witnesses are here. Thank you very much to Ms Wade and to Ms Thompson for your time. We did not receive a lot of submissions or testimony from providers and we really appreciate you taking the time to make a submission and also to appear before us today.

Ms WADE: Thank you very much.

The CHAIR: I remind witnesses about questions that were taken on notice. Can they please be returned within seven days. The ever-efficient secretariat will be in contact to arrange that.

(The witnesses withdrew.)

SAVIOUR BUHAGIAR, Director Ageing, Uniting NSW.ACT, affirmed and examined

The CHAIR: I now welcome our next witness. Do you have an opening statement?

Mr BUHAGIAR: Yes, I do. Uniting NSW.ACT is the service and agency arm of the Uniting Church of New South Wales and the ACT. We are the largest not-for-profit aged-care services provider in New South Wales and the ACT, currently providing support to about 5,000 people across 71 residential aged-care services. We provide service to about 10,000 people living in the community and about 3,000 Commonwealth aged-care packages, and we have about 3,000 people living in independent living. We have had a long interest in the issue of 24/7 RNs when it was previously raised. I echo a lot of the comments that Ms Wade and Ms Thomson made in relation to costs, but I suppose the bigger issue—I hear the concern being expressed by the Committee and I have seen previous reports around the importance of getting aged care right. Getting aged care right is more than just getting residents' nurses right. As important as they are, it is much broader than that.

That is why, when we think about the royal commission and the opportunity it presents, we have to think more broadly. I respectfully say to you to think about the idea of just tackling one issue, which is registered nurses. As important as that is, getting it right is not enough. If we are going to get our services to older people right, we have to think much more broadly. We have to be thinking about home care, transparency, integration with health, workforce and sustainability. Unless we hold all those things together we will not get this right. Simply tackling registered nurses 24/7 will not do it. Currently across our services we have about 20-odd services that are small—around about 50-odd beds each—that do not have 24/7 RNs. They mostly have RNs seven days a week and our managers of those services are registered nurses.

We have an on-call system for those, as well, so people at night-time have support. A lot of the care planning by those registered nurses and by the care staff and the rest of the team happens through the day, which tries to anticipate what may happen on a given evening and a given night. But clearly there are falls and people who deteriorate overnight, and that is where the backup is required. The good integration with health helps with that as well. Most of our services, as I say, have 24/7 RNs. We have unplanned hospital admissions from those services. We have deteriorating residents in those services. So things happen in spite of having 24/7 RNs. What I want to say to you is that if we are thinking about how to fix this system and how to make the lives of older people better—which we absolutely need to do and as a leading State we should be advocating strongly—we need to be thinking much more broadly than just the 24/7 RN issue, as important as RNs are. They are critical. That is my opening statement.

The CHAIR: Thanks very much, Mr Buhagiar. I echo what I said at the end to our previous witnesses, which is that we really appreciate you taking the time to appear before us today. We have had limited submissions and testimony from providers, so we really appreciate that. Certainly what we have seen in our testimony so far and what was highlighted in the royal commission has been that there are a lot of problems in aged care. That is certainly where our inquiry has been taking evidence on a much broader range. Specifically about that issue, the royal commission has recommended a model for a staffing and skills mix that would be required in aged care but in effect would mean that an RN would be on 24/7. That is correct, is it not?

Mr BUHAGIAR: Yes, absolutely. We are totally supportive of that recommendation because if implemented properly, what comes with it is a whole range of reforms that really need to be there that go to transparency, greater home care, a better skill mix, better pay, better integration with health and sustainability. If we do all five things well—or five things in our mind, although it is probably six that I have included—we will get this right. We need to get this right. Older people deserve better than what they are getting at the moment.

The CHAIR: We would certainly echo that. The Country Women's Association [CWA] made a submission to us in which it said that the view that we should give exemptions for country areas is based on an entrenched belief that country people should accept second-class care. What would you say to that, Mr Buhagiar?

Mr BUHAGIAR: I would say look at our hospitals. Look at our GP practices in regional New South Wales. Look at access to specialists in regional New South Wales. They are already receiving care that is probably not at the same standard as you would receive in a metropolitan city. People in regional New South Wales already know that experience and they have worked around that experience. Again, if we want to think about a much broader issue than just how aged care works, think about rural health services and the experience that they have. Yes, that is a problem. We ought not have differences between regional and metro health services, but we do. It is the same thing in aged-care services.

The CHAIR: Mr Buhagiar, in your submission you talk about the roughly $600,000 or $700,000 figure that it would cost to have an RN 24/7. Have you broken that down to what the cost would be per resident?

Mr BUHAGIAR: Let us think about a 50-bed place. You just divide it by 50 and work it out by resident and you think about the cost of that person. But let us keep in mind that that resident number that you spoke about earlier, that funding by the Commonwealth of about $68K or so, on average includes probably about $10K or so that is paid by the consumer. That $75K or so per person is paying for everything that person receives—their staffing, their meals, their cleaning, their administration, the upkeep of the property et cetera. The whole works is being paid for. About 70 per cent of that goes to staff, of which a portion goes to nurses. The bulk of the staff in residential aged care are care support staff but there are also cleaners, cooks, laundry people, property people et cetera that also make up part of that staffing regime.

The CHAIR: Yes, and we have certainly heard evidence that the holistic nature of aged care, that we need to view it as a full picture, that each of those is a really important part. For example, we have seen cleaners during the COVID-19 pandemic that is a crucial part of keeping our aged-care facilities safe. Is that not correct?

Mr BUHAGIAR: You were talking earlier about palliative care, end-of-life care. Think about aspects of spiritual care, pastoral care, that also pay a critical role in that period of time. So a whole lot of people contribute to the wellbeing of that person, particularly at end-of-life stages.

The CHAIR: So let me ask you this: Have you looked at or would you be prepared to commit to increased transparency—

Mr BUHAGIAR: Certainly.

The CHAIR: —if residents were able to see exactly where that funding was going?

Mr BUHAGIAR: We have been very clear in all our submissions and in our arguments with the Commonwealth that increased transparency needs to be put on the table and certainly is a function of any increase in funding. As a provider we are very clear that increased transparency around clinical indicators, transparency around staffing, transparency around complaints, transparency around incidents all need to be put on the table. So we encourage our services to be talking to their families about our falls rates, about our medication rates, and we are just at the moment exploring whether we want to publicly put those out there ourselves. But we are very open to the idea of increased transparency and, as providers, that has to be a function of asking for more money. If we are serious about wanting more funding, which we desperately need, then a function of that is to be more transparent about how we use that funding.

The CHAIR: Thanks very much, Mr Buhagiar. I will pass to Mr Fang.

The Hon. WES FANG: Thank you very much for appearing today and thank you for your fantastic insights and your very strong opening statement. We have heard evidence previously that, much like you said, registered nurses are important, but if you ask the workers on the ground that are doing the tasks day to day they will say that what they need is more, I guess, hands on deck—more support and personal care workers in the facilities, particularly overnight. Is that your experience and do you think that would be of more benefit and increase the welfare and enjoyment of residents more so than having a registered nurse in the facility 24/7?

Mr BUHAGIAR: Absolutely. Just think about not only would more care staff be helpful but I mentioned earlier about allied health staff—speech therapists, occupational therapists, having more ability to bring those sorts of specialisations into planning—but certainly more registered nurses would be also helpful. An increase in staffing—one of the key issues that residents talk about is people having more time. Time is a critical issue. One of the residents, I remember an anecdote, said "People walk at my pace." In order to walk at people's pace you need to slow down; you need time. So time is a critical issue within residential aged care. Think about things like loneliness and boredom. Having time to stop and have a cup of tea, having time to have a biscuit with somebody and just give them a few words of encouragement about their day and how their day has been, those things take time, and time is a precious commodity in residential aged care at the moment.

Let us think about at the moment the average residential aged-care resident receives about three hours per day per resident. The recommendations of the royal commission's final report will take them up to about four hours a day per resident. That is a significant increase but it is still four hours a day per resident, and that includes registered nurses, care staff—the whole works are included in those hours. So yes, absolutely we need more time. Time is a critical issue. But I cannot over-emphasise enough you need to do the other things: you need to do the workforce planning, you need to do sustainability, you need to think about the mix—things like allied health—you need to do all those things to make that time valuable. And you need to have good models, you need to have a good model of care as well. We do not want to treat people like they are in a hospital.

The Hon. WES FANG: We have heard a lot of focus around the time when people are approaching the end of their life and how a registered nurse will provide a greater level of care for that person as they are

approaching that period. In your experience, the residents in those facilities they are not all that way, are they? They have got sprightly minds, bodies; they want to have their days in that nursing home fulfilling and supported. So there is an argument that those other workers will actually provide a greater level of care and support to the residents perhaps than maybe a registered nurse. That is the first part of the question. The second part is: If there is only a single pot of money and registered nurses are mandated 24/7 would you be having to cut other services potentially to residents?

Mr BUHAGIAR: The reality is that the people coming into residential aged care today are frailer, do have more comorbidities, but we still have people coming into residential aged care at a stage of life where they can do a lot of things for themselves. A lot of our services that I am talking about where there are low-care services where we do not have 24/7 RNs but we have RNs everyday are, relatively speaking, traditional low-care services. They are people who are either experiencing mental health issues, issues with dementia, so they have got issues needing to be reminded about medication, maybe needing to be reminded about showering. So there is a lot of those sort of services, and certainly in our network of services—that is 21 of them—there are about 1,000 people that are still receiving that low level of care, but important, but critical, and they are there for maybe four, maybe five years and they need that level of care. So that still exists.

But yes, the bulk of the people coming in today are needing higher levels of care and the aged-care network—certainly ours—caters for that. So people with high-level support in terms of dementia or high-level support in terms of palliation, that is still part of the mix, but residential aged care is much more diverse, and then if you think about home care, even more diverse again. In terms of what we need to do, it is always about juggling; it is always about saying what does this group of residents or this particular resident need in terms of staffing support—what skill mix, what levels of care, what sort of time is needed? So not everybody gets three hours—bang; we spread that out and some people may need more of it in a given day or a given week or month, whatever it happens to be, all for their whole time with us, if they come in very late in their life and use that palliation. So I think there is always a juggle—do I get to your second question there? It is always a juggle about making choices between what roles and what people to put in place.

The Hon. TAYLOR MARTIN: If I can just pick up on the point you were making there at the end. Some of your facilities do employ RNs, albeit not for 24/7.

Mr BUHAGIAR: Yes.

The Hon. TAYLOR MARTIN: Do any of your facilities have a 24/7 RN?

Mr BUHAGIAR: Yes. The majority—

The Hon. TAYLOR MARTIN: Sorry, before you go on can I ask, just for the brevity of time, what factors go into that decision-making?

Mr BUHAGIAR: The majority of our services have 24/7. We look after in our residential aged-care service about 5,000 people—so about 1,000 people in 20 services. Mostly our smaller services—around about 50-odd people per service—operate with just seven days a week, so operate with RNs during the daytime, not 24/7 RNs. All our other services have a 24/7 onsite RN—all of our high-care services, all of our ageing in place services and the next two tiers up, if you want to talk about it in the old language, which is useful sometimes, all have 24/7 RNs. Sorry, I have just forgotten your second part.

The Hon. TAYLOR MARTIN: What factors go into that decision-making?

Mr BUHAGIAR: It is about our offering. It is about who we can look after. Clearly, if someone approached us to go to Irwin Hall in Newcastle—a 50-bed service that is pretty low care and does not have 24/7 RNs—if someone approached us who needed end-of-life care we would say, "Unfortunately, down the road may be better. Maybe Garden Suburb or one of our other services might be better for you. This service would not be able to cater for you." So it is about our offering; it is about who we can look after, whereas someone else might say, "Hey, there's probably more people I am going to be able to talk to, more people I can engage with", so that service might be better suited for them. So it is about the individual's needs and about what we are able to offer.

I look at a service in Annesley House in Haberfield. That service is all about supporting people with mental health issues and people who have been homeless. They are quite ambulant, they go in and out of the service—albeit a little bit differently over the last year with COVID—but that service caters for those people and does not have a 24/7 RN, but has good connections with Concord Hospital and has great connections with mental health therapists who are in and out of there all the time. It is about trying to tailor the staffing mix and the networks to the cohort that you have in front of you.

The Hon. TAYLOR MARTIN: Thank you.

The Hon. MARK PEARSON: We have had evidence that 64 per cent of aged-care homes are operating at a loss. Is that the case for UnitingCare?

Mr BUHAGIAR: This is the industry average. That is StewartBrown data that you are looking at there. No, that is not our situation. Probably about a third of our services are operating at a loss. A lot of those are situated in regional New South Wales. All of them are small, funnily enough, and not all of them are aged-care services.

The Hon. MARK PEARSON: How do those services that are operating at a loss keep going?

Mr BUHAGIAR: We cross-subsidise across the network.

The Hon. MARK PEARSON: Does the Uniting Church actually make any money out of this industry?

Mr BUHAGIAR: No. We try to put money back into our residential aged-care service. You have got to imagine that, out of that 75-odd thousand per person, we have got to upkeep that building, depreciation on the building, replace the building—

The Hon. MARK PEARSON: Where do those funds come from?

Mr BUHAGIAR: They are a mix of Federal Government funding and the persons themselves.

The Hon. MARK PEARSON: So nothing is coming out of the pocket or the purse of the Uniting Church, to care for these people.

Mr BUHAGIAR: No.

The Hon. MARK PEARSON: It is all public funding, being administered by the Uniting Church.

Mr BUHAGIAR: Public funding and consumers.

The Hon. DANIEL MOOKHEY: Do you have the ratio between government funding and residents' contributions?

Mr BUHAGIAR: I am happy to check it. It is around about 80 per cent government funding and about 20 per cent from consumers. I would have to just double-check that number—about 65 to 75.

The CHAIR: If you want to take that on notice.

The Hon. MARK PEARSON: I am just interested in comments you made earlier in relation to the royal commission. You would appreciate that the royal commission did a very forensic, thorough, intensive analysis of the aged-care issue in Australia. Correct?

Mr BUHAGIAR: Yes.

The Hon. MARK PEARSON: Why does the Uniting Church not agree with their fundamental recommendation that there be a registered nurse in each facility 24/7?

Mr BUHAGIAR: We do. But we want it among a whole suite of activities, including sustainability et cetera.

The Hon. MARK PEARSON: I understand that. I have read it. I understand it. It should be a multidisciplinary, comprehensive, holistic approach. Understood. But the royal commission, after looking at all of the evidence, came to a conclusion: that in the best interest of the aged person, juggling up all these things you have talked about, they still say a registered nurse should be 24/7, even if it is an aged-care facility with half the people who were homeless or mentally ill or are in the last hours or weeks of their lives. They would have taken all that into consideration but still come through with that.

Mr BUHAGIAR: I am not going to sit here and say to you that the royal commission has delivered exactly what I would have given. But let me say to you that it has given a really good set of recommendations. It is a once-in-a-lifetime opportunity. If 24/7 registered nurses are part of that, I am happy to take that, as long as it deals with the whole breadth of aged care and actually provides us with a system where we can actually look after people properly, from when they initially have some issues, getting older, right through to when they are palliating. I am saying to you that I agree with you. I actually do want to see 24/7 RNs in place. But they need to be done within a whole suite of activities. I also want to ask you to just have a think about what just going for that one activity means. You mentioned, earlier, unavoidable hospital transmissions. We have those—

The Hon. MARK PEARSON: Just going back to that point, though, you would not say that it would be appropriate to say, "We're going to have less registered nurses so more residents can go on activities." Surely,

if the royal commission is saying the bare minimum, foundation or ground is a registered nurse 24/7—and then it is our responsibility to ensure that all those other factors of enriching the resident's life is in place. I am just going back to a comment for this last question. You said people in regional or rural areas tend to accept that they probably will not get the best services. You brought registered nurses into that sort of equation. Is that really true? Would not most people in rural and regional areas expect the bare minimum of a registered nurse, as opposed to a gastroenterologist or a dermatologist? I think most people in these areas would accept that they might have to travel for specialised services. But, surely, registered nurses are not specialised.

Mr BUHAGIAR: I am not saying they are. You are taking my answer out of context. There was a general question around regional New South Wales and what they have experienced. I was just making a general point, that they also experience a lot of other inequities, between what people in a metro setting receive compared to what people in a rural setting receive.

The Hon. MARK PEARSON: But they should not put up with not having a registered nurse available to care for their elderly people.

Mr BUHAGIAR: They clearly should not, in the same way that someone in a metro setting should not put up with it, either, if that is part of a fuller system that is funded properly and that actually has the workforce planning done behind it.

Ms CATE FAEHRMANN: You mentioned before that you cross-subsidise between different facilities or services. Does that mean that a high-needs resident has to pay more? Do the services cost more? Is it standard?

Mr BUHAGIAR: No, the services cost the same. The fees are all dictated the same. So there is no change in what a person experiences. Keep in mind that even the royal commission—arguably, I think, probably not so well—argued that user-pays ought not to apply to care; it ought to apply to accommodation services, for example, but not to care services. That is the bulk of the aged-care system, and we are saying, "Let's rule out user-pays for that part of the system." Now, we can have a debate about whether that is right or wrong. But from a sustainability point of view it is problematic to not have that portion exposed at all to user-pays. But at the moment, no, there is no difference in what a person—when I say "cross-subsidise", I mean the surplus made in one service, say, in a metropolitan service, cross-subsidises a regional service and sometimes vice versa, depending on the sustainability of that regional service.

Ms CATE FAEHRMANN: Do you charge bonds to each resident?

Mr BUHAGIAR: Yes, to those residents who are deemed non-financial. About 52 per cent of our people pay a RAD—a refundable accommodation deposit—or a daily accommodation fee, which is similar to what you are describing as a bond.

Ms CATE FAEHRMANN: Some of your facilities have registered nurses on site 24/7. Are there any vacancies? We have heard a lot about the difficulty in terms of recruitment. What is the job vacancy rate at the moment?

Mr BUHAGIAR: It is always harder to recruit nurses in regional New South Wales.

Ms CATE FAEHRMANN: We have heard.

Mr BUHAGIAR: We did an estimate. At the moment we would need about 168 more nurses in our sector. Currently in our services we have about 600 nurses—

Ms CATE FAEHRMANN: Is this just in New South Wales?

Mr BUHAGIAR: Just in New South Wales. We are only in New South Wales and the Australian Capital Territory. The bulk of our services are in New South Wales. We have two services in the Australian Capital Territory. So, please, I can talk across the whole network. We have about 580 nurses. We would need about another 168 nurses. On average, our nurses work about 21 hours a week. They are permanent part-time. We would need about another 168 in order to cover the rest of our network, which does not have 24/7 RNs.

Ms CATE FAEHRMANN: Has that been relatively stable during, say, the last 10 years or so, that figure, which is—what is that? Roughly 20 per cent?

Mr BUHAGIAR: Roughly 20 per cent, I would have thought. I have been in aged care for about eight years or so. We know that pre-2000s the percentage of registered nurses was far higher than it is now. It has reduced. That is on the public record. There are plenty of records that talk to the percentage of registered nurses reducing in aged care.

Ms CATE FAEHRMANN: The percentage of registered nurses compared to the rest of the workforce, you mean?

Mr BUHAGIAR: Absolutely. Yes, that is what I mean. Sorry. Is that where you were going?

Ms CATE FAEHRMANN: Yes.

Mr BUHAGIAR: Absolutely. It is a matter of record.

Ms CATE FAEHRMANN: That is very useful. You have got on your submission "Scheduled and Planned Registered Nurse support on-site with on call Registered Nurse". We have heard about the situation where there is one RN sometimes in regional areas, rural areas, they are the ones on call as well and sometimes how unsustainable that is. Is that also an issue? You are saying that you have on-call RNs but in fact it is the same person and there is potentially another vacancy?

Mr BUHAGIAR: This year we introduced—we have a dedicated RN on call for our 20 services that do not have a registered nurse on site. But even where you do have 24/7 RNs, the ratio of RNs to residents can be quite high. We could have a service with 100-odd residents with one RN on site. Again, it is why I keep coming back to the idea that what we need to do is deal with this holistically rather than just something blunt like a 24/7 RN, which cannot achieve the kind of results I think you are after, which is better aged care. I think we need to do more than that, is what I am trying to say to you.

Ms CATE FAEHRMANN: Yes. You do understand that this is not a royal commission and we are tasked with looking into a bill—

Mr BUHAGIAR: I do, but I—

Ms CATE FAEHRMANN: —specifically in relation to RNs and 24/7, hence probably why a lot of the questions are in relation to that.

Mr BUHAGIAR: I get that. I suppose what I am asking is that we think more broadly. With all due respect, if we want the outcomes for older people that we all generally want—and I get that that is what you want, and we all want it—then we need to be thinking about the broad range because aged care is much more complex.

Ms CATE FAEHRMANN: Of course.

Mr BUHAGIAR: You think about falls or palliative care: That starts well before the need for a syringe driver or the fall occurs. The planning, the assessment work starts well before that. It starts with how their day was on that particular day. Were they feeling a bit ginger? Were they feeling a bit wobbly that day? How were they going through their day in order to build up to that fall that occurred at night-time? Were they feeling a bit disorientated? What were all those things that came to that factor? That RN at that point: Yes, it is important and critical—or that person at that point of the fall is critical—but what was the lead-up to that? How could we have done that better? How could we have prevented that from even happening?

Ms CATE FAEHRMANN: We have had a lot of witnesses talking to us about the importance of that. Thank you.

The Hon. GREG DONNELLY: Thank you very much for coming along, and thank you for the opportunity to speak to your submission. I would just like to take you to a line of questioning about palliative care, palliative care nursing and the improvement of palliative care in retirement and aged-care facilities. I think the secretariat staff have provided you with a copy of some correspondence we have received. It is some answers to questions on notice that I had arranged to be sent to Palliative Care Nurses Australia, which has given evidence to this inquiry. On page 1 my first question states:

> **Question 1: Any further comments regarding the current provision of palliative medicine, nursing and care in nursing homes/aged care facilities in NSW**

In the paragraph beneath that heading they refer to the report entitled *The economics of increased investment in palliative care in Australia*, which was a report produced by KPMG for Palliative Care Australia. Is that a report that you have some knowledge of or some familiarity with?

Mr BUHAGIAR: I must say I do not know it, but I am happy to take questions.

The Hon. GREG DONNELLY: That is okay. I am not going to quiz you about the report. Rather, if you go down two paragraphs the letter then states:

> The above report provides evidence for palliative care workforce requirements (pages 30 to 32) and outlines the significant shortfall of palliative medical specialists of two full-time equivalent palliative medicine specialists per 100,000 of population—

this is the part I wanted you to speak to, if you can—

> and further describes specialist palliative care nursing (page 31), particularly noting that relative to population specialist nursing numbers have remained constant.

Are you able to speak, from your experience in the position you have, about this matter of specialist palliative care nursing and how it interfaces with aged care broadly, but particularly the facilities that you operate?

Mr BUHAGIAR: Absolutely. One of the things that I think we need to do if we are going to get aged care right, and we have learnt a bit about it through the COVID experience through the pandemic, is our integration with health—aged care's integration with NSW Health, in our case. That intersection is really critical. We draw on the palliative care teams at our local hospitals. We draw on the geriatricians at our local hospitals. We draw on geriatric flying squads that New South Wales hospitals and Health run. That integration between aged care and health is really critical. We have learnt that, you would have heard evidence, through the COVID pandemic. Your point about the number of palliative care specialists in our network is absolutely critical. Being able to access—

The Hon. GREG DONNELLY: Sorry, if I can interrupt you there: Without reflecting on your own organisation, because this is not what I am endeavouring to do today, but just a general comment, you have said that COVID has put into sharp focus this integration, if we can use that word. Would it be your evidence that, in general terms, in retirement and aged-care facilities that sort of integration perhaps either is not there or may not have been there pre-COVID, in terms of the thinking and the way in which management dealt with palliative care?

Mr BUHAGIAR: I think from both ends it was not there—from NSW Health's perspective and from an aged-care perspective. I think both parties have realised that if we are going to deal with health, generally, of older people then we need to work better together. Initiatives like telehealth, initiatives like geriatricians who come in and do some in-house activities within our services: Those sorts of things have taught us that we can do this better. We can prevent the idea of someone getting carted off to hospital and spending a time in a waiting room, or we can actually get them to the right place, which is the hospital, when they need it. Getting that interaction clear is really important to people's health because older people in residential aged care are entitled to use the hospital system. That is what it is there for. They are citizens of New South Wales.

The Hon. GREG DONNELLY: Indeed. No, I do not cavil with that point. If I could just take you to the second page, your comments are quite prescient because it is what I want you to refer to here. My second question to them was about the improvement of access and availability of palliative care in retirement and aged-care facilities. I will read the paragraph beneath the heading and the one after that. They state:

> Models of care need to continue to develop, those that support the integration between residential aged care facilities [RACF], GP's, Specialist Palliative Care services and geriatric outreach programs, along with Hospital Emergency Departments and NSW Ambulance.

That is almost exactly the point you made. The letter goes on to state:

> These models of care need to include clinical care and consultation, technology and telehealth, clinical handover—

I will not read the rest of the paragraph; you can read it for yourself. In terms of the provision and the delivery of that, if the evidence is that COVID has been, amongst other things, this moment of recognition or realisation that all this can be and needs to be done better with respect to the residents of retirement and aged-care facilities—in other words, there has been this sort of moment of realisation—what needs to be done to ensure that that does not settle and we forget about it, so to speak? In other words, if there has been this moment, how do we take full advantage of it and not lose the opportunity to follow through with it?

Mr BUHAGIAR: I would not call it a "moment of realisation". We have always known that integration with hospitals is really important. What it has done is taught us that we can do it and that we need to do it more. I think it is about building on those relationships between local aged-care providers and their local health districts. Let us be clear: In some of our districts—I will point to Illawarra, for example—they have gotten to know our services in a way that they did not know before. It has been a real advantage to those services and to the hospital system as well because they have actually known some of the people who are attending their hospitals. That integration is really important to people's health and it is really important to how we best manage what are, on both the health side of things and also the aged-care side of things, scarce resources.

The Hon. GREG DONNELLY: But can I just now circle back—and this was not a set-up to say "gotcha", although perhaps it was—

Mr BUHAGIAR: Circle away!

The Hon. GREG DONNELLY: If one agrees with what is there in those couple of paragraphs, it is very hard to see how that can be brought about and concretised and delivered over time without having registered

nurses integral to that. I am not asking you to make a bold statement on behalf of your organisation, but if we are to reach up and get to those levels and sustain it over time—and obviously that will require funding; I am not arguing that—it is very hard to see how registered nurses and specialist nurses with palliative care expertise are not quite integral to delivering on that, would you agree?

Mr BUHAGIAR: I would agree totally. But let us keep in mind it is a matter of degrees. We already have 24/7 nurses in most of our sites. In our sites that do not have 24/7 nurses we already have nurses there seven days a week. We have managers who are nurses there. They are already there, and that integration can happen via those channels. Then it is a matter of saying, "Can we do more than that?" Yes, of course, both in terms of specialist palliative care people and also in terms of the amount of registered nurse time there is available at all our services, or careworker time, or the time of other people who are able to provide case management and support services—for example, allied health specialists. All of those skill mixes are really important if we are going to get this right.

The CHAIR: Can I just quickly ask: Do you track the numbers of young people in your facilities?

Mr BUHAGIAR: Yes.

The CHAIR: Perhaps you could provide us on notice with the numbers of young people.

Mr BUHAGIAR: We have about 130-odd people who are younger than 65. Probably about 50 or 60 of those that are accessing the NDIA. The reason why most of them are there is because they have got no other choices. If we could actually fix their access to specialist disability supported accommodation in towns where they live and where their families live so that they can stay connected then, yes, we could fix this. No-one in a nursing home or in an aged-care service is sitting out there saying, "Come here, young person with a disability, here is a great place for you to live." What they are saying is, "Do you need a place to stay? Do you need a place to live? The alternative is to move 300 kays to Sydney to find a supported accommodation service that may or may not be available—you may not have to wait for." What I would say to you is: Fix the accommodation issue, fix the access to specialist supported accommodation issue, and you will fix the young people in nursing homes issue. Because the aged-care sector is not dragging them in nor are people going there because they have got other choices.

The CHAIR: To be very clear, Mr Buhagiar, I was in no way implying that you were encouraging young people in. It just shows that we are so many years on now with the NDIS operating and we still have young people in aged care.

Mr BUHAGIAR: Absolutely.

The CHAIR: It seems remarkable that they are still there.

Mr BUHAGIAR: Prior to working in aged care, I was in disability services. So with seeing that system from the other side, there is a paucity of genuine, purpose-built specialist accommodation services where people are, particularly in regional New South Wales—going back to that question we had before.

The CHAIR: Are the majority of those in regional New South Wales?

Mr BUHAGIAR: Yes. A good number of those are in regional New South Wales because the Sydney people have more options.

The CHAIR: We have just run over time. If I could just ask you, if you would not mind taking a couple of questions on notice from me. We have not heard a lot of evidence around this issue, but it is around our culturally and linguistically diverse [CALD] communities. If you could just provide us with anything, on notice, about the specific challenges that they face as they age—even for people without dementia—and any lessons you might have from the COVID pandemic. That would be really helpful for the Committee.

Mr BUHAGIAR: I think it is probably important just to make one comment. We talk about people from CALD backgrounds and their desire to hear from a doctor or to hear from a hospital. When it comes to health, they are probably a little bit more conservative, if I can put it that way. Although that is by no means universal. Their role, in terms of saying whether someone should go to hospital—as said earlier—can trump a nurse's call as to whether someone should go to hospital. So probably the one comment I would make in the public forum, while I have it, is that comment. I am happy to take on notice some general questions around CALD.

The CHAIR: That would be fantastic. We really appreciate your time. We really appreciate your very insightful contribution today, Mr Buhagiar. I understand you have taken a number of questions on notice, including those couple from me at the end there. The secretariat will be in contact with you. We do ask if you can get them back to us within seven days. We would really appreciate it. But we know that is a very tight turnaround.

(The witness withdrew.)

(Short adjournment)

LYNDAL NEWTON, Head of Department – Department of Geriatric Medicine, Northern Beaches Hospital, affirmed and examined

The CHAIR: I welcome our next witness. Dr Newton, you are welcome to make an opening statement, if you would like.

Dr NEWTON: I was hopeful to do that. I was a little bit late to the invite and therefore have not submitted something. I thought if I may beg a little moment of your time—maybe three or four minutes—just to make a statement so that you could potentially ask questions that you feel are appropriate for my role and position. My name is Dr Lyndal Newton and I speak today as an executive member of the New South Wales division of the Australian & New Zealand Society for Geriatric Medicine. I am a practising geriatrician in New South Wales. I have worked in both public and private hospitals and extensively in community outreach services. The experience that I have includes metropolitan, regional and rural areas, serving Australians of all cultural background, including people of Aboriginal and Torres Strait Islander descent.

As an advocate for older Australians, I would like to reiterate that our residents in our aged-care facilities are amongst our most vulnerable Australians. Whilst they are predominantly, but not exclusively, older persons, they are all cognitively, socially or physically frail. For some of those residents in high-level care, they are a combination of all three. Australians are supported as long as they can be in their own residential address before moving into residential aged care. We at the society support the increase in the home care packages. However, we know that they do not meet all needs. When the person can no longer be supported at home and their physical or cognitive health requires the expert care, that is when people are moved to these facilities. Therefore, in these facilities where the care needs are the highest and the most complex, it is imperative that we have staff who are able and most skilled in these areas.

Registered nurses are integral as a member of that team for those high-level patients or residents. The older Australians in these facilities are entitled to the right care at the right time and in the right place. This allows us to put the resident first and to let their needs drive the care. Registered nurses are skilled in recognising the unwell patient that requires transport to hospital. Knowing when someone needs to go to hospital is important but, more skilfully, when the resident does not need to go. Registered nurses are then able to liaise with medical and other service providers to provide high-level quality care in the facilities in situ.

The most vulnerable people in aged care are those with terminal dementia and frailty. Registered nurses are trained to recognise those signs of end of life and can provide and support good palliative care in those facilities. These patients or residents will require the administration of medications to provide relief and dignity that cannot be provided by staff without registered nurse qualifications. It is not really about hospital avoidance. I do not like the words hospital avoidance. I think it implies that old people should not go to hospital. What I would say to you is that it is about the right care, in the right place, at the right time. Hospitals are very distressing for people with cognitive impairment or terminal illness. It is unkind to most of these people at this very vulnerable time. I would acknowledge that keeping these residents in their facilities is of benefit to State hospital emergency department waiting times and provides a significant reduction in cost to those hospitals.

As an advocate for older people, the emphasis is not really about saving money and saving waiting times. Though that is really important, it is actually about good aged-care practices. The last few things I want to say is that residents with behavioural disorders are a complex group that require specialist input. These are best looked after in facilities. It is registered nurses that can provide the environmental and cognitive support for those people. I also feel—and so does the society—that self-regulation of staffing is not really that appropriate. There are multiple examples in our society where residential aged-care facilities have not had the requisite staff to return patients or residents to their own home. Whilst many providers will do the right thing—and I fully accept that many people will do the right thing—there are many that do not, and we need to ensure that they all do.

I can give you a numerous amount of examples where patients cannot receive the right medications, be they antibiotics—not just end of life, but antibiotics—Parkinson's disease medications and comfort medications at the end of life. The refusal is not always about medication, though. Some people say, "It is all about palliative care." It is not all about palliative care. Some of it relates to specific expert nurses requirements to manage those patient behaviours. There is now more than ever—with the COVID-19 procedures—the need to provide care to those facilities. One of the startling things that came up for us was that we would train people, particularly in northern Sydney health, in the use of the telehealth equipment. So we teach them how to use the iPads and to do the telehealth. But we needed somebody who could listen to a chest and tell us what the clinical signs were for those patients to assess whether those people needed to come to hospital.

An assistant nurse cannot do that. A registered nurse can do that and a medical professional can do that. But you need a person who has the training in how to listen to a chest and to do a blood pressure test. Those are the things that became very evident during COVID and it restricted our ability to provide the excellent care that we would otherwise have been able to in facilities where they did not exist. But I am talking from a society perspective about high-level needs. I am not talking about low-level needs. Where people have high-level needs, we need the registered nurses. The best places I visit are those who have registered nurses because I know that I can give instructions to those people who are able to carry out those instructions or liaise appropriately with other people in the facilities who can.

My final comments really relate to the interplay with the royal commission into aged care. Several local health districts across New South Wales have implemented geriatric outreach services. I was involved in the set-up in south-eastern Sydney and we provided a very large coverage of over 40 nursing homes in our area, as they do in northern Sydney—about 39 for the North Shore's area. Where we did that, the care provision and the training in those facilities escalated to a point where there were competencies there, which meant that we had to provide less input because we were there. I would promote the use of geriatric outreach services, which utilise registered nurses to provide those supportive services in situ. It saves time, efficiency and cost savings for the State hospital system, but more importantly it provides dignity and appropriate care at the right time, at the right place, for the right people, with the right needs. On that note, I would say thank you for offering me to come. I will give this information to the secretariat so that they can provide it to you.

The CHAIR: Thank you very much, Dr Newton. If you could provide it to Hansard as well that makes their lives much easier.

Dr NEWTON: Of course.

The Hon. GREG DONNELLY: Dr Newton, thank you very much for coming along today to provide your expert testimony and views to this important inquiry. You have just been provided with a copy of a piece of correspondence that the Committee has received back as answers to two questions on notice that were provided to specifically the Palliative Care Nurses Australia organisation—one that I am sure you are familiar with. I would like to take you to the second page. In other words, turn over to see question number two, where the question is: Any further comments regarding ways to improve both the access and availability of palliative care in nursing homes. I will just give you a couple of moments to read those first two paragraphs.

Dr NEWTON: Yes. Would you like me to offer a perspective?

The Hon. GREG DONNELLY: I want to tie it directly back to those comments that you concluded on, effectively, in your opening statement about the geriatric outreach programs. You may not have heard the evidence from a witness earlier today, just before morning tea—Mr Buhagiar, who is the director of ageing at Uniting NSW.ACT. His testimony was that with the COVID emergency that we have had one of the effects of which has been to bring into some sharp focus the way in which standards of care are examined and decisions are made—particularly in the context of dealing with the COVID emergency—about the elderly in retirement aged-care facilities, which has picked up a number of issues including end-of-life care. His testimony was that there has been—my words not his—almost a seismic shift taken place, that he has detected, where there is an awareness of matters which otherwise were not being so clearly understood or even flagged prior to the COVID emergency.

I put to him that that obviously is interesting. But how, if we have got to a new plane—if I could describe it that way—of understanding the issues that need to be better addressed, putting aside the revelations in the royal commission, what is necessary to stop us sliding backwards or sort of just putting to the bottom drawer what we have learnt because the world has moved on, so to speak? The geriatric outreach programs obviously are important. They seem to have come to the fore in relatively recent times. Could you elucidate on those and tie them back to the issue of the delivery of palliative care and what the effect of that has been in terms of enhancing or improving or your other observations, but also tying it back to the point about the registered nurses and their integral role in delivering what we heard there.

Dr NEWTON: There is quite a lot in that. I will narrow that down if I can. We have always known that the palliative care services into aged-care facilities was not enough. This is not a new revelation regardless of COVID. We have, as geriatricians—it was one of the fundamental reasons, actually, why we started setting up geriatric outreach services, amongst many others. But one of the reasons was that we were getting people presenting to us in hospitals from residential aged-care facilities in extremis, within half an hour of death or, alternatively, with a little bit of time where had there been appropriate input we could have managed slightly better.

The Hon. GREG DONNELLY: That is coming through the emergency departments in hospitals.

Dr NEWTON: Coming through emergency departments into wards from residential aged-care facilities.

The Hon. GREG DONNELLY: Via ambulances.

Dr NEWTON: It was usually in the context of after-hours where there were not services that had registered nurses in place. At that time it was not our issue to keep the registered nurses in, it was: How do we support these people in these facilities to stop them from coming into hospital? The geriatric outreach services—the flying squad from southern Sydney, the Geriatric Rapid Acute Care Evaluation—GRACE—unit up at Hornsby and then North Shore. Subsequently, most areas in Sydney developed outreach services where there would be a geriatrician who would go out from that service to the community—whether they be called as a semi-emergent process or in planned anticipation of—reviewing these residents and trying to facilitate palliative care in the institution or facility or to have a plan for that person to move to a palliative care unit if that was more appropriate given the situation.

So that was always known about. Unfortunately, there were not the palliative care services to manage that and so that fell to geriatricians or GPs. I think we cannot underplay the importance of GPs in this matter in managing end-of-life care. When GPs would struggle they would call us in the hospital and we would give advice. So that was the initial reason why it started. The other reason was behavioural and psychiatric symptoms of dementia, which is a whole other issue. That is why we started going out looking at how we can make the end-of-life experience a more dignified experience.

COVID potentially revealed that even though a lot of the geriatric outreach services were there and willing able to help, when we could no longer go into the facility we were back where we were because we could not get in and we did not have someone who could necessarily—unless there was an registered nurse on site—listen to that chest and say, "Look, they do sound really terrible." Then I would decide what medications or suggest what medications were appropriate for that person.

The Hon. GREG DONNELLY: And that would be over the telephone, for example, in providing advice?

Dr NEWTON: Yes, although where we did have access to iPad Skype we could actually physically be showing the person—that worked. Unfortunately, there is a lot of staff turnover in facilities and retraining took up a lot of time and was very evident, particularly in northern Sydney. They would train a group of nurses and they would move on and then we were back where we were. So that is partly what the problem with COVID sort of brought out, was the fact that even though we had this set of services that we had just started to really implement, they kind of came to a halt for the most part unless somebody was COVID funded for somebody to have the appropriate equipment to gown, glove and go out and see some of these residents. But that COVID funding finishes in June and that is as it is. So that is that part of the question. In terms of the future and how registered nurses fit in, the Palliative Care Network of nurses really is vital. As much as we provide that care as geriatricians and are expert in end of life and the elderly, not all people in a nursing homes are elderly, as you have heard from other evidence.

Where the focus is on living a longer life but not necessarily—you want it to be a good life but longer. So when you are a 30-year-old with motor neurone disease in a residential aged care, you are more likely to want to be with your family for as long as you can be. When you are 97, your priority may not be living as long as you can live; it may be about ultimate comfort. So we as geriatricians are not the experts in 30-year-old motor neuron disease and that is where palliative care is really vital. But it is still vital. We cannot provide all the services to every facility as geriatricians in Sydney and rural areas. There are just not enough of us and so we do need expert palliative care nurses who can come into those facilities. But, again, you cannot fund every single palliative care nurse you need for every single facility. Therefore, that experience they have needs to be able to be transferable to the registered nurse who is able to manage those medications and behavioural modifications for end of life.

As I say, it is not all about medication. People who are at the end of life cannot necessarily toilet properly and will need bladder scans and an assistant in nursing [AIN] cannot do a bladder scan. There are a lots of procedures at end of life that registered nurses can do that other providers cannot.

The Hon. GREG DONNELLY: Just finally, with respect to palliative care specialist doctors, where do they fit in as a piece of the puzzle for those residing in retirement aged-care facilities?

Dr NEWTON: They would fit in in the sense that a GP can contact a local palliative care service and ask for a visit. I would be happy to be corrected by the Palliative Care Network if this is incorrect, but my understanding is that the palliative care nurse will visit that facility and will determine whether a visit is required by a specialist and the specialist will go to that facility. The waiting times for that I could not tell you but they are very much longer than a geriatric service if you need them.

The Hon. GREG DONNELLY: Do you mind, just as a follow-up, not reflecting on you individually but you say "much longer". For a geriatric service, how long might that be in terms of delivering a visit upon request?

Dr NEWTON: We would triage. So those calls would come to us and we would triage appropriately. If you had someone who was imminently at end of life and required visiting that day, they would be seen that day. If you had someone who needed some end-of-life planning and you had a week or two, then it would be one to two weeks that you would get seen. Some services run clinics, so to speak. I call them "clinics" loosely because it is the doctor going out. They will go out to a facility, in particular once a week, and see residents in that facility where they are large facilities that have frequent presentations to hospital.

Ms CATE FAEHRMANN: Thank you for appearing today. In your opening statement you gave an example of somewhere where the workforce basically, I think you said "increased competencies", so that in the end the result was that less care was needed overall.

Dr NEWTON: Yes.

Ms CATE FAEHRMANN: Could you explain that a little bit further in terms of specifics?

Dr NEWTON: One of the facilities that we used to visit in that sort of clinic situation that I was speaking about had registered nurses who were very good but it was a very large facility and they would have benefited from more than one registered nurse. We were noticing that this particular facility was sending a lot of residents in frequently and that many of those residents you could have managed in the facility. By us going out and holding a regular clinic and regularly reviewing those patients, what we were doing was both teaching some of the less experienced nurses some simple techniques on how to manage some of these things, but teaching the registered nurses the finer points—essentially getting those nurses up to a much higher, even though they are registered nurses, what we would consider to be a clinical nurse specialist level in a hospital.

So training them up to that level so that not only were they behaving as a registered nurse but they were also behaving as an educator to some of the assistants in nursing [AINs]. The AINs would not have been able to enrol as nurses—not always AINS, but certificate nurses—but would be able to increase their training to a certain level, but the three-year training program that is required for a registered nurse is still required. But you could escalate some of that knowledge to help with the more integrative tasks such as behaviour management, eating, mobility—those sorts of things that they were able to do.

Ms CATE FAEHRMANN: Okay, that is very interesting. Do you find as well that there are quite a few vacancies, even in Sydney, in terms of registered nurses in the facilities that you have worked with or is it just a regional issue?

Dr NEWTON: When I go to the facilities that I have gone to, usually those facilities have registered nurses because we have that relationship, that integration between the registered nurses in the facilities and hospital. It does not mean that we do not see facilities where there are not registered nurses but, generally speaking, those facilities have lower care residents whose medical conditions are not such that we are putting in a lot. I think one of the things that gets lost is that when you are in a high-level residential aged-care facility it is not really the same as being a fit person with a problem or two. You are actually almost in subacute care. I know that facilities do not see themselves as subacute care—they really do not and I appreciate that fact.

But many of the residents that we see living in these facilities cannot live in hospital but they are chronically unwell and require a lot of input. So we are going almost as a chronic care team to look after subacute patients who are residents in residential aged-care facilities because they cannot live in a hospital. It is important for us to go and try to train people up, otherwise these people would be in NSW Health consuming beds and money but, more importantly, being in situations that are not kind or nice to these vulnerable people who could be looked after elsewhere. I forgot the other part of your question, sorry.

Ms CATE FAEHRMANN: That is fine. I am sure other members have some questions.

The CHAIR: I just have one follow-up. Dr Newton, you have given us a really good picture of why registered nurses are really important and to provide that work, but that is on the expectation that they will be able to that clinical work, isn't it? First of all, they are not just going to be completing paperwork all day and the second part is that they will have the appropriate either AINs or personal care workers to actually then do those other tasks. They are not going to be dragged away to be serving food or completing paperwork. Is that right?

Dr NEWTON: To a certain extent. The skill level of a registered nurse is quite encompassing and I say that as a person who started off in nursing and as a registered nurse before I trained in medicine and went on. I have had a lot of experience through the system. I think that team nursing or doing set task for one level of

nursing and set task for another level of nursing is the way that most nursing homes operate. But there is a certain skill level as a registered nurse doing your clinical tasks that when you are going through a dining room and looking at residents, you can see people who have got swallowing problems and having trouble and are likely to get aspiration pneumonias. You can then tell a GP, "By the way, I noticed in my clinical role that this person is having swallowing problems at the dinner table. Could we perhaps have a look at that? Because if they are going to get aspiration pneumonias, we need to do some advanced care planning."

So not only does the registered nurse have that procedural clinical listening sort of side but they also have the perspective of looking across a facility and being able to see who needs help and who does not, and that is where I think they fit in. They should not necessarily be caught up in the nitty-gritty of documentation, but looking at good clinical practice is important as well.

The CHAIR: That is very helpful.

The Hon. MARK PEARSON: What percentage of residents would have a degree of dementia?

Dr NEWTON: About 53 per cent would have dementia. Of those 53 per cent—well, when you look at that 53 per cent, twice as many people with dementia in facilities require higher care than those who do not.

The Hon. MARK PEARSON: Of the residents who have dementia, if they are also requiring palliative care or they are suffering from a lot of pain, I understand—correct me if I am wrong—that when people are suffering from fairly advanced degrees of dementia, it is very difficult for them to express the amount of pain that they are in. Is that correct?

Dr NEWTON: Yes, that is true.

The Hon. MARK PEARSON: So is it true that a registered nurse is more likely to recognise behaviour which is affiliated with increased pain—not maybe chronic pain but becoming acute pain or whatever the case might be? Is it more likely that a registered nurse is going to be able to recognise behaviour which reflects that concern rather than, with all due respect, an assistant in nursing or other qualification which is not registered?

Dr NEWTON: No, it is true. The end-of-life—palliation—is, yes, about pain, but in dementia a lot of those things are not necessarily pain. It is the inability to express what you are suffering with, whether that be anxiety as opposed to pain. Anxiety at end of life is—there are telling signs and registered nurses are trained in those things. They are relatively subtle and you have to have an understanding of some of the physiologies that is going on—some of the obvious clinical signs and symptoms that anyone could see, but also the not obvious signs. So without sort of saying signs specifically, distress can present in nuances on faces. It can present in a clinical sign, in a respiratory rate, in a fixed mobility pattern of not moving, and some of those things would not be obvious to someone who does not have that higher level of training.

The Hon. MARK PEARSON: Would they be obvious by video link to a registered nurse?

Dr NEWTON: No. Some of those things, the technology—I mean, we all talk about 5G and how many gigabytes you can get, but some of the technology is just not good enough on a Skype iPad.

The Hon. MARK PEARSON: We cannot palpate through a video camera.

Dr NEWTON: No, you cannot. Some of those nuances—the colour of skin, the way someone relaxes in their features as they come past the point of no return, the tepidity of skin, those things are not visual through a screen. They have to be felt; they have to be touched.

The Hon. MARK PEARSON: If those symptoms were to commence at 8.00 p.m. on Friday night at a facility where there is not a registered nurse 24/7, is it likely that that resident is going to suffer quite considerably over the next 48 hours until a registered nurse arrives on the Monday?

Dr NEWTON: Yes. I can tell you that I have put patches on people, which are not the best type of medication for acute pain, because I know that there is not been a registered nurse in the facility overnight, but I cannot leave the patient in pain—that is not dignified or kind. So I have put a patch that will last them through to the next morning on to the patient in the hopes they will get some benefit from that and not be brought into hospital and through an emergency department so that they can be calm and have some respect. Ideally, if there had been a registered nurse—

The Hon. MARK PEARSON: But, really, if that patch is applied at 5.00 p.m. on Friday, the efficacy of the patch will be wearing off pretty much after 24 hours?

Dr NEWTON: No, some of them can last for seven days, but the one that we try to use a bit more last for sort of three days. In saying that, they are a constant low-level patch, but if you have not got someone there

who can actively look at that patient—the patch may be inadequate. It may be inadequate. So you have got people there who are suffering. What would happen usually is that if a family member came in and felt they are uncomfortable, the person would end up getting sent to hospital if they could not access a 24/7 on-call GP. But then the GP would come and administer a medication, because there is no registered nurse to administer medication, and they would leave—and then what happens in four hours' time? So in four hours' time do you call the GP out again? It is not a feasible long-term management plan.

The Hon. MARK PEARSON: It is not an acceptable standard of care—

Dr NEWTON: It is not an acceptable standard of care. That is right.

The Hon. MARK PEARSON: —for elderly residents who are in that situation of dementia, with pain and terminal illness.

Dr NEWTON: End-stage dementia is a very unique situation because you cannot say this person is dying of a cancer that is going to erode through their oesophagus. You cannot say that. This person is failing slowly. They are not eating, they are not drinking—not because they are sick per se but because they no longer have the cognitive ability to do those things. So it is a very confronting thing if you have had no training to watch somebody pass like that, and you need to have the experience and understanding of how to manage that.

The Hon. MARK PEARSON: You are also saying that it is actually in terms of camaraderie and support for the other staff who are watching a person pretty much in the last hours to have a registered nurse there overseeing everything and looking after even the other staff as well in how they are handling the dying of a person they have cared for for maybe two or three years.

Dr NEWTON: It is good to have a registered nurse with the experience. I think after a while all nurses in nursing homes cannot avoid observing death. It is part of what happens in nursing homes. It is not to say that you do not have some excellent end-of-life nurses who are not registered nurses in nursing homes. I have seen some beautiful nurses manage people very well that are not registered. However, that is because they are well supported and are appropriately managed and investigated and treated by registered nurses in those facilities that can allow those nurses who do not have those skills to focus on comfort.

The Hon. MARK PEARSON: Is that some of the standards that you have got that facility up to where then you did not have to put in as much resource?

Dr NEWTON: We did not have to put in as much resources once we got the plans and programs in place. We had relationships—I remember someone else was talking about New South Wales ambulance service prior to this, and we had set up a relationship with NSW Ambulance as well. So if they got called out to these facilities in the middle of the night, they had an on-call person that they could call at the hospital to discuss that with. Could it wait until the morning? Do they need to bring them in? What other plans would we recommend to try and hold this person in the facility where they would be more comfortable? So we had those set-ups as well. So we had quite a good set-up out at south-eastern Sydney for that, and Northern Sydney has something similar. So that was a good way to integrate them into the system as well.

The Hon. MARK PEARSON: Thank you very much. That was very helpful.

The CHAIR: Dr Newton, I am very sorry, but we have actually run a few minutes over time. We really appreciate your very valuable testimony today and your incredible experience in the aged-care sector. We also know you are very busy, so we appreciate that very much.

Dr NEWTON: That is all right.

The CHAIR: I think—did you take a couple of questions on notice?

The Hon. MARK PEARSON: I don't think so.

The CHAIR: We might have some supplementary questions for you.

Dr NEWTON: Absolutely. Very happy.

The CHAIR: We would just ask if you get back to us in seven days, but the secretariat will be in touch. Thank you so much for the important work you do and for your testimony today.

Dr NEWTON: Thank you.

The CHAIR: We are now on a break until 12.30.

(The witness withdrew.)

(Short adjournment)

DIMITY POND, Professor of General Practice at the University of Newcastle, affirmed and examined

STEPHEN GINSBORG, General Practitioner, affirmed and examined

The CHAIR: Do either of you want to make an opening statement?

Professor POND: I have explained that I am a Professor of General Practice, but I am also a general practitioner in clinical practice. For around 30 perhaps years of clinical practice I have been visiting residents in residential aged care so I have experience of that. I have got a strong interest in older people in my own practice and as part of my research into dementia, and as leader of the World GP of Organisations Special Interest Group in Aged Care. And so my opinion on this issue around registered nurses in residential aged care is that they are vital from my perspective as a GP. People living in residential aged care often have complex chronic diseases and they need someone with an understanding of medical conditions to look after them properly.

Needs often express themselves in falls, episodes of confusion or deterioration in a condition and it is important for a clinician, such as a registered nurse, to be able to hand over information about what is going on, to whoever she or he may call in, whether that be the GP or ambulance or seeking some advice from elsewhere. Without a nurse to hand over that clear medical history, the person will often just end up being sent to the local emergency department at great cost to the system, I might add. It is not only an issue that that might be a cost to the system and could be easily handled within the facility if there was someone competent to give some medication but also it is that the person themselves does not necessarily benefit from being in hospital. It is confusing for older people. They do not know everybody and they may have a whole lot of unnecessary tests because of an inadequate handover. For all of these reasons I think we the GPs looking after patients in residential aged care need registered nurses to communicate with.

Dr GINSBORG: Good afternoon. Thank you for inviting me to give evidence today. I agree with everything that Professor Pond has said. I am 72 years old. My father was a GP and I graduated from medicine from Cambridge University and for the past 40 years I have practised in Avalon in New South Wales. I am a GP currently for about 50 high-care residents in aged-care facilities. I see the issue before this Committee as a public health challenge and a test for duty of care of our elders in a civil and compassionate society. I hope to bring a lived experience approach to my preliminary comments.

May I please weave a common narrative in which a loved, elderly, frail and vulnerable family member is admitted to an aged-care facility? She may be expected to die within a year, as many are, and on admission to the facility she is asked to complete a New South Wales advance care directive [ACD]. In it she asserts that she does not want to be resuscitated or transferred to hospital under any circumstances should she suffer a life-threatening illness such as a heart attack, stroke or fall. Sadly, such an event does occur and she suffers end-of-life symptoms such as pain and distress. Her family and she may well find it disingenuous when she finds that, contrary to her wishes, as a countersigned ACD, she faces the impossible choice of suffering pain and distress or being transferred to hospital. She had trusted that a registered nurse would be available to provide palliative care, including narcotic drugs or other palliative medication but there was not an RN available in the facility—a common event.

Birth and death are normal stages of life, and we would find it, I think, unacceptable if there was not a midwife to deliver a baby. Likewise, we are rightly indignant if an RN is not available when we need palliative care to ensure a dignified and painless death. Without the RN skills, there may be no mitigation of the grief the family will suffer if the resident, the loved one, suffers what we call a bad death that is painful and distressed. It is not a luxury to have an RN available to care for our elders in severe illness or end of life. I consider it to be a human right to receive such care and that it should be mandatory in an advanced economy such as ours.

The CHAIR: Thank you very much Dr Ginsborg, that was very helpful.

The Hon. DANIEL MOOKHEY: My question is directed, at first instance, to Dr Ginsborg. Currently you are servicing 50 high-care residents as a GP? Have I heard you correctly?

Dr GINSBORG: Yes.

The Hon. DANIEL MOOKHEY: How often are you called to provide assistance?

Dr GINSBORG: To a situate such as this?

The Hon. DANIEL MOOKHEY: Yes.

Dr GINSBORG: Fortunately, the aged-care facilities—and this is a choice I have made because I find it so distressing to practice under other circumstances—in which I work have RNs. I do practice prescribing what we call anticipatory medication. End of life obviously occurs frequently in aged-care facilities so the RNs have narcotic, morphine usually, and sedative drugs—Midazolam usually—to relieve that end-of-life pain and distress. However, I have worked for aged-care facilities where in the time that it would take me to get to the facility, and particularly after hours where there are no RNs available, the situation is very distressing which why I have chosen now to work only in facilities with an RN available.

The Hon. DANIEL MOOKHEY: Is that a common choice that GPs make?

Dr GINSBORG: I cannot say. I would not like to say. I do not think there would be any figures but I think it depends on the availability of the GP to go at very, very short notice. If it took me 20 minutes to get to the aged-care facility, that would be 20 minutes where the family are watching their loved one in maybe shocking pain. I was notified this morning about a resident who had a fall in the bathroom and she was in agony. Fortunately, there were medications available to give her straight away.

The Hon. DANIEL MOOKHEY: When did you cease providing services to aged-care facilities that lacked a registered nurse?

Dr GINSBORG: I am sorry?

The Hon. DANIEL MOOKHEY: When did you cease providing services to aged-care facilities that lacked an RN?

Dr GINSBORG: Very early after I came to Australia. I was very fortunate that there were other facilities that had RNs available.

The Hon. DANIEL MOOKHEY: My final question, for the 50 patients for whom you currently provide GP services, if those facilities lacked an RN what impact would that have on how you would be treating your patients?

Dr GINSBORG: I would be treating the patients in the same way but I would be very concerned that if I do not get there within three minutes after the fall, for example, that that person is going to be in severe pain without any mitigation of that pain. Because if there is not an RN present then narcotic drugs cannot be administered. The ambulance, if we are lucky, will be there usually within 10 minutes, which is not too bad. But 10 minutes is a very long time if family are there; and of course for the resident who is in pain. The stories I do get told are of the family standing by feeling helpless to mitigate the pain and distress.

The Hon. MARK PEARSON: Just for clarification, if there was a registered nurse and there they could not administer PRN narcotics or analgesia unless it was prescribed, correct?

Dr GINSBORG: That is correct. There is, as I said, this practice which is definitely approved if one can expect that one's resident, one's patient, is likely in the near future to require such medication, to have that on their medication chart. It is called anticipatory prescribing.

The Hon. MARK PEARSON: Professor Pond, I think you referred to "duty of care". Is it your view that a registered nurse is required 24/7 in an aged-care facility no matter what challenges the residents of that aged-care facility have right from basic needs and quite functional through to the last hours of their lives? Would you say that it is a fundamental duty of care in our society for an aged-care facility—to have a social licence to care for people—to have as a bare minimum a registered nurse present 24/7?

Professor POND: Yes, I would agree with that. However, I am aware that in some rural areas that may not be possible. I think like everything else in primary care you need to take that duty of care and look at it in the context in which you are assessing it. It can be very important for people in rural areas to be in a facility close to their families or in the case of Aboriginal people in a facility that is specific for Aboriginal people. I would not like to see them having to be moved to the big city a long way from their relatives or from their community because there was no registered nurse. I have had this discussion with my rural colleagues. Nevertheless, in principle we have a duty of care to provide the best possible care to our patients in the facilities in the context in which that facility exists.

The Hon. MARK PEARSON: You are saying that we must take into account and factor in people living in more isolated rural or regional areas and balance no registered nurses being available with their community, which includes their sisters, brothers and family being close by as a comfort that is necessary, as part of that duty of care?

Professor POND: Absolutely. But I do not think that means that we should not provide a registered nurse in an urban area where there is no reason not to do so, where there is an availability of nurses.

The Hon. MARK PEARSON: This is a question to both witnesses. A question that is becoming clear to me is why do we not have enough registered nurses. This is not new, we have been travelling this journey for some time and we have a medical service that is having billions of dollars being poured into it to keep us living for as long as possible. The obvious consequence has occurred, and we are looking at it now, where people are living much longer but we have not evolved to live much longer and medicine is keeping us going. Is the issue of lack of registered nurses basically a crisis that we are facing and we have not really put in the resources to ensure that they are available?

Professor POND: I think there is a lack of resources at every level. I would let my colleague answer as well. I think there is not enough nurses trained in aged care and that starts at undergraduate level and then at postgraduate level. I think that looking after elderly people is not highly regarded, as it should be, by the nursing profession and that nurses working in residential aged care are not paid sufficiently. We are talking about millions of dollars but in fact as a percentage of GDP the money that we spend on residential aged care is not as great as it is in some other OECD countries. I think that the aged care royal commission looked at this. We have been starving the sector and there are many facilities that are somewhat marginal in their capacity to survive financially and they make these kinds of calls because of that as well.

Dr GINSBORG: I totally agree with Professor Pond. As I said in my opening comments, we would find it totally unacceptable not to have a midwife to help one of our fellow human beings into the world, so not to have someone qualified to help them out of the world I think is inappropriate in a culture such as ours. Just to add to what Professor Pond said earlier, I absolutely agree that there are situations where there may not be an RN available and there may be other factors that make it preferable not to be transported to a major city but I think it is important that it is made transparent that at the end of life there may not be anyone available who can administer these drugs. The paradox is, if this person is at home palliative care draws up syringes to be kept in the fridge filled with the appropriate narcotics, midazolam, and other drugs, that family members are allowed to administer in their own home to their loved one.

The Hon. TAYLOR MARTIN: I want to rewind back a few minutes to the funding issue that we were discussing. Could I ask either of you—or if you would like to just make comment—where this cost might be borne? Do have any comment on that issue?

Professor POND: As you are no doubt aware, John Pollaers did a review of funding in residential aged care and identified that there was really—that many of the facilities were marginal. I think it is complex, but I think actually that some of the problem comes at board level where the boards of facilities do not necessarily have a clinician on them. I have been a clinician on a board of facilities and they do not understand the relative importance of funding the clinician, the registered nurse and other clinicians to look after the patients. They may be excellent financial people, bankers and insurance people from business, but they do not know the business of aged care. So I am fully supportive of the royal commission's recommendation that there is a care committee on every board and that that committee has some significant input into the way that finances are distributed by the board. That would help. And maybe we can do with a few less chandeliers in the entrance hall and a few more registered nurses on the floor.

The Hon. TAYLOR MARTIN: Okay, understood. Dr Ginsborg?

Dr GINSBORG: I absolutely agree. The necessity to have a care clinical governance committee for each organisation that is providing care is essential. So if that committee was to consider whether the safety and dignity of residents was being set aside by a situation where there was not an RN in place, I do not see how any committee could hand on heart say, "No, that is fine." In terms of the financing of it I think it is not my place to go into the profit and loss. I do know that some facilities—quite a large number of facilities—are running at a loss. But that is not necessarily any excuse in our culture, I do not think, to deny people this right.

The CHAIR: Just on that point, we heard evidence this morning from several providers that having an RN as a manager at a facility is appropriate clinical oversight of these decisions and therefore there is not a need—or there is clinical oversight over the decision whether to put an RN on 24/7. Do you think that is enough or do you think they actually need these clinical care boards? Perhaps first to you, Dr Ginsberg.

Dr GINSBORG: As I said in my story, which I do not think is an unusual story by any means—it is a very common story. But the RN to have oversight, I think, is an excellent idea, but at two in the morning when a frail elderly person has fallen and fractured their hip and is in agony, I do not think having someone who has clinical oversight is going to help them. The nurse assistant who may be on at that time is not allowed to administer

narcotic drugs, so that woman or man would have to wait until the ambulance comes. Then, as I said, if her wishes had been and it had made transparent to her that such care would or would not be available but had she said she did not want to go to hospital knowing what that might lead to, she would surely have the right to stay in her own room and be administered appropriate medication to relieve her pain. So having the director of nursing off site or half an hour away will not help that person no more than not having a midwife would help the labouring mother, even if the birth unit had an oversight by an RN or professors of obstetrics.

The Hon. GREG DONNELLY: I would like to focus on residential and aged-care facilities away from the major population centres, the major metropolitan areas. I am thinking about those in regional and rural and perhaps even remote parts of the State. I am going to pose a question in general terms. I am not thinking of any particular aged-care provider or any part of the State, just a general proposition here. With respect to a number of these facilities operating outside of the major metropolitan areas, we have had evidence come into the inquiry that there are not at times registered nurses rostered on at certain times, particularly overnight. I think, Dr Ginsborg, you have given an example of the potential impact of that.

We had evidence that these places may not have ready access to advice coming into them from palliative care specialist doctors or even geriatricians, who are specialised obviously, and that, with respect to GPs, it is a case of trying to contact a GP who may not necessarily be there at the end of the line to deal with at that point an immediate request for advice coming in from an aged-care facility. In that scenario that I have just outlined, I am trying to grasp in my mind—I will use the word advisedly—the almost tragic circumstances that have befallen that elderly person in that facility who perhaps has had that fall, Dr Ginsborg, that you referred to. I am wondering—as plainly as you can for people who are not medically trained and I am not medically trained—how difficult it is for such a person in those circumstances in terms of their pain, suffering and what perhaps is psychologically going through their mind at that time.

Professor POND: Yes, I have visited facilities like this because I have a particular interest in dementia and Alzheimer's disease. I have been working over the years with groups, including projects that are dealing with dementia in Aboriginal people in remote areas. I visited some of the facilities out of Alice Springs and even in more remote areas—Tennant Creek and so on. The situation is as you described in those very remote areas. But it would not be beyond the bounds of reason to put in place some processes by which a person could be palliated or at least have their pain relieved in those circumstances. The Royal Flying Doctor Service, for example, can give advice over the phone and can authorise, if a facility has medications available, for those to be administered by people and by families in family situations.

As Dr Ginsborg said, we also do that in palliative care in the community. That is legally a thorny issue no doubt, but it works well in practice with the flying doctor service and with palliative care in the community, so I think that should be possible for those remote facilities. Rather than trying to have more facilities allowed not to have a registered nurse because there are some that cannot, I think there needs to be some special consideration for those that cannot.

Dr GINSBORG: I was just going to add that the tragedy—I carry with your word "tragic", which I think is very appropriate—extends, as I mentioned, to the family as well. The trauma of witnessing such pain and distress stays with loved ones through their life and there is a lot of research on the financial and emotional burden to those people of carrying that. It is called prolonged and complicated grief. It is beyond the grief that we all feel when a loved one dies. To witness such a tragedy is of huge consequence for the loved ones and family, so this affects the whole community.

The CHAIR: Thank you so much to both of you for your time and your expertise and, of course, for the important work that you do each and every day caring for our older people. There were not any questions taken on notice but I know I might have a question or two that we would like to send to you afterwards. The secretariat will be in touch. Thank you again for your time. That draws this session to a close.

(The witnesses withdrew.)

(Luncheon adjournment)

PAUL VERSTEEGE, Policy Manager, Combined Pensioners and Superannuants Association of NSW Inc., affirmed and examined

The CHAIR: We now welcome our next witness. Did you want to make an opening statement? We have got your submission. We have received that and we thank you for it.

Mr VERSTEEGE: Yes, I just have a few comments that I would like to make. The royal commission is now finished and it has made recommendations about staffing in residential aged care. It has also made specific recommendations about the attendance of registered nurses in residential aged care. However, the requirement for a 24/7 presence of a registered nurse in a nursing home would not become effective until 1 July 2024 according to the recommendations. We all know what happens to recommendations sometimes, so it could be even later. I make that point to stress that it is very important that the States and Territories, and New South Wales obviously, maintain at least what they have got in the way of staffing requirements for residential aged care.

The other point I would like to make is that I understand that this inquiry is mainly designed to clarify for the benefit of Parliament what exactly is high-level care. Combined Pensioners and Superannuants Association of NSW Inc.'s view is that there really is not a nursing home in New South Wales, or in Australia for that matter, that does not deliver high-level care and, predominantly so, most of the nursing home residents in Australia require high-level care by whatever definition you want to define that. So it is obvious that a nursing home should have a registered nurse present 24/7 and for a registered nurse to be the director of nursing. Those are the two points that I wanted to make as my introduction.

The CHAIR: Thank you very much, Mr Versteege. I might just start there with a couple of questions, because what we have heard consistently through our previous two hearings and also from today's witnesses has been there is an increasing fragility of the residents who enter care, they have got complex comorbidities and that often entering aged care is actually a last resort. They have exhausted all of their other options, whether it is home care or whatever it is, and that is why they have come. So you would agree that that is your experience as well?

Mr VERSTEEGE: Yes, absolutely. The royal commission has also demonstrated that very amply.

The CHAIR: One of the things that we have seen through the COVID pandemic—now obviously the inquiry itself is looking into the bill, but the terms of reference talk a little bit about lessons from the pandemic and it has certainly shown us some of the real issues or it has exposed some of those real issues in aged care. What I think we have also seen is that some of the areas where they might have been cut before—for example, our cleaning staff or our kitchen staff—these are actually a really important part of a holistic approach to aged care. All of these parts of the puzzle—especially our allied health as well—we need all of those parts of aged care in order to provide high-quality care to allow people to have a dignified level of care. Would you agree with that?

Mr VERSTEEGE: Yes, absolutely.

The CHAIR: We have heard a number of submissions, and in fact even from the providers this morning, that there is a need for increased funding but any increased funding should actually be tied to transparency measures. The royal commission has told us about a minutes of care operation, but what kind of transparency measures would you like to see in place if there is increased funding for aged care?

Mr VERSTEEGE: Well, first up, we think there should be clear requirements particularly for staffing and it should be verifiable by people who are interested in that nursing home. By that I mean the people who live there, if they are able. Certainly their family, friends and advocates should be able to verify that they are getting what the provider is required to provide. The aged-care industry, particularly the residential aged-care industry, has been very non-transparent. I have been involved in aged-care advocacy for a long time. Providers pleading for transparency, yes, that is a new experience for me but it is good. Transparency should not just be for staffing obviously but for anything to do with the nursing home so that people, consumers, have the information to make choices about where they want to go or where they want to put their family members.

The CHAIR: Thank you very much, Mr Versteege.

Ms CATE FAEHRMANN: Thanks for appearing. I see in the submission that you made that your key recommendation is obviously to support having a registered nurse on duty at all times. Firstly, has the association costed that at all?

Mr VERSTEEGE: No, we have not costed that. Our position is that you cannot run a nursing home without nurses and the requirement is for one nurse, 24/7, so that appears to us to be a minimum requirement.

Ms CATE FAEHRMANN: Per certain numbers of residents or—have you looked into that?

Mr VERSTEEGE: Yes, we have looked into that but just limiting it to this inquiry, which is really about making sure that all nursing homes are covered by this requirement for at least one registered nurse to be on duty all the time, we have not costed that. I think it is not the work of an association to get into that kind of detail. The work of Kathy Eagar, health economist from the University of Wollongong, is preferable to what we might have to say about those things. Obviously, we want the funding to be adequate for adequate quality and safety of care.

Ms CATE FAEHRMANN: Of course. We have heard from a number of witnesses, including nurses themselves, that making sure that any recommendation to ensure there are RNs on 24/7—there is fear from some workers within aged-care facilities that there will be a reduction in other staffing to RNs. Have you heard of that concern or do share that concern?

Mr VERSTEEGE: I do share that concern because I am used to providers really running the minimum number of staff at the cheapest configuration, qualification-wise, of staff. So it is a legitimate concern but I do not think it is something that should be a consideration in a decision on whether we impose on nursing homes the requirement to have a registered nurse present in every shift, 24/7, and also to have a registered nurse as the director of nursing. This is an absolute minimum. As I have said previously, you cannot run a nursing home without nurses. So it is a legitimate concern but it needs to be addressed by more funding at the moment. But it was also a problem when the funding was far more generous. It is not all that long ago—before the Government started to tighten the funding tap. It is a legitimate concern but not one that should influence us.

Ms CATE FAEHRMANN: So, in other words, to ensure that that does not happen there needs to be a requirement that it is in addition to existing staff, if you like, and not in replacement of. And, yes, more funding would have to be provided to ensure this.

Mr VERSTEEGE: The additional funding requirement really stems from the Federal Government having really tightened the subsidies to a level where providers which previously were able to put on sufficient staff and sufficiently qualified staff are now running on an oily rag, so to speak.

Ms CATE FAEHRMANN: In your submission on page 5 where you essentially talk about the other care staff—"Registered nurses versus other care staff"—you refer to the 2013 audit of registered training organisations offering vocational aged and community care qualifications, which found that 87.7 per cent of personal care workers did not comply with at least one of the national training standards required of programs. Has that changed since 2013? Have you seen improvements? Do you know, have there been improvements in some of the registered training organisations—we are not talking about the personal care workers but those that train them? Have there been improvements since that audit? Or have things gotten worse?

Mr VERSTEEGE: I could not give you a reference for a comment to say that it has either improved or not improved. The impression you get from talking to people is that particularly personal care workers can be problematic for residents and quite often it is communication that is mentioned.

Ms CATE FAEHRMANN: We have heard a lot about how hard it is to attract staff and how hard it is to fill vacancies for registered nurses, both regionally as well as in bigger cities like Sydney. Has the association got any recommendations as to how to ensure that there are more people willing to be registered nurses and that indeed there are more registered nurses for clearly what is—there are just not enough people for the work that is needed.

Mr VERSTEEGE: I am not sure whether there are not enough registered nurses to actually fill the positions but it is a fact that, first, a registered nurse in aged care makes a lot less money than a registered nurse in a hospital. That disparity probably defines and causes the problem.

Ms CATE FAEHRMANN: Do you know what that is offhand—what that figure is?

Mr VERSTEEGE: No, I do not have the exact figure but it is in the hundreds of dollars, on a monthly basis.

Ms CATE FAEHRMANN: Yes, that is significant.

Mr VERSTEEGE: That is a big part of the problem and the second part is that staffing—the way nursing homes staff their facilities is very much based on casual labour in personal care. It does not make for a great team and a great work environment. So nursing homes are not all that attractive to work in if you are a health professional, and probably for no-one else either but particularly for those people. If you take pride in your work and also if you are concerned about the security of your professional registration, you do not really want to be in a facility that might understaff. All sorts of things can happen. Registered nurses actually have a responsibility

above what personal carers do and if they are in unsafe situations, and continue to be in unsafe situations, they can lose their registration. Some have walked away from their jobs because of that.

The Hon. WES FANG: Just on that point, is this anecdotal evidence that you are putting forward or have you actually got evidence to support that people are walking away from jobs in aged care? Because it is very easy to make statements like that in an inquiry but it is a lot harder to identify and present evidence that that is actually occurring. Because it is not something that I have heard a lot of before.

The CHAIR: With respect, Mr Fang, we have heard that from submissions and from previous witnesses, but I am sure Mr Versteege has got a long history in the industry, so he can share that.

Mr VERSTEEGE: In the hearings conducted by the royal commission there were several nurses who made that point. I am not sure whether they actually walked away but they expressed that concern because of the levels of staffing. I have heard it from people personally and I would still class it as anecdotal. I could not give you statistical evidence but it is obviously an issue.

The Hon. GREG DONNELLY: Thank you for coming along to provide us with the opportunity to ask you some questions in addition to what is a very helpful submission. Can I just take you to page 6 going onto page 7 of your submission. In fact, page 6 has got the heading "Medication management". So we are on page 7, the back page of your submission, and specifically the second paragraph on that page commences, "The fact the Regulation only". It says:

> The fact the Regulation only applies to selected RACF falling within the NSW Public Health Act (2010) means many residents in NSW RACF are not assured their medications will be managed and administered by RNs and ENs working under their direction.

That is something that I was not aware of actually so it is very helpful that that reference is made. Are you able to, if not now on notice, elucidate on the detail there? In other words, I am trying to get a sense of what might be, in broad terms, those that might not be captured by the Act. And are we talking about a large number of facilities or a small subset of facilities? But if you are not sure, you can take it on notice.

Mr VERSTEEGE: I think it relates to the facilities that are not subject to the requirement for an RN 24/7 at the moment.

The Hon. GREG DONNELLY: Right.

Mr VERSTEEGE: But I would have to check that. This is a very technical part.

The Hon. GREG DONNELLY: That is fine. The implication is that there could be some or many retirement and aged-care facilities where there is this issue of a big question mark. I do not want to exaggerate it—but a question mark, at least, over the management of medication with respect to the dispensing of those pharmaceuticals to residents at these facilities.

Mr VERSTEEGE: Yes. Obviously it is an issue in every nursing home where there is not a registered nurse 24/7 because if you do not have a registered nurse—or an enrolled nurse [EN], at least—you cannot prescribe medications.

The Hon. GREG DONNELLY: Can I just press you on that? This may be something you can answer in general terms or specific terms; I offer you either way of answering it. Have you heard of instances or had instances drawn to your attention where there is in fact this distribution of medications not in conformity with what, strictly speaking, is the law?

Mr VERSTEEGE: Again, this is anecdotal evidence that I have heard personally. I again refer to the hearings and the evidence given at the royal commission, which goes on at great length about the failures of medication management and the non-adherence to regulatory requirements in dispensing medication simply because the staff are not there to follow the rules.

The Hon. GREG DONNELLY: Without nominating individual providers or locations, have you had anecdotal evidence provided to you in your capacity, in your role as policy adviser, that ventilated these examples? In other words, your experience aligns with the evidence in the royal commission on this matter?

Mr VERSTEEGE: What I am hearing, yes.

The Hon. GREG DONNELLY: What you are hearing?

Mr VERSTEEGE: Yes. My anecdotal evidence is sometimes direct evidence from people that ring up or speak to Combined Pensioners and Superannuants Association of NSW Inc. [CPSA], but in a lot of instances it is nurses. We do a lot of work with the New South Wales Nurses and Midwives' Association—yes, from them. They would have given evidence here, as well, about that.

The Hon. GREG DONNELLY: Just following on—and related to this because obviously it does turn on this issue of the administration of medications, specifically end of life medication for pain relief or relief around anxiety experiences a person might be suffering at that time. In terms of how palliative care is being managed at the very end of life stages of palliative care in retirement and nursing home facilities, are you able to make any general comments about what your membership says or has been saying about how this is done? Is it done to a high standard, an okay standard, a poor standard, or is it hard to pick? Just your general comments about it.

Mr VERSTEEGE: Yes. It is done, generally speaking, to a poor standard. The shortage of nurses simply means that there is not always qualified staff to administer medication. It sometimes leads to family having to be there and be the nurse, so to speak.

The Hon. GREG DONNELLY: Would that include—once again, without giving specific individual examples—family members administering pharmaceuticals or pain relief or medication? Is that getting to that level, or just being by the bedside trying to comfort, or both?

Mr VERSTEEGE: Well, both. Somebody who is at the end of their life usually has people there, who they know and love. I have seen it personally where family members have been operating the oxygen. People have told me that the person has been given a prescription and they actually have the medication. In the absence of a nurse, they will give it.

The Hon. GREG DONNELLY: Administer it, yes. Finally, with respect to your organisation, CPSA, you are obviously representing the New South Wales branch or chapter of the organisation. Are there branches elsewhere in other States and Territories around Australia?

Mr VERSTEEGE: No. There used to be CPSAs all over the country, but we are the last of the Mohicans.

The Hon. GREG DONNELLY: The last one standing?

Mr VERSTEEGE: Yes.

The Hon. GREG DONNELLY: That is okay. My question was going to be your insights, to the extent that they exist or could be obtained, in regard to the provision of nurses in retirement and aged-care facilities in other States and Territories in Australia, and what goes on there. I invite the question but you may not know the answer, so that is fine.

Mr VERSTEEGE: No, but what I can say is: At least New South Wales has a requirement at the moment. The intent of the requirement is really to cover all nursing homes to have registered nurses 24/7 and a registered nurse to be the director of nursing. Not all States and Territories have that. Victoria obviously operates its own facilities—not all that many—and it has extensive mandatory staffing requirements. But the impression I get from other States where there is nothing—it is a free for all. I also have to say that I am not all that confident about the policing of the New South Wales requirement for nurses to be present in nursing homes.

The CHAIR: Yes. We are still trying to get to the bottom of it, as well, Mr Versteege.

Mr VERSTEEGE: Absolutely.

The CHAIR: We have limited time left and I said I would pass to Mr Fang for some questions from the Government.

The Hon. WES FANG: Thank you very much for appearing today. I just wanted to follow on from Mr Donnelly's line of questioning around the CPSA. How many members do you have?

Mr VERSTEEGE: I can take it on notice, but it is in the order of 20,000.

The Hon. WES FANG: Twenty thousand members?

Mr VERSTEEGE: Yes.

The Hon. WES FANG: Okay. When you are formulating policy like you have put forward in your submission and today, do you use your experiences from your members? Do you survey them to generate this policy? How is the policy generated within your organisation to present to a Committee like ours?

Mr VERSTEEGE: Okay. The structure of CPSA resembles the structure of a political party or a union.

The Hon. WES FANG: Do not confuse the two.

Mr VERSTEEGE: That means that the grassroots organised within branches can put forward motions, which are voted on in the end at the CPSA annual conference. That is the way policy is made. Because it is an

annual conference, there is only one a year. In the interim we have an executive, which is really a board, which makes policy and also talks to branches. We also have a few councils, which is a sort of coalition of branches, and that is how that sort of policy is put together.

The Hon. WES FANG: So this policy—was this born out of a conference or was this born out of something the board would have developed?

Mr VERSTEEGE: Well, whatever the board develops goes to conference, so it is—

The Hon. WES FANG: Has this gone to conference, this policy?

Mr VERSTEEGE: Yes, absolutely—twice. We have had two of these inquiries.

The Hon. WES FANG: I am just wondering exactly how many of your rural and regional members may have had some input into this, given that we have heard quite a bit over the last few inquiries that the impost of having a registered nurse 24/7 in a lot of those smaller regional and rural communities may mean that if they are unable to get a nurse, they may have to close—or if the cost becomes so great that they are operating at a loss, they may have to close—and whether all the arguments have been presented when this policy was voted on by your members.

Mr VERSTEEGE: I cannot say whether all the arguments were aired, but whenever this sort of stuff is discussed—there were other questions just now about the cost of this and the availability of staff, and that if you make this a requirement then that requirement may not be able to be met. With the greatest respect, I think that is a spurious argument. The royal commission has demonstrated very vividly that aged care in Australia, residential aged care in particular, is in a woeful state. It is not really relevant to talk about whether we will make this requirement or whether we will we just water it down or do away with it altogether because it is too expensive or too difficult to comply with. These are nursing homes; they need nurses.

The Hon. WES FANG: But, to the point, it is not spurious at all. It is entirely appropriate that we ask the questions.

Mr VERSTEEGE: Yes.

The Hon. WES FANG: Firstly, the Federal Government and the Federal inquiry has made recommendations. There have been recommendations out of that royal commission. That is for the Federal Government to implement. What we are talking about here is a State government operating on its own to look at an implementation system separate to what the Federal Government is doing. It is entirely appropriate for me to be asking you the questions on this and I am just trying to establish how it is that your organisation has come to the view that this is appropriate. If I ask any community group, "Would you like a doctor 24/7 in a nursing home?" you will not exactly turn around and say no. But there will obviously be issues around us having enough provision of doctors to put a doctor in every nursing home, let alone a nurse.

The CHAIR: With that question, I will just note the time. I have given Mr Fang five minutes and I note that the bill is actually to put a registered nurse into nursing homes 24/7. Mr Versteege, thank you so much on behalf of the Committee for your very valuable submission. I confess that I also have your 2015 submission in my folder and it was particularly useful, so thank you very much. I know you have a long history of advocating on behalf of Combined Pensioners and Superannuants and we really appreciate your time today.

(The witness withdrew.)

COREY IRLAM, Deputy CEO, Council on the Ageing Australia, before the Committee via teleconference, affirmed and examined

KAREN APPLEBY, Senior Policy Officer, Council on the Ageing NSW, before the Committee via teleconference, affirmed and examined

The CHAIR: I welcome our next witnesses from the Council on the Ageing [COTA], one from the Australian branch and one from the New South Wales branch. Do either of you wish to make an opening statement?

Ms APPLEBY: I will make a brief statement on behalf of both of us. Thank you for the opportunity to be here today. Council on the Ageing NSW is a not-for-profit consumer-based organisation. We have been working with older people in New South Wales since 1956. We also felt it was very important to have COTA Australia here today. They have long been a powerful and knowledgeable advocate and policy influencer in the area of aged care. We felt that it was really important, based on some of the recommendations relating to aged care reform and possible intersection with New South Wales State legislation, that they could provide their perspective. As the Committee would be aware, moving into residential aged care is very often the last resort for many older people when their health has deteriorated to a point where they are no longer able to care for themselves. The waiting lists for home care packages have resulted in many older people having to move into a home because they do not have the support they need and are entitled to because of long delays in the system. This means that the majority of residents in those facilities are frail aged with high care needs and require a mix of registered nurses, enrolled nurses and care workers.

As has been articulated in our report from the Royal Commission into Aged Care Quality and Safety, there needs to be improved systems and regulations in place for access to GPs, allied health professionals and other specialist medical staff. We are well aware of and horrified by the reports of neglect and abuse of older people within residential aged-care facilities. Much of this can be attributed to staffing—whether it is understaffing, the mix of skill levels or inadequate training. We therefore support COTA Australia's call for ensuring minimum staff times, including nursing units. This is consistent with the royal commission's findings, but COTA Australia also notes that the proposed model could be enhanced to include minutes of care from allied health professionals as originally proposed by the University of Wollongong methodology. Older people with dementia may need more time from a personal care worker to sit with them. Residents with medical needs may need more time from a registered nurse. Ensuring that any approach in the future is flexible to adapt to the best practice care needs of the individuals living in nursing homes is critical.

The Royal Commission into Aged Care Quality and Safety also laid out a timeline to achieve 24/7 registered nurses in all nursing homes across Australia. Reporting of the skill mix and staff time is also critical to ensure for example that RNs' time for care is fully devoted to residents and not used for other duties such as administration or management, per site or per team. The recommendations of the royal commission are currently being considered by the Federal Government, which may make a decision by the 11 May budget but is required by the royal commission to respond to each recommendation in the report no later than 31 May. As such, we are mindful of the possibility of this bill introducing additional reporting and potentially unnecessary regulation if the bill's objectives are achieved by changes at a Commonwealth level.

Given the potential introduction of a range of aged-care reforms at the Commonwealth level in relation to staffing, reporting and regulation, we recommend that the Committee await the Australian Government's formal response to the Royal Commission into Aged Care Quality and Safety to assess how the reforms agreed to by the Australian Government would impact upon the proposed New South Wales bill. Therefore, while we support the retention of a requirement to retain an RN on duty in nursing homes, we urge the Committee to devise such a mechanism that would only come into force in the absence of a Commonwealth requirement equal to or greater than the New South Wales legislation. While those reforms occur, we think it is essential that today's current nursing care is maintained in all New South Wales nursing homes.

The CHAIR: Thanks, Ms Appleby. We have heard submissions that have advocated for more transparency to be associated with funding. Would you agree with those submissions?

Ms APPLEBY: Absolutely. Would you like to provide further detail, Mr Irlam? I think it is absolutely essential.

The CHAIR: He was nodding very enthusiastically.

Mr IRLAM: In our response to the royal commission's final report we have spoken about the need for government to require of providers a real-time financial transparency. So, if you are going to receive public funding, where and how are you spending it? This is not just an issue for the shareholders; it is an issue across the board. We recently saw reports in in the media, for example, of many millions of dollars being sent back to the Greek Orthodox Church in the form of rent by one of the facilities in Victoria that did not do so well during COVID. It may be an entirely appropriate rent but the suggestion in that media report was that the amount of rent was far above market. If this was transparent, if there was a requirement to identify third-party entities that were receiving funds, it would ensure that there was more appropriate use of funds for the purpose for which they were given—the purpose of giving care to those older people.

The Hon. GREG DONNELLY: Thank you both for making yourselves available this afternoon. I am wondering if I can ask you both—and one perhaps may be in a better position or would prefer to answer this question but it is open to both—about the perspective of the organisation, Council on the Ageing Australia, on its direct insight into the matters of particularly the treatment of the palliation of patients in retirement and nursing homes through feedback you have received from either constituent members or other bodies that may be associated with yourself or your general engagement with like organisations who operate in this area. We have received evidence and, in fact, I have been asking questions of most witnesses—and perhaps the Committee members are going to get tired of me asking these questions—but I would appreciate your insights as a pretty well-known organisation about insights you can bring to how we are going in terms of the delivery of palliative care, particularly the end-stage palliative care, to residents in retirement and nursing homes in Australia.

Mr IRLAM: I might take that, Karen. I think we do need to distinguish between retirement village or palliative care services provided in somebody's home, regardless of whether that is their lived-in-always home or their later-in-life home in the form of a retirement village, compared to a residential care facility where there is much more medical-based skills available. We talk about in-home palliation first; you would hope that there are better linkages in the future between the State-run health palliative care teams and the aged-care system. The royal commission talks about the need for a national Cabinet subcommittee on health and one of the things they should talk about is how do we better improve that interface between the health system delivering into aged care because sometimes there is not and we still need that. Some people go, "Oh well, you're over 65, therefore everything should be delivered to you under the aged-care system." There would be less of a priority placed upon providing services to people over the age of 65 where there is a perception by that other system that they could get some support in aged-care programs, packages, access to a nurse and things like that.

The royal commission also talks about the need for an increase in the palliative care skills of the aged-care workforce. Ultimately, my view would be that that is not a responsibility of the aged-care system to deliver in-home care palliation; it supplements what is the primary delivery of the State and Territory health services. So it could be better integrated, it could have better linkages, a little bit better skills of the staff to know when that is needed and how to link them into that State service.

Separate to that is the issue of delivering services in a residential care facility where you might be able to work in a local health network area and rather than employing additional teams of palliation specialists out of the State health system, rather focus on training the aged-care services to deliver that palliation within the staff that exist within a residential aged-care facility.

I would not want to see a loss of connection with the specialist palliation team at a State level because they understand best practices and how they change over time. Whether the day-to-day delivery of those services would be an in-reach team from the State palliation service into the residential aged-care facility or whether it would be more focused on the professional development of those staff and the Commonwealth funding the palliation services I think is a live question as we start to define who has the primary responsibility to deliver that service.

The Hon. GREG DONNELLY: Just following that up, the matter of persons who have a registered nurse qualification or greater, certainly below a registered nurse qualification there are legal limitations on their ability to administer pharmaceuticals that are regulated, but there has been a preponderance of evidence from various witnesses that with respect to palliative care, and particularly at the very end stage, sometimes there is a need to move pretty quickly in terms of being able to administer the palliating pharmaceuticals to relieve pain or anxiety or whatever the case may be, and that may then, for the argument or part of the articulation that registered nurses do have an integral role to play, in fact, the case could be made that they need to be available 24 hours a day, seven days a week because we do not know when there might be a need for them to be able to act at short notice to deal with this. Would you agree with that, that if we are going to do this palliation better, particularly at end stage, that advances the argument about working out how we can afford to have registered nurses or above in these types of facilities?

Mr IRLAM: We have had a longstanding position there should be 24/7 nurses in residential aged care. I would draw the Committee's attention to recommendation 86 of the royal commission where they talk about this in some detail. Some of the things they do talk about that I have not seen the Committee's paper talk about is where there would be a need for exemptions. There will be unique challenges in finding 24/7 nurses in some regional and rural settings within New South Wales. So whilst you can apply the principle, you also need the flexibility to not apply that in situations where it literally cannot work, to make sure that people are still compliant. I think the issue of palliation comes down to two things: one is identifying the care plan for that palliation, that a registered nurse inside a residential aged-care facility who is not a specialist in palliation may not have the skills to do that, and that is where you find that multidisciplinary team that the royal commission is talking about outreaching in to identify the whole palliation—what is the care plan; what is the type of drugs and when?

That is still an important role. That is separate from the day-to-day administration of implementing that plan where I absolutely think there is a role that registered nurses can play in applying that drug that has been agreed within that palliation plan on an overnight basis, all the time. The royal commission recommends 16 hours per day by 1 July 2022 and 24 hours a day by 1 July 2024. I think that is a long time and it is in recognition of the fact that there are workforce challenges to have the number of nurses within that time frame, but I think absolutely we have had a longstanding position that there should be 24/7 nurses beyond just palliation—to be able to provide administration of the clinical side, to ensure that they are able to respond clinically to issues that pop up not related to palliation.

The Hon. GREG DONNELLY: Of course, thank you very much.

The CHAIR: Mr Martin?

The Hon. TAYLOR MARTIN: Thank you both for your attendance here this afternoon. Could I ask you what your opinion would be on whether this bill might result in regional aged-care facilities closing because of either the difficulty in actually recruiting RNs in rural and regional areas as they are mandated as a result of this bill or due to the cost imposition?

Mr IRLAM: Sorry, I am struggling to hear your question.

The Hon. TAYLOR MARTIN: What would your view be if I were to put to you that it has been put to us in earlier submissions that regional and rural aged-care facilities may well cease to operate because they are unable to recruit RNs in regional and rural areas if they are mandated, or if they can actually recruit them due to the cost being imposed?

Mr IRLAM: I think it is a stretch to say somebody will close because they cannot get nurses. I think, though, the royal commission struck the right balance where it set the expectation that you will have RNs and it proposed a mechanism to individual people to justify why they could not achieve that to gain an exemption. In their case they talk about applying to the system governor, whoever the Government decides that may be—the aged care commission or the Department of Health. So I think in applying the rule for RNs you would need to provide a pathway to individual cases to receive an exemption, but I do not think that you should automatically denote people cannot receive them.

One of the things, for example, in rural areas, is an RN on site sufficient if they are awake? Is it that they are in the breakout room having a nap because they are doing an overnight on-call shift? Is it that they are within 10 minutes on-call because they live five minutes down the road? You need to look at how can that practically work for a workforce. I think the issue of funding is a live one. This is about making sure that we set the right price for the type of care that Australians expect and I think that is an issue that the Federal Government will be exploring in the light of the royal commission. I can understand why providers might say to you right now that it would put them under if they were required to do that today. I do not think that is a reason not to do it; I think that is a reason to fund them properly.

The Hon. TAYLOR MARTIN: I really want to thank you for that answer. It builds on some of the conversations we have had throughout these three days of hearings. Ms Appleby, did you have anything more to add or will I move on?

Ms APPLEBY: No, other than to say, as I think someone previously has said earlier today at one of the hearings, that people that live in regional and rural areas are absolutely entitled to the same level of care as those living in metro parts of New South Wales, for example. So I think we should be doing everything we can to ensure that the workforce is of a good standard for those facilities.

The Hon. TAYLOR MARTIN: Can I ask a bit more, a bigger-picture question than my first one? How would we be better able to integrate aged care with the health system that we have to ensure that people are

actually, as you just put then, Ms Appleby, better able to get the care that they require, considering that there are different levels of care that are required in this system?

Mr IRLAM: I think part of the answer there is identifying what do we expect to be delivered under the banner of aged care, what are the services that we are saying, "No, you don't have an entitlement to go to the hospital. You don't have an entitlement to go to the local specialist. You don't have an entitlement to go to allied health. We're going to provide it to you through aged care" about. I would be very sceptical about any of those things should be preventing somebody from getting that best care, the best source. But if we talk about how to bring those health services into aged care, we talk about how to do an outreach model of palliation specialist and allied health teams so that they are able to either have continuity of care, where somebody might go into residential care as an alternative to rehabilitation for a short term, where somebody might have continuity of their specialist they have been doing in the community.

The challenge that the royal commission has identified is two things: Transport from residential care, to let someone out into the community to visit those doctors, has been woefully inadequate; secondly, the price that you pay a healthcare professional to come to a facility to visit one person has not been a great enough incentive to encourage them to do so. How we go about identifying those two challenges, how we give better transport access to allow support for leaving the residential aged-care facility or better incentives for the healthcare professional to come in, I think, will be part of that. This is more than just nursing. Lots of people need allied health professionals to be able to keep that mobility up and running, more than they need just what is there. But it is expected that we will see a greater level of subacuity type of residents rather than low-level care residents in aged care as we go forward.

But there will still be, for example, people who are physically fit, experiencing dementia, that will perhaps need more of that restorative and preventive health measures from allied health rather than that subacute care from a nursing and primary healthcare team. So we need to be able to make sure it works for both.

The Hon. MARK PEARSON: Ms Appleby, I would just like to ask a couple of questions about your evidence. You seem to have a very strong view, that we should really wait for the Federal Government to decide which recommendations it will adopt or, maybe, amend. Let us say that the Federal Government does not actually a hundred per cent adopt the recommendation by the commission regarding registered nurses but the New South Wales Government did. Would that not be a better outcome for the residents in aged-care facilities in New South Wales, at least?

Ms APPLEBY: That is why in my opening statement we had the proviso that, if the mandated levels of staffing, for example, exceed that recommended by the Federal Government then I would definitely be supporting the New South Wales level.

The Hon. MARK PEARSON: This happens quite often. I think a good example is the New South Wales Government grappling with the model slavery bill. It is a bit different. We are not satisfied with what the Federal Government wants to implement in terms of modern slavery and protecting these people from exploitation. Therefore we are moving to take it to the next step. This could be what happens with this. If the outcome is better for the residents, then we may well set an example for the rest of Australia. I am glad you agree that that would be a good thing.

Ms APPLEBY: I think the main concern is—obviously, you do not want the State and Federal legislation to be at odds. I think it is really important to see what the recommendations are from the Commonwealth. That can be aligned with New South Wales State legislation.

Mr IRLAM: I think the really important point there to consider after 31 May, when the Federal Government responds, is two things. One is the time line. If you are wanting to move earlier than that 1 July 2024, what happens when that comes into force? Is there a sunset clause? When the Federal Government makes a requirement, the New South Wales legislation goes away, therefore there is not double regulation? I think the second process is how will a Federal Government exemption process, as outlined by the royal commission in that recommendation 86, apply if there is a black-and-white you must have under New South Wales legislation. I think time lines and dealing with those tricky one-off exemption processes just need to look at how those interactions happen.

Ms CATE FAEHRMANN: Thank you. That is really useful. Just a quick question from me. I am just wondering about whether you have any recommendations for attracting more people into the workforce within the aged-care sector, and of course into those registered nurses' positions that we have heard so much about during this inquiry that we are having such a hard time filling with the people with appropriate qualifications.

Mr IRLAM: I do not think it is just RNs. This is across the board. How do you create a need for a staff member in aged care? What is the career path? What is the reason somebody wants to live and breathe 30 years of their life in aged care? How are you giving them meaningful incremental changes to their role? How are you paying them equitably? Why would somebody work in aged care when they can earn $6 an hour more as a personal care worker, just doing the same thing? How do we actually make this an attractive and equitable position for other opportunities that people had? That becomes particularly acute in registered nursing in relation to the variety of work that they deliver, in relation to the primary health system paying them more than what they currently get paid in aged care.

But I think this value of work and the type of work role is the starting point to being able to capture people across the board, personal care workers, the lot. I think, for some of the health professions where they are reaching in, it does come down to a bit more of a financial incentive, because it is about "Why would I go there when I can see one person and get X dollars but I can run a half-day clinic in my own office and see 12 people and receive Y greater dollars?" I think there is also how we do that as incentives to have that in our reaching.

Ms CATE FAEHRMANN: Thank you. Ms Appleby, did you have any comments to make there?

Ms APPLEBY: At a State level I see, especially in regional and rural areas, there is a real need for many different staff. I get complaints and concerns from older people seeing specialists, for example, having to travel half a day to find a specialist or having one specialist, in a regional area, that charges whatever they like, really, because they have a monopoly. So I think, as Corey said, it is actually quite a wicked problem and it needs to have a really comprehensive strategy. I know the Federal Government is looking at workforce strategies, and I am sure there will be lots of input from consumer groups and consumers and providers as well to address that.

The CHAIR: Unfortunately, that is bringing our time to a close. Can I thank our witnesses very much for your participation this afternoon. I do not think you have taken any questions on notice. So we can just thank you very much for your time and your testimony today.

(The witnesses withdrew.)

DANICA LEYS, Chief Executive Officer, Country Women's Association, sworn and examined

The CHAIR: I now invite our next witness, Ms Danica Leys. Do you have an opening statement you would like to make?

Ms LEYS: Yes, I do. Thank you to all of the Committee members for the chance to be here today to convey the views of the Country Women's Association of NSW on this topic. We are one of the largest member-based groups in the State, and certainly the largest one with rural, regional and remote issues at its heart. Aside from my experience as a policy professional and being a representative for the CWA of NSW I also have some personal experience in this area that I can draw from here today. My mother is a registered nurse working in a high-needs private aged-care facility in the Southern Highlands. She has held various roles in the aged-care sector over the last four decades, including a significant amount of time as a nursing unit manager of a dementia ward in the Macarthur area. My aunty is also a registered nurse and chose to take care of my ageing maternal grandmother at home before she passed, with significant assistance and input from my mother. My paternal grandmother is a current resident of an aged-care facility.

My final anecdote is that some years ago I assisted my husband and his family to care for my mother-in-law in her final weeks. She was struggling with the dual afflictions of bowel cancer and dementia. Her daughter—my sister-in-law—was also her carer for many years before that and she is also a registered nurse. Before my mother-in-law passed, we as a family explored options to have her enter an aged-care facility as her needs were becoming greater. These options were very quickly cast aside one Sunday afternoon when I arrived to pick her up from Dubbo nursing home after a weekend of respite and found her tied to a chair. She was never placed in a care facility ever again.

Apart from my personal position, our organisation's position is clear and has arisen from a very strong democratic process that the CWA has had in place over—we are 100 years old next year. As you have read from our brief but forthright submission, we are of the strong belief that there should be a mandated requirement for a registered nurse to be present in aged-care facilities at all times. As an organisation, we struggle to understand how and why in 2021 this issue is up for debate when, clearly, the aged-care system is in a state of crisis. That said, we do appreciate your time in looking further into this issue.

Some of the reasons for this requirement include the following. Aged-care homes are looking after people who are living well into their 80s, 90s and, more commonly, into their 100s. That means people are living with complex healthcare needs that need to be managed by registered nursing staff. Carers are predominantly Certificate III qualified. They can complete their course in six weeks, often barely touching or interacting with an older person. New carers need the support, advice and management that an RN provides. Medications, especially those for pain relief, must be administered by two nurses, one of whom must be a registered nurse.

The nature of ageing, as this Committee has heard, is that more and more people are living with dementia. That is a reality, but it also presents a complex and confronting disease with sometimes challenging behaviours. To manage these behaviours effectively an RN needs to be intricately involved in presenting and managing incidents and promoting resident quality of life. Care homes are increasing in size. Expecting carers and enrolled nurses to manage 120-plus residents means that the likelihood of incidents occurring increases and the knowledge of RNs is crucial. RNs are best placed to implement and oversee resident care and to help residents to live as well as possible across a 24-hour period. Care homes have also morphed into pseudo palliative care units.

A person's palliation, comfort and symptom management needs to be managed by an RN. The argument that it is too expensive for providers in rural, regional and remote areas to provide RN resources misses the point completely. If there is an issue with recruiting, retaining and resourcing registered nurses in country areas, that is the question that this Committee and this Government should be focusing on, not how legislative loopholes can be created for country providers. We should not be exploring the option of least cost or what we can get away with as the lowest common denominator.

The answer to the care needs for rural people is not to create a two-tiered system where rural aged-care residents do not have access to an RN 24/7 whilst their metro counterparts do. Look at the deeper systemic issues at play as to why there is a resourcing problem, in the first instance. To argue that providers will just leave so we must accept lesser quality care is not acceptable. It has been put to me that it is also discriminatory, to which I would have to agree. We have many examples from our members that have been relayed to us, and I am happy to take any further questions from the Committee. Thank you.

The CHAIR: Ms Leys, I thank you very much. I like how you characterised your submission. I was going to say "concise" but, yes, it was certainly forthright. It was very helpful, thank you—as was that opening

statement. I have a couple of questions and then I will pass to Committee members. In your submission you said it is clearly the counterargument that a legislated requirement would place an unnecessary burden on rural, regional and remote aged-care providers. I love your quote; you stated, "This is clearly a nonsense position based on an entrenched belief that country people should accept second-class health care." Can you just explain where your position comes to on that?

Ms LEYS: My position is the position of the CWA of NSW, which has been lobbying on this issue from at least 2015 and possibly earlier. I had not been around in the organisation before then, but it was at least 2015 that it was a policy position that the organisation took very strongly. It is, I suppose, based on a belief that country people should have equity of access to services across the board. They can be health-related services, education-related services. There is certainly not an expectation that there are highly specialised people on every corner in country New South Wales, but a level of access to basic health care is what is expected and should be expected, especially in 2021.

The CHAIR: Yes, absolutely. In your submission you also referenced a survey of 800 members that you had undertaken. I know we have a couple of members of that Committee here as well, but for the benefit of this inquiry—and certainly for myself—could you explain some of those key findings specifically in relation to aged care?

Ms LEYS: We did annex that survey to a separate submission that we made into health outcomes in rural, regional and remote New South Wales. There were over 800 respondents to that survey. I think the most interesting thing that relates to aged care is probably what I spoke about before, in that there can be an acceptance, if you will, that sometimes to access very specialised medical services is harder in country areas. We would love to see more specialists in country areas. We would love to understand and work with Government on what we can do as an organisation to attract more specialists to country areas as well. But there should not be the types of barriers that are in place when accessing basic services like GPs and like registered nurses being present in a nursing home 24/7. Those were some of the key themes that came through in our survey. People were acknowledging that, yes, it is harder for them to get access to specialised services, but they were not as concerned about that as what they were about just accessing their everyday-need services.

The Hon. WES FANG: Thank you for appearing today. I note your submission and your opening statement. I guess when I am looking at your submission and the policy areas around there, ideally no-one would like to see a two-tiered system. Certainly I would be one to advocate against it. But the reality is that with the inquiry you referenced, which was the provision of rural and regional health care, in our first hearing we heard of the difficulty in recruiting nurses to rural and regional areas already. How do you see that playing out in rural and regional communities, when potentially you have got hospitals fighting with nursing homes for the same resource—i.e. registered nurses in a small town? We know of places like Harden, where the St Lawrence nursing home has already closed because of difficulties in a number of areas. How would that affect the community, do you think, and how do we get around that as a Committee and as a Parliament?

Ms LEYS: I think what you have just outlined and illustrated is exactly why we need to look more broadly at how we properly resource—if we are talking about registered nurses in aged care, how we attract them to come and work in regional areas, specifically to work in aged care. How do we retain them? There are also problems with retention of medical people right across the board. To me it would seem there is an ideal opportunity to really look at that issue in a lot more holistic fashion. Yes, it will cost more money; I think nearly all witnesses have raised that as an issue. Yes, it will cost more money, but it is worth funding and it is worth finding the money. It is worth making sure that rural people have that basic level of care that their city counterparts do.

The Hon. WES FANG: But one of the problems that we have heard, particularly in the other inquiry that I referenced, is that it is not always about money. The resource does not exist.

Ms LEYS: Correct.

The Hon. WES FANG: We just do not have enough registered nurses. And with the ongoing issues of COVID where we would potentially have brought nurses in under special visas or people from overseas might get experience here where they have had work overseas as a nurse, we are not able to do that at the moment. Again, we have got this limited resource. How do we distribute it? And if we do something like this, can you see that it may have an effect on rural and regional locations—like we have already had in Harden?

Ms LEYS: I would say that if the outcome from this inquiry is to just simply look at the challenges that face rural, regional and remote areas, and therefore that is somehow the argument as to mandate registered nurses in nursing homes being present 24/7, then that is an opportunity missed to look at how we look at growing the pool of whatever medical professionals we need—in this case, we are talking about registered nurses—how we

grow the pool of those people who come to country areas and how we fund them properly. You are correct; there is very much a huge challenge in getting people I would say not only to come to country areas but, after hearing from many of my members on this issue as well, actually getting them to stay employed as registered nurses.

Many of our members are retired registered nurses because they, frankly, just got sick and tired of the type of work they had to do in aged-care facilities where they might have been single-handedly, as a registered nurse, looking after a 120-bed facility through the night and not being able to get access to GPs when they needed them to be able to come in. When we talk about resourcing and COVID, that has come up in COVID situations as well. There is a pool of resources out there in terms of already trained nurses who are choosing not to work as nurses, so how do we get those people to come and join the workforce as well. There are no easy answers, but my fear is that some of the line of questioning that is being raised is seeking to somehow lead to an outcome where there may be a two-tiered system for services for country people. That is just not something that as an organisation we can accept.

The Hon. WES FANG: I take your point. I guess, the characterisation around the questioning is leading to a two-tiered system I think I would differ with you on. I would just point out that what we are seeking to do is make sure that there are not unintended consequences from doing this. As I said, ideally we would like to do these things but there may be unintended consequences moving forward for those smaller communities where the provision of a nurse 24/7 may have flow-on effects. With the Federal Government now having taken the royal commission's findings and then they are looking to respond to them, do you think it is more appropriate that we look at this across the wider Australia gamut—that instead of New South Wales going out on its own to do this, we wait for the response from the Federal Government and perhaps look to do this through the Federal sphere, seeing as they do control the provision of nursing care facilities?

Ms LEYS: No, I do not. I think that if there is a gap and a need for New South Wales to mandate the fact that registered nurses should be in nursing homes 24/7 then, yes, ideally that would be standardised nationally. But in the instance where it is not I do not think New South Wales should be dragging the chain, so to speak. I think it is an opportunity for New South Wales to show leadership in that space and provide the very best level of care that it can for all its residents.

The Hon. MARK PEARSON: Is your position that it is actually not acceptable to not have registered nurses in nursing homes in regional, rural or metropolitan areas? That is just a fundamental base.

Ms LEYS: Correct. Perhaps what I did not get to outline in my opening statement as well is that in some regional areas—in some instances—we would argue that there is even more of a need to have a registered nurse in nursing homes 24/7 because of the lack of specialist services that I have spoken about. It may take someone a very long time to see, for instance, an orthopaedic specialist if they have a fall and they sustain a break in a rural regional facility. In that instance, it is even more important that there is a registered nurse there—I would not even argue on call—present in the facility 24/7 to be able to handle that person's pain and other complications that they may have.

The Hon. MARK PEARSON: So your organisation, for the last almost 100 years, would be well and truly aware of the dynamics, the mindsets and the attitudes that are happening in rural and regional areas compared to metropolitan areas?

Ms LEYS: Correct.

The Hon. MARK PEARSON: Do you think there is a culture or a mindset in the care provision services which says that aged care is not as important as emergency?

Ms LEYS: I do not know that I would agree with that. I think if you talk to anyone that works in aged care, whether they work in metropolitan or rural areas, they are certainly very passionate about their job.

The Hon. MARK PEARSON: But they are paid less, aren't they?

Ms LEYS: They love their job. You have to love your job if you are being paid less to do it.

The Hon. MARK PEARSON: That goes to my question. If they are being paid less, by average, to work in an aged-care facility with exactly the same qualifications—unless you choose to specialise in something as a nurse—is that not the culture we are talking about?

Ms LEYS: It could be a cultural issue from a broader management perspective, but certainly not from the grassroots workforce perspective. We certainly cast no aspersions whatsoever on people that are choosing to work in rural, regional or remote areas as an RN or in any other medical field. We referred earlier to the inquiry that is going on in relation to rural health outcomes and some of the frankly horrific stories that we are seeing

come through in relation to medical treatment of people in rural areas. It is important to note that when we make strong statements about how some of this is managed we have the deepest respect for the people that work in the field. Our criticism lies in how the system is being managed.

The Hon. MARK PEARSON: Are you saying that it is all those factors that need to be addressed, not to say, "Well, we will just have to wear it because we haven't got enough and we can't attract them, and therefore services will have to be of a less standard"? That is not acceptable, you are saying?

Ms LEYS: Correct. I would think it is a perfect opportunity to address those broader issues.

Ms CATE FAEHRMANN: Thank you for appearing today, Ms Leys. I just wanted to get your view on a statement that was made earlier by a representative of the previous witness from the Council on the Ageing that gave us the information that a personal care worker working in the disability sector is paid $6 more per hour than somebody working in an aged-care home. After the disturbing story that you told us in relation to your mother—and I am so sorry that that happened—how does that make you feel knowing there is now such an undervaluing, if you like, of people caring for older people as opposed to pretty much everybody else?

Ms LEYS: Again, it is a glaring issue that needs to be addressed. We live in a society where we have more and more people aging, and more and more people are aging with quite complex needs and high-care needs. So for the people who are closest to them in their everyday lives—the carers, registered nurses, enrolled nurses and other carers—it is unacceptable that they are paid less to do what, in some instances, is a harder job. It is certainly a harder job from an emotional point of view, as well as the actual physical aspects of the work that needs to be undertaken as well.

Ms CATE FAEHRMANN: That is your own personal story that you shared with us. I am sure there are other members of the CWA that have similar stories of putting their parents into care.

Ms LEYS: Yes. I have got an example here from one member who said that one of the main things that she noted when her dad was in aged care is that if he was sent to a public hospital for ongoing care or for something that they could not manage in the aged-care facility—often on his return with some treatments ordered by the treating doctor—the aged-care facility would get their doctor to change those treatments so that the enrolled nurse could actually administer the medications without a registered nurse being present. That was one anecdote that was relayed to me.

Another was from a Gunnedah resident—well, she actually lives in a place called Goolhi, which is west of Gunnedah. She used to be a registered nurse at a Gunnedah facility. She said that in her situations they had 88 beds and never enough RNs on duty. After hours and on weekends one RN was on duty and was in charge of the whole facility. It was bedlam for most shifts. A dementia specific unit and many high-dependency clients, there was rarely a shift that she did not witness a fall or a client requiring further medical treatment. She goes on to relate a lot of the other issues that she has observed as a recently retired RN in a country facility.

The Hon. GREG DONNELLY: Thank you so much for coming along. We appreciate your submission and the elucidation of some of the points in your submission. A theme I want to return to, which members would be aware I have been pressing with other witnesses about, is the delivery of high-quality palliative care, particularly at the end stage of life in aged-care facilities. I am just wondering—and you can take it on notice if you wish to do so. That is perfectly okay. Amongst the examples you have given, obviously there are first-hand examples provided to you by members of the organisation, about experiences in regional, rural and remote New South Wales. Any insights you might be able to give about palliation, particularly in facilities outside the major areas, because we have had some evidence which does raise concerns for many because of not having an RN, not having access to a palliative specialist, a GP being some distance away, whatever the case may be. These places, as best intended as they may be, do struggle greatly to provide that particularly important care. Do you have any examples, particularly about palliation and end-of-life care?

Ms LEYS: One of the main things I hear a lot from members in relation to palliative care is obviously access to adequate palliative care. But what they mean in relation to that often is access to palliative care in an area that would suit their family member that is not hours away from their family. That comes up quite often because that is a very important part of people's end stage in life—being surrounded by people who they love and they are able to help in caring for them as well. That comes up fairly often. I would say different towns have—there is probably a cross-section of experiences in relation to palliative care across different towns. Some towns have been very active as a community, I suppose, in getting involved and helping to be engaged with their local health district on how palliative care is delivered across their community. There are probably some very good stories out there in relation to palliative care, but one of the main issues that I hear conveyed to me is about having

adequate access to palliative care in a location that is suitable for family members and loved ones to be able to visit easily. It may not be in that town, but a town nearby.

The Hon. GREG DONNELLY: You are specifically associated with the New South Wales branch of the organisation, I gather from your credentials.

Ms LEYS: Correct.

The Hon. GREG DONNELLY: In terms of what is happening in other States and Territories—and you are obviously in regular contact with people in procurement positions in those other States and Territories—is there anything that you wish to bring to this discussion in terms of things that may be going on elsewhere that have been drawn to your attention or the way in which other States may be dealing with this, both good and bad? It is worthwhile trying to draw a map.

Ms LEYS: I am happy to take that on notice, if you like. We do stay in very regular contact with our counterparts in the other States and Territories and we are members of CWA of Australia as well, so it is a federated model. There are probably some interesting policy positions from the other States that may interest this Committee, which I am happy to provide, and also that national perspective as well. CWA of Australia are also on the board of the National Rural Health Alliance, so they may be able to provide some useful insight from a national point of view. But I will take that on notice.

The Hon. GREG DONNELLY: That would be helpful. Thank you very much.

The CHAIR: We have got a couple of minutes left so I am going to sneak in a few more questions with the Chair's prerogative. We have had quite a few submissions saying that there needs to be an increase in transparency in the information that is available for residents and for their families if there is to be this almost inevitable increase in funding. Would you support those kinds of transparency measures?

Ms LEYS: Absolutely. We are also part of what is called an Aged Care Roundtable. The secretariat for that roundtable is the NSW Nurses and Midwives' Association. There is a long list of organisations that are part of that roundtable. The reason I mention it is because some of the work of that roundtable has been to develop a range of leaflets on all different aged-care issues. The leaflets are set out in a format of: If you are a family member here are 10 questions to ask of an aged-care provider or 10 questions to ask about palliative care or things like that to try and empower people to get the answers that they need from a transparency point of view. We have supported that, but it would be better if that information was just provided up-front so people did not actually have to actively go out and seek it. We would totally support that.

The CHAIR: Absolutely. That would obviously extend to providing potential residents and their families with information around the care minutes and the other things that have been recommended by the royal commission.

Ms LEYS: Correct. That would be great.

The CHAIR: One of the things that we have heard a lot about during the inquiry—and this is our third hearing day—is that all of the parts that make up aged care are actually really important. This bill specifically deals with registered nurses, but everyone—the people who work in the kitchens, the chefs, the dietitians, the allied health professionals, the cleaning staff, this holistic approach to aged care is so important. One part is obviously registered nurses, but then the other part is all of these other important parts. We need to have a more holistic approach. Would you agree with that?

Ms LEYS: Yes I absolutely would agree with that. There are—as you have outlined—many crucial roles that contribute to the successful running of any aged-care facility in terms of keeping people healthy and happy, which is just as important as keeping them healthy. These are their homes. So I absolutely would agree with that. I do not think, though, that that argument should detract from the need to, at a basic minimum, be providing an RN on duty 24/7 in any facility. Perhaps there is further opportunity to look at how the appropriate mix of people in each aged-care facility is funded properly into the future.

The CHAIR: I, of course, neglected to mention personal care workers, who are really the crux of so much of the work that is happening in our aged-care facilities—

Ms LEYS: Absolutely.

The CHAIR: —and are such an important component. I have one final question for you. Our next witnesses are the Older Women's Network. They have been doing some very important work around the rates of sexual assault in aged-care facilities, which is just horrifying, to be perfectly frank. They are such vulnerable

people. This is something that we have not heard a lot about. Does your organisation have anything that you would like to contribute on that issue?

Ms LEYS: I suppose we can contribute the fact that our members see domestic violence, generally, as a very big issue for them. In our most recent membership survey, which surveyed our members across a lot of different issues and asked them to prioritise some of the policy areas that they wanted us to work on as an organisation, domestic violence came up as their number one issue, amongst a lot of issues. But it did come up very clearly as the number one issue. If I think back to—I was talking about the survey that we recently conducted, which we had 800 respondents to. We asked people to please tick a box in relation to how easily they could access a range of different services in their local area.

It is important to note that the survey was only done in rural, regional and remote local health districts. When those access to services are ranked, domestic violence is very low on the scale in terms of people being able to access appropriate services. People rated that they were able to get to their GP—that was the highest—and then there were a range of different services scaling down from that. I believe domestic violence was probably one of the last, if not second or third last, out of, say, 10 services that we had in that survey. So there are issues on both sides; there are issues in terms of the rates of domestic violence that our members are seeing and there are also issues in terms of how people access assistance if they are being affected by domestic or family violence.

The CHAIR: Thank you so much, Ms Leys. Thank you for your submission, for your testimony and for your advocacy on behalf of country women. We have really appreciated your time this afternoon. Unfortunately, that brings our time to a close. We do have a brief break for afternoon tea until 3.30 p.m.

(The witness withdrew.)

(Short adjournment)

CORRECTED

YUMI LEE, Manager, Older Women's Network, affirmed and examined

BEVERLY BAKER, Chair, Older Women's Network, affirmed and examined

The CHAIR: Good afternoon and welcome to our very final session of our hearings into the need for registered nurses in nursing homes bill. I welcome our next witnesses and thank them for coming. Did either of you want to make an opening statement?

Ms LEE: Yes, please. Firstly, we would like to acknowledge the traditional custodians of the land on which we are on and pay our respects to Elders past and present, and to those present here today. We would like to thank the Committee for the opportunity to provide testimony today. We would like to focus specifically on item (d) from the terms of reference: "the need for further regulation and minimum standards of care and appropriate staffing levels in nursing homes and other aged-care facilities". We would like to do so using the example of sexual assaults being perpetrated in nursing homes. Based on KPMG's *Prevalence Study for a Serious Incident Response Scheme*, we know that there are at least 1,730 incidents of resident-on-resident cases of sexual assaults. If we were to add to this the 816 reported cases in 2018 to 2019, the reality is that there are at least about 50 sexual assault cases in nursing homes every week. The aged care royal commission has rightly categorised this as a national disgrace.

We deplore the lack of leadership shown by the Federal Government to end sexual assaults in aged care. Aged care is a Federal Government responsibility, and the status quo is unacceptable. Without further regulation, minimum standards of care and appropriate staffing levels, we will continue to face the situation of older women being sexually assaulted in aged care. We do not deny that there are providers who are giving excellent service; however, only 1.3 per cent of nursing homes are found to be in the five-star best practice category. The aged care royal commission has proven that they are more the exception than the rule. We want to see further regulation to ensure the safety of residents in nursing homes. We would like to highlight in particular the Serious Incident Response Scheme, which, as it stands, is a seriously disappointing and ineffective way of dealing with cases of abuse. Why? The Serious Incident Response Scheme asks providers to categorise incidents based on the impact to the person affected by the incident into whether it is a critical incident, which has a high impact, or a serious incident, which has a low or no impact.

This categorisation will determine the type of reporting to be done. KPMG's research noted that 58 per cent of sexual assault cases were categorised by providers as not having any impact on the victim. We find this totally unacceptable. This tells us that without regulation for all sexual assault cases to be classed as critical incidents of high impact, older women who are sexually assaulted in nursing homes will continue to be victims of repeated assaults, and steps will not be taken to keep them safe. Regulation in this matter is critical because research has shown that providers are reluctant to face the reality that sexual assaults are taking place under their watch. There are also numerous reports in the media which bear this out—the most recent involving a man who reported the sexual abuse of his wife when he found her in the room of another man who had one hand on her breast and another up her thigh. He was understandably distressed, and what caused him to be even more upset was the provider categorising this incident not as sexual assault but as "cuddling".

We also call for regulation to ensure that all staff who work in nursing homes are given training on sexual assault: how to prevent it, how to spot it and what to do when it happens. This should end the myth that older women who have dementia are not impacted by sexual assault and therefore nothing need be done to protect them, nor report cases in a timely manner. We have been working with Dr Catherine Barrett on this issue since 2019, and we believe that the training model that she has developed for providers should be rolled out nationally. We also want to see regulation of aged-care workers such that a national register exists to enable providers to check if workers have been implicated in the sexual assault or abuse of residents. We hear rumours that the Federal Government intends to pour $10 billion into aged care over four years. This is not enough. However, we believe that unless we also have regulation on transparency and accountability of how much providers actually spend on direct care and meals, nothing is going to change.

There should also be regulation on how much aged-care workers are paid. They must be paid more if we want to professionalise their work and ensure that they are better trained. There should be regulation on ratios. Professor Kathy Eager's research shows that people living in nursing homes now are typically very frail and have complex physical, cognitive and social care needs. Improving the staffing mix, having registered nurses onsite and increasing staffing levels to an acceptable standard are critical to the care of residents in nursing homes. The need to regulate, monitor and evaluate provider responses to sexual assaults is vital if we are to protect the older women who end up in nursing homes. These older women are our grandmothers, our mothers and, one day, they will be us.

The CHAIR: Ms Lee, thank you for that incredibly powerful opening statement. I think we both have read the media report that categorised the sexual assault as cuddling. Can I first of all ask you: How common is this kind of categorisation where a sexual assault is actually treated in this way in aged care?

Ms LEE: Based on our work with Catherine Barrett—because she is the one who collates the information and people contact her about these reports—practically all of them indicate an absolute lack of will, ability and capacity to deal with sexual assaults. Apart from categorising this case as cuddling, we also have cases where providers refuse to accept that sexual assault is happening in their facility. I can give you one example where staff informed the daughter of a woman that she was being sexually assaulted by another resident. When she went to report this to the manager of the facility, she was told by the manager of the facility that she was depriving her mother of her sexual freedom. The staff had categorically told the daughter that the look on her mother's face indicated that she was absolutely being traumatised by the event. So it is an issue that providers find very difficult to deal with based on all the reports that we have heard.

Ms BAKER: If I could just enter the conversation here. We had a stall at a seniors week and at that time we were requesting that the aged care royal commission actually have a look at this as a discrete item. When people who were simply walking past us and had a look and we said, "Would you like to sign this petition? This is an issue", the stories that came out were horrific. I still have nightmares about the stories that I heard. One in particular was that the woman had dementia, but her neighbour—it was her son that was visiting her, and the whole nursing staff, the whole—not the nursing staff; the care staff at the home were saying, "Isn't he a wonderful son? Isn't he fantastic? He comes and sees you every day." Every day he was sneaking into the room of the woman with dementia and sexually assaulting her. It was not until a nurse busted him, caught him in the act and chased him down the corridor. He threatened her life.

The whole story was—I mean, if you had read it in a book you would say that was a flight of fantasy, but the thing is that person after person after person told us that when they lodged a complaint they were told, "Your mum has got dementia. She is imagining things," or, "It is not happening. That is not real. She has got dementia, so really it is not having any impact on her," forgetting completely that these women grew up during the period of the cult of the Virgin where virginity was the only thing that you took to your marriage with any value. You could be divorced from your husband if he found out that you were not a virgin when you got married. You could have your marriage annulled. So these women are coming through from a culture of that in our society up to now and they are being physically assaulted in the one thing hardwired in that has value. We are just absolutely appalled that this is being treated as having no impact. It has an impact. It has a massive impact because the things that you value and that you attribute value to, whether you have dementia or not, they are hardwired in. They will not leave you. We are just absolutely—we were horrified at the story after story after story that we heard of women in this situation as they willingly sign our petition to say we must do something about this.

We were equally appalled to discover that when opportunities were offered at a Federal level for transparency and for reporting so that we know how much was being spent on food and how much was being spent on staffing and what the staffing ratio was and what the qualifications of the staff were, that was actually shut down and knocked out. As far as we are concerned, if you are privatising services, you cannot claim commercial in confidence. You are privatising a public service, and therefore your roles and responsibilities must remain the same as if it was still provided by a government instrumentality. We are not seeing that occurring. We are seeing people who are not even allowed to run a chicken farm being able to run nursing homes and buy 10-storey gold-plated yachts with the profit while their patients—or their inmates—are left sitting in soiled nappies for days on end and being fed frankfurts. It is just not good enough.

So the regulation must be not just on reporting but it also must be limiting the profits. There must be regulation that says that you cannot simply take all the money because—and twaddling on about how the market will rule, we know what the market does. The market ensures that executive officers get paid massive bonuses and owners live in absolute luxury and get paid millions. It is not good enough. We really do need to go back to Tradern Australia to say, "Okay. What is the best we can deliver for our aging population and how do we ensure that we get the best expenditure for money?" Currently, privatisation—if you ever want to see it failing, have a look at aged care. It is screeching to a halt there, exposing all of the dangers that people who had been opposed to privatisation have been saying for decades.

Ms LEE: Can I please add also that Aged Care Quality and Safety Commission is very much ineffectual in how it regulates the safety of residents. It has been recording an increasing number of sexual assaults over the years, but we have absolutely no idea where that data disappears. It goes into a black hole and we cannot see any concrete measures that have come out to protect residents at all.

The CHAIR: I just have a couple of quick questions, and then I will pass over to the rest of the Committee, who I am sure will have plenty of questions. I have a feeling we are going to run out of time very quickly this afternoon. In terms of vulnerable people—and we would class people in aged-care facilities as very vulnerable, particularly if they have dementia—the question of the national register for people who are working, it seems like a no-brainer. It seems like a very obvious thing.

Ms BAKER: Absolutely.

The CHAIR: Have you had any traction on this particular proposal?

Ms LEE: We are continuing a lobby process for this issue. We believe that it is one instrument that we can use to protect residents. I think the staffing issue is critical. We just do not have enough people working in aged care who are qualified, who are professional and who are paid adequately. So this also impacts on issues of gender equality etc. We believe that a lot needs to be done. There has to be leadership, there has to be a political will, and there has to be acknowledgement that the current model is not serving us well at all.

The CHAIR: You have answered my second question, so I am going to pass to the Committee.

Ms CATE FAEHRMANN: Thank you for appearing today, and thank you to the Older Women's Network for bringing this issue up and for having the courage to speak about it and bring it before the inquiry, because we have not discussed it and we have not had witnesses talking about it. I think it really is obviously extremely important for us to also be addressing. This inquiry is obviously talking about RNs and looking at a particular piece of legislation in relation to that. We have had some witnesses who have expressed concern that any legislation that dictates having 24/7 RNs in every facility would mean that there would be less staff; that providers would make money—would not want to lose money by employing RNs. You addressed, Ms Baker, the desire to make money by some of these providers.

Obviously, to help with addressing sexual assault and to ensure it does not happen in the first place, one way is to make sure that there are more people in care, more people walking the floor, more people with appropriate qualifications but just more staff generally. Clearly these residents have been left alone for so long; you are talking about soiled nappies. But if they are left alone to the point that this gentleman, as you said, was able to sexually assault a particular resident day after day, that points to an extreme lack of staff coming in to check that resident. That is just so alarming. So it is much more than just registered nurses 24/7. You would not want to see legislation that takes away the ability for more staff to be on more broadly.

Ms BAKER: Absolutely. It is completely vital. My father passed last year, and for the last two years of his life, he spent in a nursing home in which he was miserable. Now, he was fiercely independent. He was not incontinent, but he could not get out of his chair. When he zapped the bell to get someone to help him, he was left there for an hour and a half. I do not know what your pelvic floor is like, but mine will not last that long. He would then urinate in his bed. So they said he was incontinent and made him wear a nappy. Now, that is humiliating, especially to a man who has been fiercely independent, who still straps on his medals and went off to celebrate his horrible experience of the Second World War. But to stick him in a nappy and leave him sit in that all day, with the full knowledge of what was going on, is unconscionable.

The nursing home changed hands. When he went into the nursing home, they had a full-time RN on site all the time, 24/7. That was part of the deal and that was why we put him there. They changed hands. All of the long-term staff left and were replaced with short-term staff. Now, it is not intended as a racist comment, but very few of the staff had English. My father was deaf, so he had terrible difficulty—as did a lot of the people in there—understanding what he was being told, understanding the reasons he was being given. But instead of having somebody dropping in every hour and checking on him and seeing how he was going as they were doing rounds, he could be left there for hours without any contact, without anyone even checking on him. Then when they did check he did not know what he was being asked so that he could answer honestly. It was a dreadful experience for him.

Ms CATE FAEHRMANN: Just one final question because we are short of time. You said in your submission that the Federal Government intends to put $10 billion into aged care over four years. This is not enough. Comparatively we could think about the many tens of billions of dollars that the State Government is putting into roads, for example, and I am sure there are comparative examples at the Federal level. Could you just explain to the Committee why that is not enough? I think some people might think $10 billion is a lot of money over four years. What is that being spent on?

Ms BAKER: Because there is absolutely no guarantee that one cent of that will be spent on service delivery, staffing, food and all of the things that you expect. We do know that profits have gone through the roof. We do know that owners are sitting there taking down $84 million a year in profit. That should be ploughed back

in and it is the whole argument around privatisation. If you have got $100 in a public service, a percentage of that is spent on administration, and a percentage on service delivery. If it is privatised, you have to add another plank to that, and that is profit, and that is unlimited.

Ms CATE FAEHRMANN: Any increases in funding should be tied to service delivery, increases in staffing?

Ms BAKER: Absolutely.

Ms LEE: And transparency because, as you know, the ABC reviewed the Greek Orthodox Church which channelled $31 million into its coffers while claiming that the facilities were running at a loss.

Ms CATE FAEHRMANN: Yes, disgraceful.

The Hon. GREG DONNELLY: Thank you very much for coming along today. I thank you for your submission and the opportunity to ask you questions. I too, like Ms Cate Faehrmann, acknowledge the advocacy work that you are doing. It is critically important that these matters be ventilated by people who are very determined to have these wrongs righted. I may have to put some questions on notice because we have limited time.

Ms BAKER: Certainly.

The Hon. GREG DONNELLY: With respect to these examples that have been touched on today—some referred to specifically in your submission and some provided as illustrative examples—they are criminal actions that are occurring, for example, the sexual assault. In a typical circumstance—of course it is not an appropriate word—whereby they happened out in the community more broadly, we know how they are dealt with which can ultimately involve the charging of an individual by the police and obviously the processing of the matter through the court system as a criminal charge. In dealing with this terrible matter that is before the Committee—and feel free to take this question on notice if you wish to do so—do you see a role where the criminal justice systems fits into tackle this, in addition to what, in fact, must be done at that level of the operators to ensure that, as far as practicable, these matters do not occur? In other words, once you have a reportage of these matters—whether it is from a staff member, a fellow resident or from a visitor—that are criminal actions, where do you see the criminal justice system fit in to deal with this juxtaposed with lifting the standards inside the retirement nursing homes?

Ms BAKER: It is as if we have learnt nothing from the royal commission into child sexual abuse. It is like it did not happen. To me, all that has happened is that the perpetrators have simply shifted their target group. Because once where they could get away with assaulting children, and have it swept under the carpet, hidden, moved around and pretended it did not happen because our "reputation" was everything, but now it seems to me that it has just shifted to another section. I do not understand why people would sexually assault anyone. I just do not get it. But somewhere along the line, a screw is loose, and they think this is okay.

The criminal justice system must be there. I accept that under criminal justice there is diminished responsibility but let us have it in the open. Let us have it discussed so we know that that person, yes, has diminished responsibility because of their mental state or whatever. But once you shine a light on it, the cockroaches run, and it is time a light was shone upon it, the same it was in the royal commission into child abuse. Shine a light on it and let the cockroaches run. We will just chase them down until we find them, and stop it because at the moment it is hidden. People with peculiar behaviours go to where those behaviours are not exposed. At the moment, they are not being exposed in aged care.

Ms LEE: I think one thing that needs to be mentioned is the capacity of our criminal justice system to deal with this. Police find it very difficult to prosecute because they hold ageist attitudes themselves. There needs to be separate training. We have seen cases where police do not take these cases seriously and they say the women have rape fantasies. There is a lot of work that needs to be done to address this issue.

The Hon. GREG DONNELLY: Just quickly, I put this to you, and I suspect you would agree but you can develop a position if you have got it. We have obviously done a great deal at the other end dealing with children and young people with a register of child-safe arrangements with respect to people being checked and that information maintained by the Children's Guardian at a State level, or whatever the case may be. Obviously a capacity to do this, to maintain a register to cross-check and do that is something that society can do. We might not like to do it but tragically the evidence is we need to do these things so we can do it at this end. Surely it cannot be an overwhelming task to set up something equivalent at the other end of life when we are dealing with people who are vulnerable in nursing homes and retirement villages.

Ms BAKER: I actually thought that did exist. I have a Working with Children Check. My Working with Children Check was expanded to allow me to work with older people and I thought that it was there.

The Hon. GREG DONNELLY: Oh, okay.

Ms BAKER: I thought that register was there. In some instances it is the staff and in a lot of instances it is not the staff.

The Hon. GREG DONNELLY: No.

Ms BAKER: Unless the criminal justice system is involved, how do you actually get those people on any kind of register to start with, especially if the homes themselves, do not want to admit it is even going on and are able to then say "Oh, it had no impact. It does not matter." If you target your victim very, very well you can continue on this platform for a long time without ever being pulled up. I think that is where that transparency, reporting and capacity and the rejection of ageism is in that. Women do not have rape fantasies. That is a rape fantasy. It is not reality. This myth that is around these things has simply got to be knocked on the head.

The Hon. TAYLOR MARTIN: I want to briefly thank you for your time this afternoon and for your submission and, most importantly, for all the work that the Older Women's Network does.

The CHAIR: Our time has expired. I again sincerely thank you for the incredibly important work that you are doing raising an issue that is not being discussed enough, as it should be. Hopefully our inquiry's report will be able to address some of these really important issues in aged care. On behalf of the Committee thank you very much for your time, your testimony and for your advocacy work.

Ms BAKER: Thank you.

Ms LEE: Thank you.

(The witnesses withdrew.)

GERALD ANTHONY BROE, Senior Principal Research Fellow, Neuroscience Research Australia, University of New South Wales, affirmed and examined

The CHAIR: Before I invite you to make an opening submission, you forwarded some useful information to the Committee secretariat. Are you willing to provide us with permission to publish that as a submission in your name?

Professor BROE: Yes.

The CHAIR: Excellent. Do you have an opening statement?

Professor BROE: I understand that I have been called in large part because of my involvement in Aboriginal health and ageing and I am a member of the national advisory group for Aboriginal and Torres Strait Islanders on aged care across rural, remote and metropolitan or urban areas. That advisory group is to the Department of Health. It is in that capacity I will be talking. I have also had a long time working in health and ageing. I have had a long career and participated in the development and coordination of Australian health and aged-care services, mostly within NSW Health and with the Commonwealth Department of Health. I have been with Sydney University for 20 years as a professor and now at the University of New South Wales. I was awarded a Public Service Board fellowship and have worked in the public service or academia all of my life.

I was trained overseas on a two-year fellowship with the World Health Organisation Public Service Board in neurology, geriatrics and chronic diseases. Relevant to the terms of reference: As well as being a public health physician and an epidemiologist I have worked continuously in hospitals, hospital in the home, residential aged care, respite care, and all the usual parameters of aged care, advanced care directives and aged-care service development. I have run a number of epidemiological studies of ageing—in fact about six—including, the Sydney Older Persons study and the Koori Growing Old Well study. I think that covers basically what I do.

The Hon. GREG DONNELLY: That is a fair bit.

The CHAIR: That is a fairly concise summary of a lifetime of work. We only have half an hour to tap into it. The document that you have provided to the Committee, can we treat that as part of your submission?

Professor BROE: Certainly you can.

The CHAIR: I will start with a couple of questions. We did invite you specifically because we have not received a lot of evidence around the very specific and discrete challenges that Aboriginal people face when accessing aged care. Can you elucidate on parts of the information that you have provided to us about what are the specific needs and why it is important that we do cater specifically for those unique challenges when we are talking about aged care for Aboriginal people?

Professor BROE: All populations are ageing, the world is ageing, as you know. Aboriginal people are ageing at approximately twice the rate of non-Indigenous people. We are going to have a major number of older Aboriginal people. There are already—even though it is not often recognised by Aboriginal communities—a lot of older Aboriginal people. Because once you have gone through the risks of early childhood, early life and mid- life, you get a life expectancy which is approximately that of non-Indigenous people by the time you are 80 because you are a survivor. People of 80 are now surviving quite a long time. We get at least 100 people in every community of a few thousand and that is not recognised and they are not well looked after, not even well recognised, in those communities. Everyone is taught that Aboriginal people do not get old, and they do.

They are ageing rapidly and they are ageing with serious disability. I have handed out the first slide, or from a slide, and that is the rate of dementia in our Aboriginal communities across the whole of Australia. The average rate for non-Indigenous and Indigenous—because the Indigenous do not change the data—people in Australia 60 years and over for dementia is 6.8 per cent. With Aboriginal people it is three to four times that. In the Kimberley 24 per cent and in urban New South Wales and metropolitan Sydney it is 21 per cent. That is three times the rate. That is replicated in the Northern Territory and in the Torres Strait Islands. That is my first point.

The second is the coloured slide referring to a major risk factor that Aboriginal people have for ageing with disability and with ill-health. This shows mental health and multi-morbidity. In other words, multiple disease patterns across the life course in Aboriginal Australians. The reference is given there by Randall and we wrote an editorial on that because it is an excellent paper and the first to show in scientific published terms multi-morbidity. If you look at that slide you will find above the blue line at the bottom, which is where we have non-Indigenous morbidity, you will see a yellow line which is mental health only problems. Those mental health problems, as you

can see, started at five to nine years of age diagnosed. Of course, they start before that but they cannot be diagnosed until a child gets to five, six, seven.

Next is a green area which is the combination of mental and physical diseases because one leads clearly to the other. The third area in red is physical diseases such as heart and lung diseases, diabetes, stroke, renal disease and gut diseases. They are similar in pattern to non-Indigenous people. They do not start until mid-life. In the past that is where we have concentrated our efforts on preventing them. When you add all that together you get this massive added morbidity in multiple areas for Aboriginal people. The third area I want to take you to is a hard one and I found it quite hard to understand my own slide so I will forgive you if you have trouble. The colours on this slide are those of the Stolen Generation.

We have had those minimised by our politicians and their importance minimised because at the moment it is only about 8 per cent of the population that is stolen. But, 37 per cent of the Aboriginal population alive today are descended from a Stolen Generation ancestor and they are deeply affected by that. Fifty-five per cent of the Aboriginal population were not personally involved in the removal of an ancestor—father, mother or grandparent. If you can look at those slides and look at what affect it has had on just the incidence of childhood abuse, which we have measured in our studies, the Stolen Generations have enormous rates of childhood abuse because they have been brought up without parenting.

Those in the family that have been removed have above normal rates and those who have not been removed have below normal rates and that is what one would expect if this is the only risk factor. There are many others but it is a principal one. On the other side, on the right-hand side of the page, is resilience, which is a much talked about term. You will see that those people—it is hard to follow—in the brown who were not removed have a strong resilience, and one would expect that. The central slide in yellow are the people who are in the family and they have very low resilience to stress and to trauma and to any effects of their life-cycle. The green people are the people who are actually stolen. They do not show a great drop in resilience and that is because they are mostly dead. If you are not resilient you do not survive in a major sort of way.

So that is my background to the problem we are looking at in providing aged care for this group of people. Why I want to stress that is because we have the multi-morbidity thing, the dementia thing, the early onset of disability, the mental health permeating this population, and the lack of social and emotional wellbeing. Just by the by, all this is due to us. As Paul Keating said in the Redfern speech, we did it. We traumatised them and we are still doing it today. Early on we sort of felt it was necessary to get them off the land. Now we just do it out of habit, I think. God knows why we are so racist. I think it is a human habit unfortunately. So we have the major risks of the Stolen Generation, the trauma that follows that often—but there are many other sources of trauma mostly from racism and the fact that they are ageing more rapidly. I have given a background. Should I speak to what we can do about it or would you like to ask me questions?

The CHAIR: Please. That was literally my next question.

Ms CATE FAEHRMANN: Very helpful.

The CHAIR: Are there any examples of where we are doing well or where it is being catered for?

Professor BROE: Yes, there are. We are now talking about residential aged care. I will try and concentrate and get my mind off home care and all the other parameters that this Committee is not primarily interested in—although I am sure you are. Yes, there are areas where it is done very well. There is a corporation that I visited many times in Queensland, Jimbelunga, run by a member of our National Advisory Group for Aboriginal and Torres Strait Islander Aged Care [NAGATSIAC] group. There is an aged-care service in Kempsey run by Gary, who is a member of the group. They are urban services. The first one is in Brisbane. The second one is in Kempsey. The third one is perhaps the service that is classic in the centre of the Anangu Pitjantjatjara Yankunytjatjara [APY] lands: a beautiful residential-care facility that was purpose-built for the area by a now deceased architect. So there are examples of really good Aboriginal aged care. They are run by Aboriginals. They are not necessarily only for Aboriginals. The Kempsey group has about 50/50. The non-Indigenous people in them are extremely happy with the level of care. They are mostly staffed by Aboriginal people, which is really important.

The principles I would like to bring out—this is where I feel a bit of difficulty because I have not been able to talk about the general run of residential care and of aged care and the deficit in that because it is all impinged on Aboriginal people. From our studies about 55 or 60 per cent of Aboriginal people use and prefer Aboriginal medical services to provide their health care. That is aged health care and all health care. What we are proposing—the second point that I would like to make is the vast majority of Aboriginal people now live in urban or major regional centres and towns. That is, over 80 per cent of Aboriginal people are urbanised, as all Australians

are being urbanised. A tiny minority live now—14 per cent live in the Northern Territory, for example. It is even smaller in the Kimberley. But they are still a very important home base for many of our people. I have looked after personally in terms of health care the La Perouse community, which is spread out across Randwick and Botany. Their health status, lifespan and needs are virtually the same as the population I have done consultations on in the APY lands in central Australia and northern and South Australia.

Not only that but the numbers are the same. There are 2,500 people in Randwick-Botany municipalities. There are 2,700 in the whole APY lands. And the ageing population is the same. So what we are dealing with is not going to be solved by looking after people in the centre, but it is going to be solved by providing care which caters for their needs in terms of cultural relationships, sensitivity, having been traumatised, having been put down and having been subjects of racism for their whole lives. You may say that is not happening anymore. It certainly is. It is a sort of silent epidemic. It is getting better but it is still there. Now how does that impinge on aged care? You put a non-Indigenous person—no matter whether they have two months or a month or even perhaps a year of training in cultural sensitivity and cultural awareness—in with a group of older Aboriginal people and they freeze. They cannot talk to them. Put them in as an assessor of the service. They cannot talk to them. Put them in as a manager of the service. They have the same problems.

I am going to say, first up, that I totally support the provision of registered nurses in residential aged care in all three shifts at all times. But that has to be in some way modified in terms of prioritising Aboriginal care by using Aboriginal health workers who have less than RN training. So we have to have an escape clause if we are going to bring in this law, which I certainly support. I have looked at other submissions which say it is far too expensive to do this in the country, in rural settings or for Aboriginal people. That is a load of rubbish because we have just got to find the funds. You cannot say we cannot do it because it is too expensive. What you have got to do is find the funds to do it. I have read, for instance, the Uniting Church's submissions and the Aged and Community Services Australia's submissions. I just do not think that wears well. What you must be able to do is allow Aboriginal controlled community health organisations to provide the care.

I have got one more point to make. I think we could have a model of aged care from Aboriginal health. We have 128 Aboriginal medical services or ACCHOs—Aboriginal community controlled health organisations. The number might not be accurate. I read a recent report that there are 148, so the numbers are increasing. Not all of those should have an aged-care set-up. Not all of them are able to do it, but those that are in large, dense populations of Aboriginal people such as Campbelltown, Randwick Botany, Redfern, Kempsey, Coffs Harbour, Nambucca, Lismore, Dubbo, Broken Hill, Brewarrina and Walgett should be able to provide or have aged-care facilities such as residential care. There is a major legal problem here and that is the only service in many of those regions qualified to assess Aboriginal people is the service that would provide their care. There is a problem there in so-called equity. That has to be balanced out. One has to prioritise whether equity is important or it is important that there is a safeguard put in place that there is not favouritism. That can be done.

I guess what I am suggesting for Aboriginal aged care is we need residential aged-care facilities in high density populations allied with ACCHOs, that is, Randwick, La Perouse, Botany—I have been through them—south Sydney, Campbelltown, western Sydney, and then Newcastle, Taree, Kempsey, Coffs Harbour, Lismore and so on. We need carer support by Indigenous workers who are able to be sensitive to the needs of frail, older Aboriginal people who are scared stiff often of being taken away. Forty-five per cent of them have had their relatives taken away or they have been removed themselves. They are terrified of being invaded and their sensitivities neglected. We need supervision—

Ms CATE FAEHRMANN: This is about the workforce, Professor Broe. Thank you so much for the incredible work you have done over so many years and for agreeing to appear before this inquiry.

Professor BROE: Sure.

Ms CATE FAEHRMANN: It is extremely important that we do make recommendations in this regard. We have heard from many witnesses—pretty much every one I think—how hard it is to attract people for the general aged-care workforce. Obviously wages is a big issue there. You talk about—and you have just mentioned it then—the workforce. Have you given much thought to what is required to attract young First Nations people into training for these types of residential facilities and then how different—because you did say there needs to some kind of an exemption or out clause in terms of 24/7 RNs. But has there been much thought given or research or work into what the future workforce needs to be, what the qualifications need to be as well, for First Nations staff? Because obviously there are lots of cultural qualifications there.

Professor BROE: It is a difficult area because of the attitudes of non-Indigenous people largely. One of my first year students did a survey of 120, 70 Aboriginal people and about 40 or 50 non-Indigenous people, in terms of their expectations between about 14 and 24 years of age. What she found was that the Aboriginal young

people did not know the difference between a university and a college and a TAFE. They had a very impoverished general knowledge of what goes on. This is young people, 14 to 24, who have been though high school. It was extraordinary findings, but it was quite clear. So what we need to do is to make people work ready and it is going to be quite a long process. In the interim, you are going to have to use TAFE and college short-term training programs for Aboriginal health workers.

Now we have had Aboriginal health workers within 128 Aboriginal medical services [AMSs] for the last 10, 20, 30 years. They are very efficient and good people. They do not even have a cert III often—many of them do have a cert III these days, but they certainly are not either AINs or RNs or ENs. So we have got a lot of preparation to do. It is not perhaps the time to say it, but we have got to start early. Kids do not get a job if they are not job prepared. I have just explained how young Aboriginal people are not job prepared. They do not know where to go to get training and they need to be guided. Kids do not get schooling unless they are school prepared. Now how do you school prepare a kid? You reinforce it is preschool education. Preschool education is useless to a child that is not being brought up properly. How do you bring them up properly? You have to look after them in pregnancy and you have to look after the mothers and you must not take the mothers away, so that they learn to do things.

I am not answering your question specifically, but we have just got to explore all of these avenues. But the most important thing to do is to get RNs eventually into ACCHOs into Aboriginal medical services. Now Aboriginal medical services are well set up for social and emotional—which we call mental health—for diabetes, for heart disease and lung disease and cancer, the general practice settings as they should be. They are not set up for aged care and we have got to fund them to do it. That is where you will get your staff who will then go on to get training. In the interim, you could use people in each centre. In the hospital you would have an Aboriginal hospital liaison officer, almost universally I think these days, across Australia. That would be a facility that could provide education.

Ms CATE FAEHRMANN: Speaking of training, do you happen to know—and perhaps this is something you could take on notice if you do not, Professor Broe—the extent of scholarships within colleges and TAFEs for nursing for Aboriginal and Torres Strait Islander applicants?

Professor BROE: I cannot—

Ms CATE FAEHRMANN: I assume that there are some, but it might sound like there are not enough and possibly that could be a recommendation.

Professor BROE: Many of the older Aboriginals in our surveys—we do population-based surveys. We survey whole populations. We have surveyed 60 per cent of Aboriginal people 60 years and over living in six Aboriginal communities across New South Wales. So we have got really good data on the question you are asking. A large number of those people have got TAFE education and training. We have changed the whole system. We have, in a way, not abolished the TAFEs but we have decimated them.

Ms CATE FAEHRMANN: Of course, yes, we have.

Professor BROE: That was their major training area. So we are going to have to be pretty creative in terms of finding ways to train them. I think the way to do it is through the Aboriginal medical services, to provide an educational support base to those services.

The Hon. GREG DONNELLY: I have just got a general question, Professor. Thank you so much for coming along today. I am interested in your opinion and thinking around what does ageing mean for Indigenous Australians—so the process of ageing in the context of Aboriginal culture as opposed to, let us say, the Anglo culture and what we are used to. Can you just give us a bit of an overview of what it means?

Professor BROE: Yes, it is a good question because it is quite different, and it brings me to the fact that I have not been able to expound on non-Indigenous ageing. We have a culture in which we are trying to bring about person-centred care so that the individual makes the decisions and individualised care so that the individual gets the benefit. What we lack is systems that provide for a group of people—in other words, an epidemiological or population base. So the difference, and of course we are generalising—

The Hon. GREG DONNELLY: Yes, of course.

Professor BROE: But the difference between Aboriginal communities—and they are very strong communities throughout Australia that support these Aboriginal medical services. They remain strong and they are culturally quite turned on. Where they differ is in one respect for Elders. It is an absolute tradition that an Elder is the wisdom of the group. Now that does not extend to people with dementia. They are perfectly sophisticated about people with dementia; they lose their credibility as Elders. But elders in general are respected. Second,

community is respected—the community attitudes and the community support systems. You probably all know that you are brought up by a mother and a father in an Aboriginal community, but you can be equally brought up by an uncle or an aunt because they are all regarded as mothers and fathers.

The Aboriginal kinship system—I must remind you, I think I have got it in my CV that I handed out, but I did anthropology and geography before I did medicine. So I really had a background from Professor Elkin in this amazing Indigenous kinship system, which provided every aspect of life with a meaning and a purpose and so on. Kinships are still terribly important. What we do is ask isolated Aboriginal Elders through a My Aged Care —MAC—system that is centralised in Canberra, where you get to it by phone or email, to provide information and do not allow them to bring their loved ones along with them, and that is their purpose in life—community. So what we are proposing is family-centred care rather than person-centred care. Now I think that is what we need for non-Indigenous old people. Can I give you one reason for that that is more non-Indigenous—well, it reflects both cultures?

In terms of systems, there are two types or groups of old people. There are young-old and old-old. The young-old are 60 to 79. They are active, mobile, cognitively intact in 90 per cent—and I have done all the studies on these. I can tell you the exact numbers. They are cognitively relatively intact—in fact, very intact. They are out there doing stuff, they are busy and they are telling you what you should be doing for old people. But the old people who need the care are the 80s to 100s. And the average age of old people in residential aged-care facilities is over 85. At 85, you have a percentage of dependency—of disability—of about 30 per cent. You have got a cognitive impairment rate of somewhere between 60 and 70 per cent. That does not mean dementia. It takes years to get to dementia. If you have ever been in a queue with a couple of old people who are spot on in front of you, they take 30 minutes to get their bus tickets ready while you are standing there impatiently waiting for them. There is a long time of reduced awareness.

The third thing that now applies to Aboriginal people is that they never have a mobile phone that works. Let me take that back. Mobile phones usually work, but you cannot rely on it. Because their kids borrow them, their friends steal them, they always use paid cards, they run out, their phones fall in the toilet or whatever. The same as all of us, but they just cannot replace them. They do not know how to use IT. They have not been brought up with IT like the rest of us have. So we are throwing them on the mercies of this insane system that supposedly assesses them and tells them what they need but then does not provide a service. As you know, for a year 100,000 people assessed as needing major services have not got them.

The CHAIR: Professor Broe, I am so sorry. We have actually run over time because we have wanted to listen. We have all been so entranced by what you have got to say. Can I just thank you very much for the important work and for a very different perspective that you have brought to us but a very important one. It is certainly going to be part of our final inquiry report, so we thank you very much for that and for the important work that you do, particularly with the Aboriginal community. With that, I will draw the hearing to a close.

(The witness withdrew.)

The Committee adjourned at 16:32.