COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Aged Care

THURSDAY, 19 AUGUST 2004

SYDNEY

BY AUTHORITY OF THE SENATE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 19 August 2004

Members: Senator McLucas *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Humphries, Hutchins, Lees and Moore

Substitute members: Senator Allison to replace Senator Lees, and Senator Forshaw to replace Senator Moore, for the committee's inquiry into aged care

Participating members: Senators Abetz, Allison, Barnett, Bishop, Carr, Chapman, Colbeck, Coonan, Crossin, Denman, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Harradine, Harris, Lightfoot, Ludwig, Mackay, Mason, McGauran, Murphy, Nettle, O'Brien, Payne, Tierney, Watson and Webber

Senators in attendance: Senators Allison, Forshaw, Humphries, Hutchins, McLucas and Moore

Terms of reference for the inquiry:

To inquire into and report on:

the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training;

the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

(i) assessing and monitoring care, health and safety,

(ii) identifying best practice and providing information, education and training to aged care facilities, and

(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff;

the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements;

the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly; and

the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

WITNESSES

Committee met at 9.05 a.m.

CHAN, Mr Jeffrey, Director, Community Integration Program, Royal Rehabilitation Centre Sydney

KAPP, Ms Robyn Ellen, Treasurer, Australian Huntington’s Disease Association; and Executive Officer, Australian Huntington’s Disease Association of New South Wales

NORTHCOTE, Mr William Edward, Chief Executive Officer, Multiple Sclerosis Society of New South Wales

VERSTEEGE, Mr Paul, Policy Coordinator, Spinal Cord Injuries Australia

CHAIR—Welcome to the Senate Community Affairs References Committee inquiry into aged care. This is our first hearing in Sydney. The committee prefers all evidence to be heard in public, but evidence may also be taken in camera if your evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submissions, for which I thank you. I now invite each organisation to make an opening statement, which will be followed by questions from the committee.

Mr Northcote—Thank you for the opportunity to address you on this very important issue. Although I realise that the committee is examining a broad topic, I would like by way of introduction to say a few words about multiple sclerosis. Multiple sclerosis is a lifelong progression of complex symptoms, which often initially affect people in the prime of their life when families and careers are developing. It is usually diagnosed between the ages of 20 and 40, and it is three times as common in women as in men.

It is vital for people with MS, particularly if they are faced with increasing disability, that they can access coordinated care from all the professions within a multidiscplinary health team which is skilled and expert in multiple sclerosis. At diagnosis, the best of clinical science and health technology is often available. However, following diagnosis, many people with MS can lose contact with health and social services for years. That is primarily because people go into trauma and denial. Increasing disability, compounded by a lack of expertise in MS among health professionals, can mean that basic health problems, such as depression, cognitive impairments, continence issues and sexual health, go unrecognised.

Nowhere is this more evident than among people with MS, particularly younger people with MS who are forced to live in aged care nursing homes. As we have stated in our written submission, there are currently 235 people with MS housed in aged care nursing homes in New South Wales. Of these, 100 are under the age of 60. In addition, there are approximately 300 people in New South Wales who MS Society outreach workers have identified as being at immediate risk of having to be inappropriately admitted to aged care nursing homes if there is even a slight change in their current support systems.

Young people with multiple sclerosis who live in aged care nursing homes are forced to do so because they cannot live alone and family and friends can no longer cope. This is because they are almost always physically disabled. Many cannot transfer from their wheelchair and consequently become too heavy for the average person to lift. Often the person who used to look after them can no longer cope, physically or mentally. Parents are sometimes getting old. The person with MS needs assistance with all aspects of personal care—including showering, dressing and meals.

Despite these difficulties, people with multiple sclerosis have many of the same hopes, aspirations, needs and desires that you and I have. Many of them are young people who society has seemingly abandoned. We have consigned them to a life of unnecessary distress and often a feeling of despair. I should point out that in no way am I denigrating aged care nursing homes or the nursing home industry. In the main, they do a fantastic job looking after the aged, not younger people.

The long-term care that people with MS require falls into two distinct categories. The first is medical care and the second is social/psychological care. Seventy-five per cent of people with MS experience some type of bladder dysfunction during the course of the disease. The treatment and management of a neurogenic MS bladder is complex and very difficult compared with any other type of bladder dysfunction. Accurate assessment and management can mean the difference between life and death in many situations. Nurses who work in aged care facilities do not have this expertise or the specialist knowledge or training to deal with this.

Sixty-eight per cent of people with multiple sclerosis experience bowel dysfunction which can have devastating physical, psychological and social effects if not treated correctly. Bowel obstruction leading to death can occur in some people if not identified in the early stages. Strategies to manage bowel dysfunction in MS require knowledge and specific training, a skill which most nurses in frail aged care do not have.

These are just two issues that require specific treatment in people with MS. Others in the same category include spasticity, transient blindness and difficulty in swallowing, which can lead to aspirate pneumonia which can be fatal. There are also complex psychological issues associated with multiple sclerosis which are of particular concern to the MS specialist. Depression among people with MS is 10 times the national average, and the suicide rate is 7½ times the national average. Issues such as sexuality and family are also critical, particularly to young people. The private and intimate nature of issues surrounding sexuality make them difficult for both people with MS and health professionals to discuss. Experience has shown us that if concerns about a person’s sexuality go unattended following the initial diagnosis it becomes more likely that they will never be addressed as the disease progresses.

In order to achieve a full understanding of the burden of illness and implement appropriate interventions, it is important for the MS nurse specialists to be able to predict and therefore be able to implement preventative strategies to lessen the impact of MS on the person’s family. I should reiterate here that the aged care facilities do a magnificent job for the aged. They are just not equipped to deal with people with MS, who have specific and complex needs. Those deficiencies are made all the more acute when, for example, the person with MS is 30 years old, likes rock and roll music and is living cheek by jowl with a 90-year-old dementia patient who is totally unaware of his or her surroundings.

There is one other point I would like to make at this time. I would like to relate a true story told to me by a young man with MS who lives in a Sydney nursing home. He lives there because his family can no longer cope with his needs. He told me not very long ago that the thing he misses most is his mates. They used to take him to the football occasionally but now they never come to visit him in the old people's home. Quite honestly, when you think about it you cannot blame them. I would be happy to take any questions at this time.

Ms Kapp—I wish to address item (c) under the terms of reference, the appropriateness of young people with disabilities being accommodated in residential aged care facilities, as this applies to people with Huntington's disease. Huntington's disease, or HD, is an inherited degenerative brain disorder which affects individuals of either sex. Symptoms usually begin to appear between 35 and 45 years of age, often after the gene has been passed on to a new generation. After 10 to 15 years from the onset of symptoms, most people with Huntington's disease will require nursing home standard long-term care.

However, some people require care earlier than this. They include people with a lack of family support due to breakdowns in family relationships; people with younger age of onset, in their teens to 20s, who therefore have faster progression resulting in an earlier need for nursing home standard accommodation; and people with 'at risk' behaviours and cognitive dysfunction.

Today there are essentially two options for people with Huntington's disease who are seeking places in long-term residential care: there are Commonwealth funded hostels, which are most suited for people who are still mobile but may require assistance with activities of daily living; and there are nursing homes, which are also funded by the Commonwealth government and provide 24-hour nursing care for residents. Therefore, the only option for many young people with advanced Huntington's disease is placement in nursing home facilities for the frail aged. Even then they are faced with extreme difficulties because aged care assessment teams refuse to assess them, primarily because they are under the age of 65 and are therefore the responsibility of the state government under the Commonwealth State and Territory Disability Agreement.

If they are fortunate enough to be assessed, nursing homes often refuse to take them because of their age, the complexity of their support needs and the challenging behaviour associated with the progression of the disease. This means that young people with Huntington's, whose average age is approximately 50 and assuming they can secure an ACAT assessment and a place in a nursing home facility to begin with, end up living with people whose average age is 80. In fact, 70 per cent of people with Huntington's disease who are in nursing home care are under the age of 65. For these young people with Huntington's it means missing out on a range of specialist medical and health services as well as activities designed to enhance their quality of life, such as diversional therapy, outings and social interaction with their peers.

Specialist units, such as Huntington Lodge at Lottie Stewart Hospital at Dundas in New South Wales, that accommodate young people with Huntington's, are few and far between. I know, from both personal and professional experience, that young people with Huntington's living in nursing homes certainly do not experience the same rights and standards as young people with Huntington's living at Huntington Lodge. For example, at Lottie Stewart Hospital there are staff experienced in Huntington's, including nursing staff, a physiotherapist, an occupational therapist, a dietician and a speech pathologist. There is also regular input from a neurologist and a psychiatrist.

The Huntington's Disease Association of New South Wales and the Huntington's disease associations in the five other states of Australia strongly believe that the current aged care facilities are inappropriate for young people with advanced HD who are no longer able to live independently. To raise the standard of care and the quality of life of people affected by Huntington's, we would implore that the Commonwealth, state and territory governments take a collaborative and proactive approach to decision making on this issue. As we see it, the only appropriate course of action in the short term would be for all governments to consider developing more specialised nursing home care, such as designated cluster units for people with Huntington's disease, based on the models currently operating in Victoria, New South Wales and WA, and issuing a joint directive to ACAT teams that people with Huntington's disease under the age of 65 must be assessed for nursing home and hospital placement.

Mr Chan—On behalf of all rehabilitation centres, I thank the chair and the Senate committee inquiry for the opportunity to address the committee on our growing concern for young people with disabilities who require continuing care and support from their carers and support service providers. The question or concern before us is: how much longer do young people with disabilities and their carers have to wait for federal and state level coordination of, and support for, services that are required now?

There are two troubling factors in this whole debate about young people in nursing homes. One of the troubling aspects of this issue is not the lack of service providers in the community willing to support young people with disabilities to lead productive lives or the lack of capacity in terms of expertise, flexible models of support and community readiness to address the problem. Across Australia today, there are support service providers that are creative and responsive to the needs of young people with disabilities. These young people do not have to live in inappropriate accommodation, such as aged care nursing homes. So if there is the community capacity to address the issue, what are the barriers that are preventing a seamless delivery of services to young persons and their carers? Some of these barriers are discussed in our submission to the committee.

The second troubling aspect of this issue is that young people with disabilities, their carers and support service providers are not demanding ideal star treatment—a Christopher Reeve type model—at least not from our experience in the industry and from working with families and young people with disabilities that we know. Support service providers are well aware of the fact that we need to work smarter and leaner. We need to work and support people and their carers out of an ever-diminishing funding bucket that is inconsistent with the growing unmet needs—even for basic adequate services—and in an environment of political imperatives and priorities.

If young people in nursing homes and their carers are not demanding the star treatment model, then what are the barriers to achieving the goal of young people living in the community with appropriate support? These barriers are outlined broadly in our submission. The first group of barriers can be clustered around the theme of coordination of whole-of-government service delivery at federal and state levels. While there have been attempts within certain states to coordinate human services departments, there is minimal evidence of that being translated at a local level and at the level of service delivery. What is baffling is that there have been numerous reports and research both here and internationally on the necessity of the coordination of services for people with disabilities and for those most disadvantaged in our society. Yet these persons, their carers and support providers have to battle with a lack of clarity from government human services departments, priority differences within the same department depending on which region one resides in, the time lag between funding agreement and release of funding—the list of issues goes on and on in regard to the need for the coordination of services.

The lack of coordination of services is most evident in the continuum of service delivery. In our submission, we alluded to the ripple effect—that lack of coordination often leads to bed blockages from the acute care end of the hospital, to rehabilitation and to discharge into the community. What baffles service providers like ourselves is that we are trying hard to assist government departments, for example, to free up blocked acute care hospital beds so that people with medical and health care needs can access the beds and services. We are trying to discharge clients who are ready to move on with their lives after rehabilitation so that others who need rehabilitation can quickly get the service. Yet it is often difficult to get cooperation from the various government departments whom we are trying to assist.

There is ample research on the detrimental effect of the recovery process of young people with injury or illness who continue to remain in inappropriate accommodation, such as extended stays in hospitals or rehabilitation centres or, worse, in aged care nursing homes, because there is no other appropriate accommodation available. Hence, we now have this crisis where young people are in nursing homes. This current state of affairs cannot continue because the drain on government resources would be cumulative in the future and its impact worse, particularly for young people in nursing homes. The longer we wait to get young people out of inappropriate accommodation, the more costly it will be for governments and society—for example, bed blockages in hospitals, rehabilitation centres and aged care nursing homes. It will be worse for these young people and their carers because it can lead to family breakdowns where respite care becomes permanent placement et cetera.

Earlier we alluded to the fact that young people in nursing homes are not demanding the star treatment model. Funding is not about how much it costs at the end of the day, but how much and how far the funding dollar will buy each individual and what it buys for their support requirements. For service providers, it is difficult to determine immediate outcomes of cost benefits required of funding agreements when, in the majority of cases, the positive outcomes are seen in the medium to long term. In our submission, we have illustrated the case of a 55-year-old woman with acquired brain injury who lived for 33 years in an institution. Ten years ago we transitioned her into the community. In April this year she graduated with a bachelor of education. We can illustrate many such examples. Therefore, the money barrier is not just the level of funding but the models of the funding agreements, how it is being distributed and how the funding models can facilitate the work of support providers to deliver an individualised and high-quality service rather than a blanket approach of one model fits all or, worse, dishing out funding in a reactive manner when services and families break down.

Urgent action is required to address the growing concern regarding young people in nursing homes. We do not intend to propose a ‘how to do it’ model for the committee to consider. We are requesting that the Senate committee consider the following actions. Firstly, we request that the committee consider the creation of new services that are flexible, creative and based on the principle of community inclusion for young people in nursing homes and that these new services be appropriately supported so as to ensure young people are not simply redirected into nursing homes because of a complex health care issue. We recommend that the number of these services in each state be negotiated based on the current status of young people in nursing homes in each state and that the creation of these services be increased each financial year.

Secondly, we recommend the whole-of-government approach to service delivery at the local level. This is to ensure that certain services, such as nursing professionals or modified housing, are provided and adequately funded in order to support young people to live in the community. Thirdly, we recommend the expansion of current services and funding models, such as the innovative pool, to make them more available to agencies who wish to provide services to young people as their niche market program of services or to families who are continuing to support or care for young people in their own homes. Fourthly, there is a need for long-term planning and not a quick bandaid fix to the problem. The planning needs to be specific and targeted so that adequate resource allocation and policy formulation are meeting young people’s needs. Long-term planning for young people in nursing homes should be on the national agenda.

In conclusion, we want to emphasise that we need to get young people out of nursing homes now and that there are services such as ours and those around the table that are ready to facilitate transition into the community. We need federal and state level action to assist the process now.

Mr Versteege—SCI Australia’s submission responds in systemic terms to the issue of younger people in aged care facilities. The true story that I am about to tell illustrates all the points made in our submission. Ruth—which is not her real name; we have changed it—is an intelligent and sociable young woman in her early 30s. She has a degenerative muscular condition and central vision impairment. She lives in an aged care facility with people at least 40 years older than her, the majority of whom have significant cognitive impairment.

Five years ago Ruth started looking for a group home for people with physical disabilities. She was then still able to walk. She was living in an apartment without wheelchair access, but she knew that she would be in a wheelchair in a few years time. As expected, Ruth’s condition deteriorated. She then applied for additional hours of personal care. She applied to the state agency responsible for providing that care, but her application was refused because the apartment could not accommodate the lifting equipment needed for her care.

Ruth did not have sufficient equity to buy out her siblings who co-owned the apartment in which she lived and could not reconfigure the apartment to make it wheelchair accessible or to fit the equipment deemed necessary for her care. At this point, Ruth’s need for alternative accommodation became acute. There were no vacancies in the few group homes for people with physical disabilities—there are very few of those facilities around—and, because of her part ownership of the apartment, she was deemed not eligible for social housing provided by the state agency responsible for disability housing.

In late 2003, having no options, Ruth moved into a residential care facility in an area far removed from where she used to live. When Ruth’s condition deteriorated to the point where she needed a power wheelchair, the aged care facility was not resourced to supply that to her and she is now in a manual wheelchair. The state agencies responsible for providing equipment to people with disabilities do not provide equipment to people in aged care. It involves a different piece of legislation, so you do not get it. As I said, Ruth has a manual wheelchair, but she cannot move it herself. So she is stationary unless somebody is available to push her around.

Had Ruth been able to stay in her apartment or had she been able to move into social housing she would have been eligible for the state funded program that provides equipment, including power wheelchairs, to people with disabilities. As it is, apart from her interaction with hostel staff her social isolation is complete. In summary, in Ruth's case the triangle of care—personal care, accommodation, and equipment—has broken down entirely and there is no prospect of reconstituting it. She has to spend the rest of her life in a nursing home and she is 30.

Every year, there are 2,000 new stories like Ruth's. That is unacceptable. We need the government—you—to bring residential aged care for younger people with disabilities under the Commonwealth State and Territory Disability Agreement in order to stop further admissions and relocate younger people already in residential care. We also need you to ask the Australian Institute of Health and Welfare to expand its annual statistical survey to include detailed information about younger people in residential care. Why are they there? Where are they? How old are they? What is their disability? Why is it that the total number of younger people in nursing homes—that is, people under 65—remains stable at about 6,000, year after year, when there are 2,000 new admissions each year? The problem might be far bigger. We would also like you to commission an independent body to develop and implement a plan to relocate younger people with disabilities from residential aged care to appropriate accommodation.

CHAIR—Thank you, Mr Versteege. On each of your submissions I have written 'coordinate care'. It seems to be a very common theme in each submission. Mr Versteege, you said there are 6,000 young people in aged care facilities and 2,000 being admitted each year.

Mr Versteege—That is right.

CHAIR—That does not seem to add up.

Mr Versteege—No, it does not. We do not really understand why this is so, but the fact that, as Mr Chan just told us, a consumer he knows spent over 30 years in a nursing home means that it is very likely that people simply turn 65 and drop off the list. That means that it might still be inappropriate for a person with a disability who is older than 65 to be in a nursing home. That is what I meant when I said the problem might be much bigger than we think it is.

CHAIR—You referred to a survey that you suggested needed to ask a specific question. What was that survey?

Mr Versteege—Each year, the Australian Institute of Health and Welfare carries out a statistical survey of all aged care facilities in Australia on a snapshot day. It includes some information about people under 65, but that is not as detailed as the other information. In our view, it could easily be expanded.

CHAIR—Thank you, that is a very clear recommendation.

Senator FORSHAW—I thank each of you for your submissions and remarks this morning. I am sure all of us on the committee are quite impressed with the work that you have put into the submissions and also the work that you are doing in this area. I have a number of questions but there is one thing I am trying to ascertain. We accept that there are quite a lot of young people with disabilities—Huntington's disease, multiple sclerosis and a range of other illnesses—who are in nursing homes inappropriately. Could most of those people be more appropriately accommodated in another form of long-term accommodation? A nursing home is ultimately a place where people go and stay. Alternatively, are we talking about a problem whereby we need to find accommodation solutions that enable many of those people to move back into some community environment, such as home or some other form of non-permanent accommodation? As I understand it, many of these people are in nursing homes because they are unable to stay at home, for instance, due to the nature of their disability. Can you comment on that?

Ms Kapp—It comes back to the actual disability. My expertise is Huntington's disease. Because of the progressive nature of Huntington's disease there are going to be people under the age of 65 who require a nursing home standard of care. But they need those extra bits, such as being perhaps in a cluster or group. Similar to the way you might have a dementia specific unit in a nursing home, you might have a Huntington's specific unit which young people would be in together. They would not be sharing rooms. They would get extra things, such as being taken out, as well as the extra food they need, the extra time they need for feeding and all those sorts of things.

Senator FORSHAW—You mentioned the Lottie Stewart facility in your submission, which I gather is the sort of thing you are talking about and which you say should be more widespread. But I noticed you also said that in the instance of your mother—

Ms Kapp—My sister.

Senator FORSHAW—Your sister; I am sorry. When she reached the age of 50—

Ms Kapp—She had to move out.

Senator FORSHAW—she had to move out. What is the position?

Ms Kapp—That is right. The unit at Lottie Stewart Hospital—the Huntington's unit—is not a closed unit. So what happens is because you have people younger than 50 starting to need that care in their 40s, when she was aged 50 we were asked to move her into a nursing home for the frail aged. She was there for another five or six years. You have the opposite in Victoria, where Arthur Preston Residential Services, which is a specific unit for Huntington's disease, has 30 beds. My understanding is that it is a closed unit, so you can stay there for as long as you like—until you die, if necessary. But that means that there are no spaces becoming available for younger people.

Senator FORSHAW—Just to follow that through, is the ultimate model another type of long-term facility; a rest-of-life facility for people with Huntington's disease? Or would they eventually move into a nursing home facility once they—

Ms Kapp—Perhaps once they are older—once they are 65—if they are still alive they can go into a generic nursing home. But the younger ones definitely need more than an ordinary aged care facility.

Senator FORSHAW—I suppose that, when I first started to read the submissions and think about this in terms of this inquiry, when I read the word 'young' I tended to think initially of very young people—teenage victims of car accidents and brain damage and so on. But we are actually talking about quite a range of age groups. Mr Northcote, you state in your submission from the MS Society that you are looking at various models to determine appropriate housing for people with MS.

Mr Northcote—Yes.

Senator FORSHAW—In your submission you say that you ‘are examining all options and excluding none’. Can you tell us a bit more about what the options are. It appears—I think Ms Kapp and others have said it—that a short-term approach may well be to look at specific clusters or facilities within existing nursing homes but that in the longer term we have to look at some other things. Can you comment on that.

Mr Northcote—I have been in this job for 4½ years. My first experience of this issue was a visit to a facility in Western Australia which the Multiple Sclerosis Society in Western Australia has established, called Fern River. It is a fantastic example of the ability of people to be moved out of aged care and into a community setting.

A couple of things really appealed to me. One was their use of technology. They had brought state-of-the-art technology to bear, so that even a person who was very disabled was able to do the usual things that we take for granted—for example, answer the telephone, secure the premises, lock the doors and turn lights on. The other thing that impressed me was that they had actually encouraged family members either to be reunited with the person staying there or at least to stay there for night stays. They actually accommodated them in that facility. One lady who was very disabled said to me—and this brought tears to my eyes—‘Bill, I’m so happy; I’m now living again with my husband and I’m caring for him.’ What she meant was that she was assigned a carer for a couple of hours a day who actually took her shopping. She went and did the shopping. She bought a piece of steak for her husband, who was gainfully employed, and when she came home she supervised—she could not cook it herself—the cooking of the evening meal for her husband. I think that demonstrates that it is possible, given the right support, for a person who is even very disabled to be brought out of aged care.

We are looking at those sorts of options in Sydney at the moment. We have a 15-bed accommodation unit at Lidcombe. We are looking at options now to move those sorts of people—people who are fairly disabled; some of them have been there for 20 years—out into a much more appropriate community setting. We are doing that with the state government at the moment. That is on the drawing board. There has been no commitment on either side.

Senator FORSHAW—So you are looking at options to take to state government?

Mr Northcote—Yes.

Senator FORSHAW—Also, you have to look at how you actually do that.

Mr Northcote—That is right. A key element of that is use of technology and the ability to reunite people with their families.

Senator FORSHAW—On the next page of your submission, Mr Northcote, you talk about funding. You note that the federal government subsidy is $70,000 per bed per annum. You then say that if that were transferred to beds in an MS Society facility the amount needed to meet the recurrent costs would be reduced to $20,000 per person per annum. I understand what you are getting at, but could you expand on what you are actually saying in terms of what should happen with funding that is currently going to nursing homes.

Mr Northcote—I will need to take that question on notice.

Senator HUMPHRIES—This has been a very interesting session, particularly having regard to the comments that have been made about individual cases. It has illustrated for me what appears to be a significant problem with the responsibility for provision of accommodation for people with disabilities who are not elderly being essentially a state government responsibility. The fact of the existence of nursing home facilities throughout the community seems to have meant that many states have simply not shouldered that responsibility, knowing that people with disabilities will have to some extent accommodation available for them in nursing homes. You would be aware that there have been substantial increases in funding for aged services in the last few years. Have there been any significant increases in funding for disability services in states in recent years, at least in New South Wales, to your knowledge?

Mr Northcote—Certainly not in New South Wales. In fact, you have to question the way that even the indexations are calculated by the state governments, particularly in New South Wales. When we have substantial increases in the salaries of health professionals—for example, nurses have had increases of 10 to 15 per cent—our indexation rates go up by two or three per cent. I think every service provider would be feeling that squeeze. We certainly are feeling it in the MS Society, to the extent that we are going to have to withdraw services which are non-government funded, because the fundraising side of the business is getting harder and harder as well.

Senator HUMPHRIES—We know that there is a specialist facility for sufferers of Huntington’s disease in New South Wales. There is nothing for MS sufferers, I assume, apart from the ones you provide.

Mr Northcote—Apart from the ones that we provide, I do not believe so.

Senator HUMPHRIES—Do we know of any other conditions for which there are specialist facilities for non-aged sufferers in New South Wales?

Mr Chan—There is the spastic centre for people with cerebral palsy. There are specific services. The Royal Rehabilitation Centre Sydney is one of the very few organisations that provide services to a whole range of disability types from developmental disability, acquired disability to a neurological condition like MS.

I want to emphasise the point that, while funding may be an issue, how funding is distributed and the flexibility of funding that is distributed, there are also issues about housing. Spinal Cord Injuries Australia has similar concerns to ours. To illustrate, Royal Rehabilitation Centre Sydney will be moving three young people out of its nursing home. The only reason that the state government has urged the centre to move these three young people out of the nursing home—this has been under negotiation for two years—is that they were costing the state government a lot more money. When there is a vacancy, moving young people out of a nursing home becomes an issue. One of them did not have to be in a nursing home; he was there simply because he had some nursing care requirements. The Department of Ageing, Disability and Home Care does not provide or fund, for example, nursing professionals. So there is this tension between the New South Wales health department and the Department of Ageing, Disability and Home Care about whose responsibility it is. It is like a football game that we play. The only time they take it on as a responsibility is when it is costing the department more to put a person in a specialist nursing home.

Senator HUMPHRIES—You make that point about the Department of Ageing, Disability and Home Care in your submission. You suggest that some disability groups would not be eligible for services and funding by the department and that these population groups belong to New South Wales Health. How does that come about? Why would a person be classified as being a general responsibility of Health as opposed to a specific responsibility of that department?

Mr Chan—There is currently a debate within the department itself about which service providers such as us are not clear. As recently as two weeks ago, I asked the department what the eligibility criteria are to be accepted into the department and to get funding. The department have not been able to come up with selection criteria of who their clients are. For example, in the past we have been funded to provide for people with acquired brain injury, organic brain injury and hypoxia, and now we have been told, ‘We don’t fund these people anymore.’

CHAIR—Is that the department of health?

Mr Chan—The Department of Ageing, Disability and Home Care. Several years ago we struck an agreement with them and we have transitioned young people with, say, acquired brain injury, hypoxia and organic brain damage. Now the department is saying, ‘That is not our responsibility; that is a health department issue.’ Similarly, in the New South Wales Department of Health we have the same thing. We have been very successful in transitioning young people with disabilities, based on the principles of community inclusion. So we do not create our own services, such as a community access art class computer, for support; we actually take people out into the community—for example, to an Internet café, if they want to learn about the Internet and computer use.

As I say, our problem has been alluded to in our report: even within the Department of Health there are different priorities. For example, the central Sydney area house service and North Shore hospitals will provide us with community nursing for our clients, but if you go to south-west Sydney they say, ‘No, we don’t provide community nursing for wound care and blood pressure monitoring; it has to go back to your own service.’ Even within departments their priorities are different. So if you are a service like us—we are metropolitan-wide; we have 26 sites—we have to battle with four different regions in the Department of Ageing, Disability and Home Care and six different regions in the health department.

Senator HUMPHRIES—This is in Sydney?

Mr Chan—Yes. As I said, there is no clarity within government departments as to what their priority is. Another example would be housing—and this concerns spinal cord injuries in

Australia—where a nurse would share. So, for example, if we had someone who was, after rehabilitation, ready to move out into the community, the Department of Housing might come on board and say, ‘Yes, there’s housing,’ but the Department of Ageing, Disability and Home Care would have a waiting list of six months to one year for an attendant care package.

Senator HUTCHINS—That is the state government?

Mr Chan—Yes. And we can hold onto someone in a rehab centre for one year. We have had people waiting for as long as 18 months in our rehab centre just to get the right service.

Senator HUMPHRIES—Mr Versteege, I think you said that there are some disabled people who are entitled to certain equipment support from the state government who lose that entitlement if they move into a nursing home.

Mr Versteege—That is right, yes.

Senator HUMPHRIES—What sort of equipment would they be entitled to?

Mr Versteege—Basically the full range of equipment, from continence aids to power wheelchairs to lifting equipment. So it ranges from quite cheap stuff to quite expensive stuff, but it is all very essential. The problem is that in aged care facilities the resources and the equipment available are not as good as under this program.

Mr Chan—Can I just add that the equipment program is called the PADP, the personal assistance device program, which is funded by the Commonwealth.

Mr Versteege—No, the state.

Mr Chan—It is state funded. That is the issue that we also have. If a young person goes into a nursing home or into an extended care service, that person is not eligible for that kind of service. It can be as simple as an incontinence pad. Within the PADP, we have the problem that communication devices are not at all considered. So we have young people with severe communication impairment who need to communicate with an electronic device, and that is not funded by PADP. In our case, we have to seek funding from NRMA or other groups such as Rotary clubs just to purchase such devices.

Senator HUMPHRIES—I have a couple more questions. You have made a compelling case for there to be facilities outside nursing homes, particularly for younger disabled people, and particularly for services for people with particular kinds of conditions or diseases. You would appreciate that, in the case of conditions or diseases with smaller numbers of sufferers or in the case of jurisdictions with smaller population bases, the economies of scale necessary to provide individual services for sufferers of each of those diseases or illnesses are very much more difficult.

I assume that some sort of compromise is possible. Would it be possible to provide services for young disabled people within the campuses of nursing homes, for example, with facilities or accommodation for younger people—maybe for those suffering from a similar kind of condition or disease—that is separate but still within the umbrella of a nursing home or similar institution? Is there merit in that idea?

Mr Northcote—Philosophically you are taking people out of nursing homes and putting them into nursing homes. But having said that, yes, it is possible, provided there are specialist staff with the sort of expertise that I alluded to in my opening statement. I am not sure about Huntington’s, but certainly in multiple sclerosis there is evidence that the best outcomes come from multidisciplinary teams expert in MS—and I am sure that is probably true with most of the types of diseases we are talking about. To answer your question, yes, it would be possible.

In my own experience, when I first started this job I had that idea. I actually went out and spoke to nursing homes, and we were talking about establishing wings of nursing homes for people with MS. But it never really got off the ground, and I am not quite sure why.

Senator ALLISON—It has in Victoria—but only one.

Mr Northcote—It is a solution but I do not believe that philosophically it is the ideal solution.

Ms Kapp—I think from a Huntington’s point of view it can be a solution in the short term, because we have already tried to do that. There was a nursing home—the one where my sister was—where they were keen to have a cluster group. Unfortunately, they did not have the physical resources to make it a separate unit. The support they then got was from the outreach team at Lottie and Westmead Hospital; therefore, they got a lot of in-service and education, and not just generally to Huntington’s disease but over a wide range of allied health services. Also, because the person was known to the clinic and known to the outreach team, they got education in the needs of that particular individual. Unfortunately, it was only because there was a change in the director of nursing that that did not happen. There is another unit up in the Hunter, where they are building new hostel and nursing home accommodation, and they are very keen to take young people and to make it a cluster-type unit—not just for Huntington’s but also for similar neurological disorders. But they have been told that they are not going to get those licences for those beds, because they know they are going to give them to young people. So they are willing to do it, but they are being told they will not get the licence.

Mr Chan—In terms of economies of scale, from our experience, yes, that can be done. From our calculation, it becomes reasonable if there are eight to 12 young people in a cluster. But I think it has to be made known that it has to be consistent with the Commonwealth Disability Services Act and based on the principle of community inclusion, which means that you have your own frontage house and your own self-contained cluster or villa. You might be linked by a corridor in terms of economies of scale for support services staff. But philosophically, I think, to have a wing in a nursing home would be inconsistent with the Commonwealth Disability Services Act.

Senator HUMPHRIES—I have one last question. I did not quite understand the point you made, Mr Northcote, about MS diagnosis and sexuality. Could you explain that a little bit more?

Mr Northcote—The point I made was that as MS progresses, a person’s sexuality functions diminish—in both female and male—and that can lead to relationship breakdowns, which usually means that the person with MS is without their primary carer. In our experience, if those issues are not addressed very early in the disease then they are very likely never to be addressed—because of embarrassment, privacy and those sorts of things. People do not want to talk about that sort of issue, and if they do not do it early, they are probably never going to talk about it, which could lead to relationship breakdowns later on and, more likely than not, that could lead to admission into a nursing home—if you could get them into a nursing home. Our experience has been that you cannot get people into nursing homes. That is a real issue for us, because where do people go?

Senator HUTCHINS—Senator Humphries has covered some of the questions I wanted to raise. Mr Chan, in your submission you say you are not comfortable with the group home model. Would you expand on that for us, please?

Mr Chan—If any person like you or I does not want to live with four other people all the time—

Senator HUTCHINS—I preface the question with this: Ms Kapp talks about being comfortable with a cluster model. Perhaps Ms Kapp might like to comment as well.

Mr Chan—I agree if you have a cluster of housing where each has its own frontage and is self-contained so it does not become another mini institution or mini aged care facility. In the Royal Rehabilitation Centre we have been exploring various disability housing models. It is not simply a case of putting people out from an aged care facility into a group home and saying, ‘This is going to work.’ We talk about a whole-of-government approach where the housing department has to come to the party. We have developed dual occupancy models—two at the front and two at the back in a battle axe type formation; and a villa type complex with two-bedroom villas. Those are the different kinds of models. We are trying to move away from the typical group home model where you have to live with four or five others.

Senator HUTCHINS—In some areas that is seen to be a preferable lifestyle and it is supported.

Mr Chan—We do have a range of service models from a drop-in support model to the traditional group home model. What is important is that a range of options should be available to young people with disabilities.

Ms Kapp—The group home model is only really appropriate in the very early stages of Huntington’s disease, and that would be an alternative to the department of housing. Once Huntington’s disease progresses, the people are not independent to that level. They need what we call nursing home level or standard of care. That is not only the association’s point of view; that is also the belief of those who are involved in the care of people with Huntington’s disease—the health professionals, et cetera.

Senator HUTCHINS—In your submission, Ms Kapp, in appendix 1—I cannot recall what hat you were wearing in this one—

Ms Kapp—All three.

Senator HUTCHINS—you say that Huntington’s disease is not a mental illness within the meaning of the act. Do you think it should be?

Ms Kapp—Some cases should come under the mental illness act because some people do have a psychosis with Huntington’s disease. Again, that is one of the difficulties the medical profession has. If there is a problem, they have great difficulty getting the mental health teams involved.

Senator HUTCHINS—Is that common throughout English speaking countries—that it is not defined in the mental health act?

Ms Kapp—In Tasmania, Huntington’s disease comes under the department of mental health.

Senator HUTCHINS—You are not aware of any other English speaking countries? I know they do speak English in Tasmania—on and off! What about Canada, the United States, Britain and New Zealand?

Ms Kapp—I cannot answer that.

Senator HUTCHINS—Mr Chan, in point 6 of your submission the first paragraph says:

> Furthermore, people with disabilities are supported by disability workers who are not necessarily from a health-care trained background.

It goes on:

> As such, this notion contributes to the myth that young people with disabilities are better off in a nursing home facility where there is presumed better health care.

Can you expand on that for the committee? What do you mean? I think I know what you mean but this is an opportunity to be a bit clearer.

Mr Chan—Currently in New South Wales—as far as I know, not in WA or in Victoria—you are not required to have a formal qualification to be a support worker and often support workers are not health care trained. At best they are AIN—assistant in nursing—trained. As a result there is a myth that, because people with disabilities who have complex health care needs cannot be supported by non health care trained staff, they are best supported in a nursing home. So they are normally referred to a nursing home.

A good example is that we are currently moving three young people out of a nursing home. One of those young people only required a gastrostomy feed and that was seen as a health issue. So it was thought at the time that it would be best to put the person in a nursing home when, in fact, people could be trained to provide the support. Clinical nursing services can be bought or brokered to provide that support. As I said, we could link people to generic community nursing but our problem is that the health department in different regions have different priorities—hence we emphasise the whole of government approach.

Senator HUTCHINS—I do not recall which submission—it might be the Health Services Union submission—talked about a crisis of people working in this industry, not only in your area but in aged care where the work force is getting older and it is not as attractive for people to go into it. You are saying that you are trying to train people—even though they are semi-skilled or unskilled—to do these jobs.

Mr Chan—That is right.

Senator HUTCHINS—Are you coping?

Mr Chan—In our service we are now looking more closely at staff competency. We are one of the very few organisations that provide a mandatory six-day training program before they start. We are now trying to link that to a TAFE accreditation process—and they will gain competencies. We have a clinical nurse consultant, a clinical nurse educator and a behaviour support manager. We function through centres that have community partnerships and community networking. So we have linked people with MS and people who palliative care needs to generic health services. Hence we talk a lot about community inclusion. You and I should be able to access any generic health services and any local services. So a lot of our work is coordinating government departments and local services.

Senator HUTCHINS—In any of your organisations do you try to have a patient-staff ratio? Is that an appropriate question to ask and is it relevant? One of the submissions says that in one western Sydney facility there was one carer rostered at night to care for 168 residents. I assume that there was a combination of aged people and young people who had been put into that aged care facility. Do you have a rule of thumb?

Mr Chan—We do not have a ratio. It depends on the level of support needs of the individual. A lot of it depends on the personality and the ability of the person. We could have a drop-in support model of six hours a day. We have a young lady with an acquired brain injury. She is totally dependent in the activities of daily living, uses an electronic device to communicate and is in a wheelchair but she only requires six hours a day. We come in and support her, put her in her wheelchair and she is off on her own. And there is the other range where we have two staff to six clients.

Mr Northcote—In our accommodation facility at Lidcombe we have a system of total care load. Each person with MS is assessed for their daily care requirements and a ratio is struck between the total care load and the number of staff that are brought in. We also run some respite beds at Lidcombe, so that enables us, depending on the care load of the people coming into the facility for a four- to six-week stay, to adjust the number of people coming in via the number of staff that we have. We are not able to increase the number of staff but we can manoeuvre the admissions so that the number of staff can cope with the people coming in.

Mr Versteege—One of our consumers put it like this when he said, ‘I can’t walk but I’m not sick.’ What he was saying was that he needs minimal personal care, and preferably none. People with mobility impairment are able to determine themselves how much support they need. They often want as much independence as they can achieve.

Senator HUTCHINS—Mr Versteege and Mr Chan, in your submission you talk about Commonwealth-state relationships and you said, Mr Versteege, that at some point you fall off the perch for some reason or other. What mechanism is there within the federal-state system to resolve these disputes? Obviously they are not new. In both of your statements you refer to difficulties with the federal-state relationship.

Mr Versteege—If the state agencies are not able to provide a service, the fallback option, if you like, is the federal option of aged care. There is no real dispute and there is no real transition; it is one or the other. But once a person ends up in aged care it is very hard for them to come out, and it would be appropriate for them to come out.

Senator HUTCHINS—You talk about the Commonwealth-state disability agreement. You said earlier that it could go from cheap to expensive and you become ineligible at some point.

Mr Versteege—The Commonwealth State Territory Disability Agreement funds all of the disability services. The disability services are administered by state agencies. If they cannot do it, the person with the disability is not covered by the agreement but comes under the Aged Care Act, which is a federal act.

Senator FORSHAW—When you say ‘they cannot do it’, is that because of a lack of funding or places, or is it a jurisdictional issue?

Mr Versteege—There could be any number of reasons. It could be resources; it could be genuine. I gave the example of someone who was not able to move into social housing because they part owned an apartment in which they could live and for that reason they had to move into a nursing home.

Senator FORSHAW—It is a regulation kind of issue.

Mr Versteege—Yes.

Mr Northcote—The thing that strikes me about the whole sector is that there is no recognition of unmet need. There is no planning forward in terms of the next wave of people with disabilities. As I alluded to in my opening address, we have identified some 300 people with MS that will need further care if there is a change in their current support networks. That is going to happen. There is no recognition of that; there is no forward planning in those areas and there is no understanding of unmet need. When you go to state government forums you find they are very concerned about the quality of the service being provided—and I agree with that—and the accreditation of service providers to make sure their money has been spent wisely, but there is no recognition or surveying of unmet need coming through the system, through the pipeline. It is coming like a train out of a tunnel.

CHAIR—One of the gentlemen in the audience has requested that he be allowed to make comments at the end of this session. I am prepared to allow that, providing we have time. Mr Way, when we have finished this session we will call you to the table.

Senator ALLISON—This issue has been ongoing for a long time. And it is not just New South Wales: every other state government as well has been arguing with the Commonwealth about this issue. In relation to state governments, to what extent is the policy, or the lack of it, an excuse for deinstitutionalisation? I cannot remember which submission it is, but one refers to a no new admissions policy—I do not know whether that is in New South Wales. Is this about state governments hiding behind the institutionalisation issue of disability? Mr Northcote, your organisation has been very successful in raising funds over many years. You fund a service and out of donations you pay for what ought to be a standard provision across the board. Presumably, Ms Kapp, your organisation does not have quite the same access to funds; it is not able to do that. Again, to what extent do state governments rely on the generosity or the organisational capacity of the MS Society to not fulfil their obligations?

Mr Northcote—I will take that last question up. I think they are relying on organisations like us very heavily. For example, PADP is meant to provide aids for the disabled. Because we are dealing with a degenerative disease, people can degenerate very quickly. Waiting lists are quite long, and a person who has had an attack of MS can be discharged from hospital, have no discharge plan at all and require a wheelchair but that wheelchair is not forthcoming from PADP, so they come to organisations like us who understand the situation that that person is in and apply for wheelchair funding. The government is relying very heavily on organisations like us who have been successfully fundraising for many years. The issue is, though, that everybody is out there now—that is, there is so much competition for the fundraising dollar. Organisations for ingrown toenails are looking for funding. It is very difficult to cut through that clutter, that noise in the marketing areas, to put your case in such a way that it is compelling.

Ms Kapp—We are small, of course, compared to MS, but we are funding a rural outreach nurse for southern New South Wales. New South Wales is covering the ACT because there are no specific services for Huntington's in the ACT. The association actually funds that rural outreach nurse to go to Canberra. We are funding day respite holiday programs, which we conduct ourselves. We have even had the occasion where a state health department funded social worker was allowed to accumulate and take off so much leave that it would have left the service without anybody, and the association gave a certain amount of money—$25,000—in order for a locum social worker to take over that position.

Senator ALLISON—So we are depending on charity?

Ms Kapp—We are, definitely.

Senator ALLISON—For some groups and not others. Mr Chan, I imagine the people who you deal with would not have an organisation that would go out and raise funds in quite the same way.

Mr Chan—I would like to further elaborate on Mr Northcote's point about PADP. We have had a young woman with MS admitted to hospital a couple of times this year for aspiration pneumonia. She has swallowing difficulties and it is getting worse. In a discharge plan in the hospital she indicated that she did not want thickened fluids, or fluids of a thickened consistency, and she understood that she would aspirate. We called for a clinical case conference with her. The reason she gave in the end was that she was afraid she could not afford it. PADP does not supply that. Because she could not afford it with her meagre disability pension, our agency had to top it up. This is just one small example; we top up other things. For example, when that lady with the brain injury that we talked about who has just graduated with a bachelor of education went on her field placements, neither state nor Commonwealth departments had funding to allow for a support worker, a note taker—she was visually impaired—to take notes for her. The university put up 50 per cent and we put up 50 per cent for a support worker so that she could pass and graduate two of her field placements, because both Commonwealth and federal departments do not have any avenue for that kind of funding at all.

Senator ALLISON—I have visited a very good long-term rehab unit in Canberra—and, again, it was set up by charity, after some pushing and shoving of the territory government. I was told by the people there that, because people can be in acute care for periods of up to three months, particularly after a brain injury, by the time they come to rehabilitation it takes another six months of intensive physiotherapy and the like to give them back muscle control and allow them to be in any way independent. Is that your experience as well? How much money is being wasted because we are not getting to people in a timely way with rehabilitation?

Mr Chan—I cannot put a figure on it. I can only put it in terms of outcomes. We could successfully rehabilitate someone, and we have, but our concern is at the discharge end of our rehabilitation. You are right that there are people who are stuck in acute care beds for a long time. A lot of it is not just the physiological muscle wasting and waiting to go into rehab when they are ready, but also the psycho-social thing—it impacts on their psycho-social wellbeing and their motivation for recovery. Often people in rehab centres who are ready to go back home and be supported with simple things like the attendant care package or modified housing are still in the rehab centre one year later because there is no modified housing and there are no attendant care packages to support them. It is sad, because the person has finished the rehabilitation program—the goal has been achieved and they are ready to move on—but they are stuck in the rehab centre.

Senator ALLISON—What is the cost per person for them to be stuck there when they do not need to be?

Mr Chan—I cannot tell you the cost right now. I think it is more expensive. The figure might be something like $380 per day.

Senator ALLISON—In your facility?

Mr Chan—Yes.

Senator ALLISON—So that would be a lot more expensive than helping to find someone accommodation and a package?

Mr Chan—Exactly. What is baffling for us is that we are trying to help the health department to move people out of the acute care beds so that the public can access those beds—it is a ripple effect.

Senator ALLISON—I understand. What do you understand to be the policy of the state government with respect to this issue?

Mr Chan—From our experience, there is something simple in terms of the recent Sax report—the argument between Commonwealth responsibility and state responsibility. We would like to see young people being on the national agenda—this is similar to what Paula said about young people being on the national agenda. The Commonwealth-state disability agreement could be revised and expanded to include young people in nursing homes—again, taking into consideration certain disability-specific needs. We have to have a range of options for service models available to young people. A good example is the current Innovative Pool Funding, which is Commonwealth funding. We think it is a terrific model which should be expanded to include young people in nursing homes, but it should not be attached. My understanding is that the current funding is attached to a nursing home. Why not expand that to include carers who are looking after young people in their homes? There is a trend internationally, and even in Australia, whereby a lot of people with disabilities are living in their own homes or in a family home. We need to put support services there so that their families do not break down and they do not end up in long-term placement in a nursing home or in a hostel.

Senator ALLISON—What you are suggesting is a package that is flexible enough to take into account whether it is a spinal injury or whatever and the level of care that is required.

Mr Versteege—Those packages exist, but there are not enough of them.

Mr Northcote—To answer your direct question about the state’s policy: I do not believe they have a policy, and I do not believe it is one of their priorities.

Senator ALLISON—We will ask them that question.

Mr Northcote—To answer your earlier question regarding the cost of charity, the Multiple Sclerosis Society of New South Wales spends about $7 million on direct services per annum, for which we are funded about $3½ million. So, through our fundraising efforts, we match dollar for dollar.

CHAIR—It is very close to 10.30 a.m. Mr Way and Mr Fuller provided a submission but I am concerned that, if we invite them to appear now, they will have only three minutes and that is probably not enough time. We will be coming back to Sydney later in the inquiry and, given their obvious interest, we will prioritise their appearance at a further hearing. I do not want them to have only three minutes. It would be very unsatisfying.

Senator MOORE—On that basis I will ask one question, and it is for everybody. It follows on from previous comments that have been made about the complexity of the system, which is mentioned in most submissions, and Senator Allison’s questions about the amount of work that each of your organisations do. How much time do your organisations spend advocating directly with government? What is the communication link for your organisations with state and federal government? Is it formal? Is it informal? How do you feel involved in the development of policy?

Mr Versteege—We spend a lot of time in advocacy. We do systemic advocacy and personal advocacy. We fund three positions out of a total of 41, which include support staff in group homes. We have informal contacts, at state level mainly, to support that advocacy, because most of our advocacy is of course in New South Wales. We also go to more formal gatherings, such as this one.

Mr Chan—We are not funded for a designated advocacy position, so directors such as me take on advocacy in addition to our daily work. We spend a lot of time. We have formal agreements, predominantly at the state level. Because we are metropolitan-wide we have links with different regions, which makes it really difficult because they are different parties.

Senator MOORE—Six or seven of them.

Mr Chan—It is exhausting. It takes a lot of our time.

Ms Kapp—I do it for New South Wales. As we are such a small organisation, I am multiskilled. I cook at holiday camps for people with Huntington’s disease. I advocate for New South Wales, and we do it when the need arises. For example, we wanted the genetics test for Huntington’s disease to be done only through genetics units, and we had a seven-year battle with the New South Wales Health Department to make that a policy. However, I have taken on the responsibility for this issue for the whole of Australia. It takes a lot of time.

Mr Northcote—Our approach to advocacy is similar. We have really left the systemic advocacy efforts to the peak bodies—physical disability councils, ACROD and those sorts of people. We are very active in personal advocacy. Our outreach workers are in there all the time advocating for particular people with MS. Forming relationships with government departments is very frustrating for us because every time we seem to come to some kind of understanding or are able to educate a person about the issues faced by people with disabilities, particularly those faced by someone with a degenerative disease, that person inevitably moves on and so you have to start all over again. So it is a time-consuming and expensive process. Most of the time it comes to naught.

Senator MOORE—Do you feel, as organisations, that you are part of the policy process?

Mr Versteege—Yes, we do.

Senator MOORE—So you feel that you have a role to play?

Mr Versteege—Yes.

Mr Chan—We feel that we do have a role—to attend a lot of forums. Recently there have been a lot of forums by the Department of Ageing, Disability and Home Care. Whether that gets translated into action is another issue. There are times when I think, ‘We did this about five years ago.’ I think there is a cycle that repeats itself every few years.

Ms Kapp—After 25 years in the job, we are becoming more and more recognised. That is because I keep writing letters until the file gets so thick that they do not know what to do with me.

Mr Northcote—I would like to think that we are, but I do not.

Senator FORSHAW—I would like to ask one final question about young people with disabilities in nursing homes. Is this a more recent phenomenon or something that has been there for some time but something that the government and policymakers have not focused on? Is it an increasing trend that we are seeing more young people with disabilities in nursing homes?

Ms Kapp—My first letter asking for a specific unit for people with Huntington's disease was handwritten in 1979.

Mr Northcote—I think that issue has been there for a long time. Organisations like ours are so busy with the day-to-day bushfires that we are faced with that they have very little opportunity to gather data and to interpret that data in such a way that it becomes user friendly for people like yourselves. I think it is only reasonably recently that that sophistication has been adopted by the sector, so that we can make our cases. I think that, because of that, it is becoming more and more apparent.

Senator MOORE—I have one final question. In terms of the successes that I hope you have all had, and you mentioned some of them in your submissions, are there people out there prepared to listen to those in terms of getting the message out about the things that have worked and the people who have been successful? Do you have the opportunity, through the media and through community processes, to tell people that these things can be achieved?

Mr Northcote—I think, basically, that it is not newsworthy. The mainstream media are not really interested.

Mr Chan—I agree.

Senator MOORE—You had a couple of wonderful stories, Mr Chan.

Mr Chan—Yes, we have some wonderful stories to tell. I planned to tell this lady's story nine months before her graduation. We did not have one single bite, not even from the ABC. I am not pursuing Channel 9. I think it is a wonderful success story, and this is only one person's example—there are many more. We decided to go ahead on our own and compile on a DVD the achievements of these people. When I told an investigative journalist this story he said, 'We all know about the inadequacy of the funding from the Commonwealth. There's no real story to tell.'

Senator MOORE—Mr Versteege, have you had success with the media in terms of talking about your issues?

Mr Versteege—No, not really.

CHAIR—I thank all of you for your submissions and for appearing before us today. This is the first day of hearings, and the issue of young people in nursing homes is very strongly represented in a number of submissions that we have received. Thank you very much for your time. If there is any further information you would like to provide us with, we would be happy to receive it.

Proceedings suspended from 10.35 a.m. to 10.56 a.m.

SADLER, Mr Paul Michael, Chief Executive Officer, Aged and Community Services Association of New South Wales and the Australian Capital Territory

CHAIR—Welcome. The committee prefers evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. We have your submission, for which we thank you. I now invite you to make an opening statement, which will be followed by questions from the committee.

Mr Sadler—Thank you very much. We are delighted to be able to make this submission to the Senate Community Affairs References Committee inquiry into aged care. The Aged and Community Services Association is the peak body representing largely the not-for-profit aged care sector in New South Wales and the ACT. As you have the submission in front of you, I will very briefly address each of the terms of reference.

Regarding paragraph (a) of the terms of reference, on the adequacy of current proposals in the budget to address work force shortages and training, we welcome the initiatives in the federal budget. They were a very good step forward in providing further resources for training and education. In our submission, we have highlighted two areas which we believe have not been fully resolved. The first is that the primary focus of the aged care work force initiatives from the budget and the federal government’s national aged care work force strategy has been on residential aged care. The substantial work force in the community aged care area has not been substantively addressed. We recognise that that requires some joint work with the states and territories, particularly because of the Home and Community Care program, but we believe this is a priority and that it should be included in further work force developments.

The second area we point to is the ongoing challenge of meeting the pay pace that is set by the public hospital sector. We have highlighted the fact that New South Wales nurses are paid the highest award rates in the country—something like 12 per cent more than any other jurisdiction. We recognise that there are enterprise bargaining agreements in some other states that catch up at least some of that gap. This year, we moved to the national rate for the residential aged care subsidy, so we have been coalesced over the years down to a national rate, yet we still have the highest wages in the country. We are currently 16 per cent behind the wages paid in the public hospital sector.

There is currently an Industrial Relations Commission case in the New South Wales industrial court to consider a claim that the New South Wales Nurses Association has for an increase. We have put on the table the fact that, with the federal budget initiative of the 1.75 per cent top-up to COPO—the so-called conditional adjustment payment—we can afford a wages increase, which we believe our staff deserve. We have put on the table an offer to bridge, over a three-year period, the current gap between the pay rates for the public sector and those for aged care. However, this will stretch many of our members financially and, should the Industrial Relations Commission come out with a shorter time frame to try and bridge the gap, we could be seeing some substantial financial difficulties for many operators across New South Wales.

With respect to paragraph (b) of the terms of reference, the performance of the accreditation agency, we have identified three main areas to comment on. The first is process issues. We believe that there is still substantial work to be done by the accreditation agency, particularly as we enter a third round of accreditation, to ensure that there is consistency in the accreditation process and that it is adequately ensuring quality of care. The experience of aged care providers is that the accreditation process is a time-consuming one and there are elements of it that probably could be reduced in terms of their paperwork burden.

We note that the Aged Care Act places a responsibility on the agency to undertake an educational role. We believe, consistent with Professor Warren Hogan's review of residential aged care, that that is not necessarily a high priority that the agency should be pursuing. We recognise that in a free market the agency may well choose to take on a role like that, but the fact that the Aged Care Act gives it a legislative requirement to do that is perhaps unnecessary and confuses the role of the agency.

The third area comprises the more systemic issues. We are recommending, consistent with our national body, Aged and Community Services Australia, that the accreditation process in aged care, similar to what the federal government has done with the disability services sector for employment, should be opened up to a range of accreditation bodies under the JAS-ANZ—the Joint Accreditation System of Australia and New Zealand—framework. We believe that that would be an appropriate step to ensure not only variety in terms of whom providers can choose to approach for accreditation but also the aged care accreditation system can be better integrated with health and other accreditation systems, which would apply to many of my members.

With respect to paragraph (c) of the terms of reference, the appropriateness of young people with disabilities being accommodated in residential aged care and the extent to which the system is meeting other special needs, we are certainly putting forward similar proposals to those put forward by the people who appeared here before morning tea—that is, there needs to be a move away from the suggestion of residential aged care being the appropriate place to house younger people with disabilities. We believe that that is inappropriate. It has been a policy issue on the agendas of federal and state governments for many years, without a satisfactory resolution. We are proposing that, as a first step, a serious examination should be given to a 'no new admissions' policy so that at least we are not increasing the number of people who are in residential aged care. Even that step, though, would need additional resourcing to be available at the state level in order to ensure that people's needs for accommodation and care are being picked up. In effect, what is happening is that the residential aged care system is acting as a backstop when the disability service system fails to provide care. We have also put in our submission some specific comments—although I will not address them in detail—regarding culturally linguistically diverse communities, Aboriginal communities and people with psychiatric conditions.

Turning to paragraph (d) of the terms of reference, the adequacy of Home and Community Care programs and meeting current and projected needs of older people, we have identified the fact that there continues to be some substantial demand for community care services. The demand is exceeding the supply of those services and, even where people are receiving services, particularly in the HACC program, they are receiving relatively low levels of help. The statistics from the Australian Bureau of Statistics in 1998, when they last did them, showed that around 30 per cent of older people were not receiving as much help as that which they identified needing.

We are recommending that the Australian government and state and territory governments commit to increasing HACC by a one-off 20 per cent increase and ensure that the program continues to grow at six per cent real growth into the future. We have also identified the fact that, unlike for residential aged care, the federal government made no move to address the inadequate indexation arrangements for the community care programs in the federal budget. We had been advocating an increase of up to 10 per cent to address the shortfalls in indexation in meeting staff costs and other rising costs like insurance. The federal government chose not to do that in the federal budget, although it did provide the conditional adjustment payment in residential care in recognition of those issues. Our contention is that the cost drivers in community care are very similar to the cost drivers in residential aged care. If, on the one hand, we are increasing it for residential care, in recognition of that argument, on the other hand it seems anomalous not to have increased the community care programs like HACC and community aged care packages.

With respect to the final paragraph of the terms of reference, the effectiveness of current arrangements for the transition of older people from acute hospital settings to aged care settings or back into the community, we have got some good news for you. We believe that some of the work that federal and state governments have been doing has actually been very effective in recent times. We really need to see some of those programs that have been in pilot phases for some time transferred into a mainstream program that will provide an ongoing focus on transitional care into the future.

We have also provided you with some information about an innovative new pilot that the New South Wales health department has funded, called ComPacks. It is really a partnership arrangement between the health sector and the community options providers under the HACC program, whereby Health is funding the community options services to provide their case management expertise to arrange the earlier discharge to home of people with appropriate support and follow-up, with Health then continuing the funding for a six- to eight-week period. If people have ongoing needs for services after this, they are picked up through the HACC or other community care programs.

We believe this pilot program has proved to be very effective, and New South Wales Health has recently, in the state budget, extended the funding for this program into out years. It is a good example of what we believe has been quite cooperative work in the last three or so years in this area. As I say, what is really needed is to make sure that these programs become mainstream in the future.

CHAIR—It is pleasing to hear a good story.

Mr Sadler—It is.

CHAIR—I want to ask some questions about appropriateness. You said in your submission that you did not think the accreditation agency should be involved in an education agenda and that there are more appropriate bodies who would be able to do that. Can you tell us who they would be.

Mr Sadler—There are a range of bodies that have expertise in the industry. Organisations like ours are involved in providing extensive training. We are a registered training organisation, so we provide a lot of support to our members. Obviously, TAFE and the university sector provide training to aged care staff in a substantial way. We have got a range of specialist professional associations that provide courses. You will be hearing from Geriaction, the Australian Society for Geriatric Medicine. Those professional organisations often take on a training role for staff in aged care facilities.

As I said in my opening remarks, we recognise the fact that it is a free market. If a body chooses to play a role in educating and the agency gathers information that is relevant for educating the sector, they should be in one sense free to pursue that role. At another level we believe that, where the act stipulates that they must have that role, that is probably taking things a step too far. As Professor Hogan found, they really need to focus on their key role, which is ensuring quality of aged care facilities on a day-to-day basis.

CHAIR—I have a more general question about HACC. It is an area that you identify as requiring an injection of funds. More generally, though, is HACC a good model? Is it a service that is, where funding allows, meeting the needs of aged people?

Mr Sadler—The short answer is yes, and I will expand on it because there is one proviso. Every survey that is done and some of the academic research that has been done suggest that the HACC program provides services which older people—and younger people with disabilities, because it targets both groups—find very helpful to them. The HACC program does a wonderful job in generating support from volunteers. You just have to think of Meals on Wheels and Neighbour Aid programs that generate substantial support from volunteers and that governments could never afford to fund. So there is a substantial amount of evidence that they do good at that level. The research also shows that provision of low levels of community care services—this is both internationally and in Australia—has a substantial impact on preventing admission both to long-term residential aged care or disability accommodation and to hospitals. So, in terms of their efficacy in ensuring that we are getting value for money out of our health and aged care systems, community care programs like HACC are very useful.

One proviso I have got is that the home and community care system is a confusing system to access. There are lots of providers. Processes at the moment tend to mean that people are assessed multiple times. This is why in our submission we have supported the federal government’s directions for reforming community care which came out when Julie Bishop released *The way forward: a new strategy for community care* a couple of weeks ago. We believe that some of the directions for reform of community care programs are identified in that document, and it is not just the Home and Community Care program but all the other programs that have been developed since 1986 when HACC was introduced that need to be reformed and streamlined. Processes need to be improved, and certainly the experience of providers is that there is a level of overaccountability that follows all these multiple different programs. So we can see room to improve the community care system, which would make a substantial difference.

CHAIR—And you are identifying the problem as the consumer having to get through that myriad of—

Mr Sadler—Finding where they go, being steered to the right service and not being asked the same question 15 times to access basic support services.

Senator HUMPHRIES—On the process of accreditation that your members go through, we have not heard from the accreditation agency yet and perhaps we can ask them some questions about how they do this. I gather that homes and facilities need to satisfy the agency that they have achieved a certain number of outcomes in order to be able to achieve accreditation. I take it from your submission that they need to get 44 outcomes to achieve accreditation. Is that right?

Mr Sadler—Yes. The original work in the Aged Care Act listed 44 separate outcomes under four standards. In the first round of accreditation the approach of the agency was to monitor effectively the four standards. You could afford to be noncompliant in one or two individual outcomes underneath the overall standard and you would still be granted an accreditation period of up to three years. In the second round of accreditation the agency shifted the goalposts a bit and said, ‘No, we now want you to focus on all 44 outcomes,’ and the pass mark, if you like, that we should be aiming to achieve is compliance with all 44 outcomes.

The agency gave itself some room to move, in that it did not set down specific criteria that said, ‘If you fail two outcomes, we will only give you two years accreditation.’ It gave itself some room to judge it on a case by case basis, and in general terms we agreed with that approach because some outcomes are more critical to the care of residents than others. We would agree with the agency that if you are failing on a critical care area that is a much more serious issue than if you are failing on some paperwork. So the approach of the agency at the moment is that we should be striving for compliance with all 44 outcomes and that those four standards they are grouped into have become, in a sense, slightly less important.

Senator HUMPHRIES—You say in your submission that the objective of meeting those outcomes is not a bad one but the paperwork and the onus that falls on the facilities to demonstrate those 44 outcomes are onerous. You illustrate the case by saying that you might have a facility that gets all 44 outcomes, is accredited for three years and then there is a support visit—which I assume is a euphemism for a check or an inspection—

Mr Sadler—That is correct.

Senator HUMPHRIES—and you find that you have not met one of the outcomes and you are asked to explain why you have fallen back on one of those. What is wrong with that process? If you have 44 outcomes you need to identify and you have fallen back on one, why shouldn’t you have a ‘please explain’ scenario?

Mr Sadler—We do not have a problem with the ‘please explain’. What we are concerned about is the consistency in making the judgment of whether or not you have fallen behind. We held a meeting with the New South Wales office of the agency yesterday, and we were explaining to them just a couple of the examples we have had where providers have had a certain system—it might have been for medication administration—it has been checked through the round 1 accreditation, support contact visits and the round 2 accreditation visit and then suddenly somebody comes in and says, ‘No, that no longer complies.’ So the consistency issue is really the issue we are getting at, rather than the fact that you have a check between the accreditation periods. We actually support the fact that there should be checks on performance in an ongoing way. We do not believe a system that says, ‘Okay, you’ve passed; we won’t look at you again for three years,’ is adequate.

Senator HUMPHRIES—In its submission Geriaction has this comment:

> Geriaction believes aged care service providers with well established quality management systems do not find the administrative requirements of the three (3) year accreditation application onerous.

Would that be your experience as well?

Mr Sadler—I think it is certainly true that if you have a good, well-established quality system then you would find the requirements of the agency less complex to go through. That does not mean that there is not scope for improvements, for example, in the size of the accreditation kit that you have to comply with up front, and it does not mean that some of the processes and documentation focus that are required could not, in our view, be reduced without compromising the effectiveness of the monitoring of the quality. At the end of the day, the focus should be on the outcomes for the residents rather than on whether or not you have ticked particular boxes on pieces of paper. Our feeling is that the primary focus of the accreditation process tends more towards compliance with the box ticking than towards checking the outcomes for residents.

Senator HUMPHRIES—Do those of your members who have difficulty with the process and who have complained to you about it tend to be organisations, say, with single facilities as opposed to a number of facilities or people in rural and remote areas as opposed to city based people? Are there any common patterns that emerge with those complaints?

Mr Sadler—Certainly, we have had people who have had issues across the spectrum—metropolitan, rural, religious, non-religious—but it would be true to say that the people who find the paperwork angle the most onerous tend to be from small voluntarily managed organisations such as church groups, ethnic community associations and some of the rural providers.

Senator HUMPHRIES—You said that you were allocated some money in the most recent federal budget to increase wages, that your members have made offers to the work force—

Mr Sadler—That is correct.

Senator HUMPHRIES—and that if the Industrial Commission wanted a more accelerated process of wage increase or some larger increase than you were offering, your members would have difficulty in meeting that cost. I take it that because you are largely the not-for-profit sector you have difficulty in accessing funding except from government. Are there other avenues for pursuing funding to fill that sort of gap?

Mr Sadler—The dominant amount of funding for residential aged care is federal government money. About 70 per cent of revenue comes from that source and about 30 per cent comes from the users of services. There is, of course, for not-for-profit services the capacity to maximise some areas—for example, we get fringe benefits tax concessions. So those members who are public benevolent institutions can offer staff, through salary packaging, remuneration packages that are more attractive than may be available in the for-profit sector. Many of our members are significantly expanding their capacity to do that, and that will offset any shortfalls and certainly helps us to be more competitive with the public sector, for example, in terms of wages.

There is the traditional fundraising approach that the not-for-profit sector has, and there are still some providers, particularly some rural services, who find that they can attract a lot of community support. But it is difficult for those providers to rely on donations as a constant source of income. It will go up and down in any given year. Most prudent providers in the not-for-profit sector would use that money for capital costs such as improvement of equipment. They would be very reluctant to take donation revenue and put it towards staff costs. It is not a sensible way to structure yourself because if the donations drop off—and they are donations; they are free gifts—you could have put staff on or offered them more money and you are not able to meet that cost in the next year.

Senator FORSHAW—You mentioned what is happening with respect to the proceedings for wage increases for nurses. What about the other employees such as personal carers? It is often said—it is in the submission from the Health Services Union—that their level of wages per hour is very low compared to a range of other industries and that there is a significant gap between that wage rate and what might otherwise be seen to be a reasonable rate. If nurses' wages ultimately do increase over three years or whatever the period is, presumably that will have some impact because other workers will want wage increases as well.

Mr Sadler—I agree with you, Senator. The approach in New South Wales is that historically we have had a fairly good relationship with the Health Services Union. They have substantial coverage of personal care workers in the state. The Health Services Union recently put to the Industrial Commission the flow-on of the national wage case, which we obviously supported. The position that the Health Services Union have taken in its preliminary discussions with us is that they, too, are awaiting the outcome of the nurses award case in New South Wales, as theirs is a similar category under the nurses award of assistants in nursing. By and large, there has been close to parity between the rates for those two sorts of staff.

Senator FORSHAW—I do not want to try to pre-empt what decisions might be made in the commission or in your negotiations, but you mentioned that funding has been made available in the recent federal budget which I understand is primarily directed at nurses.

Mr Sadler—It is directed at staff costs generally, rather than at nurses specifically.

Senator FORSHAW—On the issue of accreditation, you—and others—have raised concerns about lack of consistency by the agency in their accreditation processes. A lot of publicity has been given to situations where a home has been accredited for all the 44 standards, some issue arises, a serious incident, and they go back in and suddenly find they have failed half the standards or whatever. You have suggested that it needs to be opened up to competition. How can we improve the accreditation system of the agency? Why would opening it up to more bodies that could do accreditation improve it? It might lead to even greater inconsistencies across the industry and across the country.

Mr Sadler—I believe we need to focus on improvements to the agency's own processes. We believe they did make improvements between the first round and the second round. I think our submission reflects that the experience of providers was that the second round of accreditation was significantly better in terms of how it was run by the agency. We believe more work needs to happen in that regard.

Senator FORSHAW—Can you be more specific about what the agency needs to do. Does it relate to training of the accreditors?

Mr Sadler—It is substantially around training of the accreditors and the sorts of systems they have in place that provide guidance to accreditors. The example I mentioned earlier was about different judgments on the medications process. You would ask how you can make a different judgment when you have had the same process in place for three years and it has been through three rounds of accreditation. Why is it suddenly different? It is a different issue if they find the service is no longer complying with its own policy. That is a different story. But if the policy has been there and the process has been there all the way through and a new auditor walks in the door and says, ‘We don’t think that is up to scratch,’ it is a fairly subjective judgment. So we believe it is important that the agency develop processes, particularly in key areas where it can be as objective as possible in making those calls.

Senator FORSHAW—I noticed—I am not sure it was in your submission, but certainly it was in one submission—that this word ‘subjective’ is used about assessment. Is there an objective standard, or set of criteria, available?

Mr Sadler—I think in some areas there is. There are areas of clinical care where there are quite clear objective measures you can use for how effective the services have been in the outcomes—

Senator FORSHAW—Does the agency provide to the providers any information, any sets of criteria, about these standards? I have seen the standards that flow out of the act. How is that filled out in terms of indicating to the industry just what each of those standards is about?

Mr Sadler—They have provided information over the years in different formats that have attempted to do that. Some of that has been helpful, some of it perhaps less so over time.

Senator FORSHAW—One other issue—we will hear from other witnesses later—is the work force shortages and the pressure that puts on the staff and the impact upon quality of care. I am sure you are aware of the submissions made by the unions and others, including relatives of residents. What can we do about work force shortages? Is it a major problem? Is it solely related to wage costs?

Mr Sadler—I believe there is a range of factors that contribute to the issues that we have at the moment. The first thing to say is that surveys we have undertaken of our membership in New South Wales, backed up by the National Institute of Labour Studies survey on residential aged care, suggest that concerns about the staffing issues in aged care may have been overstated in the past. There are actually relatively high levels of satisfaction in the work force; there are relatively low levels of agency nurse use, for example. Where there are problems in finding, for example, a registered nurse to fill an evening or night shift, they are acute; they are really difficult for the individual facility to manage when they happen. The evidence is that they are not happening perhaps as systematically or as consistently across New South Wales and the ACT as we might believe from some of the anecdotal feedback.

Having said that, there is an international shortage of nurses that is being attested to in many places. We believe we need to look at a range of options to improve that in the future. It is about more training—that is why we support much of what the federal government did with some of the new places—but it is also about looking at new models of care and how we can, for example, enhance the role of enrolled nurses. We now have some moves with the registration board in New South Wales in allowing enrolled nurses to administer medication. We believe those sorts of developments in the future will be vital.

Senator ALLISON—It is obviously one area where you could spend more money, Mr Sadler. Presumably your argument that indexation is not adequate is about more than staffing levels—or is it? What sort of extra services would you like to be able to provide to residents if the funding was appropriate?

Mr Sadler—We believe the area that has been challenged due to the indexation shortfalls—and the indexation covers all cost increases, so it is insurance, it is staff wages, it is meant to cover everything that is impacting—and where we believe trimming has been occurring in the last eight years under the COPO indexation formula has been in the amount of staff time that is available to assist residents in residential care—not in direct care so much as in socialisation and that sort of support. In the community care programs we have seen limits on, for example, the number of showers people receive each week. The impact there is perhaps more directly on the care available.

Senator ALLISON—So you would like to be able to fund more workers in addition to increasing wages?

Mr Sadler—Yes. We believe you need to do both, but the answer to doing both is that somebody has to pay for that and it is a mixture of governments and users that will need to fund that.

Senator ALLISON—A suggestion was made in one of the submissions that personal carers should have another qualification or be able to do further study in geriatrics—I am not sure what the need is. Once they are there they are on very low wages; they can do extra training, but they are not rewarded for that. Would you like to see another level of competence in personal carers? Would that assist with the very high turnover that I understand you have?

Mr Sadler—We are certainly very keen for an enhanced work force career in aged care. That picks up some of what you are talking about regarding additional steps, you have got more capacity to take on new learning and be rewarded for that. Part of what we have offered in the nurses award case, with enhanced roles for enrolled nurses and recognising where assistants in nursing are taking on supervisory roles, is that you are actually adjusting the award to pick up those sorts of issues. They are issues that aged care employers are keen to explore.

Some of my members in the not-for-profit sector have been actively trialling development of certificate IV courses to upgrade the capacity of staff. Baptist Community Services is a good example of that. It is also evident from the surveys that we have undertaken and the National Institute of Labour Studies survey that the majority of aged care staff are trained, even personal care staff—two-thirds of them have at least a certificate III in aged care work. They are being trained in aged care, and certainly we and other registered training organisations are actively involved in trying to expand the number of staff that are receiving that sort of training.

Senator ALLISON—Should there be a requirement, for instance, that personal carers must have that training, say, within a year or two years of taking up positions in nursing homes?

Mr Sadler—I believe that it would be useful to see at least some guidelines established. I think requirements are always difficult. One problem with putting an artificial deadline on an exercise like this is that you might have a very good staff member who has family reasons for not being able to undertake the training. Do you suddenly have to make them redundant because they have not achieved a particular qualification when on the floor they are doing an excellent job? I have some reservations about particular deadlines. I would strongly support encouraging training to be available to all staff.

Senator ALLISON—Geriaction have some fairly critical remarks to make about consumer input into decision making in nursing homes. They say that there is a lack of true input. Presumably that means that there are superficial opportunities, but not with regard to things like palliation, options for acute care and so forth or information and education. Would you like to respond to that?

Mr Sadler—That is always an area in which aged care providers are conscious that there is more that we can do. The issue of how you genuinely involve people with dementia and with end stage diseases in any way in making decisions about their own care is challenging.

Senator ALLISON—I am including consumers and carers in that.

Mr Sadler—I am aware of a number of organisations that have made great efforts to better involve families and residents wherever possible. Is there more we could do? I am sure there is.

Senator MOORE—Firstly, regarding consultation and the involvement of your organisation in the development of policy, how is that working, and do you have suggestions for alternative models regarding how your voice is heard? Secondly, regarding the accreditation process, your members obviously had views about that, and your submission says that you provided some suggestions for the process. They were not taken up. Some things have improved. How do you actually get your voice heard through that process, and are there better models?

Mr Sadler—Either at the state level or via our national body, Aged and Community Services Australia, we are represented on a number of working groups through the Department of Health and Ageing, with the accreditation agency on liaison groups. We also have consultation mechanisms at the state level and the HACC program with the Department of Ageing, Disability and Home Care. We also work closely with New South Wales Health. We do not have a problem getting in there; we sometimes have a problem with what bodies do with the advice that we give, because it does not always look like it has been heeded in decisions that are taken. That is probably more the issue that we are reflecting in the agency. We also had some concerns about the nature of the consultation process the agency undertook on round 2 of accreditation, because I think they were getting the general feedback that it had been better, as were we. They undertook a much narrower consultation process this year in preparation for the third round. While I can understand that from a resource point of view, I am not sure that we really felt that it enabled our members to feel they had been fully consulted.

Senator MOORE—I wish to follow up the point about consultation. I am trying to work out how an ongoing relationship is established. One of the issues to do with consultation is that it is not about just attending meetings and saying stuff. That does not equal consultation. Say, for instance, that something you were suggesting did not happen. Is there a process whereby you can then find out why it did not happen, so that you get a kind of ongoing communication about future options? It is that real consultation I am trying to get to.

Mr Sadler—I think sometimes it is yes and sometimes it is no. Sometimes you never quite find out why a particular decision is taken in government. The higher up the channel that it is taken, the less likely you are to find out the real reasons. Once Treasury or Prime Minister and Cabinet or whoever else get involved, the reasons for the decisions become less transparent. At the ground level we do have fairly good communication with the major departments. We had some issues with the State Department of Ageing, Disability and Home Care, who have been in chaos for the last couple of years but they now seem to be pulling out of that a bit more. At the Health and Ageing level, we have always had fairly good communication with the federal Department of Health and Ageing at a state level and it has been reasonably good at the federal level.

CHAIR—I wish to follow up a point that Senator Allison was making about it being good practice to involve families in decisions about the care of a person in an aged care facility. I wonder if you could privately provide us with the names of any of your members who, in your view, are doing that very well.

Mr Sadler—I would certainly be happy to provide some information on some of the initiatives that providers have taken on that ground.

CHAIR—Thank you. On behalf of the committee, I thank you, Mr Sadler, for coming along today and providing us with your thoughts. Please do not hesitate to contact us if there is any further information that you would like to provide to us.

Mr Sadler—It has been a pleasure. Thank you, Chair.

[11.42 a.m.]

HUNTER, Dr Peter Charles, President-elect, Australian Society for Geriatric Medicine

HURRELL, Mrs Kathryn Louise, National President, Geriaction

CHAIR—Welcome. The committee prefers all evidence to be heard in public, but if there are issues of a confidential nature on which you would like to provide evidence to us in camera we are happy to consider such a request. You are reminded that all evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submissions, for which we thank you very much. I now invite each of you to make an opening statement. After that we will move to questions.

Mrs Hurrell—I suppose that, in looking at this from my organisation's perspective, I can say that obviously we have responded to all the terms of reference. The two terms of reference which are of particular concern to our members would be those relating to staffing issues, particularly staffing shortages, and continuing of care across the continuum. Staff shortages has been an ongoing issue for our members for a number of years. We believe that there is a critical shortage of both health professionals—registered nurses—and allied health professionals but less of a one for personal care assistants. That situation is found across Australia in most jurisdictions. We believe that shortage is influenced by a number of reasons: the international and national shortage of nurses, workload pressures and expectations, and the valuing of the specialty itself. That is particularly so for nurses and other health professionals. Significantly, despite what others would say, my feedback from members is that wage parity is an issue for nurses in the residential aged care sector, that community care workers and personal care assistant equivalents in the residential sector have fairly low rates of pay and that attracting those people is very difficult. We do not believe that the recent budget initiatives go far enough in addressing wage parity issues. We are concerned that if we do not actually address that problem it will ultimately impact—if it has not already—on the actual quality of care being provided to people in residential care.

The other term of reference I want to mention is the one about continuity of care. Increasingly, in forums I attend, what is being raised is the notion of fragmentation of care between community care, primary care, residential care, subacute care and acute care. There are millions of programs, people are fragmented across those programs and that ultimately leads to poor health outcomes for older Australians. We strongly urge and constantly advocate for high-level policy and strategy to bring state and federal governments together to try and stop that fragmentation so that people get access to care at the point of entry, rather than being pushed from pillar to post and being denied access to services because of who they are funded by or where and when they enter the system. For our members, those are what we consider to be the two crucial issues.

Dr Hunter—Thank you for the opportunity to speak today. People often wonder what the Australian Society for Geriatric Medicine is, so I will fill you in on that. The ASGM is the society of specialist medical practitioners who are affiliated with the Royal Australasian College of Physicians and have an interest in the care of older people. We are mainly, but not exclusively, geriatricians. Our role as a society is advocacy for care and care systems, and also teaching, training and research.

The key message in our submission is that things have improved but there are still plenty of opportunities for improvement in the way older people are treated, both in the community and in residential care. I have distilled six sets of issues from our submission as the things I would like to concentrate on here. Firstly, health and aged care cannot be separated out. There is often an attempt to do that, but health and aged care cannot be separated. Older people in residential care facilities in particular are very frail, have complex medical problems and are medically very brittle. Issues of personal care and health care are intimately intertwined and cannot be separated out.

Secondly, an important point to make is that older people in residential care facilities are significantly disadvantaged and have poor access to both basic medical care and specialist medical care. There are a lot of issues that underpin that: remuneration, shortage of work force, structural issues and interest issues. From a medical point of view, aged care, particularly residential aged care, does not represent the sexy end of the business. MedicarePlus has addressed some of the issues of basic medical care, but it has actually highlighted some of the real problems in access to specialist care. For example, a general practitioner assessment in a residential care facility is now remunerated at a higher level than a complex, comprehensive, specialist geriatric assessment. As a result of that there are very few geriatricians or other specialists who are prepared to enter residential care facilities. There is only a handful who consider residential care their area of particular interest in geriatric practice. The consequence of that, of course, is that the best models of geriatric practice in acute care, community care and residential care are not practised in this country. The best models of care focus on a multidisciplinary approach to care, with allied health, nursing and medical practitioners working together. That does not happen in this country in residential care.

Thirdly, I want to highlight issues around the accreditation process and documentation. Our belief is that they must more clearly link to quality and quality outcomes, which does not happen at the moment. The accreditation process in Australia is focused more on paperwork and funding than on quality of care, which is a major issue. There are other models in other countries and other international systems that have been applied which much more clearly link quality with care planning and funding. I think the opportunity needs to be taken to look at some of these other models. We really do need robust and benchmarkable indicators for use in residential care if we are going to improve the quality of care.

Fourthly, I think the importance cannot be underestimated of a greater commitment to research in this country in the area of residential care. An evidence based approach is the cornerstone to practise in medicine and health in all other areas but does not seem to have become the hallmark of the way residential care is carried out in this country. There are lots of reasons why research is not given the focus it needs, not the least of which is the various funding bodies that do not take residential care seriously as an important research area, including the NHMRC.

Fifthly, I cannot get by without talking about the ongoing problems in quality care as a result of some of the divide between Commonwealth and state responsibilities. There is no integration across the continuum of care. That really is a pipe dream that most of us who work in health look towards but seems to me to be a long way off. Not a day goes by that I do not see a patient in the system somewhere—be it in residential care, in emergency departments or in the wards of hospitals—who is going from pillar to post in terms of the best quality care they can get because no-one is prepared to take the responsibility. There are no good systems that allow for acute care or even palliative care in residential care facilities. The best place for people to be treated is in their home environment. Moving older people who are at risk of all sorts of medical problems, such as delirium, confusion, pressure ulcers and incontinence, to various places for their acute care is both inappropriate and very cruel.

Finally, I have left perhaps the most important point until last: the critical issue that the whole sector faces is numbers in the work force. I am talking about the medical, nursing and allied health areas. The reasons for the shortfall in work force numbers are pretty complicated and multifactorial and I do not think there are any easy answers, but remuneration is only one of the answers. One of the problems is that, at the moment, there is a dearth of courses that specifically teach aged care, residential care and geriatric medicine. More fundamentally, in undergraduate teaching in medicine, nursing and allied health there is very little focus on both the needs of older people and the needs of older people in residential care. I do not think I spent any of my time as an undergraduate or as a postgraduate learning about the needs and care issues for older people in residential care. That is a travesty that exists in the undergraduate courses in the country at the moment. I have to say that it is very disappointing to hear that most clinicians and most health managers do not consider treating older people in residential care as their business. They consider these sorts of people to be bed blockers and acopics—the sorts of people whom you do not want to see in hospitals. It is a travesty that in this day and age we see older people as being a barrier to what people consider to be the core work of health when in fact it is the core work of health.

CHAIR—The similarity in your submissions is evident, with Mrs Hurrell talking about continuity of care and Dr Hunter saying that health and aged care cannot be separated. I think they are important points. Something of concern to me, Dr Hunter, is that you said that the accreditation program does not link to quality. Are you saying that the current program operating in Australia does not make any assessment of the quality of care being provided?

Dr Hunter—I think that everything has to revolve around quality and quality systems and that everything else should hang off that. At the moment the system is designed as a way to categorise people for funding, and everything else is secondary. You cannot have quality as a secondary outcome in the way that things are monitored and measured.

CHAIR—You went on to say that there are other models that better assess things. Can you give us some information about where we can look for those?

Dr Hunter—I do not have a great deal of expertise in the specific systems, but we do know that international models are available. There are pros and cons to all of these models, but many countries have developed models. The one that perhaps has the greatest airplay is the RAI, which stems from the RUG system, as it is called, that underpins it. There are critics of this sort of approach but I think that, far and away, it is a better starting point than the model we have in this country at the moment. It is a good model inasmuch as it not only links funding but also generates care plans, which are very useful for the way that people are treated. Care plans that flag particular issues and health issues are systems that need to be explored.

Senator FORSHAW—Thank you both for your written submissions and your comments this morning. I think you have been very forthright in the points you have made—it was very useful. Firstly, Mrs Hurrell, you refer in your submission to the abandonment of the trial of what was called the R-RCS with regard to excessive documentation. Could you expand on that: what happened, and what is your concern? We need to have that on the record.

Mrs Hurrell—Sure. My understanding was that we were trialling a revised RCS, or looking at the way we assess people's care needs and then receive funding.

Senator FORSHAW—RCS is resident—

Mrs Hurrell—Resident classification scale. This is only for residential care; this does not include community care. There were four pilot programs under way last year that were due to report in September-October. From that, a steering committee was created—a consultative committee involving industry and individual clinicians as well as government. We were about to commence a trial of a revised RCS. I understand it had a reduced set of questions and a new set of interpretation guidelines. The idea of the new, revised RCS was that it would reduce the amount of paperwork required to support evidence of a claim made to the department.

Just before or just after the guidelines were released—I cannot quite remember when; there was a lot happening at the time—the whole trial was stopped. I was informed at a meeting. Collectively, a group of us were very concerned because we perceive that excessive documentation is a key factor in taking what scarce hours nurses have away from direct patient care, and because we had been promised by both this minister and the previous minister that issues related to excessive documentation would be addressed and this new tool would be trialled in an effort to consolidate that process.

It seemed that, with the release of Hogan's report and Hogan's recommendation that we go to a three-tiered system, the revised RCS trial was put on hold. If developing a three-tiered system takes two to three implementation and consultation phases, we could not understand why, in this interim period—when we have critical staffing and workload issues—this revised tool could not be introduced. The industry were for it; they had supported its introduction. They were very disappointed and have raised that directly with the minister.

Senator FORSHAW—I do want to come back to that issue of paperwork and ask Dr Hunter a question, but I will ask you another one first, Mrs Hurrell. In your submission you also refer to your concern about the inconsistency in the application of the standards. This has been stated by various witnesses. We heard from the Aged and Community Services Association of NSW and ACT just before you and they raised that, as well as those people representing workers in the industry, relatives of residents and so on. Firstly, what sorts of improvements could be made, or what could be done by the agency, to address that? Secondly, the association raised the possibility of introducing competition into this area by opening up the accreditation process to a range of other bodies, organisations, persons et cetera. Could you give us your thoughts on where we could head to address this issue?

Mrs Hurrell—I think we raised in our submission that we saw the inconsistencies as being a real issue for the agency and something that does not reflect well on the industry. I think it has been raised before: services get 44 standards one month and then next month there seems to be a catastrophic outcome, yet how can that be? My personal experience as a consultant in the industry is that you often see the inconsistencies. You go to one place and the standard is interpreted one way; you go somewhere else and it is interpreted a different way; and there are different expectations by auditors.

So I would see one of the most important things as being training of the assessors—really robust training of assessors. Another thing is clearer criteria—this notion of benchmark criteria, if you like—so we have some definable, objective measures. Some of the 44 standards are very subjective. They are about quality of life, they are about people's social interactions, and sometimes it is very hard to have objective measures of those things. But there are certainly objective indicators that, across benchmark figures, could be utilised so that assessors had much more objective measures against which to measure an organisation.

Our organisation feels that, in part, there should be some peer review, as is currently used in the public sector, so that audit teams are not only made up of external agency providers and you get some consistency across the organisation. Our organisation is not convinced that introducing other accrediting agencies will improve consistency—in fact, there is some thought that it may increase inconsistency. I think there is a general belief that there is inconsistency, so we need to look for alternative avenues to try to improve consistency and raise the bar.

Senator FORSHAW—Good. I would like to put two questions to you, Dr Hunter. Firstly, by way of explanation, on page 3 of your submission you say:

> The current funding arrangements represent an attempt to define a range and quantum of care inputs. The system is idiosyncratic by international standards and has been condemned by two recent Australian reviews.

Can you tell me what those reviews were?

Dr Hunter—I do not have that information with me at the moment, but I can certainly make those available.

Senator FORSHAW—If you could take that on notice. If those are in the form of documents or a reference that you could provide to us that would be handy. The other question I had is again about paperwork. You referred to it as 'defensive paperwork'. Can you expand on what you mean by that? I think I understand but, for the purposes of getting this on the record, would you like to expand on that? Maybe you could also comment on whether there is 'offensive paperwork', if you like.

Senator ALLISON—It is all offensive.

Senator FORSHAW—This issue of paperwork is coming up quite often in a lot of the submissions in relation to time being taken on paperwork that could be used better on providing personal care and so on.

Dr Hunter—I suppose 'defensive' paperwork is that which requires people to sit down and spend a lot of time justifying what they are specifically doing, which may actually be best practice. An example might be the risk of falls in older people. You may spend a lot of time justifying a whole lot of approaches that you take because you do not want the patient to fall, but by doing that you are doing a lot of things that actually infringe upon that person’s right and cause them to decondition further. So you spend a lot of time writing and documenting the parameters you have in place to prevent that person from falling, whereas you are not doing things that proactively manage that person’s mobility, as it were. I am trying to give a practical example of how that may work.

Senator FORSHAW—My recollection from when the new act came in and there was a lot of debate, and in the early nineties, was that one of the issue that was often raised was paperwork—the old CAM and SAM criteria. It seems that it is still an issue.

Dr Hunter—That is why some of the new systems that have been developed internationally are very good—because they document the particular care issues, which become a flag for the sorts of evidence based approaches that are available. The documentation we specifically referred to generates a plan that gives you proactive ways to manage things, so you not only develop a care plan but you are given the best evidence in terms of a care plan for the way to manage people subsequently.

Senator FORSHAW—Do you have some specific international examples of that?

Dr Hunter—A lot of work has been done internationally in a tool called the RAI, which is going through another stage of revision at the moment. It has been so successful it has sort of become the standard in places like the States, for example, and European countries. It is being adapted to other settings. For example, there are trials occurring in Australia of an adapted tool to be used in an acute care system.

The reason a lot of us like this sort of model is that, if we can have something that can be used for older people right across the continuum of care, that is going to get us a long way in improving overall quality of care. If we can have something we can use in the community, in acute hospitals and in residential care, we will all be speaking the same language. One of the real problems in treating older people is that none of us look at the issues in quite the same way. Acute care nursing staff and doctors have a very different paradigm of thinking about those who are in residential care compared with those who are in community care.

Senator FORSHAW—Thank you. I notice you refer to the RAI. If there is anything you would like to send us or if you would like to give us some more information on that, that would be very helpful.

Senator ALLISON—Dr Hunter, figures I have seen recently suggest that older people are not getting access to private health services to the extent that they pay their premiums. What happens to someone who is in residential care and still paying their private health insurance? Do they get access to private hospitals or not?

Dr Hunter—With my tongue in my cheek, the first thing I do is tell them to stop wasting their money and give up their private health insurance. Elderly patients who have private health insurance are perhaps the most discriminated against group in the health sector. If you have private health insurance and have complex problems that require inpatient or acute care, you are actively discouraged. You are actually disadvantaged.

Senator ALLISON—How does that work? What happens when the nursing home rings up the private hospital and says: ‘I’ve got Mrs So-and-so and she’s got private health insurance. She’s got this problem and she wants to come in’?

Dr Hunter—Private hospitals cherry pick. They refuse to take older people with complex needs because they will become a funding burden for them.

Senator ALLISON—How can they do that?

Dr Hunter—They say: ‘We’re full. We don’t have any vacancies. You’ll have to send that person to the nearest emergency department.’ And that is what happens. They go to the emergency department and the emergency department do not want them, so they do not get the best quality care. They are often transferred back to the nursing home without an admission and they deteriorate. They are then transferred back to the hospital and are admitted at the hospital. They are treated by people who do not understand the care needs of older people. The older people often develop iatrogenic problems—such as delirium, pressure ulcers, falls and fractures. Things often spiral out of control in that sort of situation. Those people who do find themselves in a private hospital do not actually get the care that they need.

The private system is about five to 10 years behind the public system in terms of the care models available for older people. The old model of a doctor looking after a patient with nursing staff who are acting upon what the doctor suggests does not work with older people. You need a much more sophisticated system. You need a multidisciplinary approach. Private hospitals do not provide multidisciplinary care. They do not have clinicians who understand how to look after older people.

Senator ALLISON—Can I ask about allied health. What happens if a nursing home determines that they need special advice about, say, the diet of one of their residents, who could be a diabetic, advice from a podiatrist if there are foot problems or even advice about mental health problems? What is the current arrangement if those services are needed? Does the nursing home have to pay for it in its entirety? There is no Medicare coverage of those services. What typically happens?

Dr Hunter—They are supposed to be funded within the resources of the nursing home. It all depends on the nursing home as to whether they will employ, on some sort of basis, allied health practitioners. As I understand it, there is a lot of flexibility in the way allied health practitioners can be employed in residential care facilities. Some of them are very good and will employ on an as-needed basis speech pathologists, physiotherapists and dieticians, but not invariably.

Senator ALLISON—There is nothing requiring nursing homes, in accreditation or any of the other ways in which we decide what level of care there should be, to—

Dr Hunter—There is, but the requirement is pretty broad. Your therapy component might be diversional therapy, and that really covers the need for physio, speech pathology, nutritional services and so forth. You do not necessarily get specific allied health inputs.

Senator ALLISON—Would you like to see the MedicarePlus package be extended to allied health? I meant to ask a question in that bunch about oral health. As I understand it, a lot of people in residential care become very sick and often die as a result of poor oral health. Can you comment on that?

Dr Hunter—I cannot give you anything beyond that, but dental care and oral hygiene in residential care is a real issue—as is nutrition. Malnutrition is a very common problem of older people in acute care and also in residential care. There are a whole lot of reasons why that occurs. As for allied health and having access to some sort Medicare item, I think that would be a worthwhile thing to pursue. As I have said, a multidisciplinary approach to patient care is the best way to get good outcomes for older people. If you had access to a range of allied health professionals through some sort of appropriate funding arrangement, that would improve quality of care significantly.

Senator ALLISON—Anecdotally, it would appear that nursing homes are often required to resort to medication as a way of dealing with a range of problems, with not enough staff and not enough expertise in geriatrics. Is that your experience?

Dr Hunter—Yes.

Senator ALLISON—Would you like to expand on that?

Dr Hunter—The problem of polypharmacy and drug use is a very serious and significant one in residential care facilities, and in part it comes from the ignorance and skill mix of those who provide care. The answer to behavioural problems in patients with dementia, for example, is not to give them antipsychotic medications but to put in place appropriate behavioural and environmental strategies.

Senator ALLISON—Can this be done when we typically have a set-up where personal carers are the ones who mostly deal with people? Do you think we have got the mix right in terms of qualified nursing? As I understand it, the nurses in aged care still do not necessarily have geriatric specific training. Should there be further training for personal carers? Have you had a chance to look at the sort of training they do? Is it adequate, in your view?

Dr Hunter—There are two issues. I think that the way to improve medication use in residential care facilities is to adopt a multidisciplinary approach. It needs a combined approach from doctors—specifically general practitioners—and nursing staff and pharmacy input, with access to geriatricians and psychogeriatricians, in order to help work out what is the best evidence in terms of treatment approaches. Whilst the medication review processes that have been established through the Medicare items have gone part of the way, that has by no means answered the issue overall. We have really fallen short of having a proper multidisciplinary approach to medication management. MedicarePlus will flag a lot of issues. That is absolutely terrific and will help reduce medication use, but if you flag issues you have got to have the skills to manage those issues and you have got to have back-up—mainly from geriatricians, psychogeriatricians and palliative care positions—to help put in place best practice management.

Senator HUTCHINS—Did you mention malnutrition a while ago?

Dr Hunter—Malnutrition is a major unrecognised problem for older people in both acute hospital and residential care. One of the problems for older people with dementia when they are in residential care, for example, is that they lose weight at an astronomical rate. Some of that may actually relate to the dementia, but it also relates to how they eat and how their meals are provided. Malnutrition is often a result of that.

Senator MOORE—We could keep you all day talking about these issues. You both identified a shortage of trained people across the board, and I think there is acknowledgment that that is true. How do you address that? Some of the terms that you have used are professional terms that are very rarely even discussed, let alone talking about a strategy to attract people into the medical profession and the nursing and allied health professions. Do you have suggestions for the governments and for the community about ways to ensure that we can attract people into these professions?

Mrs Hurrell—Yes, certainly we do. Currently the national nursing task force is under way; in fact, Belinda Moy spoke to a group yesterday. A number of the strategies outlined within the recommendations they are looking at relate to not only nursing but aged care nursing in particular; although it is interesting that the two recommendations related specifically to aged care nursing are not the responsibility of that task force but have been referred back to other government departments.

As Peter has said, it is a multifactorial issue and a multiple approach is needed to solve it. It is about improved access to and the amount of undergraduate training in specialist aged care or gerontology for all disciplines. I do not think it is a one-discipline issue; it is across the disciplines. There are also opportunities for interdisciplinary training, pulling together medicine and nursing and allied health professionals to enable shared training to enhance the interdisciplinary nature of the work that is going to be of the future. We need to look at the workload issues of workplaces.

We need to look at the value that society and the community places on people in nursing. Valuing is about providing appropriate workplaces and remunerating those within them accordingly. Much of how people feel about themselves in the workplace comes from how they are remunerated. Currently aged care nurses are paid anywhere from $85 to $170 a week less than their counterparts in the public sector. If as a manager of a service I am already experiencing a national and international nursing shortage, how do I attract somebody to a service which appears constantly on the front pages of newspapers as providing poor service? The media constantly only reports on poor service and not good. However, my own experience is that, despite what we have said today, provision of services is high in the majority of cases but that is often not what is seen. Workloads are excessive. There are times when in many areas there may be one registered nurse to 40, 50 or 60 people. To try and manage that workload and get some sort of work-level satisfaction is incredibly difficult.

In terms of other classifications, I think we need to address whole models of care. We know that in the future there will probably be fewer registered nurses and they will become clinical leaders and troubleshooters. We need to address the whole emerging need for nurse practitioners in the aged care sector, both in the community and in residential care. We need to look at improving national education and scope of practice for enrolled nurses; it is variable across Australia. That causes enormous jurisdictional issues and restricts the career progression of those individuals. We need to look at career pathways within aged care. Current award structures do not allow for career progression in a clinical way as they do in the acute sector. For example, in the acute sector clinical nurse specialists and clinical nurse educators are remunerated for their additional roles that have come from the expansion of the clinical role. That is not the case in the aged care sector.

Senator MOORE—Is it a flat rate?

Mrs Hurrell—It is a flat rate, and then you go to management. There are not those clinical pathways, which I think is a hindrance for someone who wants an expanded clinical role. The role of the enrolled nurse has to be looked at, and it certainly is being looked at by the task force. In this state there is a real issue with the number of enrolled nurses who are trained. Access to training in New South Wales is a very contentious issue for my organisation. In this state enrolled nurse training is orchestrated basically by the state health department and numbers are determined by state health needs, which are acute needs. That does not take into consideration the needs of residential aged care.

Training for enrolled nurses in this state and in other states has a very acute care focus; they go off to an acute care hospital. A lot of enrolled nurse training could be happening within residential aged care. A large number of those who have done the certificate III course—nationally endorsed qualifications for care workers have existed for some time for both the residential and the community sector; in this state alone, 7,000 or 8,000 care workers have undertaken the nationally recognised qualification, and I teach those courses as part of my work role—often seek access to enrolled nurse training, and it is like a tight funnel. There might be eight in my classroom who would like to go on to become enrolled nurses and there is nowhere for them to do that. If they do get in, they have to leave their current workplace, go to an acute care environment and work rotating rosters, which is not consistent with family and other work issues.

There are some real barriers to access to those courses. That is quite disappointing because statistically we know that at the moment a large number of people entering registered nursing training are actually enrolled nurses. What we see in nursing is that people start off at certificate III level, move on to enrolled nursing and then up to RN training. I think there is a need to look at the whole notion of teaching centres for aged care where we develop centres of excellence, have training from multidisciplinary people and develop relationships with universities. They do exist—there are some joint nursing chairs that I am aware of. I know there is one medical joint appointment here in New South Wales, and I think there is one in WA. They engender the culture of learning and research which is critical to keeping people in the discipline and in the specialty itself. So it is not just one aspect. It will involve both departments of education and departments of health, state and Commonwealth, working collectively—as well as the registering authorities, because there are issues around licensing and regulation as well.

Dr Hunter—I agree with everything that has been said. Above and beyond that, I think that the universities and tertiary institutions have a lot to answer for. Very often, undergraduate teaching and places in postgraduate courses are more determined by the needs of universities than by the needs of the Australian community. If universities were really interested in training health practitioners in the real issues in the Australian community they would be changing their emphasis. The percentage of time spent learning about psychiatric problems, mental health disease in general, issues in general practice and issues in geriatric medicine is miniscule in most medical courses. It is really the politics of the various power plays in universities that determine courses, not what the Australian community need.

Senator MOORE—How long does it take to get your qualification?

Dr Hunter—In geriatric medicine?

Senator MOORE—Yes, particularly in your specialty. How long does it take to become one of you?

Senator HUTCHINS—A long time.

Dr Hunter—It takes several steps. Medical courses nowadays are either five or six years. Specialist training in geriatric medicine follows basic physician training. From completing your undergraduate training to completing your postgraduate training in geriatric medicine is another six years. So most geriatricians are delivered at the age of about 30. All up, it is about 12 years of specialist training.

Senator MOORE—After making at least two choices along the way to go down that path?

Dr Hunter—Yes.

Senator HUMPHRIES—Dr Hunter, I want to pin down the issue the chair raised with you about quality and the need for more quality indicators. You talk about us needing to have valid and objective health and safety indicators established. Can you give me an example of an indicator that we do not have at the moment that you think we should have in our aged care sector?

Dr Hunter—There are a number of dimensions. You can think of them in terms of depth and dimensions. I will focus on the area that is perhaps of more interest to me, and that is the continuity of care. In care systems per se, there are a number that you could think of that relate specifically to older people and they relate to the various geriatric syndromes. There could be quality indicators around falls and fall risks, pressure ulcers, continence and management of dementia. A quality indicator might be something around the use of antipsychotic therapy for the treatment of behaviour issues in dementia.

Senator HUMPHRIES—Our indicators at the moment tend to be things like inputs—for example, amount of hours of care.

Dr Hunter—It is more process than outcome.

Senator HUMPHRIES—You say that we do not even collect basic data about the health status of people in residential care. Can you give me an example of a datum that we do not collect at the moment that we should?

Dr Hunter—Studies have been undertaken that quantify a number of dimensions, but nothing systematically. Referring back to an earlier question: the percentage of people with malnutrition, the percentage of people with vitamin D deficiencies, the percentage of people with behavioural issues, the percentage of people who have falls and the incidence of pressure ulcers—there are all those sorts of very common problems that occur in older and more frail people.

Senator FORSHAW—Who should do that collection—the Institute of Health and Welfare? Do you have a suggestion as to how that data might be collected and who should do it?

Dr Hunter—I think the secret to using quality to improve care is to have local ownership plus some sort of robust database that allows people to compare their performance against others. I think there needs to be a central dimension to it, but there certainly needs to be local ownership of that data so that it can actually drive improvement.

Senator HUMPHRIES—Doctors who attend patients in nursing homes obviously keep records. Are there no means of collecting information from them about the sorts of things that you have mentioned already?

Dr Hunter—I doubt it. I think that the quality of documentation of medical practitioners in residential care facilities is variable, to say the least.

Senator HUMPHRIES—Mrs Hurrell, you make the comment on the first page of your submission that feedback from your members on the adequacy of work force supply and incentives:

> ... is incongruent with recently published research that suggests that remuneration and wage parity are not significant factors in relation to recruitment and retention.

What research is that?

Mrs Hurrell—The labour work force study? I can certainly provide the data which said that wage parity was not one of the key issues affecting recruitment and retention, and yet it is probably the most consistent thing. I am someone who is out in the field a lot and I work across a number of facilities across the eastern area. I attend a lot of meetings while representing my organisation, so I hear things at the grassroots level. At grassroots the key issue that is annoying nurses is wage parity—that and excessive workload. Regarding the current labour work force study, there are questions about how the data was collected and the volume of data collected. It is certainly incongruous with my feedback from members.

Senator HUMPHRIES—So it might be statistically invalid, do you think, in the way it was collected?

Mrs Hurrell—Yes, I think there are some questions around the statistical validity of the data. I can only go from the feedback I constantly get from clinicians at work level—that is, how do you attract staff? A colleague of mine in Tasmania has had an RN position advertised for eight weeks and not one reply. I have had directors of nursing ring me and say: ‘I have been on duty for 72 hours. I can’t find anybody and I can’t leave. I’m the only one here.’ When directors of services have to start doing night duty because there is nobody else, to me that is crucial and critical. As a clinician and a nurse I find that really distressing.

Senator HUMPHRIES—When you talk about the setting of standards within the sector, you make the point, which I think is a fair point:

> It should be noted that the development of Best Practice Guidelines should be the responsibility of health professionals and the aged care industry and not the Agency ...

That is, the accreditation agency. Given that before the agency was set up we did not have any nationally legislated aged care standards at all in Australia, why hasn't the sector developed its own best practice guidelines?

Mrs Hurrell—I think the sector is beginning to. We certainly have things like an integrated best practice model for medication management in aged care. We have research being done in relation to falls management. There are best practice guidelines and material out there. I think one of the biggest problems is that it is funded from a number of sources. It is undertaken spasmodically and often under small research grants. There is no collective central pool. One of the things that we would love to see is a central repository—a clearing house—for endorsed best practice guidelines specific to aged care.

Given that aged care is not a highly valued area, attracting research money to undertake the research and development of best practice models is incredibly difficult. Dr Hunter raised the issue of NHMRC grants not readily flowing to aged care and residential care. If we are already finding workload difficult, it would be yet another issue to try to involve nurses at a clinical level to get involved in research. Involving people in research and freeing up clinicians so they have time to participate in research is a fantastic way of improving quality and a fantastic way of involving them, retaining them and putting work value into what they are doing. I would love to see research money available for collaborative best practice development at a local level.

Senator HUMPHRIES—We hear a bit about the use of ambulances as a fallback in hospitals for provision of care, for example, at night when there is a fall or when someone needs to be attended to for primary care but they cannot get a doctor or appropriate person. How widespread is that practice? Do you think there is a solution, other than simply increasing staffing levels?

Mrs Hurrell—I think it is variable across jurisdictions and across geographical areas within those jurisdictions. I would suggest that it is particularly so in low-care services, where often at night there is no health professional on duty. We now know that about 60 per cent of clients living in low care are classified as high care; yet there is often no health professional on duty and there may be only one or two carers. So an incident occurs which, had there been a health professional there—a registered nurse, for example—may well have been managed on site and a clinical decision may have been made to keep the person there until the morning when an assessment could be done. A carer is in the situation where they are unable to make those clinical judgments—and appropriately so—so organisational policy is to transfer that person to hospital.

In other areas where there may well be a health professional, there may be one health professional to 40 or 60 people. There may be two falls that have happened plus there is somebody who is highly agitated whom you are trying not to restrain with medication. It is impossible to try to manage all those three situations at once. So certainly staffing levels and, more importantly, skills mix often impact on that rotating service.

As someone who has worked in those environments, I think the other major issue is access to medical care after hours. Increasingly, a lot of general practitioners are themselves not offering an after-hours service but are offering it through a locum. You can literally have someone who has fallen and no-one to organise a mobile X-ray in the middle of the night. So, rather than send them via A&E, you ring the medical practitioner and you get the locum saying: 'I'll be four hours. What's the problem? Transfer them,' or, 'I'd love to do an X-ray but I can't; you'd better transfer them to the local hospital anyway.'

So it is multiple. It is access to medical care. It is access to mobile diagnostic services. It is also about advanced health care planning. That is another issue that is emerging as one of the reasons for inappropriate transfers in and out of hospital. There needs to be a strong all-stakeholder involvement in increasing people's awareness of the need for advanced health care planning. People are getting admitted to hospital at 11 o'clock at night with aspirate pneumonia in end-stage dementia. I was talking to someone about this only yesterday. There is a need to discuss with families what the options are—that is, whether they want to be transferred to hospital at that point in time or whether there is a more appropriate way.

It is also about breaking down barriers between the states and the Commonwealth and allowing outsourcing of acute services and support services to clients in residential care. There is no doubt that nurses in residential care would prefer to keep people there as long as they can, but often they do not have the support of allied health and of medical care to be able to do that. Nor does the current funding arrangement fund acute care in the residential sector. The ability to purchase equipment and undertake dedicated staff training around technical procedures and the management of subacute problems is just prohibited by that, so services then do not want to take on the risk of offering suboptimal care. It is a multifaceted problem that needs a whole-of-government approach.

Senator FORSHAW—The NLS study notes that only 11 per cent of employees are permanent, full-time employees and that the sector is characterised by permanent part-time and casual employment. Is that an issue for recruitment or is that actually a good thing?

Mrs Hurrell—You need to look at it in two ways. I think this whole notion of recruitment and retention needs to be viewed in the context of the work force generally and not just in the health and ageing sector. People now do not stay in the one career for all their lives—they will often move in and out. If we can keep nurses now for seven or eight years, that is great. The chances of seeing a nurse doing the same job 30 years down the track is probably gone, and that would be true of other industries as well. We have a work force in nursing that is ageing, particularly the aged care nursing work force. Our work force is predominantly women, and there is a need for part-time work. I am a working mother, so I know that you need to have flexibility in the workplace. One of the selling points for aged care has been that we can say to people: 'We can give you fixed shifts. We have some flexibility for child-care purposes.' Child care is incredibly difficult for nurses. What child-care centre opens at seven, is still open at 11 o'clock at night and opens on Sunday night? They just do not exist. Given the salaries and hourly rates and the issue of child care, it is almost impossible to actually want to work on a Sunday afternoon. I would say that that is true for a number of other disciplines as well, but is particularly true for nursing because it is 24 hours a day, seven days a week.

So part-time work has its benefits in that we can offer flexibility and offer a return to work for working mothers. We offer paths in the work-life balance issue which perhaps you cannot get in other occupations. Having said that, for a manager, part-time work creates the need for very tight systems and processes to ensure continuity. It also raises some difficulties in that there are more people to train and more people to manage from a HR perspective. There are some indirect costs related to an increased part-time work force.

CHAIR—Thank you both for your openness and frankness. The evidence you have provided to the committee has been very good. If there is anything further you would like to provide us, please do not hesitate to contact the committee.

Proceedings suspended from 12.37 p.m. to 1.26 p.m.

KATZ, Ms Catherine, Director, Intergovernment and Funding Strategies, New South Wales Health

MANNING, Ms Elena Loren, Acting Manager, Intergovernment and Funding Strategies Branch, New South Wales Health

MATTHEWS, Dr Richard John, Deputy Director-General, Strategic Development, New South Wales Health

CHAIR—Welcome. The committee prefers evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. You will not be required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy, given that you are public servants. The committee has before it your submission and we thank you. I now invite you to make an opening statement before we move to questions from the committee.

Dr Matthews—I took the liberty of providing hard copies of a short series of what were going to be slides as discussion points. I am happy to go through those and then take questions. The first page attempts to list some of the problems in relation to the delivery of aged care in New South Wales. These include, as we all know, changing demographics in population—and I will go to the detail of that in a moment—and an inadequate and ageing work force with difficulties in retention. There are problems with the operational placements for residential aged care in terms of number, sites and payment levels and whether the supply matches the demand. Our community based services are under considerable pressure. We have large and increasing numbers of aged care patients inappropriately in acute beds—and I will go to the detail of that too in a moment. There are difficulties around funding and appropriate service models for younger people with varying kinds of disability, and it is an area where funding systems and arrangements are often confused and confusing.

The next page deals with some of the problems around younger people with disabilities who are often inappropriately being cared for in aged care facilities. There are large and increasing numbers of younger people with complex disabilities who are surviving for longer periods of time because of available care. Some of the examples of this are given here. There are, at our best count, something like 391 people aged less than 50 whose degree of disability requires residential care but who are placed in residential aged care facilities.

The next slide graphically illustrates the three problems that we have. The bar charts divide age distribution in New South Wales into four age categories over three time periods: 1981, 2001 and 2021. You can see that by 2021 the numbers of people aged between zero and 14 will be slightly less than now. The numbers of people aged 15 to 44 will be pretty much the same. This is a critical age group because it is the age group that is actually entering the work force. So, whilst the numbers of people entering the work force will be roughly the same, their relative numbers will decline significantly. The age group between 45 and 64 will increase fairly rapidly. The age group 65-plus will double. I am sure these things are known to you. They illustrate a flat line entering the work force, an ageing work force and an increasing number of old people. We are going to face the very serious problem of an older and older group of folk caring for an older and older group of folk.

The next slide is a little busy but we really need to concentrate only on the yellow line. It shows the results of two surveys of all patients aged 65 and over in acute public hospital beds in July 2001 and July 2003. It is a snapshot, and it shows that performance in this area is going backwards. In July 2001, 66 per cent of people over 65 who were in an acute bed were there because they needed acute care. Two years later that figure had dropped to 56 per cent. In other words, performance in terms of moving people from acute beds into more appropriate forms of care in New South Wales is declining over time. The slide further divides people into various categories and I can go to the detail if you wish. From our perspective, this is considerably impacting on our capacity to provide acute services, because the number of acute bed days that are taken up by people who do not require acute care is growing.

The next slide shows the same thing in a different way. One of our performance measures is access block, which is defined as the percentage of people who are still waiting in an ED eight hours after the decision is made to admit. Access block has been rising in New South Wales, but this slide shows that it is very much an age related problem. If you are under 15 there is very little access block; you go into a bed. If you are between 15 and 65 there is a fair level of access block. If you are over 65, about 50 per cent and rising are still waiting for an acute bed in the ED eight hours after the decision to admit has been made. Again, this is a sign of declining performance.

Those slides try to delineate the problem. We are anxious to say that not all the news is bad. The next slide attempts to show what strategies New South Wales Health has invested in to manage this demand pressure. We have divided the slide into three sections. Those strategies which are aimed to prevent or divert attendance at EDs—hence, into acute services—are listed there. They are: improved primary health care; the Chronic Care Program, which has prevented a lot of inappropriate admissions; GP after-hours services, which are slightly stalled at the moment; aged care emergency teams; advice lines; and the very successful Carers Program, which I may ask Elena to talk about in a moment.

Once at the ED there is a possibility of diversion to acute post-care in the community, the hospital in the home; home and facility based transitional care, which I will also come to in a moment; and the aged care services emergency teams. Once in the hospitals, again, there are a number of effective strategies, such as ComPacks; home and facility based transitional care; and the cooperation with the Commonwealth around the Pathways Home money, which has been very successful and is now becoming operational. There are a number of other initiatives, such as the planned repeal of the Nursing Homes Act, the reform of the SEPP5 to improve the approval process and the potential to co-locate aged care facilities on land which belongs to the Health Administration Corporation.

The next slide lists the number of non-operational places by region, prior to the 2004 budget announcements. You can see there is a total of 7,362 places which are in some stage between approval and notional funding and actual opening of the doors and accepting patients. The good news is that, in partnership with the Commonwealth, there has been a number of successful pilots of transitional care, which is the next slide.

I really want to focus on this slide for a moment because this is an example of a way in which everybody can be a winner. This shows 703 individuals in seven trials who, prior to going into transition care, had an average length of stay in an acute bed of 34.4 days, as against the average of something like 3.4. Their referral and assessment time was 9.4 days. Then they spent an average length of time of 38 days in transition care. These were all people who had been assessed by ACAT teams as requiring aged care. You can see that at the end of that transition care process 53 per cent, which is more than half, were able to return home and did not require an aged care facility—that is, 22 per cent went home with no need for services at all, 17 per cent went home but with some HACC services and 14 per cent went home but with CACP. Twenty-two per cent did need to go into residential care but only 12 per cent into high levels of care, some had to be readmitted to hospital, some were lost to follow-up and two per cent died.

Here is an example of where patients are winners because patients want to go home, families are winners because generally the family want them home, the state is a winner because they are not occupying acute beds and the Commonwealth is a winner because 53 per cent of them are not occupying aged care beds. So we believe that these trials have been an outstanding success. However, they have been implemented as trials and innovative programs across the state and there is now a need to match the services to the real demand as we expand these places. We also would like to put on the table that we see this as a shared responsibility because, in our view, transition care sits between state and Commonwealth responsibility. The current Commonwealth support for this—roughly $86 for facility based and $70 for home based—is far less than 50 per cent of the total cost. We are currently doing a review to look at the total cost.

Moving on to solutions, clearly supply equalling demand is the critical factor. Solutions include exploring and continuing to explore these cooperative models of care with all jurisdictions—it should read ‘all’ rather than ‘both’ on the slide—working together and expanding the transitional care program—that is, appropriate level of care in the appropriate place. Solutions also include work force initiatives, operationalising places faster—we recognise that some of that is our responsibility—and financial incentives for the private sector to accept clients or patients whose level of disability leads to some challenging behaviours. We believe that the present price signals to the private sector in relation to the most demanding patients are not sufficient. Other solutions listed are improving the range and scope and having appropriate places for the young disabled requiring care, people with mental illness, intellectual disability and organic brain damage, and those with challenging behaviour. Those are my opening remarks.

CHAIR—Thank you very much. We look forward to reading your submission at length. You have given us so much information here. Going to the slide about the transitional care program, we had evidence earlier today about the success of this program as well. Just correct me if I am wrong, but I understand that it has been through a trial and we are now hoping to formalise the process. Is that the case?

Dr Matthews—That is the case. In the first round, in New South Wales, there were 135 transitional care cases, spread across seven or eight sites; in the second round we have just implemented and received a level of Commonwealth funding for a further 120; and in the last budget there was an announcement of a further number of funded places. New South Wales will be seeking their population share of those funded places, which is roughly 32 per cent, but we do have some concern that the level of contribution from the Commonwealth at this stage does not equal 50 per cent of the true cost.

CHAIR—You were saying that $86 is paid by the Commonwealth for—

Dr Matthews—Facility based care, and $70, give or take a few cents, is paid for home based transitional care.

CHAIR—And the total cost, on your assessment, of facility based—

Dr Matthews—It varies according to the model but probably averages out at something like $320.

CHAIR—And home based care?

Ms Manning—We have not costed that. We are currently evaluating the six intermittent care pilots, which are part of the transitional care program. We will be doing extensive costing studies to compare the two models of community based care and facility based care.

Dr Matthews—We also have the ComPacks, which is a truly state funded initiative. There are about 6,000 of those now funded—or 4,000; I will have to check on that. Effectively, a ComPack is a package of care for someone to return home. There is very little difference between a ComPack and a home based transitional care program, except that there is a different assessment process and a ComPack is 100 per cent state funded whereas the home based transitional care has a level of Commonwealth support.

CHAIR—We heard today about the complexity of aged care—

Dr Matthews—Indeed.

CHAIR—and that adds to the story. I suppose the statistic I am interested in talking to you about relates to the 703 individuals that were assessed as needing care, where 20 per cent of them ended up with no care or no services. How does that occur?

Dr Matthews—After the appropriate transitional care program of 38 days, their condition and general state of health meant that they were able to return home and did not at that point require any further services.

CHAIR—And for a period of time after that?

Dr Matthews—This is early days and the follow-up is yet to be done. But as regards that 53 per cent who did manage to return home either with no level of care required or with some level of care, the next question is: how long does that state of affairs continue? We cannot answer that question yet but, as we follow these individuals and introduce more trials, that information will emerge.

CHAIR—How long has this trial been operational?

Dr Matthews—Two years.

Ms Katz—This would have been assessment from the first set of trials, so I think from 2002—

Dr Matthews—But they came online across the country at different times and in different places with quite different models. So to some extent within this 703 there would be some apples and oranges issues. It is very early data but it is extremely encouraging data.

CHAIR—You are certainly right there. I go back to your age distribution graph. It says to me that we are going to need a lot of services by 2021. Some of them will be in residential care. What is New South Wales thinking about as regards the number of extra residential care beds that will be required by that time?

Dr Matthews—I am not certain that I can answer that question.

CHAIR—I suppose it is not within your jurisdiction, but I am sure you have an interest.

Dr Matthews—This graph was actually produced as part of the first stage of what we call our futures planning project, which I have responsibility for. The first stage is the production of a report on the demographics, the population distribution, across the state by 2021 in order to inform that process. That process will be similar in nature to what was called the Wanless report on the NHS in the UK. It will try and make some predictions about what New South Wales Health will be doing in 2021 right across the spectrum of care: how models of care will change; how hospitals will change; how much more care will be provided in the community—that is, where appropriate, certainly the most economically effective way to provide care; and what effect changes in technology will have on the way that we are providing care in 2021. I do not have any accurate predictions at this stage about the number of aged care beds that we will require in 2021.

Ms Katz—Currently, the rationale for allocating places depends on a number per population over the age of 70. One of our concerns is that we need to review that allocation and perhaps look at more places because the ‘older old’ group, those aged over 85, will need a lot more support as they get older.

Dr Matthews—It is quite clear from all our population studies that, whilst people are living longer, people are also having a much longer period, on average, when they are quite healthy—50 is the new 21 et cetera, I like to tell myself.

CHAIR—I look forward to that!

Dr Matthews—This demographic does not sneak up on us quite as badly as it might appear, because the trends are that far fewer 70- and 75-year-olds will require care than was the case with 70- and 75-year-olds 30 years ago, but that will be more than made up for by the increased number of 80- and 85-year-olds whose level of care need and complexity will be far greater.

CHAIR—The other question that comes out of this graph is about not only the number of places or beds but about the work force—

Dr Matthews—The work force is the scariest part.

CHAIR—because that will continue to increase.

Dr Matthews—What this graph shows is that, in the 15 to 44 age group, the health care industry and the hidden services industry will be competing with every industry for a work force which is diminishing in relative numbers. So we will be competing with every other industry for numbers of people to provide care.

CHAIR—Whether they be in a residential institution or in community care—

Dr Matthews—Yes, absolutely.

CHAIR—the work force needs are going to be huge.

Dr Matthews—There is only one solution this side of major changes in fertility or immigration patterns, and that is that this group—the 45- to 64-year-old group and beyond—stay at work longer. There is no other solution.

CHAIR—I do not know that the community will necessarily agree with that.

Dr Matthews—The community probably, in the main, do not, but it is a simple numbers game and there is no other solution.

Senator FORSHAW—And they will all get jobs in aged care facilities.

Senator HUMPHRIES—Work till you drop, if you ask me.

CHAIR—I think that is Liberal Party policy.

Senator HUMPHRIES—I would like to raise some of the issues other witnesses have put to us today about the way state departments handle issues to do with ageing and people with disabilities. I see that your departmental motto is ‘Working as a team’ but a number of people have suggested today that you do anything but that. For example, the Royal Rehabilitation Centre were quite critical of the inability of NSW Health and the Department of Ageing, Disability and Home Care to appropriately decide which clients fall under whose responsibility. They said:

> There is also a lack of clarity in terms of the definition in which the various government agencies consider to be their “client group”. Currently in NSW, DADHC is suggesting that some disability groups would not be eligible for services and funding by the department and that these population groups belong to NSW Health ... The “compartmentalisation” of services by Government departments contribute to the problem.

What is your response to that?

Dr Matthews—That is not an unfair call. The Australian Constitution itself guarantees that these issues will occur by the way that, in the first instance, there is this somewhat arbitrary, ad hoc division of care between the Commonwealth and the states, whereby the Commonwealth is responsible for the front end and the back end and the state is responsible for the middle. There is a whole stack of nasty interfaces there that get in the way of service delivery.

Senator HUMPHRIES—Could I pick you up there. The point they are making there, although they may make it elsewhere, is not about the Commonwealth-state interface; it is about the state agency to state agency interface.

Dr Matthews—Yes.

Senator HUMPHRIES—They say that the lack of state-level coordination of services is a significant problem.

Dr Matthews—I think it is ‘a’ problem. I think the most significant problem is that there are simply not enough resources in the various buckets to provide the services that are needed by people with disability. DADHC, which have come under criticism, simply do not have the level of resources required to care for the rapidly increasing number of people with disability who are their responsibility. I would say that, whilst there are always agency interface issues, the major issue is lack of resources.

Senator HUMPHRIES—The problem we are encountering in this committee is that, because there are no facilities at state level to house, for example, young disabled people, they are being shunted into aged care facilities. They are the only facilities across the nation where there is care available for people with high levels of need, and the cost of that is being comprehensively shifted into the Commonwealth’s bailiwick by virtue of the inability of the states to meet that obligation.

Dr Matthews—Yes. On the other hand, we might say that in the 22 remaining state government nursing homes there is a level of state funding—approximately $20 million a year in recurrent funding—to support people in aged care facilities, which is a Commonwealth responsibility. If we could free up that money, we could notionally use it to provide services for younger people with a disability.

Senator HUMPHRIES—We were told that young disabled people who are not in a nursing home are eligible for PADP funding for equipment that they use but that if they go into a nursing home they lose their eligibility for that funding. Is that the case?

Ms Manning—Not quite. With regard to PADP in New South Wales, the policy is that people in the community are entitled to PADP. People in nursing homes are entitled to PADP if it is for a piece of customised equipment but, if it is a piece of equipment that can be used by other residents in the residential aged care facility, then it is the responsibility of the residential aged care facility to provide that. That is within the funding arrangements.

Senator ALLISON—What about a motorised wheelchair?

Ms Manning—If it needs to be customised then it is the responsibility of the PADP. The difficulty that we have—

Senator ALLISON—What does ‘customised’ mean?

Ms Manning—‘Customised’ means that only that person can use it. Obviously, people’s postures, weight issues, disabilities and medical issues are all different. There is a degree of overlap and confusion about that policy. I understand that. We are trying to resolve it. It has been a longstanding issue between the Commonwealth and the state. But PADP is one of the programs that is absolutely critical to supporting people with disability in the community. I know that New South Wales Health has increased its investment in dollar terms by 70 per cent over the last five years, and it is still not enough to be fair. It is now close to a $19 million program and we keep on investing money in it. Obviously, there is a need that we need to be cognisant of.

Senator HUMPHRIES—Why should the fact that a disabled person is in a nursing home mean that the responsibility for funding their PADP-type equipment—customised or not—is taken off the shoulders of the New South Wales government?

Ms Manning—That is the funding arrangement—that is my understanding—from the Commonwealth in order to fund the residential aged care facility. So part of the funding for that bed includes equipment costs within it.

Senator HUMPHRIES—So you are saying the Commonwealth is happy to take on the responsibility for the equipment funding?

Ms Manning—I am not sure if they are happy. My understanding is that the cost for that bed is inclusive of equipment that is non-customised. I can get some further information, if that would be helpful, and provide it to you.

Senator HUMPHRIES—That would be useful.

Ms Manning—It has been an ongoing policy issue that we have been trying to address.

Senator HUMPHRIES—The Inner West 5 Home and Community Care Forum take up the question you raised about additional resources going in to assist young people with disabilities. They say:

> ... the Department of Ageing, Disability and Home Care has embarked on a significant Devolution Program to relocate people with disabilities living in large institutions, into community living situations ... Yet to date no move has been made to relocate the estimated 450 people under 50 years who are resident in aged care facilities in NSW.

Aren’t they saying that, because you have a responsibility for those young people who are presently in a facility that you run, you are happy to move them into boarding houses or places like that—wherever it is you are moving them to—but you are not so keen to move those who are in nursing homes into more appropriate facilities?

Dr Matthews—The DADHC move from institutional care is part of a very long move that is often labelled a Richmond initiative, but in fact the move in both mental health and disability commenced in about 1944, and there has been a reduction since. That is largely driven by model of care ethical issues around keeping in institutions large numbers of individuals who could in fact be cared for in the community. In New South Wales in 1944 there were something like 8,000 beds in total. The number of beds is now somewhere around 2,000. So very large numbers of people have been moved from institutional care into the community.

Senator HUMPHRIES—I understand that. But why hasn’t that also been taking place in regard to aged care institutional care—putting those people back into the community?

Dr Matthews—I do not know that it has not.

Senator HUMPHRIES—Or indeed to other sorts of appropriate accommodation?

Dr Matthews—My understanding is that that would be happening. The problem is—and this is a very real problem—is around whether it is sustainable. I am not here to speak for DADHC. But there are increasing numbers of individuals being cared for in the community by DADHC where in some cases the annual cost of care is up to $900,000. There are very many individuals whose annual cost of care is over $500,000.

Senator ALLISON—Per person?

Dr Matthews—Per person per year. Because they require 24-hour personal care by individuals it is an enormously significant impost. As I say, the question is, despite the desirability of the best model of care—the ethical considerations and all those things—as there are increasing numbers of people with profound levels of disability surviving, there is a very real question as to whether the model is sustainable.

Senator HUMPHRIES—I was not necessarily suggesting that you move young disabled people out of nursing homes into community care, group houses or whatever, but the tenor of the submissions to us has been that they should not be in nursing homes with much, much older people around them, no social interaction with peers of their own age and so on. Transition into other sorts of institutional care that is more suited to their needs is what is being talked about. Why isn’t that taking place?

Dr Matthews—After a meeting took place between our director-general, the Director-General of DADHC and me, I have been given responsibility for conducting a review of what used to be the schedule 5 hospitals across New South Wales, of which there are eight or nine still in existence. Those schedule 5 hospitals, such as Morisset, Kenmore, Bloomfield et cetera, are in the main jointly shared between Health and DADHC. They contain subacute mental health beds and rehabilitation mental health beds. They also contain relatively large numbers of people under DADHC’s care in institutional care. I have been asked to review what we have there and to explore potential alternative models of care within our existing facilities for those people with disabilities who do require institutional care.

Senator HUMPHRIES—I think exploring those issues is welcome, but some might argue we should be going further than just exploring those issues at this stage. Could I just clarify something? This is a joint submission from New South Wales Health and DADHC, but there is no-one here from DADHC today to talk to the committee; is that right?

Dr Matthews—No, there is not.

Senator HUMPHRIES—Can you explain the point in your slides about offering financial incentives for the private sector to place challenging clients; what you mean by that?

Dr Matthews—With the exception of the state government nursing homes, which are ours, aged care is almost universally provided by the private sector—the private sector, of course, has a profit motive—and, of course, there is some not-for-profit involvement.

Senator HUMPHRIES—Isn't that the majority of the aged care sector in Australia?

Dr Matthews—Yes. The point is, however, that in our view the funding for the various levels of care is weighted towards the lower level of care, and the funding available for the higher levels of care—for the people with the greatest level of need—is not sufficient to be able to provide the care. It is for that reason that the state government nursing homes have increasingly carried the burden of the people with the most difficult and challenging behaviours. Also, when you look at my rather busy slide of people in acute beds who require other forms of care, it shows that increasingly they are the people who are most difficult to place because that higher level of care is inadequately provided. That is what we mean by that.

Senator HUMPHRIES—Presumably the financial incentives in that situation would have to be Commonwealth provided, wouldn't they, since they are the ones that fund the places?

Dr Matthews—Indeed.

Senator HUMPHRIES—You are in discussion with the federal government about that, are you?

Dr Matthews—Constantly. There is an alternative solution of course: the Commonwealth could make a decision to be not just a fund holder and service director; it could become a direct service provider and provide the service itself.

Senator HUMPHRIES—Another alternative that has been put about is that the Commonwealth should take over the running of health in this country altogether, which is a debate we can have another time.

Dr Matthews—We would welcome it.

Senator HUMPHRIES—I am sure you would. Whether Tony Abbott would or not is another matter; I am not sure about that. You talk about one of the strategies being the repeal of the Nursing Homes Act. Why do you want to repeal that act?

Dr Matthews—It is my understanding that New South Wales is the only state that still has a nursing homes act and a role in the regulation. The regulation of accreditation and standards is appropriately a Commonwealth matter and we are really in catch-up mode with the other states.

Senator HUMPHRIES—As to the accreditation process for nursing homes, you are not directly involved with it, obviously, but do you have an opinion as to whether this process is appropriate? We have had views that it is a bit heavy-handed and time consuming. Have you had any feedback that might give us some clues about how the process has been handled?

Dr Matthews—As we say in the submission, we are in favour of robust accreditation. All of our acute care and other care facilities are to undergo accreditation from external providers. Clearly, this is an area where abuse has great potential, and indeed has occurred in some places, so it needs to be robust and regular. We feel it is a Commonwealth responsibility to do so.

Senator FORSHAW—Senator Humphries has covered the range of the issues I wanted to follow up on—that is, young people with disabilities in nursing homes. I turn to your table of the reasons why patients 65 years of age and over are in hospital and I wish to clarify something. The table for 2003 shows 81.1 per cent of patients in that age group receiving care in hospitals. Are these both public and private hospitals?

Dr Matthews—No, this is exclusively public health.

Senator FORSHAW—The next line states ‘Awaiting RAC placement’—that is, awaiting placement in a residential aged care facility, as I understand it.

Ms Katz—Yes.

Senator FORSHAW—The figure is 6.9 per cent. In the top part of the table you identify the percentage of patients who are receiving rehabilitation care, palliative care and so on. I am trying to ascertain the proportion of people in this age group who are in an acute care facility, a public hospital, who should be in a residential aged care facility. Is it just 6.9 per cent, or does it also pick up persons who may be in some of those other categories? I would have thought so.

Dr Matthews—Yes, it would be some of those others, but not all of the others.

Senator FORSHAW—Are you able to give us a more definitive figure? You might like to take this on notice: how many people are currently in an acute care facility that would, if they could, translate to an aged care facility—both as a number and as a percentage? If you cannot do it now, you can take it on notice.

Ms Katz—We can take the question on notice. I am looking at the figure of 11.02 per cent in the table. The patients at the long-stay unit or ward have generally—and I am probably speaking anecdotally; I would have to go back to the figures—given up hope of being housed in a residential aged care facility, so they are not actively waiting. But they would go there if there were something—so there is definitely 11.02 per cent. Then there would be a number of the group in the 4.9 per cent category—

Dr Matthews—They are still awaiting assessment or the family is still pondering the decision.

Senator FORSHAW—This is what I was trying to work through in my mind. We will say it is 11.02 per cent as a minimum figure. They would all be persons who have been assessed in one way or another as appropriate for aged care nursing home places, and then there could well be others in addition to that. Is that a fair assessment?

Ms Katz—That is a fair assessment. There may be others in the middle category—patients of a long-stay unit or ward—who may have received an assessment, but not a recent formal assessment, for a residential aged care placement. It would be reasonable to expect that they would have had an assessment for placement but that might not have been recent. You said 11.02 per cent, I think.

Senator FORSHAW—Yes—of that 3,697. And is the reason unavailability of places?

Dr Matthews—It is unavailability of a place or often unavailability of a place somewhere reasonably close to the family. There are those kinds of issues. The level of care is another—there may be a place, but there may not be a place with the level of care required for this particular person. So it is about matching supply and demand.

Senator FORSHAW—Can you tell us the average length of stay in the public hospital or the minimum and maximum length of stay for persons in this position?

Dr Matthews—We know from the transition care slide that those people who were going into transition care had had an average length of stay of 34 point something days—10 times higher than the average length of stay in a hospital. That would probably be a fair bet for most of these as well.

Senator FORSHAW—You may need to take this on notice. Have you costed out what that means to the state health or public hospital total budget?

Dr Matthews—We would need to calculate the total number of bed days for you and take an average cost of an acute bed per day. The real cost is actually in the people who are not getting into the acute beds. If these people were moved on, we would not save the money because there would be other people who needed acute care in those beds. So the real cost is not the dollar cost; it is the people who are not getting in.

Senator FORSHAW—I appreciate that, but I suppose those people who are not getting into the public hospitals because of the blockage can have all sorts of impacts on costs everywhere else—

Dr Matthews—Absolutely.

Senator FORSHAW—including additional cost to the Commonwealth through Medicare treatment and so on not being done in the hospital.

Dr Matthews—It is a cost to us all.

Senator ALLISON—Can I take up that point. In the schedule you have given us of reasons patients are in hospital, you have come to a figure of 6,588. That is not that far away from the current non-operational places in New South Wales. This raises the question: if those places were operational, would that mean there would be an excess in the number of beds available for need, or is there a much larger cohort coming through without going via acute hospital care?

Dr Matthews—This is only the group of people who are actually occupying an acute bed on a particular day. There are people who are currently at home who have been assessed as needing aged care.

Senator ALLISON—Do you have that figure?

Dr Matthews—We can come back to you with the total number of people who have been assessed as needing it, yes.

Senator ALLISON—Can I ask about private provision. We raised this question earlier this morning. It concerns the number of people who might have private health insurance but who are typically denied access to private hospitals—I am told that it is pretty much 100 per cent of those people who are already in residential care. If they need to go to hospital, the option is often not open to them. This morning, the committee heard that those people are told there are no beds available—‘Sorry, they are full up’—and they have to go to the public sector. Is that of concern to you? Do you know about this? Can you quantify it?

Dr Matthews—Most people, but not all, who go from residential aged care facilities go to EDs as acute admissions. Where a person in a residential aged care facility would be in the category of booked elective surgery for a hernia repair, say, there ought not be any impediment—

Senator ALLISON—We know there ought not be any impediment, but is there one?

Dr Matthews—Probably. New South Wales is also bedevilled by having the lowest level of private hospital bed availability per 1,000 people anywhere in the country. We have about 88 bed days per 1,000, as against 123 in Queensland.

Senator ALLISON—How does that match the number of people who pay their premiums to private health insurance? Is it also lower in New South Wales?

Ms Katz—I do not have the figures at the top of my head, but New South Wales would have either the average or just around the average patient rate across the country.

Dr Matthews—We are the lowest state in terms of private hospital bed availability—that is largely historical.

Senator ALLISON—It sounds like you are being dudded. I have a question about the work force. This morning, the committee heard—and this is a particular problem in New South Wales—that there is no career pathway for personal carers who might want to do additional training to move to be enrolled nurses and then move on to be registered nurses; there is no seamless transition. They have to leave aged care and go into acute hospitals in order to qualify. This is a problem for keeping nurses in the aged care sector, leaving aside other issues like wage parity. Do you have a role in this question? Also, do you make representations to universities about the number of places for aged care workers?

Dr Matthews—We are constantly making representations about the training of the undergraduate work force because, with the exception of the enrolled nurses, undergraduate training is a Commonwealth responsibility. We are in the difficult position where our work force, at least at undergraduate level, is trained by the Commonwealth.

Senator ALLISON—It is my understanding that neither the Commonwealth nor the states is able to say to universities, ‘We want 1,000 extra nurses, please,’ unless the Commonwealth funds those places in an extra way. Have you made representations to the universities and said, ‘This is what the needs of the aged care work force are and this is how we would like you to think about the numbers’?

Dr Matthews—What I can say is that our Premier has raised the work force issue as a whole at COAG and our health minister has raised the work force issue as a whole in fairly great detail at AHMAC, the health minister’s meeting.

Senator ALLISON—What is New South Wales calling for?

Dr Matthews—We have produced a fairly comprehensive work force plan and we are calling for the cooperation of the Commonwealth in, amongst other things, training more people at undergraduate level in almost every category of the work force. We are going to increase the number of people entering the enrolled nurse training program in order to increase that section of the work force.

Senator ALLISON—Are you able to answer my first question about the transition from personal carer, to enrolled nurse to registered nurse and the need to go into acute?

Dr Matthews—I think all the enrolled nurse training would be in the acute sector.

Senator ALLISON—Yes, that is my point: you cannot keep the work force in the aged sector whilst training them.

Dr Matthews—It is a good question. I will have to take that one on notice and get back to you as to whether there are any initiatives in that area; work force is not in my portfolio, so I will come back to you on that.

Senator ALLISON—Going back to the former question: is it possible to give the committee a breakdown of your work force or training asks, as it were?

Dr Matthews—Yes, we can do that.

Ms Katz—We have a document that we can give you.

CHAIR—There are no further questions. Thank you very much to the representatives of New South Wales Health. Thank you for taking those questions on notice, and if you can provide answers as quickly as possible that would certainly be appreciated. If you have any other information you would like to provide us with, we would certainly be happy to receive it.

[2.21 p.m.]

ALLEN, Mrs Tracey, Subbranch Delegate, Aged Care, Health Services Union

BRADBURY, Ms Natalie, Acting Assistant Secretary, Health Services Union

FOX, Mrs Elsbeth Evelyn, Subbranch Delegate, Aged Care, Health Services Union

HUGHES, Mrs Sheila, New South Wales Counsellor for Aged Care, Health Services Union

PEACOCK, Ms Josephine Sally, Subbranch President, Health Services Union

CHAIR—Welcome. We are aware that you do not want to identify the facilities that you work in. We respect that, so do not feel pressured that you need to identify the place where you work. Our committee prefers all evidence to be heard in public, but should you think at any stage that the evidence you want to give is confidential, please advise the committee and we will consider that request. You are reminded that evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. We have your submission. We thank you very much for that very comprehensive submission. I now invite you to make an opening statement, which will be followed by questions from the committee.

Ms Bradbury—As you have said, the committee is in receipt of our submission. The Health Services Union is a registered trade union representing some 37,000 health and aged care workers in New South Wales. In the aged care sector the HSU represents aged care workers in both the charitable and the not-for-profit sectors. We represent care workers, including personal carers and care service employees, and support staff, such as cleaners, cooks, recreational activities officers, diversional therapists, administrative staff and maintenance and outdoor staff.

Our submission makes it quite clear that in our view current proposals, including those in the 2004 budget, are totally inadequate to address or overcome shortcomings in the aged care work force. While the 2004-05 federal budget contained $2.2 billion in extra spending for aged care, our concern is that none of that money was directly allocated or tied to addressing staffing shortages. While the government has encouraged providers to spend some of that funding on staffing and training, there is no formal requirement to do so. In our view that is simply not good enough.

In the view of the Health Services Union, the current aged care system is failing to deliver sufficient staff to provide the care and safety that residents require. Therefore, in our view there needs to be greater regulation of the staffing requirements in the industry. The union supports the establishment of minimum staffing levels for the care and ancillary staff in aged care to ensure that all facilities provide a basic level of care. Minimum staffing levels would, of course, need to be based on the number of residents, the needs of those residents and the acuity of those residents.

In the lead-up to this inquiry, we had an opportunity to canvass our members in aged care about their concerns with the industry. Insufficient staff and excessive workloads were their primary concerns. Members explained it as a vicious circle where excessive workloads, due to understaffing, lead to staff burnout, exhaustion and morale problems, which in turn lead to resignations, which in turn further exacerbate the original workload issues. Members argue that, as the needs of residents have risen exponentially with the ageing in place policy, staffing levels in most cases have not been enhanced and in some cases have been reduced. The majority of residents in hostel care are now much more frail and much less mobile than they were before and are therefore much more dependent on care staff than ever before. This has obviously led to an increase in the workloads of care staff and it has meant a reduction in the actual care that they can provide to residents.

Members continually express their frustration at the way that they have to shower, feed and toilet residents as if they were on a production line, constantly rushing from one resident to the next with very little time for real care or for any personal attention. Members have expressed concern that time demands and lack of staff mean that sometimes residents have to go without showers or go without having their teeth cleaned, their hair combed or their basic needs being attended to.

We found that the staffing shortages in aged care are most acute overnight, when it is not uncommon for one carer to be rostered on to care for in the vicinity of 50 residents—sometimes more. Our submission detailed one incident on the Central Coast where a single carer had to deal with an emergency situation at the facility overnight when a resident had a cardiac arrest. The carer had to make a call to 000 whilst trying to administer CPR and actually had to leave the resident to go and open the gates to let in the ambulance and then return to the resident. These sorts of situations are, as you can understand, quite harrowing for these staff to have to deal with and involve levels of responsibility that go way beyond their skills, their expertise and certainly the remuneration that they receive.

We hear that ambulances are regularly called at night to help sole carers lift patients back into bed if they have suffered a fall during the night or that staff are advised to make the resident warm and comfortable on the floor and wait for staff in the morning to help them. I do not believe the community at large would think that the first option is a cost-effective use of health funds or that the second option is an adequate response to the needs of those residents. There are numerous other examples in our submission and in that of our national office as to how residents are adversely affected by inadequate staffing levels.

I want to touch quickly on poor salaries in the industry which are a significant factor in why it is hard to attract and retain skilled staff. It is virtually impossible to attract young people into carers’ jobs as they simply think it is too much hard work for the money that they are paid. With the recent application of the $19 a week state wage case safety net increase to the aged care awards, the hourly rate for a care service employee 2, which is a carer often with a certificate III or a certificate IV TAFE qualification and many years experience in the industry, is $14.33 an hour. Quite unbelievably, it is less—$13.89—in the not-for-profit sector.

This is the rate at which most carers are employed, so you would be looking at a gross salary of around $28,000 for working a 38-hour week. So whilst there are obviously issues in terms of the comparison between nursing salaries in the aged care sector and the public sector, there are clearly issues about the remuneration of personal carers. People certainly do not do it for the money. They do it for the love of the residents and the job, but it is becoming increasingly difficult to attract new starters into the sector.

In regard to the accreditation process, members consistently argue that spot checks or checks without notice would be more effective than the current scheduled visits. Members tell us that often management select the staff who are to speak with the accreditors when they come. Members advise that additional staff are rostered on and that much effort in the weeks leading up to accreditation goes on making sure that paperwork and documentation are up to date and on smartening up the look and the feel of the place et cetera. Members advise that considerable pressure is put on staff to work harder and faster in the lead-up to accreditation, with a lot of threats and plays on their emotions as to what would happen if the facility did not pass accreditation.

Members have also expressed the view that there is an excessive paperwork burden in aged care and that something needs to be done to reduce that. In terms of the RCS paperwork we have identified that there is an excessive burden. There is a view that some documentation appears to be documentation for the sake of documentation and that it is aimed purely at funding rather than at the level of care being delivered. Carers report that they have insufficient time to do their required daily duties, let alone the documentation and trying to deliver the care in the plan that they are to deliver. In terms of documentation it is a vicious circle: if there are not sufficient staff to get the documentation right, that results in a reduction in the classification of the residents, which means less funding, which ultimately means fewer staff and less capacity to get the documentation right in the next round. The title of the HSU submission is ‘More time to care’, and that is the call from our members: they want more staff in the industry so that they can provide the level of care that the aged in our community need and deserve.

CHAIR—Thank you, Ms Bradbury. Does anyone else wish to make a comment at this point?

Ms Peacock—I would like to talk about staffing issues. The first point is about staffing levels. It is a commonly held opinion that staffing levels in aged care are inadequate to provide the quality, individualised care that residents and families expect and that staff want to give. Some examples include the difficulties that cleaners have in maintaining standards when they are allocated only enough time to clean a resident’s room once a week, regardless of the needs of the resident. Many facilities employ only one staff member for the night shift, regardless of the number of residents with a high-care classification. There are some 18- to 20-bed dementia specific units with only one staff member on for part of the afternoon or evening shifts, when residents are going through the sundowning period and might be displaying challenging behaviours that might need staff intervention. All these residents are high-care and have complex needs. There is a reluctance by many organisations to employ activities staff seven days a week. One facility has only one activities officer four days a week for 40 residents, so on the other days nothing happens. Another nursing home has one activities officer for about 95 people.

Personal care hours have not kept up with the increasing needs of residents. Whereas 10 years ago you had to be independently mobile to be able to live in a hostel, now it is very unusual for someone to enter a hostel who is able to walk, shower themselves and self-medicate. The amount of time required to care for each of these residents has dramatically increased, without any extra time or staff allocated to do so. On a weekly and sometimes daily basis organisations are working short-staffed, thereby putting a very heavy extra load on those staff on duty. This leads to high levels of stress among the remaining work force, which in turn affects the care of residents. On shifts that are short-staffed it is not uncommon for residents not to be showered, and when the residents know the staff are working short they are often reluctant to ask for much-needed assistance, putting them at greater risk of falls and things like that. On some days when staff numbers are low on the afternoon shift, the day staff will get the residents ready for bed and put them to bed in the early afternoon before their shift is over. This directly affects the quality of life for these residents because they are totally reliant on staff to help. Being in bed for 16 to 18 hours a day is not living, and it is certainly not quality living. Being old does not mean that you stop enjoying life; it just means that you might need some assistance to do so.

The most pressing issue of late has been the difficulty that organisations have had in recruiting staff. Many advertisements have gone unanswered, or the skills and qualities of the applicants have been woefully inadequate. Due to the shortage of qualified and appropriate staff, unskilled and untrained staff have been put into positions they cannot fulfil to standard. I know of dementia specific units that employ unqualified and inexperienced staff, some who are 16 or 17 years old, to care for residents who have very complex needs, simply because there is nobody else to do it. Many of these residents also flatly refuse to have someone so young looking after their personal hygiene needs. They feel that all their dignity is taken away.

Some new staff resign shortly after starting the new job because of the amount of work, the physical and emotional toll involved, and the very low remuneration. Some facilities expect staff to complete their duties after their shifts have finished. It is not uncommon for staff to arrive at work early so that they can fit in the tasks expected of them. Many staff also do unpaid overtime to cover the workloads. I am aware that a local Centrelink office suggested to two of their clients that they not go to work in the aged care sector because the rates of pay were too low. Centrelink would rather retrain them so that they could work in higher paying jobs thereby reducing or ceasing the benefits that Centrelink would have to pay them.

Mrs Allen—I would like to explain what a PCA does in a day.

Senator HUTCHINS—What is a PCA?

Mrs Allen—A PCA is a personal care assistant. The duties include showering 10 to 12 people a day. They do not have time to shower everybody so residents are showered three times a week. The personal care assistant does 10 to 12 bed changes a day. There are three rounds of medication—breakfast, lunch and tea—and, if they have sedations, there is one at night. Doctors come to see six to eight residents in a day. The personal care assistant has to record the doctors' orders and help them with their procedures. Then the personal care assistant has to fax the chemist about any changes in medication, make appointments with pathology and specialists, and liaise with the residents' families if there are any problems. We do that in the morning. Maybe, in the afternoon a second doctor will arrive and you go through the whole process again. While the personal care assistant is doing all this they are answering buzzers and attending to sick, incontinent, and maybe even confused, residents. There are daily changes of catheters for people and the PCAs have to attend to puffers, eye drops, wound management, nebulisers and rubs. They have to help the residents with any personal or medical problems that they may have.

Then there is the documentation. At my facility we do documentation for about 20 residents a day—that is an exceptional amount of writing—and there are another 44 residents who have bowel management charts. You have to go around to these people and ask them whether they have had their bowels open. That is embarrassing for them and sometimes for the care worker. The resident might be sitting in a dining room and you have to call them aside. The personal care assistant has to write about daily events—whether there have been any falls or sickness—update care plans, make any changes and evaluate them. We keep the documentation up to date for when the assessors come. We have a care plan, front and back, and therefore the documentation has to coincide with each of these care plans. Each care plan has 21 points, including communication and hygiene.

We have to keep the documentation up to date so that when the assessors come there is evidence that the care plans are the same and that evidence matches the care plans. If the evidence is not there the facility will not get the funding or the staff. Everyone is working long, long hours and at the end of the day residents feel that they are an inconvenience. They do not tell staff that they are sick because they are worried that we are overworked and do not have the time to give them. That is really sad, because that is why we are there.

I have a list of other duties that we do: caring for residents with high and low care; administering medications from Webster packs, including schedule 4s and schedule 8s; giving insulin; attending blood sugars; taking blood pressures; administering expectorants and nebulisers; transferring people with lifters; pushing them in wheelchairs; giving them arm support; showering, drying, dressing them, and cleaning their teeth; positioning their hearing aids, cleaning their glasses; putting on their support limbs; toileting and assisting them with their clothing after same—even cleaning and wiping them if they need that; attending to people who are incontinent with urine and faeces; putting on their pads; serving their meals; carrying their trays to their room if they are unable to come to the meal table; attending to their treatments and wounds; directing them to all parts of the hostel; reminding them of time and place if they have forgotten; dealing with physical and verbal residents—they sometimes become very aggressive and abusive because of their dementia.

We are responsible for their documentation; keeping their assessments up to date; collecting urine and faecal specimens for pathology; attending to doctors and their needs; ensuring that the medication changes are recorded; attending to transfers to hospital—when no RN is on the floor we are responsible for deciding whether a resident needs to be sent to hospital. We are also responsible for making the residents’ beds; tidying their rooms; emptying their rubbish bins; collecting their dirty clothes, washing them and returning them to their room afterwards. We are responsible for everything in the whole place.

Mrs Fox—I would like to talk about staff education and training in the workplace. Staff continue to fund their own education and to do training in their own time. They receive no recognition or monetary consideration for this. Staff are not being recognised for continuing to upgrade their education to a higher standard, although these skills are being used by management. Staff are funding their own education, which is costing hundreds of dollars.

For example, staff have just completed their certificate IV in assessment and training in the workplace at a cost of $750, plus three months of their evenings attending training facilities. There was no recognition or monetary gain for them. The skills that they have just attained are being used in the workplace. Staff have paid for their own training to gain certificate IIIs, AIN certificate IIIs, aged care certificate IIIs and certificate IVs, but they are paid exactly the same as employees who have no certification whatsoever.

Fifteen years ago, there was education—including numerous workshops—relating to all areas of aged care. For example, dementia specific workshops within a facility were organised and paid for by the facility. These educational workshops were valuable as they related to specific problems faced by staff on a daily basis. Staff were taught different ways to achieve a good outcome in various circumstances. They were able to ask the questions that they needed answers to. Staff were motivated. The positive reaction from the staff would obviously have good repercussions for the residents they were looking after.

The question is: what happened to the funding allocated to education in the workplace? Staff recently attended a workshop that was offered by management on RCS documentation. Staff were informed that they would not get paid for that day, even though it was their normal working day; management would only pay for the workshop. Staff were also informed by management that they would like a written report on the workshop so that they could share with other staff what they had learnt. When management were asked why staff should not be entitled to be paid for the day they attended the workshop—especially when the information from it would be used to help educate the staff on RCS documentation—their answer was: ‘It was not compulsory for you to go.’

The problem is that management realise staff will go to these workshops even if it costs them, because staff want to be efficient in their work. Conclusion: staff are leaving to take up better-paid and more respected positions elsewhere. This is adding to the problem of staff shortages, unskilled staff and increasing pressure and stress on the declining number of qualified staff. These problems need to be identified and addressed so that the standard of care our aged deserve is achieved.

In 1999, staff were told that they had to get either an AIN certificate III or an aged care certificate III or they would not work in aged care, as this was going to become a legal requirement to be employed in the aged care industry. Staff went out and paid to get this qualification themselves. The average cost was $1,000-plus and the course took 12 months—nights or days, depending on who ran the course—and many people also lost a huge amount in working hours and pay.

Mrs Hughes—I would like to talk about workplace injuries. I have worked in aged care with the same organisation for 18 years, and in that time I have noticed an upward trend in the number of staff on workers compensation—both nursing and auxiliary staff. This I believe is due to the frailty of the residents moving into aged care facilities. They have higher dependency and are more frail and demanding, making them a higher category, which gives organisations more funding but no extra staff. The workload, both physical and mental, has increased, which leaves the staff being not as safety conscious as they should be as they try to look after the residents, and this leads to more workplace injuries for both staff and residents. In my facility I have known six staff members to be on workers comp at one time. This is not because they are careless, but sometimes staff have to cut corners to achieve their duties. When a staff member leaves, usually hours are cut and staff are expected to pick up the extra hours to cover the shortfall. A lot of staff start early and finish late in order to get through their workload, which also leads to exhaustion, fatigue and injuries. But they are dedicated and the employer plays on the emotions, knowing they will finish their work. Funding is needed for extra staff and equipment to help stop workplace injuries and to give residents the care and support they deserve. Aged care facilities are our senior citizens' homes, and we are like their families. They deserve better and so do staff.

All aged care staff want is a fair go. If you cannot return to pre-injury duties, instead of being retrained into another position, you are discarded. Staff deserve better than this for doing the best they can in the time allowed and with the equipment that they have.

CHAIR—Thank you, Mrs Hughes, and we thank all of you for sharing a very real part of this inquiry, and that is the work that you do. First of all, Ms Bradbury, you said earlier that the salary for a worker is $14.33 an hour and that someone in the for-profit sector would be getting $13.09, I think you said.

Ms Bradbury—It is $13.89 for the equivalent classification.

CHAIR—Why is there a difference?

Ms Bradbury—We were able to negotiate an above safety net rise with the charitable sector employers last year. They granted a 4½ per cent increase across the board to their aged care work force; whereas in the for-profit sector all we have been able to achieve each year is the national living wage case, or the state wage case as it comes through. We have that applied to the minimum rates in the award each year, and that is the only movement that we have been able to achieve in their wages over time.

CHAIR—Thanks for that. I could not understand how we would have people doing exactly the same job getting a different level of pay. That must put some pressure on the for-profit sector to attract staff.

Ms Bradbury—You would certainly think so.

CHAIR—There is obviously a problem anyway, but if you were going to get less pay, you would be looking to go to the charitable sector, I imagine. You also say in your submission that that wage is, in fact, less than you would get paid if you were working at Hungry Jack's; and I think there is a considerable difference in the level of responsibility between working at Hungry Jack's and working with my grandmother.

Ms Bradbury—It is not just the level of responsibility but the level of skill and qualification. As I said, for many workers with considerable experience in the industry it is quite an affront to find that their young children starting in their first casual job bring home more per hour than they earn caring for our elderly.

CHAIR—I think the other point was very good too; I think it was Mrs Fox who said that, even if you get a certificate III or a certificate IV, there is no recognition of the cost of getting the qualification and of any career path for people in your sector. Thank you for your submission.

Senator FORSHAW—I thank each of you for appearing today. Following on with the issue of wages for nurses, we heard this morning that there is a 16 per cent gap, if you like, between wages in the public hospital sector for acute care and wages for aged care. We heard that claim from the Aged and Community Services Association. I am sure that we will get a chance to hear from the nurses association at a future hearing. What is the position with respect to members of your organisation in the aged care sector and in other sectors? I understand that you have members in hospitals and other sectors of the health industry, the ambulance service and so on.

Ms Bradbury—There is no direct equivalent classification in the public hospitals system, but there is a similar classification—that is, a patient support assistant—which has been introduced into some hospitals. The differential in pay there is in the vicinity of 20 per cent. It is not for want of trying—certainly, we are running wages campaigns in the aged care sector—but it is not an industry with a high union density. It is an industry with a large degree of casual or temporary employment. Even those employees who are permanent are regularly made permanent with a guarantee of, say, 10 hours a week. They may be regularly working full-time hours, but they have a guarantee of only 10 hours a week. So they are reliant largely on good relations with the employer to continue getting those increased hours. It is not an area where we have been able to apply considerable industrial pressure. But certainly there is a big differential between private and public sector rates of pay.

Senator FORSHAW—I assume it is also a sector where the very last resort would be industrial pressure, in any event—certainly in this sector.

Ms Bradbury—Exactly.

Senator FORSHAW—That is the last thing you would want to do.

Ms Bradbury—The first question employers often ask us is: how many members do you have? The number is obviously increasing in this sector and we are very proud of that. The second question is: what will your members do about it? It is true that they are not about to abandon the people who they care for every day, so that is not an option.

Senator FORSHAW—I put this to you and ask you whether it is an issue: the fact that the hospital sector is funded directly by the state budget and is part of the health industry, whereas funding for, say, aged care facilities is pretty much focused upon—at least a substantial proportion of it—subsidising the number of residents or the number of bed places. Is that an issue in terms of employers negotiating wage increases for your members? We have also heard that one of their major complaints with respect to the indexation arrangements is that it is a very minimal increase compared to what otherwise might be the total wage costs increase. Do you understand the point I am making?

Ms Bradbury—Yes. Certainly, it is our proposition that it would be better if at least a component of the funding were tied to issues such as staffing. As things stand, as you say, if the funding does not keep up with indexation and things are tight then the first thing that seems to get cut, from our observation, is staffing levels. They get cut because funding is tight. So that is obviously a concern.

Senator FORSHAW—Turning to staffing levels, they are obviously a constant theme in your submission and in other submissions, from what we have heard today from employees about work force shortages. One of the employees here might want to comment on this. When you say that there is just not enough staff, can you give me an indication of what the shortfall in staffing is—for instance, in the nursing homes that you work in? Do you need twice as many staff; do you need another 50 per cent of staff? I am trying to get a feel for how significant the staffing shortage is, particularly when thinking about how you would implement a minimum level of staffing. Would it be so many per facility or per number of residents, taking into account different needs?

Mrs Fox—In a lot of cases staffing levels are based on numbers of residents and not on the care or need of the residents. The amount of staffing required should be based on the needs of the residents, not the numbers. That is where the main problem is. Our facility has three sections and one girl per section. It does not matter whether it is high care or low care, or whether you have 15 showers to fit in between six o'clock and eight o'clock or 10 showers. It is not staffed to the level of need.

Senator FORSHAW—Mrs Allen, you gave us a list of the things that have to be done where you work. On a normal day, how many personal carers would be employed where you work, and are you able to say how many more you would need?

Mrs Allen—We have three sections—three hostels. There are two girls in each section. One girl goes home at 11 o'clock and then there is only one. Given the documentation load and the fact that we are only able to shower them three days a week, we probably need another two or more in each section.

Senator FORSHAW—A substantial increase would need to occur.

Ms Bradbury—Yes, approximately double. The point that Evelyn made is right—if we categorise the needs of residents based on their acuity and we provide funding on that basis then it would seem to make sense that if their need is greater then the staffing allocation should also be greater.

Mrs Allen—In nursing homes they have staff ratios per resident per whatever the category of the resident is. Where I work, at night there are 168 residents and one night staff on. We need to look at the ratio per resident for staff.

Senator HUTCHINS—Mrs Allen, you said that sometimes you have to make decisions about whether to send someone to hospital because there is no registered nurse on. Is that another aspect of the staff shortage? You are having to assume duties that you have not been trained to do.

Mrs Allen—They have RNs at my facility.

Senator HUTCHINS—I mean as part of the system.

Mrs Allen—There are facilities with no RNs at all. It is their call to make that decision.

Mrs Hughes—Nursing homes do have minimum staffing levels; hostels do not.

Senator FORSHAW—We can perhaps get this from other sources, but could you quickly explain what a minimum staffing level is in a nursing home?

Mrs Hughes—In my nursing home there are four staff members who work 7.5 hours and they have eight residents each that they are responsible for. Most of them are high care. We have two more who work six hours and they float between eight residents.

Senator FORSHAW—That is an internal decision of that nursing home?

Mrs Hughes—Probably, yes.

Senator FORSHAW—That is not mandated, as I understand it.

Ms Bradbury—I understand that there perhaps is a requirement in terms of the nurse to resident ratios in nursing homes, but that does not apply at all in hostels. That is the distinction.

Senator FORSHAW—I want to ask again if employees experience this directly: what happens when an assessor from an accreditation agency comes in? You have commented on how, in the time leading up to an assessment, there might be a flurry of activity to get the place looking better and so on, but what do the assessors actually do when they come in to do an assessment for accreditation? I am also interested in—we have heard this put to us anecdotally in other submissions—whether or not there is any pressure applied to people completing the paperwork or responding to questions about how they might reflect upon the situation in the nursing home when that assessment is being undertaken.

Mrs Allen—There is a classification of residents and their points. They pick probably 10 residents—I am not sure how many they pick; five to 10 maybe—and they go through their care plans and progress notes. You have to have evidence in your progress notes to support the care plans. Then they go and speak to the residents to see whether the documentation and the care plans match up. If you say there are things wrong with them, I suppose they go and check. They question staff about what they do for those residents and then they go away. I am not sure what they do when they go and talk to each other, but the difficulty seems to be with their interpretation. Comments have been made that the documentation does not support the plans because of the inexperience of the people writing it and things like that.

Ms Bradbury—One of the big concerns that members raise is that, given the extent of the documentation and the impact and consequences of not getting it right, they feel that it is quite a heavy burden and that, in many cases, they have not been given appropriate training in terms of the correct way to do the documentation.

Senator FORSHAW—This is documentation about the residents, is it?

Ms Bradbury—That is right.

Senator FORSHAW—Does it also include observations or comments about the nursing home facility itself?

Ms Bradbury—No. These are mostly direct resident records, care plans, progress notes and that kind of documentation.

Senator HUMPHRIES—Ms Bradbury, you said that there was nothing in the recent federal budget for increased staffing levels. As far as I am aware, that is the case. You also, I thought, said that you did not believe there was any money in the budget that was tied to the provision of higher salaries in the aged care sector. Is that what I heard you say?

Ms Bradbury—That is right—not directly tied to that.

Senator HUMPHRIES—My advice is that there is a billion dollars over this year’s and last year’s budgets for the purpose of improving wage rates in the sector. I am just wondering what the source of your comment was. Is there a document or statement somewhere that demonstrates that? It is different from the information that I had about that provision.

Ms Bradbury—We have looked at all the budget papers and, as far as we can read it, there is money there, it is available and that is one use that it might be put to. There is a recommendation by the government that it should perhaps be put towards staffing and salaries. That is certainly a recommendation that we will happily make to the employers. But I am not confident that they will respond in that manner. I am not confident that they see that money as going towards staffing and salaries and I do not believe there is anything in the budgetary measures that actually locks them in and requires them to spend that money on staffing or salaries. That is our concern.

Senator HUMPHRIES—There have been quite a few comments and assertions by employers that they have not got the money to pay higher wages, given that about 70 per cent, I think we heard today, of the amount that they receive via income is from the federal government and only 30 per cent from residents. You have a concern that if they receive that additional money they will not spend it on salaries. Do you think they would just turn it into additional profit or something of that kind?

Ms Bradbury—A large percentage of these are in the charitable sector, but our evidence is that people are already considering additional construction and development of properties and so on to provide additional places—that most providers would like to use the money to expand their services rather than putting it into the services they currently provide.

Senator HUMPHRIES—I am not sure they could use the money to provide additional places unless they had authorisation for that. That is a matter we will have to go back and check. I think you said before that you thought a doubling of the minimum staffing levels would be about right in terms of producing better or optimal staffing levels in nursing home facilities and hostels. Is that right or have I misinterpreted that?

Ms Bradbury—That is a view. It would have to be tested, obviously. Staffing levels are better in some places than in others at present. And, as we have said, if you are going to set up minimum staffing levels they would need to be based on a range of things, including the number of residents, their particular needs and their level of acuity. It would be based on all of those things. But, given the range of duties that people are currently performing and that they are not being able to perform, that is an approximation, yes.

Senator HUMPHRIES—You do not have a stated policy on how we should formulate that minimum staffing level in different sorts of facilities, or what it would cost to do that?

Ms Bradbury—No detailed costing, but it is certainly something that our national office has been working on in terms of a minimum staffing levels policy. It is something that would obviously have to be subject to broad industry wide consultation, not just with unions but with all stakeholders.

Senator HUMPHRIES—You argue for a better wage rate but you do not quantify how much better it should be. Have you got an idea of what level you would say was fair and appropriate? This committee will need to make recommendations at the end of the day about what should be happening in this sector. We could recommend that you be better paid, but that is a bit unspecific. I think you would appreciate something more precise that you could grab hold of and do something with, so what would you recommend that we should be saying?

Ms Bradbury—In the first instance, equivalence with the similar classifications in the public sector would be one point we could look at. At that rate, that would probably be an increase of 20 per cent.

Senator FORSHAW—Do you mean with public hospitals?

Ms Bradbury—Yes.

Senator FORSHAW—The acute care sector.

Ms Bradbury—Yes. We currently have a claim which we are developing and are almost about to put on the aged care providers. We are seeking $150 over three years. That is our claim at this stage.

Senator HUMPHRIES—Okay. I had a bit of a wry smile when I read the part in your submission where you talked about some of the nursing homes that gear up for accreditation and then, when inspectors have gone, what they had put in place gets dismantled. We were told this morning that the opposite is the case, that once they are there they do not need to be checked again, they are all right. I cannot prove which is true, but what you have to say does have a certain ring of authenticity about it, I might say. Could you explain the comment about a new personal carer classification in the public hospital setting. What do you mean by that? Do you mean a classification for a patient or for a worker within the sector?

Ms Bradbury—It is a classification for a worker within the acute health sector. Essentially the union’s position is that, if there are aged people occupying acute care beds in public hospitals but they do not have an acute health issue, they are just aged, then we see that there is a possibility to provide care for them in that public hospital environment that would be similar to the care that would be provided to them if they were in a residential aged care facility. So, if you had a ward or an area where you had these aged care people then you would not necessarily need to fully staff that with nurses, but personal carers could work under the supervision of nurses, as they do in residential aged care, and that could assist, given the shortage of registered nurses in the health system.

Senator HUMPHRIES—I think that would encourage hospitals or the system to see aged people as having a permanent place in the hospital sector, as opposed to pushing them back out into other sorts of care, either transitional care or nursing homes.

Ms Bradbury—That is certainly not the intention. But, if they can be accommodated elsewhere in a hospital so that they are not taking up those acute care beds and not impacting on the front end of the system in terms of the access block issues and the code red issues that we have been experiencing in Sydney of late, then we see that as one way that they could possibly be dealt with in that process of transition. Obviously, you still need to get them out of hospital, but it is just to assist in that transition.

Senator ALLISON—Can I ask about your experience—perhaps yours, Mrs Allen—of complaints processes with the accreditation agency? Do you or any of your colleagues, if you are encouraged by your employer to clean up, to do extra stuff, ever blow the whistle on that sort of activity by ringing up the accreditation agency? And, if you know of any instances where that has happened—

Mrs Allen—No.

Senator ALLISON—No? Okay. Why not?

Mrs Allen—Because they impress on you all the time that if they do not get the funding you will not have a job. Your concern is the resident—I have been where I am for 18 years and my concern is my residents. I do not want to do anything that will hurt them. That is just the way it is, I think, for everyone who works in this area. Everyone really loves their job, and that is why nothing is ever done.

Senator ALLISON—Those people that you care for, the ones you say do not tell you when they are sick just in case you have got more work to do, do they talk about their situation with their family or with other carers? Would they be likely to make a complaint?

Mrs Allen—I am sure they do. I am not sure about families; they have their own major problems. Nowadays, family problems are becoming more and more of an issue. Once you just dealt with the person; now you deal with their whole family. So there are issues. They know that we are looking after their parent and that we are doing the best we can, and they know we are underpaid and understaffed. They feel sorry for us.

Senator ALLISON—There is supposed to be a complaints mechanism in place. Residents are supposed to know what their rights are—put a chart on the wall somewhere everywhere.

Mrs Allen—Yes.

Ms Bradbury—Yes.

Senator ALLISON—Is that being overlooked?

Mrs Allen—We display our complaints system. They know. But I think with that generation, again, you are looking at people that do not want to complain.

Ms Peacock—Some are worried about repercussions, I think, as well.

Mrs Fox—They have a fear—

Ms Peacock—They are worried that if they complain too much it might affect them negatively.

Senator ALLISON—And you think the next generation will not be so accommodating?

Mrs Allen—I will not be! I know my rights.

Senator ALLISON—We talked this morning about the special needs of people in residential care and the lack of access to specialists, allied health workers, dieticians, podiatrists, psychologists and those sorts of people. Do you come across instances where you wish you were able to call in someone or get the nursing home operator or the director of nursing to get that expertise into your workplace? Can you give us some instances where this might happen?

Ms Peacock—In our facility we had a long period of time where we could not get a physiotherapist to come and visit. We have one now, but for probably two or three years no physiotherapist wanted to come and look after the residents in the facility so they did not get physiotherapy, which a lot of them need. There is always a shortfall of podiatrists, too. We cannot get the podiatrists to come and visit. A lot of them cannot get access to the services outside for varied reasons—transport, not having family nearby, cost or whatever.

Senator ALLISON—You are identifying a problem of shortage, but is there a problem with being able to pay for those services? Who does pay for them? Do you ask your residents?

Ms Peacock—The residents pay for podiatry.

Senator ALLISON—Do they pay the full amount? There is no subsidy?

Ms Peacock—Yes. Some seem to pay for physiotherapy themselves and for others it is covered by the organisation, but I am not sure how it works.

Mrs Hughes—We have the same problem with physiotherapy. It is very hard to get someone to stay. Over the past 10 years we have had someone there for probably six months. We have just started another physio, but they come and they go.

Senator ALLISON—These are people who are not brought in on a consultation-by-consultation basis? These are people who are employed?

Mrs Hughes—Yes.

Senator ALLISON—Full time?

Mrs Hughes—No. They are employed for a couple of hours once or twice a week.

Senator ALLISON—It was also suggested earlier today that this lack of both expertise and sufficient staff numbers leads to higher levels of psychotropic medication. I do not expect you to necessarily have the expertise in this, but is there anything you would like to say from your experience about whether patients are unnecessarily drugged up in order to keep them quiet because of the level of staffing? You do not need to answer that if you do not want to.

Ms Peacock—I do not know enough about it.

Mrs Hughes—No, I do not know enough about it either.

Senator ALLISON—To clarify: maybe this is something the committee can find out anyway, but as far as you are aware what other specialisation or extra training can you do beyond certificate III? Do you do it through the TAFE system? Is it full fee paying?

Mrs Fox—Personally I have done certificate III in aged care nursing and certificate IV in workplace assessment and training—and paid for them 100 per cent myself—through an external education and training organisation. When I did the certificate III, back in 1999, we were told by management that if we did not have that certificate we would no longer have a position and that it was going to become a legal requirement, which it never, ever did. Staff who have now gone ahead and educated themselves are, because of the situation of staff shortages, pressure, stress, pay et cetera, moving on to other areas—to the public system or whatever—where they are getting the proper pay packet at the end of the week for the qualifications they have. Unfortunately, now we are putting people with no education into our workplace. What we do is a profession.

Senator ALLISON—Indeed.

Mrs Fox—The staff who are left and who have the qualifications and the years of experience now have to train the people who have none. If they wish to have any training, they are probably going to have to pay for it themselves because there is nothing in place in the facilities for that. There used to be a system where we had quite a lot of workshops et cetera. When I first started—and I have been in aged care for 16 years—I attended workshops at least four times a year, and they were paid for and held at the facility.

Senator ALLISON—And that was at the workplace?

Mrs Fox—Yes. All the facilities in the area were encouraged to put one on so we all attended, and it was paid for by the facilities. As I said in my statement, I and another staff member went to the RCS documentation course, which is of no value personally to me but is for my workplace, so that I can do the documentation for the RCS so that the funding can come to the workplace. They would not pay for my day, so I lost the day's wage, which I cannot really afford to do, but they know we are going to do it because we want to do the correct job.

Senator ALLISON—A bit related to that is the problem of the lack of career path in staying in aged care, which was raised with us earlier today. You might have heard my question a little earlier.

Mrs Fox—I did, and I thought it was a very good statement.

Senator ALLISON—Is there anything you would like to add?

Mrs Fox—I think that is something that should be looked at, definitely. No matter what certification you have, you will still be graded as you are and paid as a person without any education, which is an unfair system for any professional who goes out and educates—and keeps educating—themselves so that they can give their best in their workplace. There needs to be something put in place so that they can go further up the ladder.

Senator ALLISON—If we were to see it as a seamless transition, without moving out of aged care, from personal carers through to enrolled nurses and then to registered nurses, if you could stay working and train in that way, presumably that would mean we would have positions as registered and enrolled nurses specific to aged care. Is that something the sector discusses, and is that something that you want to see, or not? I will raise this with other trainers. Presumably, if you did all your training in aged care, you could not then move across to acute care.

Mrs Fox—I think there needs to be the same opportunity as in nursing, where you can start as a trainee nurse and go up and come out as an RN or a matron. There is nothing. You become a personal carer and it does not matter how many certificates you do, you do not go any further—unless you leave.

Senator ALLISON—My question, though, is: is there a need for a category of registered and enrolled nurse in aged care, as opposed to someone who can work across the sectors?

Ms Bradbury—I guess that is probably more a question for the nurses association because it more directly relates to them, but it is a possibility. The point you make about the lack of opportunities in the industry is an obvious one. We in fact had a colleague and member who was quite active, who is now training to be a registered nurse and has left the sector to be able to do that. So you have lost a young, enthusiastic employee from the sector to go and train as a nurse, and whether she will ever come back to aged care, nobody knows.

Senator ALLISON—You are also losing some specific skills in aged care, aren’t you?

Mrs Fox—Yes, we are.

Senator ALLISON—Even if they do come back, they have done their training in acute care and not—

Mrs Fox—That is what is happening, yes.

Senator ALLISON—Indeed. I have one other question about the sort of training that you would like to do. Mrs Fox, you mentioned the workshop you did which does not add value to your own personal skills but is of value to the workplace.

Mrs Fox—I suppose it is not correct to say that. Of course everything adds value to your skills as a professional, but the skill was actually going to be totally directed to my place of work, because RCS documentation is RCS documentation, which feeds the funding.

Senator ALLISON—I understand. Are there any other areas that you would desperately like to see training opportunities in? Are there areas where you feel you have a lack of expertise and knowledge that would be useful in your workplace?

Mrs Fox—There need to be more workshops in the workplace, especially for the young people coming through in aged care. I do not think the certificate III in aged care and nursing is significant enough to show the insight, especially of dementia specifics, in Alzheimer’s and Parkinson’s and all the different areas that you come up against in aged care. I think in-house education was brilliant. It is something that should never have been lost in aged care, and it needs to come back so that we can keep the younger staff, so that we can have them educated not only in their certificates. They are coming up against problems that they do not know how to handle. With in-house staff education, you are able to feed off the more experienced staff, with the younger staff, with the educators. It worked.

Mrs Allen—Also we need people within the facility who are able to train. We had an educator at my facility who did all the educating, but she left—for better opportunities, I assume, because she was an RN. Since then we have had none. You need someone within the facility all the time to train people in all the specific areas.

Senator HUTCHINS—You have certainly painted a very disturbing picture for us this afternoon about the state of the work force. Mrs Hughes, you talked about an increase in workers compensation because of the demands of the work. Mrs Fox, you were telling us about work that people are doing for which they are not being recognised. Mrs Allen and Ms Peacock, you were telling us about people carrying out work that they are not trained to do. Mrs Fox, you said you had been in the industry for 16 years. Are you full time?

Mrs Fox—Yes.

Senator HUTCHINS—Mrs Hughes, how long have you been in the industry? Are you full time?

Mrs Hughes—For over 18 years. I am full time.

Mrs Allen—I am full time.

Ms Peacock—I have been full time for 12 years.

Senator HUTCHINS—You are exceptions though, aren’t you?

Mrs Allen—Yes.

Mrs Fox—Yes, I am the only one in my area.

Mrs Allen—There are only three in mine.

Senator HUTCHINS—Out of how many?

Mrs Allen—In my section there are probably 20.

Senator HUTCHINS—I will ask that along the table.

Ms Peacock—I think I am the only full-time staff member from all the care staff, apart from the registered nurses. We have one full-time registered nurse; the rest are part-time staff.

Senator HUTCHINS—Out of roughly what number?

Ms Peacock—Probably 20 or 30 staff, maybe more.

Mrs Fox—I am the only full-time staff member—even my coordinator is not full time—out of the recreational staff of nine. Of the caring staff, I think there are two personal care staff who started around 15 years ago and the RN. That is it. We have 74 residents.

Mrs Hughes—There are two full-time staff out of at least 40, besides a registered nurse.

Senator HUTCHINS—In the time that you have been involved in aged care, is that representative or has it been moving more and more to part-time, casual workers?

Mrs Hughes—It has been moving more and more to part time, yes. When I started, there were a lot of full-time staff; but as they leave, the hours decrease.

Senator HUTCHINS—I suppose the training does not get made available either.

Mrs Hughes—No, it does not. It used to be that, if people wanted to go to courses, the notices would be put up and people could put their names down and go. Now it is on a need-to basis. If you need to go to whatever course, you are selected. It is not open anymore.

Senator FORSHAW—Following up on that, would trying to shift the balance to more full time and less part time, without necessarily increasing manning substantially, address some of the pressures on staff, particularly paperwork and things like that?

Mrs Fox—It would certainly address the pressure that staff feel, on a repercussion level, about complaints. As I think Natalie said earlier, we have staff who have been contracted for 10 hours and work 30 hours a week. We are trying to address that at this time. After a 12-month period, it should definitely be looked at; but for nothing to be done about it is not good enough. It becomes a problem for staff, especially those with families. If they have an issue and they want to make a complaint, they are not going to for fear of losing work. At the end of the day, if you are signed up for 10 hours and you are working 30 hours, there is nothing to stop management cutting you back down to 10 hours legally. It becomes a problem. It takes over a little bit from unfair dismissal. A lot of us feel that it is sometimes used to keep the staff from saying too much. It is a situation that needs to be looked at.

Senator ALLISON—You can make an anonymous complaint at the present time, can you not?

Mrs Fox—People go through anything; it is never anonymous.

Senator ALLISON—You are not here anonymously either, I have to say!

Mrs Fox—We are willing to stand up. Even if there were repercussions, we all feel strongly enough about what we do and how important it is that it is brought forward.

Mrs Hughes—We are always told that we have complaint forms and a process to go through but, if you are not going to name people and do it the right way, don't worry about it—so it goes nowhere.

Ms Peacock—Going back to the full-time issue that you raised, I think you are right in that more full-time staff would give the continuity of care to residents that we do not have at the moment. Especially in specific units, like dementia units, we have different staff coming in every day of the week, and that can add to a lot of the problems that might be exhibited by some of the residents. I think that continuity is really important for the aged.

Senator MOORE—You have all spoken about your experiences, but I would like to ask this for the record. When you have all had so much experience in the industry and you have identified the things that are negative, why do you stay? I think it is important, for the record, to hear from people working in the industry why you are there and why you are hanging in there.

Mrs Fox—It is because we love what we do. We love our residents. I work in an ex-services home, and I feel privileged because I work with people who fought for our country. I listen to their stories, and I can tell them to my children and my grandchildren. I feel privileged that I can work with these people and give them quality of life for the rest of their lives.

Mrs Allen—After all, they do deserve it.

Mrs Fox—They fought for us.

Ms Peacock—As a diversional therapist I can make a difference to their day, and that is why I do it.

Mrs Hughes—I think that is why we are all there—to do our best for them every day and to give them quality.

Mrs Fox—But we need more staff.

CHAIR—I thank you all for giving up your time. Please be assured of our support for the work you do. Also, please do not be troubled by the fact that you have come here honestly today. That should certainly not have any impact on your employment, but if anything were to happen we certainly would want to know about it.

Proceedings suspended from 3.31 p.m. to 3.43 p.m.

BRANDON, Mr Mark, Chief Executive Officer, Aged Care Standards and Accreditation Agency Ltd

BUSHROD, Mr Ross John, General Manager, Accreditation, Aged Care Standards and Accreditation Agency Ltd

CHAIR—Welcome. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. You are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. I also remind you that, as you are public servants, you shall not be asked to give opinions on matters of policy. We thank you for your submission. I invite you to make an opening statement, to be followed by questions from the committee.

Mr Brandon—I will be addressing only part (b) of the inquiry's terms of reference. The system of accrediting Australian aged care homes against the legislated standards was introduced under the Aged Care Act in 1997. The legislation sets out the agency's role as part of the broader scheme relating to residential aged care services funded by the Commonwealth. Round 1 of accreditation ended in December 2000 and round 2 ended in December 2003—three years later. Clearly it is a relatively new system, with only three years between the ends of the rounds. It is also relatively unique because it aims to assess outcomes for individuals. The accreditation process looks at how outcomes are achieved and what outcomes are achieved in relation to individuals. These are sets of standards that go well beyond systems and processes; they go to considering what those systems and processes deliver to residents. From the commencement of round 1 to June 2004, we conducted 6,478 comprehensive audits and 11,164 support contacts. Seventeen per cent of those support contacts were spot checks or visits without announcement.

In the short time since we began assessing homes against the standards, there has been an improvement in care. If we use the compliance scores as a measure, 68 per cent of homes were fully compliant at the end of round 1. Now, just over three years later, the figure is in the 90s. We also note that in submissions to this inquiry there have been numerous comments that there has been an improvement in the performance of homes since the introduction of accreditation.

I also make the observation that compliance with expected outcomes is a measure of a home against the standards; it is not, as some would have us believe, a measure of the agency's performance. Our submission outlines the details of the act, the framework, our board and our functions as set out under the various pieces of legislation. It also sets out the formal performance indicators against which the agency is assessed every year by the Department of Health and Ageing. As mentioned in the submission, there are a number of bodies who also provide some oversight of and input into our activities. At the moment, our own certification to the internationally recognised standard ISO 9001/2000 is under way. This is but one of the many improvement initiatives we have taken to constantly review our performance and seek feedback from those whom we serve. I draw your attention to pages 5 and 6 of the submission where we list some of those things.

There are three points I want to highlight from our formal submission. One is assessing and monitoring care, health and safety. There are 362 registered aged care quality assessors registered by the Quality Society of Australasia. Sixty-five of those assessors are currently permanent employees of the agency. Over half of them are registered nurses and around 80 per cent have post-secondary qualifications other than registered aged care assessor. The additional contractors are also used to supplement the employed work force, particularly during peak periods.

Assessors are specifically trained and assessed for the job they do. They receive update training and most have post-secondary qualifications. In fact, the vast majority of assessors have worked or are currently working in the aged care sector. They normally work in teams of two. The audits of homes against the 44 expected outcomes are quite rigorous. They do not just look at documentation. Part of the assessment process is to talk with residents and staff. Most importantly, they look for evidence that what the home says is being done is in fact being done and that those things are delivering the outcomes that the home says are being delivered. Following each visit we seek feedback and we act on the suggestions.

Apart from the comprehensive accreditation audits, we also visit homes for review audits and support contacts. As I said earlier, some of those are spot checks. Where noncompliance is identified, it is generally the agency that finds the noncompliance and it is the agency that takes the action. Combined with the improved compliance levels over the last three years, this suggests the system of monitoring works. We do find instances of noncompliance, and they occur for a number of reasons. As part of our case management processes, I think we are now better placed to identify the risk indicators for where noncompliance might occur. Our processes are open and transparent about our findings. We are open about what we expect and how we do our work. Assessor reports are on the web site, as are substantial documents which detail how we conduct audits, what expected outcomes mean and how we expect homes to demonstrate compliance with the outcomes.

I will move on to better practice and providing information. Both part of our charter and consistent with our underlying philosophy is that better quality outcomes will not be achieved and sustained without supporting education. It is in no way helpful for us to tell a home that they are noncompliant and not be able to tell them how they might become compliant or to help them. In reality, assessment, monitoring and education go hand in hand. We look to identify education gaps and to fill them; we are not, nor do we wish to be, the major source of training in aged care. There are a lot of other people who are involved in aged care training. We do what we do because approved providers told us we were not doing enough in this area. The providers and their staff—once we asked them—asked us to provide more education.

They have invested time and money in attending the events we have organised. They have certainly told us since then that it was a worthwhile use of their time and that we should do more. Our education activity, whilst created by us, is simply responding to the requests of members of the industry. We see no logical reason why the agency should not continue to meet the needs of providers and their staff. In any event, the arrangements of education, assessment and monitoring are not dissimilar to some other standards where certifiers commonly perform assessments—what they call surveillance audits—and provide education.

In relation to paperwork and to implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff, the agency and the accreditation standards have no expectation that any home will create additional paperwork or administration other than that which is expected in any well-run organisation. Documentation in nursing homes is not about achieving accreditation; it is about the management of residents and the facility and should be seen in a much broader light than accreditation. Arguably, round 2 of accreditation moved expectation away from paper trails to more of a people focus and facilities started to rationalise their paper records which they had kept as evidence of compliance particularly in round 1. We are going to continue to progress that as we move into round 3. The important point about this is that homes demonstrate to assessors why they believe they are compliant in any number of ways, and we look for evidence to support their assertions.

In summary, we think that the current arrangements generally work well. The industry has expressed a view that the introduction of accreditation has brought positive change. Our experience supports that position. We aim for accuracy of our assessments, and there is no obvious argument why introducing a multitude of providers to accreditation would create a more accurate set of reports. There is a lot of inflammatory comment and speculation from some of the industry bodies about what is sometimes described as inconsistency of assessor reports. This is often from people who are not qualified assessors and certainly have never set foot inside the home about which they comment.

Things can and do change quickly in a home, and a change in the compliance score does not mean that the assessor has got it wrong. In fact, there is no logical reason why one should expect compliance rates to be identical across any cut of the sector, given that homes have a number of different characteristics. Each home is unique, and the agency’s goal is to strive for accuracy, regardless of the unique set of circumstances in which the home exists, and to work with the home to improve the quality of care. As we enter into round 3 of accreditation we are finetuning a robust system of accreditation processes and working with the Department of Health and Ageing, industry bodies, providers and staff to inform and educate them about how they can ensure the standard of care is sustainable.

CHAIR—Thank you, Mr Brandon. Mr Bushrod, do you want to add anything?

Mr Bushrod—No, thank you.

CHAIR—First of all, I will go to that issue of consistency. It was put to us today that the standards and the way they are described sometimes make it difficult to be consistent because you are making subjective judgments. Can you respond to that? Secondly, in another example, the gentleman from the Age and Community Services Association suggested that, for the first two assessments of a particular institution, their medication regime had been approved and then, when another assessor came in, that same medication regime was not approved, which seemed to be not really a subjective judgment but a quite straightforward analysis of one of their systems. Could you comment on those two issues?

Mr Brandon—In answer to your first question, accreditation arrangements are outcome focused, unlike some of the other standard systems such as ISO, which is very much about systems and processes. The fundamental strength in the accreditation arrangements is that they actually look at the outcomes that are being achieved for residents. Insofar as how people understand them, the guide that each home gets, which is called *Results and processes in relation to expected outcomes*, is a fairly comprehensive document. There is no shortage of information in it. There is an accreditation guide. There is also an audit handbook. So substantial information is available about what those standards mean. They are available on the web site. We know that people access them because they talk to us and even ask us questions about them. It is a subjective system, but there is a lot of information there. As I said, it is distinguished from other systems because it is about outcomes for residents. That leads me to the question about medication management. We do not approve medication regimes. We look at systems and processes relating to medication that lead to outcomes for residents. A system and process that might be quite valid in one nursing home may well be not valid in another—and I will say ‘compliant’ rather than valid—or it may not be compliant in the same nursing home six months later if circumstances have changed. You can look at the process and say that it is okay today, but it would only be valid in six months if nothing else had changed in the home.

CHAIR—Let us look at the medication management program. Are you saying that it is a question of compliance with the stated program? I cannot see how something changing would mean that that regime would now not be effective.

Mr Brandon—What I am saying is that it could change. The fact that you have a system in place in one home today and, at the same time, you have an identical system in place at another home does not mean that they would both be compliant. We would ask: how do those systems deliver outcomes to residents? The resident mix and the resident requirements may well be quite different. I cannot comment about the specifics because I do not have them. Prima facie, if nothing else changed in the home you would expect that if they were compliant one day they would be compliant the next, but things could have changed.

Senator FORSHAW—Could I interpose here. What sorts of things are you talking about? You state in your submission, on page 7, that ‘circumstances can change quickly in an aged care home’. What are you actually driving at there? Let us take a hospital that has hundreds of patients with different complaints, different levels of acuteness of the reasons they are in the hospital and so on. The hospital has a management system for medication that has to work across the range of people, and if it changed every couple of months you would have chaos. I am trying to understand what you mean when you say there is a system or a process that can somehow be constantly changing.

Mr Brandon—It gets down to how that system and process is applied to residents. That is the end point of it. It is not a blind system; it is about how they apply the system and process to residents. You referred to page 7 and asked what we were driving at when we said circumstances can change. When homes have a change in their compliance, following one of our audits, we look at it to understand why that happened. Typical things include: a change in resident mix, a significant change in size, a change in key personnel or a change in industrial relations. We had a case in a state where we looked at why things went bad—why did their compliance level drop so suddenly—and we were able to identify that they went from 57 residents to 100 in a short period of time, key staff left and they were involved in an industrial dispute. Those things can be dislocating.

Senator FORSHAW—They are the exceptions, aren’t they? Nursing homes just do not suddenly go from 57 to 120 residents.

Mr Brandon—I agree.

Senator FORSHAW—We have a pretty good understanding of the profile of people who are going to be resident in nursing homes. The mix may differ between high care and low care, more dementia and less dementia, and so on. But, as an overall picture, I suppose one thing that is constant across the board is that we have a reasonably good understanding of the residents in nursing homes, of the range of issues and complaints they may suffer. I have trouble understanding how you can say that somehow there can be sudden changes.

Mr Brandon—You are right to say that it does not happen often. Page 7 sought to address what happens and what we do when the compliance levels do change. I agree with you entirely: it is not that common—although it is something we have talked about before. Going back to the question about medication management, what I was saying was that the things we look at include how those systems apply to residents. If nothing else changed in the home, I would say that if it got compliance one day it should get compliance the next day. Then I speculated that, if it became noncompliant, one of the reasons that it could become noncompliant is because of changes in the home—changes in the resident mix or changes in something else. Absent the name of the home, it is quite difficult, if not impossible, to be definitive about why that would have happened.

CHAIR—What review processes occur in a situation where the home is of the view that, let us say, their medication management program is efficacious and the auditor is of the view that it is not? What opportunity does the aged care institution have to seek a review of that assessment?

Mr Brandon—The accreditation grant principles provide that after an assessment and following the statement of major findings at the end of the audit they can make a submission to the agency. And they do. Homes make submissions to agencies where they have a different view from the assessor. That is one of the other strengths in the system: that homes and their staff get to meet with the assessors—and they are required, in fact, to meet with them—at the end of the audit. They get a sense of what we are going to say and, following the legislation, they can put in submissions.

CHAIR—What happens then?

Mr Brandon—The decision maker, who under the grant principles is appointed by me, is bound to take into account the submissions. From time to time, if there is a difference of view, they will go back and do a support contact or a spot check or make inquiries of their own with the home. What we are chasing is accuracy in the assessments so that the end point is fair to everybody. That sometimes means going back and redoing.

CHAIR—Do you have an opportunity for an independent assessor to come in and arbitrate in a situation like that?

Mr Brandon—If we go back and look at the home we would normally send a different assessor. They have that. And then once we have made the decision there is a provision that they can seek a reconsideration of our decision. They put up more information at that stage. That is as simple as writing a letter and saying: ‘Thank you for your decision of such and such a date. We seek reconsideration.’ A number of homes do that. Following that, if they are not satisfied with the decision they can then go to the Administrative Appeals Tribunal.

CHAIR—That second review is not necessarily done by a different assessor.

Mr Brandon—Yes, it is. We have centralised the reconsiderations in the last 12 to 18 months. They are done by people who are outside the area where the original decision was made. Most of them are done by specialist people in our national office who work with Ross Bushrod. If there is an issue of workloads or something, in order to speed it up they will send it to another state. With the internal reviews, we move them away from where the original decision was made and we ask them for, and they are required to give us, reasons why they made the decision they did.

Senator HUMPHRIES—I have a couple of questions about some of the criticisms that have been made elsewhere of the agency. There is an argument that people might brush up for an accreditation process and then let standards drop back. Does that happen? If so, how do you deal with that? How do you prevent that from occurring?

Mr Brandon—We have that put to us. Somewhat disappointingly, sometimes the people who say these things will not come to us formally; in fact, they will not come to us informally. I sat here earlier and heard people talk about how things like that happen. It is a bit disappointing, because with the anonymous arrangements for the complaint resolution scheme and for complaints, we could deal with that. But, to go to the question, the nature of the auditing is that they do not just accept what someone tells them. We use a system called triangulation. We are looking at the expected outcome—and there is a description of this in those large manuals I waved around before: we ask them to look at the documentation, to talk to staff and relatives and residents and to ask them: ‘Are you getting the services or the outcomes that we are told you are getting?’ It is basically triangulation. We look at a number of different places to validate what the home says. Fundamentally, we do not just accept that something is happening because a nursing home proprietor says it is.

Senator HUMPHRIES—The Australian Society for Geriatric Medicine talks about ‘defensive paperwork’. People are not trying to reflect the spirit of what is being aimed for by the forms they fill in but, rather, trying to cover their backsides. Has your experience in these first couple of rounds of accreditation been that the paperwork needs substantial modification?

Mr Brandon—The providers in round 1 had a strong view that they needed paperwork to demonstrate their compliance. When we moved into round 2 we were able to convince them that we were not after paperwork. The paperwork we would have would look at things like care plans, which would exist whether there was accreditation or not. We are looking at paperwork which would normally exist in any well-run business with quality systems. As with all things, when you are looking at continuous improvement, there is no doubt that all of us could improve. It is just a question of looking at it and working out how we can do that. We certainly see that providers and their staff want to improve, as we want to improve, and we encourage that.

Senator HUMPHRIES—You say that the people who get an adverse assessment can take their appeal to the AAT. Have you had many appeals to the AAT since accreditation began?

Mr Bushrod—I cannot give you the precise number off the top of my head. It is not a large number; it is in the order of 10 or 12.

Senator HUMPHRIES—Out of how many accreditations approximately?

Mr Bushrod—Out of the total number of accreditation decisions the number is approaching 6,000.

Senator HUMPHRIES—That would suggest that there is a fairly good rate of acceptance of the outcomes.

Mr Brandon—I think the reconsideration system works quite well because it is simple and easy. As I said before, it is simply a matter of putting in a letter that says, ‘I want to have this decision reconsidered.’

Senator HUMPHRIES—The Society of Geriatric Medicine also suggested that the indicators we are using to accredit should be more outcome oriented than input oriented, that they should be more about indicators—like the number of occasions when pressure sores are revealed, where malnutrition is recorded among the residents and things like that. What is your view about that claim?

Mr Brandon—The expected outcomes are outcome measures for residents, but the development of the standards is a matter of government policy.

Senator HUMPHRIES—So you just administer them; you do not actually determine how they are set.

Mr Brandon—That is correct.

Senator HUMPHRIES—Does the federal department of health determine those?

Mr Brandon—The accreditation standards and expected outcomes are part of the legislative arrangements.

Senator ALLISON—Do they include bedsores?

Mr Brandon—No. The standards go to the many areas that are of interest to residents, which include clinical issues, lifestyle issues and health issues. When looking at the expected outcomes, if bedsores were an issue for a particular resident, we would look at how they had been managed, whether they had a process for managing bedsores, whether they implemented that process and whether it worked. That is the methodology that surrounds the accreditation arrangements. Within the context of the accreditation arrangements, the number of bedsores in a home might be an indicator of something. However, what is important are the residents who have bedsores, at an individual level. Dare I say that, if the rate of bedsores is one in 100 and you are the resident with the bedsores, the statistics do not mean a thing, because the whole system is driven towards individuals.

Senator HUMPHRIES—Do you have a mechanism for consultation with the sector to talk about the way the agency works?

Mr Brandon—Yes, we do. We have a formal mechanism through the national agency liaison group, which I chair. It includes the senior people from the industry bodies, unions and consumer groups. We have an equivalent at the state level called the state agency liaison group. We also have a number of other feedback mechanisms. We have questionnaires which we ask people to fill in following site audits and support contacts. We recently commissioned an independent review of our performance by Westwood Spice. We asked them to talk to people on the ground in nursing homes about how they found our services, how our systems worked, how our processes worked and how we behaved in the field. The outcomes of that were very positive.

Senator HUMPHRIES—I think you made reference to the Auditor-General's review of the agency. The Aged and Community Services Association has highlighted some of the criticisms. Do you feel that overall the audit was positive about the agency or was it more negative than positive? In respect of the things that were negative about your performance, what is being done to address those?

Mr Brandon—The ANAO report stated that we had adequately identified our responsibilities for accreditation and implemented adequate processes—and that our management of people and workflow supports the process. They made five recommendations, and within the body of the report they made a number of comments, all of which we have taken up. We have made the changes recommended, which I think were quite appropriate at the time. It was a learning experience for us. It was a review of round 1. I came on board at the agency just before that report came down, and the management and the board were aware of many of these things and working on them when I arrived.

Senator FORSHAW—I have a number of questions which I am not going to get through this afternoon. Some of them are in the nature of giving us some more detail so I could put them to you on notice. I would appreciate it if, later in our hearings—towards the end, if necessary—the agency could appear again, because we have a lot of other witnesses who have put submissions in who have commented on the agency's performance, standards and so on. I think you should be given the opportunity to respond to whatever comes up in the course of the inquiry. I will not necessarily go to some of those issues now, but I will work through your submission. At the top of page 5 you refer to the agency liaison groups established in each state and nationally. They have regular meetings with providers and their associations. Could you give me some more detail about what these agency liaison groups are, how many there are and how often they meet? How are they structured and what happens out of those discussions?

Mr Brandon—The national agency liaison group is the peak consultative body with us. The members of that group are the agency, the CEO of ANHECA, the CEO of ACSAA, a representative from the ANF, a representative from the national ex-servicemen's roundtable on aged care and a couple of others. It represents consumers, employers—

Senator FORSHAW—You might like to provide that to us in written form. That would be fine.

Mr Brandon—I can provide you with the terms of reference if you like. They are documented and have been agreed.

Senator FORSHAW—Yes. Some of this information may be on the record in estimates proceedings and the like but, rather than having to go searching for it, I would appreciate it if you could make it available.

Mr Brandon—The membership is reported in our annual report and we can provide the terms of reference. They are mirrored in each state office. The groups are chaired by the state manager, and the terms of reference are quite similar. We meet quarterly. We insert the state meetings between the national ones so that the state ones feed into the national agency liaison group. In fact, when we set up the review of our performance in round 2, using Westwood Spice, we used a subcommittee of the national agency liaison group to select the suppliers of that service.

Senator FORSHAW—On page 6 you refer to the action you have taken in response to recommendation 5 of the Audit Office report. You note that you advertised a tender in March this year for the development of a plan for the evaluation of the impact of accreditation on the quality of care in the residential care industry. Tenders closed on 17 May and you now have a team assembled to examine the proposals. What has happened since May?

Mr Brandon—That project is being managed by the Department of Health and Ageing, and we are having our first steering committee meeting next week in Melbourne. The recommendation was that the agency and the department take on this piece of work.

Senator FORSHAW—So the preferred tenderer is the agency and the department.

Mr Brandon—No, Senator. The preferred tenderer has not been identified. What I meant to say was that the ANAO recommended that the agency and the department do this. The department has taken the lead in letting a tender, and the tenders are being examined now for legal compliance and things that go with that. The steering committee will meet next week in Melbourne.

Senator FORSHAW—And that is to determine who the successful tenderer will be?

Mr Brandon—It will be for the tenders to be reviewed. The steering committee will make a recommendation to the secretary of the department.

Senator FORSHAW—What is the anticipated time frame of getting this under way, getting a preferred tenderer?

Mr Brandon—We are expecting the preferred tenderer out of the next few weeks. Many tenderers came back with long time frames, because there is a lot of groundbreaking work in this—it is certainly worthwhile and important work, but it is groundbreaking.

Senator FORSHAW—So we can expect some action on that in the near future.

Mr Brandon—Yes.

Senator FORSHAW—On the same page in the second-last paragraph you say:

> The Agency’s performance record shows its systems and processes are robust, effective and efficient.

I do not want you to go into detail about that at the moment but when you say ‘the agency’s performance record’ are you referring to something specific?

Mr Brandon—I am referring to our link with the accreditation arrangements and specifically to our performance against the contract we have with the Department of Health and Ageing, which is set out in the deed of funding agreement. Also, I am referring to the significant changes we have made in the last 18 months to our infrastructure, such as gaining a better understanding of our cost structures and costing all the infrastructure things which support our work.

Senator FORSHAW—That statement is based upon your own agency’s evaluation.

Mr Brandon—No.

Senator FORSHAW—Is it a performance record that someone else has—

Mr Brandon—It is also based on the feedback we get from providers, not the least of which was the feedback we got through Westwood Spice, which was an independent review of our performance.

Senator FORSHAW—Yes, I see that. I was trying to clarify whether it was a specific external evaluation.

Mr Brandon—The other thing which has happened since then is that we are well down the path of ISO certification, and the feedback we are getting from the auditors is positive, too.

Senator FORSHAW—At the top of page 8 you refer to the number of site audit visits conducted in the year ending 30 June 2004:

> ... 965 site audit visits and 2,815 site support contact visits of which 14% were spot checks.

Are they all separate nursing home visits or are there multiple visits to nursing homes?

Mr Brandon—I do not know the exact figures.

Senator FORSHAW—You might want to clarify this by taking it on notice.

Mr Brandon—What I can say is that the minority would be multiple visits to the one nursing home.

Senator FORSHAW—I would particularly like details of the number of nursing homes that have had spot checks in the last 12 months. As I said, I appreciate that these are questions we have put to the agency previously for previous periods at estimates, but if you could give us the latest set of data then that would be useful. For the record of this inquiry, what generally prompts a spot check?

Mr Brandon—A spot check would come about in a number of ways, one of which is a reference from the Department of Health and Ageing. We have a protocol with them and they send us information. A spot check could be purely random or because we have a reason or concern based on something we heard about in the home. One of the processes we have in place that leads to support contacts as a part of our case management process is where we become aware that there is some concern—it might just be through the media; it might be through any number of things—and we do a file review. The state manager looks at the file and ascertains whether we have been there lately and whether we are planning to go there, and a specific decision is made about the home, taking into account the information to hand. It is a structured approach.

Senator FORSHAW—Is the figure of 14 per cent that you have given at the top of the page a target figure?

Mr Brandon—The 14 per cent is in fact 14 per cent of the total figure. It is 17 per cent of support contacts. There has been speculation or discussion in the past about 10 per cent. I have heard that said. By and large, my view is that we do support contacts and spot checks where and when they are required. The accreditation arrangements do not easily lend themselves to deciding that you are going to do that particular number, and that number only, in a particular place. It is very much about monitoring compliance. I suppose the context of that is the accreditation grant principles, where it is set out quite clearly that we are to use support contacts to monitor compliance with the standards.

Senator FORSHAW—I have a couple of other quick questions. On the same page, in the middle of the page, you state:

> In the lead up to Round 1 some 300 providers exited the residential aged care industry. The Agency has analysed the performance of homes between Round 1 and Round 2 of accreditation. The analysis reveals that 899 homes improved their level of compliance and 217 homes' performance levels deteriorated.

My quick maths suggested to me that the 217 represent approximately 20 per cent of that total number of 899 plus the 217 that had deteriorated. How do you rate that figure?

Mr Brandon—I think your arithmetic is right—

Senator FORSHAW—As I said, it is a very rough analysis. You are talking around 1,100 homes and 217 deteriorated, so it is a bit under 20 per cent.

Mr Brandon—There are also the other 1,800 which did not move; that is the point of it. There are 2,900 homes. On those figures, 1,800 remain unchanged. The point of putting that in is to identify that there was an improvement, and I can also say that, for those 217 homes, the changes were around 1 and 2 non-compliance. Some of the 899 were a bit bigger than that. But I think it is worth noting that, across the sector, there was an improvement in performance. That is what that is saying. I think that is largely to do with the fact that the agency was out there doing support contacts and working with homes.

Senator FORSHAW—I have one other question for today. On pages 10 and 11 of the submission you refer to what you called the higher awards. Can you explain these higher awards arrangements. I was not quite sure what that was about. It says:

> Homes achieving a higher award are showcased on the Agency website

What is a higher award?

Mr Bushrod—We felt that we needed to put in place an arrangement whereby homes which performed exceptionally well could act as exemplars for other homes in the industry and that this would be beneficial. Indeed, there was a lot of feeling in the industry that that was the case. So a higher award scheme was implemented through which homes could apply for consideration for a higher award at the same time as they applied for accreditation. They could be given a higher award of ‘commendable’ or ‘merit’ based on their expectation of their level of performance and our assessment of their level of performance. If they achieved an award of ‘commendable’ then consideration was given to longer periods of accreditation, because an award of ‘commendable’ carried with it an assessment and an acknowledgment of very sound management systems that were regarded as very reliable—and reliable into the future. That is what that is referring to.

Senator FORSHAW—Is that used as a marketing tool, if you like, by the homes?

Mr Bushrod—I would not be surprised if they used it as a bit of a marketing tool.

Senator FORSHAW—It would have to have a purpose, I suppose.

Mr Bushrod—They might hang it on the wall. I think, having given the award, we in fact encourage them to promote themselves and to promote the quality of care that goes along with it.

Mr Brandon—Usually the homes organise presentation events and certainly, from the ones I have been to, the staff in the homes see it very much as a recognition of their work. That is probably the theme that comes through. People have said to me, ‘This is great and the residents are chuffed.’ There is certainly a very positive feeling about the recognition being given to the work that the staff in the homes do.

Senator FORSHAW—This question probably requires a longer answer and again you may want to take it on notice. A couple of today’s submissions have said quite strongly that the agency should not be involved in education—that you should not be involved in that facet of your charter. Do you have a quick response on that? Perhaps a more detailed response can be given later. Have you read the submissions of those other bodies?

Mr Brandon—Yes, I have.

Senator FORSHAW—So you are aware of what I am talking about.

Mr Brandon—The agency’s view is that, first of all, it is a legislative requirement of ours anyway and that education, accreditation and monitoring go hand in hand. Other organisations do similar things. But what is most important in this whole discussion about whether we should be doing education or not is that providers—not industry associations but actual serious providers—have said to us, ‘You guys should be doing more in education.’ Everything we have done so far has come back with feedback analyses, and I will give you an example of what has been said. In the ‘better practice’ events, amongst many questions about the speakers, we ask them things like: was this useful; did you find something you could learn; would you come to other events; would you recommend it; and should we do more? With every event we have run so far, of the people who have attended, who are providers and their employees, 90 per cent have said that we should do more, they would come back and they thought it was a good use of their time. So, if you took that perspective, you would say that the market recognises there is a need for it, and we are meeting that need.

I should also say that we have approached education by looking at it and saying, ‘Well, if someone else out there in the education market is doing it then we won’t do it, because that is counterproductive.’ We have not found anyone across Australia, including rural areas, who has run seminars like Turn Data Into Action; we certainly have not found anyone who is running ‘better practice’ events. I notice that in some of the submissions they talk about best practice. I think that demonstrates that perhaps they do not understand aged care as well as they probably should, because in aged care it is really hard to put your finger on best practice; it is really about better practice—what works in a nursing home. From the feedback we get, the major strength of these ‘better practice’ events is that people walk away and say, ‘Yes, I’ve seen something that I can adopt in my home.’

Senator ALLISON—I know that you have not responded to these terms of reference, but could you tell the committee what considerations the accreditation agency takes into account for young people in nursing homes? Does their presence have any bearing on what you do, the expected outcomes or any other aspect of your accreditation process?

Mr Brandon—I will have to take that on notice.

Senator ALLISON—Thank you. Earlier there was a call for the collection of national health data by the Australian Institute of Health and Welfare. Do you see that as being a useful tool in your work?

Mr Brandon—I think the collection of any sort of health data is useful to a range of people. We would continue to assess homes against the standards, as the legislation provides; if some of that data helped us do that, we would be grateful.

Senator ALLISON—Earlier today there was criticism of sector policy in connection with a lack in the area of geriatrics; in other words, not enough GPs are trained in geriatrics, no pathway exists for aged care workers to stay in the sector and develop such skills and there is a lack of specialist knowledge in the sector. Do any of your 44 expected outcomes rely on that specialisation?

Mr Brandon—The 44 expected outcomes measure how the care and so on are being delivered to residents. As to the systems and methods that are used, it is open to the provider to work out what is appropriate for his or her service and for the residents. If those things are appropriate in specific circumstances, the answer is yes.

Senator ALLISON—Surely you are not suggesting that we leave it entirely up to providers to determine this. You must make some judgments about whether or not what they are providing is meeting those expected outcomes.

Mr Brandon—Those judgments are the very essence of the expected outcomes arrangements. We go through with this book and say, ‘These are the expected outcomes for individual residents. This is what we mean. Demonstrate to us how you do that.’ We can see examples of where people achieve the same positive outcomes for residents in different ways.

Senator ALLISON—I am sure they do, but can you give the committee some advice as to whether, as we are about to make recommendations for this report, we should be calling for greater training in geriatrics across the board, whether it be for physiotherapists, GPs or personal carers?

Mr Brandon—I do not think we are competent to answer that. We are about the end point, the outcomes, and we look at how they do it. We know that most homes are achieving the 44 expected outcomes.

Senator ALLISON—You did not provide us with a copy of those 44 expected outcomes in your submission, did you? I did not see it.

Mr Brandon—No.

Senator ALLISON—That is public knowledge, presumably.

Mr Brandon—In addition to the voluminous documentation, we also produced for industry something called a *Pocket guide to the accreditation standards*.

Senator ALLISON—Is it possible for you to leave that with the committee?

Mr Brandon—Yes, it is.

Senator ALLISON—It was said earlier that there is a great flurry of activity prior to your assessor’s arrival at nursing homes; there is cleaning up done, extra staff are put on and a bit of an effort is made to impress you. I notice your spot checks can be done with less than 30 minutes notice. By my calculations, at 14 per cent of the total that is about 300 a year that are done. Do you give any credence at all to these claims?

Mr Brandon—When doing an assessment against the standards, we look at a number of things; it is not just one particular piece. We look at the documentation that exists. We talk to the providers; we talk to their staff; we talk to the nursing homes. In essence, the assessor looks at all the evidence that supports the provider’s contention that they are compliant. I have no personal knowledge of homes being tarted up whatsoever, but I think that would be a very short-sighted view. The whole accreditation process is much broader than that and it actually looks for a lot more evidence than that. Our experience would be that from time to time staff say things to us like, ‘This is not the way we normally do it.’ Residents and their relatives can be quite outspoken. It is a question of bringing all the information together and then forming a view.

Senator ALLISON—Do you interview residents and their families in confidence?

Mr Brandon—Yes, we do. The legislation requires that we speak to a minimum of 10 per cent.

Senator ALLISON—And you do that in a place where they cannot be heard and the providers do not know they are being interviewed?

Mr Brandon—I think the providers know they are being spoken to.

Mr Bushrod—When assessors speak to residents, they are required to do so in a way that does not identify residents and does not cause residents to be identified. That does not mean that an approved provider of care might not be aware that certain residents had spoken to assessors, but it would not be because of the way the assessor carried out the interview or discussion with the resident. It could be because the resident was quite happy to speak openly with the assessor.

Senator ALLISON—You would have to interview at least one resident, would you not, if you were going to take on board an adverse complaint?

Mr Bushrod—At least, yes.

Mr Brandon—They put up notices, don’t they?

Mr Bushrod—Yes, there is a requirement for the approved provider to inform residents and relatives ahead of the site audit that the site audit is going to occur, so that they then have the opportunity to decide whether or not they want to seek out the assessor and provide comments to the assessor or indeed directly to the agency.

Mr Brandon—What often happens during an audit is that residents or their rels will come up to the assessor and say, ‘I’d like to speak with you.’

Senator ALLISON—Your assessors do a training course and orientation of some sort. How long is the training course and what are the prerequisites, the qualifications, they must have in order to come into this field?

Mr Brandon—The legislation sets out a process which talks about people meeting an industry panel which we have set up through QSA of people who understand the industry, and we have set them up as a proper selection panel. The course is five days full time and there is an assessment both at a practical and—

Senator ALLISON—But there is no qualification required before they come in?

Mr Brandon—There is no formal qualification. However, the selection process, which is set out on our web site, is now quite rigorous. People who want to become assessors, whether or not they are going to be employed, are treated as if they are going for a job interview. You would understand that a lot of assessors do the course and then work for us as contractors. Or, in fact, some of them go back to the home where they work and adapt what they have learnt to introduce quality systems into that home.

Senator ALLISON—Could you provide the committee with the criteria that you use in the panel process?

Mr Brandon—Yes.

Senator ALLISON—Thank you.

CHAIR—Thank you very much, Mr Brandon and Mr Bushrod, for your evidence. I do hope you will be able to come back and talk to us at the end of our inquiry; I think Senator Forshaw’s suggestion is valuable. We will see you then.

Mr Brandon—Thank you.

[4.38 p.m.]

FULLIN, Ms Janine Patricia, Community Worker, Aged and Disability Services, Ashfield Council

CHAIR—Welcome. Do you have anything to add to the capacity in which you are appearing?

Ms Fullin—I am also representing members of the Inner West 5 Home and Community Care Forum.

CHAIR—Thank you. The committee prefers all evidence to be heard in public, but should you at any stage wish to go in camera please ask us and we will consider that request. You are reminded that evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. We have your submission, and can you also pass on our thanks to the Inner West 5 Home and Community Care Forum for theirs. I understand they could not provide a witness today. I invite you to make an opening statement and then we will follow with some questions.

Ms Fullin—Firstly, I would like to thank the committee for the opportunity to attend the hearing today. As I stated earlier, I am representing Ashfield Council and members of the Inner West 5 Home and Community Care Forum. I am a community worker at Ashfield Council, within the community services department. I am responsible for aged and disability services. In my capacity today on behalf of the forum and the council, I am also expressing concern that some of the home and community care—or HACC—services in the inner west are experiencing some difficulties in meeting the demand from residents. I want to convey that it is certainly not my intention nor that of Ashfield Council to imply that home and community care services staff are in any way relinquishing their professional responsibility, but rather perhaps that funding and resources are a greater cause for concern, as I will outline.

Unfortunately, the author of submission No. 13, Christine Mifsud, could not be here today. She is overseas. When I was preparing for my appearance today it was suggested that the committee might like to consider liaising with Christine Mifsud when she returns from overseas—that will be next Wednesday, 25 August. I understand there are other hearings to be conducted and she may be in a position to attend a hearing in Canberra, for example.

Returning the focus to today, my presentation is fairly brief but covers two main HACC services: firstly, the Home Care Service of New South Wales and, secondly, a service provided by Inner West Community Transport—namely, the health related transport service. Inner West Community Transport is a service based in Burwood in the Sydney metropolitan area. It covers the local government areas of Ashfield, Burwood, Strathfield and Canada Bay. It provides services such as shopping, social outings and individual transport, but I will focus on health related transport.

In 2001 funding for the health related transport service, or HRT, was decreased from $25,000 per year to $15,729. Currently, funding is $15,000 per year. This means that the service, which transports residents of the local government areas I mentioned earlier to medical appointments, was cut from three days to one. It is difficult to get an exact figure but advice from Inner West Community Transport is that currently there are up to approximately 40 people on a waiting list for that service. The service is limited: it is only providing health related transport to Concord hospital. Hospitals such as the Royal Prince Alfred Hospital and Balmain Hospital are not included in the current service. This is somewhat restrictive as a person with complex care needs may need to access specialist services other than those provided at Concord.

A service on only one day a week might impede treatment for a person who has complex care needs—who requires physiotherapy, for example, or other rehabilitation services. Clients may be able to attend one day but, as you are probably aware, often those services are ongoing—maybe two or three times a week. Because people may not be able to get to the second or third treatment per week, their rehabilitation may take longer. Clients who might require chemotherapy or dialysis treatment are not necessarily accommodated by the current service. This raises the issue of how such people are getting to hospital to receive their treatment and whether this is an unmet need. Social workers from Royal Prince Alfred Hospital often contact the community transport service. I have had phone calls from social workers at RPA asking for general transport assistance—not just health related transport. They may ask for transport to get patients from hospital back home upon discharge. Perhaps this indicates a wider need in transport for the frail aged or people with general disabilities. The individual transport service which is provided by community transport is now often primarily about taking people to hospital and to doctors appointments. That is not necessarily the intention of that service.

Individual transport is essentially there to provide people with an opportunity to do things that do not fall into the streams of shopping or health—things such as going to visit a friend in a nursing home, going to the cemetery, going to get their hair done, or a whole lot of other individual requests. Those social requests are often put aside now and the individual transport service is like a pseudo health related transport service. It is just simply recognising the demand. The service that is currently funded for health is unable to meet demand and it is bleeding into other services like the individual transport service.

Moving to home care, I have had conversations with home care staff who have made the following points. Firstly, people are assessed by home care in three categories: low, medium or high need. Staff are advising that people are essentially only being provided a service if they fall within the medium-need category. The services that are provided—these are all in the home—are personal care, domestic assistance or respite. Currently there is a two- to three-week wait for an initial assessment. People assessed as low care or high care are placed on an unmet need register. People are not necessarily contacted when a place becomes available but, rather, need to continue to register. It is unclear whether this arrangement is conveyed to people who might go onto the register. They may not even realise that they need to keep registering. People may be under the impression that they are on a waiting list as such—termed by home care staff as an unmet need list—when in fact they are not and they have to keep registering. Again, it is not clear to me how long people stay on the unmet need register before their names are not necessarily deleted or dropped off but there is a process of turning over of names on the list. If someone’s name is taken from the list it is unclear how that process works. So people are thinking they are on a waiting list and are expecting a call from home care but that may not be the case.

The potential waiting period for low- and high-care groups according to home care staff in the inner-west branch is two to six months. People are advised about services provided by other agencies—non-government agencies like Wesley Home Care or Baptist Community Services. The concern is, I suppose, that people who are placed on the unmet need register do not receive a service and are left to manage in the home alone. Whether informal support networks come in through family, friends and neighbours is unclear. But the bottom line is they are not receiving a home care service. It is thought that this is poor preventative practice because people who might initially be considered low need would be less likely to deteriorate to a high-risk category if they were able to get some assistance, even a couple of hours a fortnight, in the home.

I do not have a copy of the criteria used to assess people. The sense I get is that it is about determining whether a person is able to feed themselves and to bathe themselves, to do that essential care a person needs. I cannot go into much more detail about the criteria but perhaps that could be obtained from Home Care Service of New South Wales. Should a person's circumstances change—I am now talking about someone who is actually receiving service, not someone on the unmet need register—and they need an increase in hours for whatever reason, maybe due to a temporary illness or a fall in the home, it is unclear whether a new assessment is undertaken to determine the new need and, even if that assessment is undertaken, whether there is the capacity for the service to increase the hours according to the new need. One of the final points is whether the Home Care Service of New South Wales can provide service to people with intermittent needs such as a short-term illness or post hospital care.

A final piece of information that is not in the submission from Ashfield Council but that I believe is of interest is that the Central Sydney Area Health Service—which has recently had a name change, but I will still refer to it by that name—that is based at Concord Hospital houses the aged community assessment team. It is often the main gateway for people to get access to Home and Community Care services. Often when people phone me and say, 'I have concerns about my 80-year-old mother; she is living alone at home,' it is one of the main referral numbers or agencies I will give people so that they can get an assessment through ACAT. At the moment there is a four-month wait for an assessment, so when I tell people about the service I have to also tell people that there is a wait. People have to be aware that informal support networks or some kind of strategy has to be put in place by family, friends or neighbours. I am told that, if a call through the central intake number is deemed urgent, an assessment can be made within three days. Again, the criteria that is used to determine what is urgent is unclear. If the committee needs clarification of that I would be happy to follow that up with ACAT. That concludes the key messages I want to get across today.

CHAIR—What you have described shows that a lot of difference occurs across regions. The health related transport program is a completely new one to me; I have never heard of anything like it for an urban area, although I know that in rural areas people are moved quite long distances. Senator Moore and I are from Queensland. I have not heard of anything similar. I can understand your concern at it being cut.

Ms Fullin—I take your point that in other areas there is not that service.

CHAIR—It is relative. For people to access health related transport, do you do some sort of means test or other analysis to determine whether they have other methods of accessing transport to go to their doctor?

Ms Fullin—I do not believe the community transport service uses a means-testing mechanism or assessment. Essentially, it covers a person who is deemed to be frail aged or a young person living with a disability and/or their carer, so it is really a general description of the Home and Community Care client group. Of course, boundaries will determine if a person is able to receive the service. They must live within the local government areas that I mentioned earlier—Ashfield, Strathfield, Burwood and Canada Bay. I am not aware of means testing.

Senator HUMPHRIES—The information you gave us about the lack of funding under HACC to fund services like the transport service is quite disturbing, particularly given the fact that, at least at the Commonwealth end, there have been very substantial increases in HACC funding in recent years. In this year's budget, for example, there was an 8.1 per cent increase, and the number of community aged care packages has been increased since 1996 by about 820 per cent, so I am wondering where the money is going. Does the Home Care Service of New South Wales make decisions centrally about allocation throughout the state? Does it decide where those funds will go? Is there any mechanism for involvement of local councils in how those funds are allocated?

Ms Fullin—In terms of your reference to local councils, I am not aware, particularly in the inner west, of any local government having input as to where the funds go. How they are distributed across the state is something I would need to seek clarification on from the Home Care Service of New South Wales.

Senator HUMPHRIES—I assume the state government is well aware of the service you are running in this area and that you have presented the arguments for it. Has the transport scheme you are talking about been trialled for possible use elsewhere in the state or is it just an idea that has been developed for local needs?

Ms Fullin—No, I do not believe it is a trial. If it is, it has been a fairly lengthy one. As far as I know, the health related transport service has been operating for many years under the umbrella of Inner West Community Transport, so I do not believe it is a trial service.

Senator HUMPHRIES—It is mentioned in the Inner-West submission that Baptist Community Services, New South Wales and ACT, has piloted a successful transitional care model for reducing the number of older people requiring residential aged care. Whereabouts does that operate and is it possible to get some details of that? The committee might be interested in visiting a model like that that is successful.

Ms Fullin—Is that in Christine Mifsud's submission?

Senator HUMPHRIES—Yes, it is. It is on page 11. You can take that question on notice and give us the information about that if you like.

Ms Fullin—Yes, I will seek some information for the committee on that.

Senator HUMPHRIES—If she could recommend a successful site where that is happening we might be able to visit that next time we come to Sydney.

Ms Fullin—I will certainly follow up on that.

Senator MOORE—You mentioned the assessment tool for determining home care. Had you asked for that and not got it?

Ms Fullin—I had not.

Senator MOORE—I want to be clear about the process. So it is not that you could not acquire it; it is just that, before today, you had not got it.

Ms Fullin—It is not because I could not acquire it; I have not asked.

Senator MOORE—I do think it is public, but I was not absolutely sure.

Senator FORSHAW—I do not have any questions, but I do have a comment. I was very impressed reading the submissions of the council and of the Inner West 5 Home and Community Care Forum. I thought it was a very thorough presentation and I commend you on it.

Ms Fullin—Thank you for that feedback.

Senator ALLISON—What reason were you given by the state government for the cut in that transport funding? It sounds like a great idea.

Ms Fullin—It is something that the community transport organisation would probably be better able to clarify. I do not know why. It is funding that is coming from the state health department, and reasons are unclear as to why the cut was made. But if you are interested in finding out why I could follow that up with community transport to look back through their records of when the initial funding cut correspondence was sent to them.

Senator ALLISON—How much does your council contribute to HACC funding?

Ms Fullin—The council is not contributing to any HACC funding as such.

Senator ALLISON—So it provides the services through the state.

Ms Fullin—Council are not providing HACC services. Fifty per cent of the funding for my position at council is HACC funding. My role is to liaise with the local HACC services and advocate on their behalf. But council is not a direct service provider, no.

Senator ALLISON—Thank you. You do not do Meals on Wheels?

Ms Fullin—Yes, there is a Meals on Wheels service. It is funded by the Home and Community Care umbrella. It resides in the Ashfield council building and we support the service through free rent and paying for utilities et cetera. But, again, it is an independent, incorporated non-government organisation.

CHAIR—Thank you very much. We will take up your offer to contact Christine Mifsud, because we do intend to come back to Sydney at some point.

Ms Fullin—That would be wonderful. Thank you.

CHAIR—That concludes today's hearing. I thank everybody for their attendance and interest, and I am sure we will be back in Sydney.

Committee adjourned at 4.59 p.m.