COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH, AGED CARE AND SPORT

Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018

(Public)

FRIDAY, 26 OCTOBER 2018

CANBERRA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH, AGED CARE AND SPORT

Friday, 26 October 2018

Members in attendance: Dr Freelander, Mr Georganas, Ms Sharkie, Mr Zappia, Mr Zimmerman.

Terms of Reference for the Inquiry:

To inquire into and report on:

Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018.

WITNESSES

BARRALET, Mrs Kay, Consumer Representative, Dementia Australia

BRANDON, Mr Mark, Chief Policy and Regulatory Officer, Estia Health

BUHAGIAR, Mr Saviour, Director, Residential Aged and Health Care, Uniting NSW and ACT and UnitingCare Australia

BUTLER, Ms Annie, Federal Secretary, Australian Nursing and Midwifery Federation

CALLAGHAN, Ms Elizabeth, Chief Executive Officer, Palliative Care Australia

EMERSON, Ms Susan, Member Representative, Australian College of Nursing

GIUSTI, Ms Cristina, National Policy and Strategy Adviser, Dementia Australia

GREGURKE, Ms Judy, National Manager, Aged Care Reform, COTA Australia

GRIEVE, Mrs Jennifer, General Manager, Health and Care Services, Western Australia, Hall & Prior Health and Aged Care Group

HARDING, Mrs Gail, Chairman, Aged Care Quality Association

HEALY, Mrs Kristine (Kris), General Manager NSW, Hall & Prior Health and Aged Care Group

JOLLY, Ms Maria, First Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health

LAFFAN, Ms Amy, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch, Department of Health

LIM, Dr Kean-Seng, President, AMA NSW; Member, AMA Council of General Practice

McCARTHY, Mr Andrew, Acting Senior Industrial Officer, Australian Nursing and Midwifery Federation

McGOTHIGAN, Mr Nigel, Member Advocate, Leading Age Services Australia

MERSIADES, Mr Nicolas, Director, Aged Care, Catholic Health Australia

O'SULLIVAN, Dr Robert, Treasurer, Australian and New Zealand Society for Geriatric Medicine Inc.

PARKER, Professor Deborah, President-Elect, Palliative Care NSW, Palliative Care Australia

RICHTER, Mr Matthew, Chief Executive Officer, Aged Care Guild

ROONEY, Mr Sean, Chief Executive Officer, Leading Age Services Australia

SEWELL, Mr Mark, Chief Executive Officer, Warrigal; and Chair, NSW Divisional Advisory Council, Aged and Community Services Australia

SPARROW, Ms Patricia, Chief Executive Officer, Aged and Community Services Australia

STRIVENS, Professor Edward, President, Australian and New Zealand Society for Geriatric Medicine Inc.

TORVALDSEN, Dr Simon, Chair, AMA WA Council of General Practice; Member, AMA Council of General Practice

WARD, Ms Kylie, Chief Executive Officer, Australian College of Nursing

WESTENBERG, Mr Luke, Chief Executive Officer, Aged Care Industry Association

Evidence from Mrs Grieve, Mrs Healy, Dr Lim and Dr Torvaldsen was taken via teleconference—

Committee met at 09:17

CHAIR (Mr Zimmerman): I declare open this public hearing of the Standing Committee on Health, Aged Care and Sport in reference to the inquiry into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018. Thank you for participating this morning. I want to acknowledge the fact that the committee's membership has been supplemented for the purpose of this inquiry, with the member for Mayo, Rebekha Sharkie, joining the committee for the conduct of this inquiry. As you know, this is in relation to a private member's bill that Ms Sharkie has introduced into the parliament, and it was referred to this committee for investigation by the parliamentary process. Basically, we report back on the terms of the private member's bill, which could be to

endorse the principles behind it, to not endorse the principles behind it or to land somewhere in the middle, which would be to recommend support with amendments or something along those lines.

Before we get underway I just need to do a couple of formalities. Firstly, is it the wish of the committee that the media be allowed to film the proceedings today in accordance with the rules set down for committees? There being no objection, it is so ordered. Is it the wish of the committee that submissions 34 to 41, as circulated, be received and authorised for publication? There being no objection, it is so ordered.

We obviously have a large number of organisations here today, and we have two organisations that are participating by teleconference, the AMA and Hall & Prior. Does anyone present today have any objection to being recorded by the media during the course of the hearing? There is no objection. Does anyone have any additional comments to make on the capacity in which they appear?

Dr Lim: I'm also deputy chair of the AMA Council of General Practice.

CHAIR: Thank you all very much. I am required to remind you that these are formal proceedings of the parliament. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of the parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege.

We are attempting to structure today loosely around two themes: first, new staff ratio regimes and, second, transparency and privacy considerations. But I suspect, with this number, that it might be best if we simply combine the sessions, and I suspect we'll need the time to get through contributions that everyone would like to make. We will break at 11 o'clock briefly, and our aim is to finish around 12.45. I am going to invite every organisation here to make a short opening statement, and I would encourage you to be brief—around two minutes. If anyone starts to get a little bit verbose, I might clink a glass or something like that. We might start, appropriately, with the Department of Health, and then I will go to the people on teleconference. Representatives of the AMA and Hall & Prior, out of sight can sometimes be out of mind, so feel free to jump in if you feel like you're not getting a hearing during the course of this morning's proceedings. Would the department like to make an opening statement?

Ms Jolly: Thank you, Chair. We hadn't proposed to make an opening statement. We'd just like to refer the committee to the submission that we've provided.

CHAIR: Okay. I might go to the AMA.

Dr Torvaldsen: Thanks very much, indeed. I'd just like to point out that, as part of my general practice, I visit aged-care facilities and provide medical care to over 50 residents in aged-care facilities as well as looking after hundreds of older Australians in my general practice. This is something I do every day. It's very important that we recognise that older Australians deserve high-quality care appropriate to their needs and should be treated with the highest level of dignity and respect. This should not just be in theory; we need to make sure this settles in practice.

Before I begin, one of the most important things that we need to recognise is the enormous amount of good care being delivered at present by dedicated staff working for organisations that are committed to high-quality care. There are a lot of good staff out there who really care about residents. The problem is making a system that allows them to deliver that good care. It's really important that we look beyond the newspaper headlines and examples of abuse to the system that all these people work within because, although there might be the odd bad person out there, there's far more harm and poor outcomes that result from good people working within a bad system, and our job is to improve that system. When I ask almost any nurse or care provider in any aged-care facility, 'What's the No. 1 thing that could be done to improve the care that you deliver?' almost every single time they'll say to me, 'More staff and more time to spend with the residents.'

I think it's important that we recognise that adequate staff alone does not guarantee quality care. and there are certainly examples of that. But it's also very true that, if you have inadequate staff, it's actually impossible to deliver high-quality care. So adequate staff is a necessary but not sufficient condition for quality care. And, as pointed out by the Australian Nursing and Midwifery Federation, there is a significant body of evidence that higher staff ratios are associated with overall higher quality care, which simply confirms what everyone working in the aged-care industry would see as common sense.

But, from our point of view, it's very important that the staffing ratios are considered within a meaningful context. Simple figures considered in isolation can be quite misleading. So it's important that any ratios are related to the care needs of the resident mix. There needs to be some kind of meaningful, weighted resident number that allows for the differences in complexity of care required, which can vary very significantly from one resident and one facility to the next. Pure numbers alone could potentially be misleading and quite unhelpful. We think that

this needs to involve staffing at night as well as during the day. I've certainly visited facilities that simply don't have any nurses overnight and any problems are simply sent to the emergency department.

I think that it's also important that any regulation as a result of this bill is not imposing an unnecessary burden upon these already stretched facilities. It's incumbent upon all of us to recognise that any time spent on compliance is time that cannot be spent actually looking after people. That's the second most common complaint I hear from those working in the system. They say, 'Take away the burden of compliance, box-ticking and paperwork and just allow us to get on with doing our jobs and looking after people.'

Finally, I think that it is important to recognise that the current system which attempts to measure the quality of care and outcomes actually has its limitations. It is simply not possible to accurately measure the quality of care with the methods used currently. For example, I know of one facility that had an excellent response time of under two minutes to every resident call. This was simply achieved by a staff member coming into the room switching off the alarm and saying to the resident, 'I'll be back later.' It's important to recognise that good staff really feel terrible about having to do that sort of thing. It's not something that they want to do. They all want to have time to do their jobs properly, and I think that it's our job to make sure that this occurs.

It's for this reason that we actually not only support this bill but support mandated minimum staffing ratios. We see this bill as simply the first step along that road, providing it's adjusted for case mix. It needs to include, as this bill does, all staff, not just nurses. This will at least ensure it's possible to deliver quality care. Then we can move on and look at building a system around that that ensures that we do that and that it's properly recognised, measured and paid for.

So, whilst we are very supportive of this bill, we see it as only the first small step to reforming our aged-care system. It lays down the basic groundwork. But we need to pay attention to training, pay, morale, appropriate regulation and not just red tape, supporting adequate medical care, quality end-of-life care and minimising unnecessary trips to the hospital. So we commend this bill, but we think that there's a lot more work to be done and it's very important that this bill not be seen in isolation as just providing the entire answer.

CHAIR: Thanks very much. We appreciate that. That's a good, agenda-setting opening statement. With additional statements as we go I might encourage people not to reiterate too much the points that have already been made and obviously to focus very squarely on the bill and your views on the bill. Mrs Grieve, did you want to make an opening statement?

Mrs Grieve: Yes, thank you. Good morning and thank you very much for this opportunity. I concur with the previous speaker that this is a good first step, and Hall & Prior commend Ms Rebekha Sharkie on putting forward an important private member's bill on publishing staff ratios. Hall & Prior is a family owned aged-care provider with 25 residential and homecare services in both Western Australia and New South Wales. For the past 25 years, we have really supported the need for increased transparency in our industry. We want to achieve a balance of absolute accountability with, as the previous speaker said, minimised bureaucracy when informing the public about aged-care activities that are funded by the government.

I too concur that we have a lot of very good people doing very good work and a lot of people who believe that it is a privilege to have the trust of a fellow human's life in their hands and who want to do their job well and with high quality. We think that publishing ratios is one way to do this. We have, since our inception, been wedded, for want of a better word, to a registered nurse-led clinical care program, and we are absolutely committed to transparency and truth telling. We believe those are two fundamental tenets which must be observed when looking after any vulnerable group of people in an aged-care setting or, indeed, in any setting.

We also acknowledge that there's a lot of sensitivity in the industry around the complexity of agreeing on aged-care ratios. As per the previous speaker, we believe ratios on their own are not enough. We believe that ratios need to be responsive to the complex high care and the increased acuity of that care that we are now seeing and looking after in our aged-care services, be they in home care or be they in residential care. So this sensitivity is important and it demonstrates that it's a critical issue that deserves our time and due consideration. It's the first step, but we must get it right.

We're here today because our goal is to have a robust conversation about what care ratios providers are prepared to offer, what the government is willing to fund and pay for this and what role the community has in supporting our industry to ensure that our staff are proud to work in the aged-care sector. It's sometimes thankless, and I don't think it's often enough recognised—the incredible contribution, and excellent contribution, that it makes to the society of Australia as we know it. With that, could I please hand over to Chris, my colleague in New South Wales, to conclude our opening statement.

CHAIR: We might need to keep moving, but there will be time during the course of proceedings for people to make additional comments. I'll start in a clockwise fashion, so I'll go to you, Saviour. And I'll just give everyone a reminder that we do need to try and keep to two minutes, so we encourage brevity—there'll be a prize for the shortest!

Mr Buhagiar: Thank you, I'll look forward to receiving that.

CHAIR: And a week in parliament for the longest!

Mr Buhagiar: Uniting NSW and ACT Residential Aged and Health Care services look after over 5,000 people in our services at about 60 sites across New South Wales and the ACT. We're supportive of transparency, and we commend the bill. We think it's a good bill. We do think that the information provided to consumers needs to be simple and meaningful. That's the key point that we've made in our submission. So we would want to see that there are some levels, or some bands, against which staffing hours or staffing ratios are published, so that actually can be meaningful information—so people can make sense of it.

We're also concerned that this is just one indicator of quality, and there are many others. If we focus on staffing, that is one, and it provides some information, but there's a range of indicators that people need when they come to make decisions, not least of which is how other people experience the service. We're concerned, I suppose, around medicalising that model, and so there's a focus on nurses. There's many good models that don't necessarily have to focus on nurses—not that nurses aren't important; they are critical to aged care—but we're concerned about that. Also, we're concerned about how regional, rural and remote services—smaller services—would cope with this sort of regime, and particularly the need to publish and to revise that regime, so we're concerned about the complexity of that regime for smaller and rural and remote services.

In summary, our point is that transparency is a good thing, but the information's got to be meaningful for consumers. And, unless we can come up with a simple method to do that, and that includes looking at a range of indicators, as well as trying to match it to people's needs—and I think the AMA went to that point: unless we match it to what people's needs are—it won't be helpful. That's our submission.

Mr Rooney: There are many inputs into good-quality care, the primary input being the people that provide care and services. We believe that good-quality care is the product of meeting the specific and assessed needs of each individual in care. That covers their physical, social, emotional, psychological and spiritual needs. The way to achieve this has actually been outlined in the recently released Aged Care Workforce Strategy. Then, in order to deliver that good-quality care, the workforce must possess the commitment, the attitude and the willingness to serve older Australians. Having that in place, then we need to have the correct number of these staff in various care settings with a variety of skills, skills mix and qualifications, and we need them to be appropriately remunerated.

We assert that giving older Australians and their families appropriate information about the quality of aged-care facilities is crucial to supporting their informed choice, and also to improve community confidence in the aged-care system and drive continuous improvement in the quality of the care delivered. When considering the proposed changes to the Aged Care Act regarding the disclosure of staffing ratios, I think the starting point is to consider: what's the desired objective here? If we're looking to provide information to the Department of Health, that would be valuable information, transparent around staffing models and staffing levels in different care settings and different models of care, and that's useful for government and useful for industry. As others have noted, making that information available to the general public may provide greater transparency with regard to the provision of residential care services; however, we're not sure as to how this information would support more informed choice for older Australians when considering their care options.

Specific things to consider here are that every individual's needs are different and every facility is different. So a facility that's accommodating people with lower levels of acuity or care needs would have either lower numbers of staff or a different mix of staff. There are different models of care that attract different levels of staff. Architecture and building footprint determine, in some cases, the levels of staff. In some locations, the availability of suitably qualified staff would affect the numbers of staff. The number of community volunteers working at that facility can also be a complement and affect the numbers of staff. Care recipients may access care in a facility, but that care may be provided outside of the staff that are actually employed by that facility through palliative care or other support arrangements. So you wouldn't be able to consider that level of care because it's not going to be recorded as a staff level. Given these factors, what we caution is that reporting just a blunt staff-to-care-recipient ratio may provide information, but it may be hard to interpret. It may be not readily comparable across facilities or services and could potentially be misleading. So I guess we caution that.

We would also note that implicit in the desire to make this information available is an assumption that this information is a proxy for quality of the care delivered. This is not the case. There are better ways to measure quality and use this information to better support informed choice. Specifically, the Australian Aged Care Quality Agency consumer experience reports have been implemented. They're a useful way for people to understand comparability across services. The Carnell-Paterson review has recommended a quality rating and reporting system. We assume, with the establishment the quality and safety agency, that would also come into being. We know there's any number of third party platforms—the TripAdvisor-type models—already starting to promulgate across the industry.

In addition to those comments, we've got a number of specific comments around the mechanics of the proposed amendment, and they're covered in our submission. We'd also recommend that we need to understand any costs associated because I think the point made earlier was that more time or more cost spent on compliance is less time and less cost spent on care.

In closing, let me reiterate: giving older Australians and their families appropriate information about the quality of the care facilities is crucial to supporting informed choice, improving confidence in the system and driving continuous improvement in our industry. We are already working towards these objectives. There are lots of reforms currently underway, and we welcome the discussion with all stakeholders to make the system better.

CHAIR: Thank you.

Ms Sparrow: In the interest of brevity, I'll speak on behalf of both myself and Mr Sewell. Thank you for the opportunity to present and to talk about a topic that's so important to Australia today. I'll be very brief. ACSA and its members are committed to the highest quality of care and providing meaningful information to consumers, their loved ones and the community. We support the principles of transparency and comparability advanced by the bill.

Similarly to how others have spoken this morning, we would state, as we do in our submission, that we think publishing a ratio on its own isn't going to tell the consumer about the quality of care that they can expect in any particular home because it doesn't take account of so many different variables that impact on staffing, including service models and types, the resident acuity mix, staffing sometimes for specialist services, building design and things like use of technology. We believe that we need to look at alternative approaches, that need to be identified and explored, including, as some people have already said this morning, linking staffing numbers to the resident acuity as defined by the funding that we receive. We think that if we look at ratios, we need to look at it in the context of a range about what's actually going to be meaningful for consumers—things that they will be able to understand and that will tell them about the quality of care that's to be delivered.

We have a range of other specific suggestions in our submission. Hopefully through the course of today, we'll be able to advance those, but we're also happy to talk about that if need be or provide further information. I've brought Mark Sewell with me today. He's one of ACSA's not-for-profit members. We thought it would be useful for you to have an aged-care provider—there are others here in the room today—so that they can answer questions you may have about how it would actually work in a facility. I echo the comments that, as we do this, we also need to look at compliance, particularly for our small rural and remote members. I'm looking forward to the discussion.

CHAIR: Thank you very much.

Mr Richter: Good morning. The Aged Care Guild supports greater transparency like, I think, everyone does in the aged-care sector. We think we need it. Transparency is about providing access to meaningful information that gives clarity on the quality of care provided, assisting consumers to make informed decisions. We know that making informed decisions in this sector at the moment can be difficult. There is clearly a way to go on this journey, but looking at mechanisms to improve and support consumers in their journey is something we need to progress now, not after a royal commission. So given that, we support this bill, its principles and its intent, and we consider it a positive step forward in transparency in the sector.

In considering the practicalities of the bill, we have some principles that we feel are very important. The information must be meaningful to consumers and we look to consumers and consumer groups, not members such as me, to inform that. Given the current environment and the reform generally under way, we must ensure that it doesn't increase administrative burden on providers, as every minute directed to admin is a minute away from care. Any legislative changes need to be applied to the sector as a whole, not leaving any black holes. There are some implementation considerations to be worked through, such as how the variance reporting works in practice, but I don't think any of these are insurmountable.

In my view, it is worthwhile also to consider a range of ancillary factors, either now or through this journey, that many people have already mentioned that are integral to the quality of service provision in aged care. These are things such as training and development of staff, processes of recruitment that people go through, availability of end-of-life programs and other programs that might be present in the facility and support infrastructure to assist workers connect up and maintain their skills, connectivity and development in the system. We need to recognise that complexity is different among consumers. There are a range of other mechanisms that people have said that contribute to quality of care, but this is a positive first step.

We look forward to working with the committee, Ms Sharkie, colleagues and government on looking at this bill and at its implementation arrangement to ensure that it does present an accurate picture of every provider's situation. In considering the implementation arrangements, we recommend that we work with providers on the ground and consumers on the ground to ensure that the technical details, in practice, are feasible and fit for purpose. Thank you.

CHAIR: I think you might be winning so far. Mr Westenberg, can you beat that?

Mr Westenberg: I'll give it my best shot! Thank you for the opportunity to come along and present to the committee. Like all the other associations who've spoken, the ACIA supports increased transparency and clarity around care quality—of the inputs and what consumers expect. We think that publication of staff numbers by category is a useful step if there is sufficient framing information to allow consumers to make an informed judgement. A number by itself is likely to create only the illusion of information, not necessarily actual understanding.

Some of the specific areas of concern that I want to touch on very quickly include the focus on clinical staff. One of the main impacts, of course, on a resident's quality of life is actually non-clinical staff—lifestyle activities, quality of food, all that sort of thing. The bill in its current form would lump all of these activities together as 'other staff', so therefore you wouldn't necessarily be able to see where are facility is investing in lifestyle and non-clinical activities which will impact on a resident's wellbeing. The definition of 'staff' as used in the bill would lump any agency staff in with any ongoing staff. It would certainly seem at least possible that a facility with a very high proportion of agency staff may not necessarily be providing the best quality of care, but if these numbers were all rolled in together in the bill you couldn't distinguish those. As has been noted, staffing is, of course, not the only input into quality of service. I would cite the Oakden Older Persons Mental Health Service, which had a very high staffing ratio and lots of qualifications and provided dreadful care.

We'd be keen to work through some of these issues to ensure the information could be presented with sufficient context to be meaningful and informative to consumers. Thank you very much.

Mrs Harding: The Aged Care Quality Association is an incorporated not-for-profit organisation. Our members are from across a range of aged-care service providers which include for-profit, not-for-profit, faith based, charitable, community, rural, remote, government and non-government organisations. Our members don't support the bill as it stands, primarily because of factors such as acuity and diversity that haven't been taken into consideration but also because there are too many other parameters that indicate quality. We believe that this is a huge, onerous task on service providers, particularly when you look at rural and remote facilities, where they don't have economy of scale to have huge numbers of administrative staff. This will require somebody within that organisation every day to calculate every person who has provided care in that facility. It's not something you'll be able to draw off rapidly from a payroll system, because there would be a lot of service providers who come in on a contract basis or a fee-for-service basis who are not paid directly out of a payroll function. Therefore, somebody in that organisation would have to monitor all the care hours that are being provided within that organisation. Having been a director of nursing in aged care for 35 years in rural areas of South Australia, I believe that that is a hugely onerous task. I implicitly understand the burden that's going to place on facilities. I think also that we underestimate the community's intelligence if we assert that one parameter is going to give them a good quality indicator and give them the transparency in making a choice of where they're going to place their resident. We don't believe that this indicator is an indicator of quality service, pretty much for the same reasons that have been spoken to before. We feel that there is the ability to be able to fudge those statistics. Are we going to take into account those people who are actually responsible for direct resident care, or are we going to be counting in our numbers people who are off site, maybe in a DON role over five or six facilities? Will they be included on each person's stats as a full-time equivalent for that facility? We believe there's too much scope for fudging the statistics and therefore it doesn't give true transparency.

We also feel that clumping staffing numbers into their qualifications doesn't look at the roles that they are performing. It may encourage some organisations to put skilled staff, RNs, into roles that are not necessarily suitable for RNs just so that their statistics can look very good. We also recognise that there are a number of

functions within organisations that are performed by registered and enrolled nursing staff, such as quality management, human resource management. Those sorts of statistics aren't taken into account. So we don't believe that categorising your staffing on their qualifications is a true indicator of the role that they are performing. I think that's all we've got. Thank you.

Ms Ward: The Australian College of Nursing is the pre-eminent and national leader of the nursing profession and is a member of the International Council of Nurses. We have nurses working in all settings in aged care in every state and territory, including rural and remote as well as regional and metropolitan. We are focused on residential aged-care facilities, but if we don't get this right there is an impact on primary and community health as well as the acute settings. We concur with most things that have been said. I'll just add a few things. We welcome transparency, and this is a step forward in achieving that. However, direct staffing ratios alone do not give an indicator. We would like to see, for consumers as well as residents, the ability to interpret from a health literacy perspective indirect staffing as well as the importance of leadership and culture. There is no question that the future of the aged-care workforce will rely on an increased number of nurses who are trained and competent in the demanding field of aged care. This deserves the respect that it should be given. Care should be holistic in its ability to be provided and not down to a simple number. We too are concerned about the other staffing category and in terms of providing spiritual care and psychosocial needs. We also want to reinforce the complexity of the Australian community, with one in four Australians being born overseas, and also making sure that we meet the cultural and language linguistically diverse needs of our community as well as the needs of our Aboriginal and Torres Strait Islanders. One staff member does not equal one set of care delivery in every setting, so one number is not enough. We need to consider outputs and quality outcomes as well as satisfaction, as opposed to the ratios being an arbitrary single unit that is made transparent to the public. Thank you.

Prof. Strivens: Thank you very much for the opportunity to contribute to this discussion. The Australian and New Zealand Society for Geriatric Medicine represents specialist geriatricians and medical practitioners. Both Rob O'Sullivan and I are practicing clinicians. We visit residential care facilities and we also look after aged Australians within acute and subacute care settings. Our position is very much around working in conjunction with primary care and the whole multidisciplinary team and staff in residential care to look at preventing or delaying functional decline by treating the common conditions that you find in older people through professional assessment and tailored interventions, as well as contributing to maintaining a specialist skilled workforce to meet future needs and challenges of an ageing population. We strongly advocate for improvements in policy and social attitudes to recognise older people as valued members of society, recognising the health care needs that come with functional decline, where people will often require residential care.

We haven't had a lot of talk yet of the challenges of dementia and cognitive decline in older people, which I suspect we'll hear more of with Dementia Australia, but we really recognise the importance of health in the individual, irrespective of age, and the support required to age well, as well as looking at the need for specialist medical input in the complex care needs of older Australians.

Broadly speaking the society welcomes the move to improve transparency in the setting of residential care and also the ability of older Australians and their care partners in improving choice. With regard to some specific comments for consideration, I think we agree that total numbers of staff should be reported, not just ratios. That's especially important when it comes to smaller aged-care facilities. I work up in the far north of Australia and cover small facilities in Cape York and the Torres Strait as well. We also need to look at numbers and ratios across all shifts, throughout the day and at weekends, not just headline figures. We also need to look at that published skills mix, including a bit more detail of access to medical and specific allied health care types as well as other specialist services and the combining of that with some measure of acuity. Our thought is really that some further consideration should also be made to how any of this published data can be presented to really enhance further consumer and residents' choice; whether or not we need to look at something like a quality and safety dashboard which will improve consumer and health-care provider information, which would include staffing ratios but would also look at skills mix; access to primary care in hours and out of hours; access to specialist services such as geriatric medicine and palliative care; also looking at things like unplanned referrals or readmissions to emergency departments, the ambulance service and acute care, especially when we're looking at that out of hours as well; and as well as facility, acquired complications of care, such as falls, pressure area cares and other complications. As we know and as we've seen, the current excessive and often inappropriate use of antipsychotic medications within some settings is a good example of where that better integration of complex health and social care could be used to drive better practice and where the presence of appropriately skilled and numbered staff and models of care can drive better practice.

People living in residential care receiving these services should have timely access to specialist medical and multidisciplinary care at all stages of their journey. It makes little sense not to help the health supports available to people who need them most at the time they need them and in the location that they need them.

Ms Butler: The Australian Nursing & Midwifery Federation is Australia's largest national union and professional and nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches we represent the professional, industrial and political interests of more than 275,000 nurses, midwives and carers across the country. Our members work in the public and private health, aged-care and disability sectors across a wide variety of urban, rural and remote locations. Wherever there's a place in the country, there's a nurse. We currently have more than 40,000 members working in the aged-care sector.

We welcome the opportunity to comment on this bill and to participate in this roundtable discussion today. We support the intention of the bill and we recommend that it be passed with amendments which we've outlined in our submission and which have already been discussed by a range of people here today, most particularly our medical colleagues including the AMA. We regard the bill as an important first step in improving staffing levels and mixes in aged care, but we continue to advocate that work needs to continue on legislating minimum staffing levels and mixes beyond just disclosure of current levels. As our colleague from the AMA pointed out, there is a growing body of international evidence that indicates the effectiveness of mandated minimum staffing ratios. Also, and I've discussed with several people in this room and will continue to discuss, they can be applied flexibly to meet a range of various care needs.

The ANMF also considers that the bill would result in more transparency concerning how government funding is spent by aged-care providers. We support the concept that to staff the sector properly we need increased funding, but we say that funding must be tied to the delivery of care. We also support the AMA's idea. It's just common sense. It's logical to provide access to this crucial information for consumers about the staffing levels that are available across a range of residential aged-care facilities. I know we'll have many more discussions as the morning goes on, but I would like to advise against one thing. We certainly appreciate that there are a range of indicators and inputs and things that are involved in producing quality in the residential aged-care sector. We do not want to see this bill stymied because people get tied up in saying it's not complex enough; it doesn't consider this thing; it doesn't consider that thing. We believe we can make the amendments and make a start on at least taking us a step forward on having some disclosures around staffing and continue work on the other quality inputs at the same time.

Mr Mersiades: I'm from Catholic Health Australia. The bill's aim of supporting consumer choice in aged-care services through publication of information about aged-care services has merit. However, we have concerns that the mechanism chosen in this instance to improve consumer information, the public disclosure of staffing data, will be of limited use to consumers for differentiating services and may be potentially misleading. There is no conclusive evidence that clinically-based staff ratios as an input measure are a reliable indicator of the quality of aged care. Many other staffing-related matters influence care quality, including the skills and qualifications of staff; the quality of their training and experience; the appropriateness of the skills base; the care needs of the resident profile; the culture of the organisation and the personal qualities of the staff themselves; the adherence to clinical governance standards; the quality of management; and the effectiveness of interfaces with primary care services and health specialties such as palliative care and programs such as the severe behaviours response teams. All these come together. Staffing ratio data are not straightforward for consumers to interpret and, if relied upon, are potentially misleading. Staff ratios can be expected to vary for good reasons that are not always obvious to consumers—for example, the design and layout of the aged-care home; the size of the aged-care home; models of care being employed, including the use of outsourcing, particularly at allied health homes; each home's residents' profile; and, importantly, the care funding they attract under ACFI. A service with an average daily ACFI payment of $160 a day per resident will have a very different staffing profile to one of a similar size with and ACFI payment of $190.

The scope and regularity of reporting envisaged would create considerable administrative costs for providers, especially smaller providers, and the department. These resources may be better directed, for example, to improving the quality, coverage and currency of consumer experience surveys, which are easier for consumers to interpret, and to introducing performance rating. Finally, I have to observe that there are limits to the benefits of improved consumer information while ever consumer choice and control are constrained by the cap on the supply of aged-care services and service types. Thank you.

Ms Gregurke: Thank you very much for the opportunity to be here and to speak in favour of our submission from COTA Australia. I'm really pleased to note so many of my colleagues talking about the needs of consumers. I hope to be able to say more about that. I'd also like to commend this committee for its work in its recent report

on the inquiry into the quality of care in residential aged-care facilities. COTA Australia shares many of the common views about the recommendations, particularly recommendations four, five and 14 of that report.

I'd just like to draw attention to a couple of things in our own submission. We certainly support the intent of the bill, but we do have some minor concerns. Some of those have been covered by others. What I do bring, though, is some suggestions from our submission about what we think will help to resolve that.

The first thing is around amending the categories of staffing. I've particularly noted the concerns that others have raised about getting the nursing categories simplified and so on and the concern that 'other' may well leave some really important specific staffing categories that can't then be extrapolated or translated into data, where they may well have a distinct impact on quality of care and, more so, quality of life for residents. We suggest there, particularly, that ratios are not enough and would uphold other attendees here today who've nominated that the number of staff as well as ratios be published for, at least, the five categories that we've spelled out.

We also support others who've called for the capacity, in some way, to make a like-for-like comparison, whether that's between facilities—the best way we could think of to, somehow, indicate the acuity of residents was to use the ACFI data and divide it by quartiles. This information is available to the department already. So we propose that ACFI quartiles be a way of grouping residential facilities that would, in a way, pick up resident need in some kind of relative way.

We also support the need for the ratios and numbers to be published on a full-day basis, whether that's daytime and night-time or by shift. We're happy to be flexible about that but recognise that the 7 am start to 3.30 or 4 pm finish is not the time that consumers are worried about. Consumers, particularly around high-clinical-care needs, want to know there's a nurse overnight and want to know there's a response capacity for if there's a need in that time frame.

For the committee's benefit, I have brought along COTA's latest document, and I'll table this and provide the link to it. It's called *Keep fixing Australia's aged care system: taking the next steps in tandem with the Royal Commission*. This paper absolutely highlights the top priorities for consumers. The ones that are most relevant to this inquiry are more information and increased transparency for consumers, and they say they want information about staffing levels. Even though my colleagues, here, have challenged what this bill will provide that is going to be meaningful for consumers, it is still something they say they want. We also highlight in this report that it's not just numbers and ratios but the right quality and mix of aged-care staff. At a facility level, one of our key themes is the need for an RN on at all times, and safety for residents must never be compromised. We do understand, as others have said, that regional, particularly rural and remote, needs need to be addressed in some way. I think there are ways, and we can demonstrate there are ways, that we can capture the intent while adding flexibility for those settings.

In closing I have happily brought you another report, which I don't really expect anyone to read—except that this is our project report on measuring quality and consumer choice in aged care and there is a wealth of information in that report about what consumers want, what they've said they want. We wanted to make sure that there was a way for the committee to be informed about and aware of what the voice of consumers has been, recognising that COTA Australia brings the voice of thousands of consumers to the table and the diverse needs, the characteristics, the whole individuality—recognising that when we bring consumer stories they are absolutely rounded up and itemised down in whatever way they need to be—and to ensure you that COTA Australia is willing to participate and support the ongoing work of this committee in finding the voice of consumers.

CHAIR: Thank you. Thankfully we have excellent staff who'll be able to read the report and give us the highlights. Dementia Australia.

Ms Giusti: Thanks for the opportunity to speak today. Dementia Australia represents the more than 436,000 Australians living with dementia and the estimated 1.4 million Australians involved in their care. Our close engagement with individuals living with dementia, their families and carers means that we are an important advocate for people impacted by dementia. I'm very pleased to have with me today Mrs Kay Barralet. She is a direct voice of a consumer. She is the carer for her husband, Greg, who has younger onset dementia and is currently living in a residential aged-care facility. I'd like to also remind everyone that 52 per cent of the residents in aged-care facilities are living with dementia.

Our carers and advocates of people living with dementia consistently tell us that they have concerns about staffing—numbers of staff, quality of staff, how they are trained, their attitude and knowledge of dementia and what they bring with them. Dementia Australia supports transparency in all areas of care and recognises that what consumers are after is appropriately skilled staff who can deliver quality care which leads to better quality of life for people. We also support sufficient staffing to care for people living with dementia—we don't want staff to

have to resort to chemical or physical restraint; this is very important to us—access to appropriately trained staff and the skill mix of that staff, also considering the acuity of the residents and taking that into account.

How is all of this being managed and how is it being addressed? As the prevalence of dementia increases in our community—it is projected to be almost 1.1 million in in 2056—it's critical that all aged-care services are well equipped and supported to provide, as part of their core business, high-quality care for people living with dementia.

CHAIR: Thank you very much. Estia.

Mr Brandon: Thank you for the opportunity to present in today's proceedings. Estia looks after over 8,000 residents in 68 homes across the four eastern states. So we have a sense of how one compares homes, and I'm using many of the metrics that you use. Our position on the broader issue of transparency by aged-care providers is that we support the publication of information that's provided in a way that informs the consumer and does not have the potential to mislead. The information should be comprehensive and assist informed decision-making. Having said that, we shouldn't underestimate the capacity of consumers to read and understand the information that we provide. However, that information needs to have meaning in its own right and to have context and also to be what they want to know as well as what we want to tell them.

We support the publication of staffing numbers, so long as they are part of a broader suite of information and enable a like-with-like comparison. Without a like-with-like comparison, there can't be informed decision-making. I also note the comments about how long it might take to develop a broader suite of measures. I note that other jurisdictions haven't struggled with this and there doesn't need to be a redevelopment of work that's already been done in other jurisdictions, including the European Union. Our read of the bill leads us to conclude that most consumers reading the numbers would assume that more staff per resident is better. That's demonstrably not always the case. What I know from my observations of the sector over many years is that there are many things that drive quality. Staff are in fact a key driver, but it is not the number that is the determinant; it is their approach to their role, corporate culture, their qualifications and experience and the qualifications of the leadership at the home. Our concern about the publication of staffing numbers outside a suite of other information is that, in doing so, we create an illusion that the number of staff by category, compared to the number of residents, is a proxy for quality. That's certainly not to say that staffing shouldn't be published, but let's not give the number a credibility that it doesn't deserve. It certainly challenged our thinking on how we can meet the tests we apply of meaningful and not misleading in the sense that, while the numbers might look better, the picture of quality in the home is not necessarily better.

Just to go back a little to some of the earlier conversations and my comments, the roster, the staff that you have on board, driven by resident need—and that's actually the primary measure; experience and qualification of the staff on the roster—I don't think anyone thinks a first-year nurse has the same productivity level as a 20 year experienced nurse who's been in 20 years of professional development; certainly model of care and allocation of responsibilities; and as we've talked about, building layout and design. Our experience is that residents have a range of expectations of the services they expect, and each will have their own view of what is important to them. Measuring inputs is rarely a guarantee of outcomes, particularly when we are talking about a person's daily life experience.

I will just make a couple of comments about the proposed structure and reporting by worker. The current structure reporting suggests that a careworker is a careworker is a careworker and nurses are nurses and so on. I don't think that the approach to reporting categories supports things such as some of the genuinely innovative programs that we see around the world and in fact within Australia. HammondCare is not here but I would draw attention to HammondCare's submission, which is No. 19, where they describe their model of care, which would have quite a different staffing model than you might have in a nursing home down the road. I don't think you can underestimate how we can manage reporting in some of these innovative care models.

In summary, Estia supports the provision of information that informs resident choice, with the caveat that it must be comprehensive enough to make sure it's an informed choice and not mislead. We are also drawn to the schemes of reporting in the US and UK, where staffing is reported but in a context and in a meaningful way.

CHAIR: Thank you. And, last but not least—

Ms Callaghan: Thank you for allowing us to be last. It's good; everyone will remember what we are saying.

CHAIR: Is there anything that you want to say that hasn't already been said?

Ms Callaghan: There is. Professor Parker, who is a professor of aged care and dementia and a board member of Palliative Care NSW, and myself are very grateful for the opportunity to make a statement this morning—so thank you, Chair and committee members. This is of importance to Palliative Care Australia given that 35 per

cent of all Australians who die do so in residential aged care. That equates to approximately 60,000 people per year.

Our position that we're putting today is a result of consultation with members, services and consumers across the country. PCA supports the intention of this private member's bill to increase transparency and communication between aged-care providers and the general public regarding staffing levels to assist in informed decision-making—noting that the bill does not mandate particular staffing or skill mix ratios. A key concern, however, of PCA is the quality and availability of after-hours care, including weekend care for residents—and I think a couple of people have made that point. A blunt reporting instrument of numbers of staff on any given day may reflect the period of the day where most staff are working but not capture the number of staff in the facility after core business hours, including on weekends. It would be beneficial to the community to have the ratio information for a 24-hour period, reflecting both core business hours and the after-hours period, including weekends. The outcome PCA seeks is to ensure that a predictable standard of care is provided.

But, whilst it's important to have a minimum staff to resident ratio, the skill mix is also a key consideration that is probably of greater interest to us as a group. Staff working in residential aged care needs to be suitably trained and equipped to work with residents who have palliative care needs and their families, including the ability to administer pain medications as and when required. In addition, staff need to have the ability to recognise deterioration, the need for pain and other symptom management, the signs of impending death, and the response to family and carer grief and bereavement issues.

That is why PCA is supportive of the Better Quality of Care Comprehensive Palliative Care in Aged Care budget measure announced this year, which supports new approaches to how care is delivered by state and territory governments that improve palliative care and end-of-life coordination in residential aged care. We think the measure will provide early access to specialist palliative care—and I think the point about the need to access specialist services was also made—will reduce the need for many of these hospitalisations and will address some of the current skill deficits faced in aged care. So we think the measure will provide early access to specialist palliative care support—and I think the point was made about the need to access specialist services—and will reduce the need for many of these hospitalisations and address some of the current skill deficits faced in aged care.

PCA also support the Commonwealth funded End-of-Life Directions for Aged Care project, which aims to improve the care of older Australians. Through this project, health professionals and aged care workers can access information, guidance and resources to support palliative care and advance care planning for older people and their families. They are also specifically developing a palliative care quality and safety dashboard, which was also previously mentioned.

So in summary, whilst minimum staff-to-resident ratios are important, the skill mix for us is a key consideration.

CHAIR: Thank you very much, and thank you everyone for largely keeping it brief. We'll move to questions and discussion. I was just going to ask the department whether, just for the record, you could outline what indicators are currently publicly available to consumers, either mandated or otherwise, with universal coverage across the aged care sector?

Ms Jolly: I'm not sure how to answer that question. The current accreditation arrangements that we have and the standards that are monitored are certainly widely available and the details of the standards by which we monitor performance—we being the quality agency and others. There isn't an indicator set in the way that you've described it.

CHAIR: But the accreditation process is publicly available?

Ms Jolly: That is publicly available. It is an outcomes based system. Some of the discussion around the table today is drawing attention to the difference between an input based assessment and an outcome based discussion. Certainly the current arrangement really is about assessing those outcomes. It doesn't have that sort of input measurement in the way that has been described.

CHAIR: Is there work under way within the government on developing a set of quality indicators? I know that, for example, Monash University has been a leader in the field in terms of some of its work in relation to quality indicators. Is that something the government is pursuing?

Ms Jolly: Certainly in the previous More Choices for a Longer Life budget package there's a number of things that have been agreed to by government that we are working on. There are three existing reform elements which I draw the committee's attention to, one of which is the development of some form of performance rating

arrangement that can be publicly available and allow consumers to have more comparable information about services.

CHAIR: So this is a possible star system?

Ms Jolly: That's certainly one way of describing it—a possible star rating type system. In order to get to that point, the first stage of that process has been the development of a new set of single quality standards, because it is in the measurement of those standards that you will be able to eventually draw information into some form of star rating system. That work is underway but it will rely on those other processes to roll through, and those standards have now been agreed to and will be coming—

CHAIR: Do you have a desired finishing date for that exercise?

Ms Jolly: I think the government commitment is the middle of 2020 to have that system available. To complement that, there is work happening on risk profiling. So in order for the accreditation system if you like to look across the data and information that is available to it—and that is information that is available either complaints mechanisms or through the standards process or through individuals calling or through existing data sources that government might have. Bringing that together in an algorithm based arrangement should actually assist in identifying where you might best place your resources for accreditation, so which services might have higher risk and which services you might visit sooner or more often. That work is also underway. And the reason that I mentioned that reform process is that some of the information that is being discussed around this table would be the sort of information that you would draw into a risk algorithm. Whilst you might not have indicators publically available, you would certainly want to draw that sort of information into some way of assessing whether or not services would be more or less at risk of care issues.

Just quickly, the third area is that we do have a voluntary national quality indicator program, and about 10 per cent of services currently provide data through that program. That is certainly something that is being looked at, but it really needs to be understood in the context that, whilst there is a small voluntary program, many providers have and use existing benchmarking services themselves, but they are not publicly available in the same way. So there is a small, quality indicator program already in existence.

CHAIR: Mr Brandon referred to the systems in the United Kingdom and the United States. You mentioned that they publish staff numbers but contextualise it in a way that you found quite attractive. Are you, or anyone else in the room, able to give us a more detailed outline of the system that's in the UK and the US?

Mr Brandon: I was hoping for a saviour amongst the gang! If you go to the US, the government website for Medicare and Medicaid talks about staffing numbers, and there are a whole lot of other clinical indicators data. The basic premise is that the consumer is better informed. The Care Quality Commission doesn't actually publish numbers, because it has a slightly different approach to looking at services—whether they're safe and a whole range of things like that. So, it's more the broader concept that we don't have to go off and develop a whole new system. My concern follows from the conversation that says, 'We need to do staffing numbers, because it'll take us forever to do the rest.' My proposition is that it should not take us forever, because we can take this information from other work that's been done in other jurisdictions.

CHAIR: I'd typify the evidence we've received so far as: everyone thinks transparency is a great idea, but there's a lot of buts. And there are a range of views within the 'but spectrum', if I can put it that way. Obviously, very reasonable issues have been raised about the limitations of what I'd describe as raw data and contextualising it. I think someone talked about a dashboard being developed. There is a strong argument that this information is, of itself and alone, not an accurate picture of the quality of care in the aged-care sector. But there are also a million reasons why you delay and delay doing something. I'm wondering whether anyone has any thoughts about a dashboard system, and what data that would capture in an easy way for consumers to understand, which includes staffing but might include other things that help contextualise the information available to consumers.

Mrs Harding: We have a platform that is a whole quality platform that is used by all of our members. The government in South Australia uses it for all its country health facilities in measuring their quality performance on that. That gives us the ability to benchmark all of our users, and it gives us the ability to look at that in terms of acuity, where we can take into account what the average ACFI rate is per day. We've divided facilities up according to the ACFI dollars per day, so that we can measure those outcomes against acuity. It takes into account things like medication, incidences, falls, skin integrity issues and behaviours of concern, and people can see from that platform what's happening across each facility. We have that at the moment for our members. It is only available through subscription, but it does really give a very clear indication of where each facility sits.

The other really good thing, I guess, about the association is that we run quarterly meetings where our members get together and discuss those metrics, the quality indicators and also the audit tool itself, so it's actually

co-written with our member organisations, provided that their suggestions are in line with current standards. We have had some extremely good outcomes by that process. It has been voluntary. It's obviously driven by quality and not by compliance, and I think therein lies the distinct issue between trying to make people compliant and looking at raising the level of quality within an organisation because it's innate in that person. I think they are two very, very different issues. I don't necessarily believe that compliance brings quality, because compliance means that you're only reaching a certain level; quality means that you are striving for something that's better than that. I think meeting the existing standards is really only a base level, and there are many organisations out there at the moment that are exceeding that compliance level and producing some really good outcomes for residents.

Mr GEORGANAS: The voluntary scheme that you've got—what percentage participate?

Mrs Harding: We have a third of all the beds in South Australia and we are now into Victoria and New South Wales.

Mr GEORGANAS: Could you give me a percentage, though, of how many people participate in the voluntary disclosure thing that you were talking about.

Mrs Harding: I would say it would be 33 per cent—well, 100 per cent of our users participate in it, because the platform requires auditing and data collection on a regular basis.

Mr GEORGANAS: The voluntary bit that you spoke about—you said it's a voluntary participation earlier.

Mrs Harding: No, I don't think I said that. I think that was a speaker up there who talked about the quality indicator program and said there's 10 per cent that use that.

CHAIR: But your scheme—not every aged-care facility in South Australia participates in the scheme.

Mrs Harding: No, it's just an audit tool.

Mr GEORGANAS: So that's the 30 per cent?

Mrs Harding: It's subscription based, so it's—

CHAIR: Who are the subscribers?

Mrs Harding: Aged-care providers across a whole range of networks.

CHAIR: But not consumers as such?

Mrs Harding: No, not consumers. It really is an auditing tool for organisations for a quality system.

Mr GEORGANAS: My first question to the department—and it's separate from the questions that I asked you about how many were participating voluntarily in the scheme that you've got going, which was about the 30 per cent mark. But in this area you said that there already is a voluntary disclosure system and that 10 per cent participate. Is there a reason why such a big amount do not participate? Ninety per cent is basically just 10 per cent off 100 per cent.

Ms Jolly: My understanding—and there are people around the table who can provide you with a more comprehensive answer—is that there was a voluntary program introduced a number of years ago to establish a set of national indicators, and, whilst we had a good take-up from a small number of providers, there are many providers who already use existing auditing and benchmarking tools. So really they could speak for themselves about—

Mr GEORGANAS: Their own systems.

Ms Jolly: whether or not this was considered to add anything specifically to their analysis of their own services.

Ms Laffan: That's their own systems or commercially available systems.

Ms Jolly: It would be a supposition as to why we've had a 10 per cent take-up, but I would suggest that it is a combination of those who have existing platforms that are either, as Amy has indicated, commercially available or that they use as part of a suite of benchmarking information and those who are participating, finding value and so continuing to participate. I'll leave it to others to provide—

Mr GEORGANAS: In the opening statements you said there's no real indicator set to show a whole range of things in this area, but you do have the outcomes, so you can work everything out and give us the outcomes. If we had ratios, would they still be able to produce the outcomes through the metrics and everything else that you have? Do you look at those current ratios—all the current numbers of staff?

Ms Jolly: Again, it might be useful to hear from some of the providers. The way the current accreditation arrangement works at a legislative level is that providers are required to deliver a certain level of care standard; that's the compliance accreditation regime. It has 44 standards that have been specified, and the quality agency

assesses performance against those standards. Those standards are changing. There's just been the introduction of what's called the single quality framework, which will revise those standards and make them much more consumer focused. Those new standards will be in place from July of next year. But the underlying principle of the system is that there is a set of standards that providers are assessed against. That is the basis of the current accreditation regulation arrangement.

Mr GEORGANAS: That would include staffing levels within that?

Ms Jolly: It doesn't specifically include inputs in the way that it is described.

Mr GEORGANAS: So, if there was a provider who had 100 people and another one who had 20 people, that's not picked up in this particular—

Ms Laffan: The standards require that services have an adequate number of appropriately skilled staff to meet the care needs of the care recipients of that service. The sorts of things that the quality agency would look at in monitoring that are the rosters—how many staff are on board, how many staff are there at night, how long are people waiting for call bells, things like that. That's one of the inputs that they use, as well as observation, to test whether a service is meeting the standards.

Mrs Harding: Can I add to that. It's mandatory for providers to give a roster over a two-week period prior to the accreditation team coming in. So that information is already available, albeit that they are directly employed people on their roster. It doesn't take into account those allied health professionals or visiting specialists, which I believe is a much bigger indicator of quality of care because you are utilising those external services.

Ms SHARKIE: I have a couple of questions. Can I go to the quality tool system that you use. Do you think that your subscribers would be keen for such a tool to be publicly available?

Mrs Harding: I think we would have to survey them. The information that we gain is de-identified information. We don't use individual names or staff names; it's all de-identified. Off the top of my head, I don't believe that people would have any problems having that information publicly available. It certainly has been a driver of quality when we've had our own network meetings and looked at facility against facility. They have the ability to benchmark, albeit de-identified information—so an individual organisation can benchmark against all of our users. If it's a facility, it can benchmark against its own facility but then ultimately benchmark against all our users. When we've done that, it's actually been a driver of quality.

Ms SHARKIE: When you say 'de-identified', are you talking about the residents or the organisations?

Mrs Harding: The residents and the staff are de-identified. Each organisation doesn't have access to other individuals' data except for the final benchmarking, but it doesn't give individualised data.

Ms SHARKIE: Thank you. To the department: are you a little disappointed with just a 10 per cent take-up of the department's tool? I know you referred to the individual systems that some organisations have. Have they shared their own systems with the department, and can you see any comparable difference of things that the department could perhaps use for a universal system?

Ms Jolly: Let me answer that in a couple of ways. I think that, recently, the current voluntary system has had some commentary. Certainly Carnell-Paterson has provided some commentary, and your committee has also provided some commentary. COTA—I think it may have been one of the reports that was tabled this morning—had some further discussions with consumers about what sort of information they would find useful in the context of what a more useful set of information would be. Obviously I'll let them summarise their own report, but some of the findings from that report are around quality of life—consumer experience—as being a more useful consumer indicator for comparison purposes. So, we are looking at that and obviously providing advice to government in the context of recommendations about what you might change with the existing program.

Part of the reason I mention the context of the program is that I think sometimes there is an assumption that, because there's a 10 per cent take-up on a voluntary program, that is the only thing in existence. From discussions I've had with providers and services, whilst I haven't been provided with copies of individual provider data—that's certainly not our role—I am aware that quite a diverse commercial set of products are used by providers to do their own internal auditing and benchmarking. So, an implementation challenge for a national system, should a national system progress, is how to best align the existing effort and investment in the sector to ensure that you get a comparable set of information if that is what the government decides to pursue.

Mr Brandon: Perhaps I could just add why Estia is one of the 90 per cent. We participated in the early trials, and the important thing about the quality indicator set that's out there now, the one that government's running, is that it picks up pressure injuries, restraint and weight only. So, it's deficient in that it's not a suite of indicators; it's three indicators. The nature of these things is that if you measure three things you'll drive people's attention to

those three things when all the other things that happen in a nursing home are equally important. So, we use our own indicator set across our 68 homes, which has something like 18 or 20 elements. We have a comprehensive view of it, not a narrow view. We also use indicators to trend our performance and drive quality improvement. And to go back in history, quality indicators were never created as a tool to talk to the public about how you're going. They were actually created by nursing homes and hospitals as a quality improvement tool.

Ms Gregurke: I would make a couple of points, one in relation to the report I gave you. There are four appendices that have different elements of the data and the processes that happened through that particular work that might be helpful. But I would also note that COTA Australia has been a member from the beginning of the National Aged Care Alliance Quality Indicators Reference Group, which has now disbanded, and the current Quality Advisory Group, which is ongoing. So, the origins of the quality indicator program came out of that joint work we had been doing with the department, with obviously a number of other organisations at this table also represented.

The three quality indicators that Mark referred to that are currently in use in the voluntary program are three of a much larger suite that are in use in the state of Victoria in the public sector residential aged-care facilities. I spoke with Brett Morris from the Department of Health and Human Service in Victoria, who was at a department event on Tuesday, and we recommend that you consider engaging with the Victorian department, because they have about 12 years of data across 172 public sector residential aged-care facilities showing what they've done and the trends and what the quality changes are—the trend analysis and so on. As far as I know, that is still not publicly available information. It doesn't cover, for the most part, all the members of the peak organisations in this room and individuals. It is Victorian government owned and run—so, often small rural hospital type residential facilities. Certainly there was foundational work from the National Aged Care Quality Indicator Program, which the Commonwealth government implemented, that has been available. I think we always intended that it wouldn't stop there, but other things have happened, so I think it's really timely that we're talking about it.

COTA would insist on and has driven through those processes the need for quality-of-life indicators. I can remember some pretty robust arguments in that room about what it means for quality of life. I think a lot of what we're saying and why consumers want to know about quality, why the consumer-experience reports are important and why the star-rating system, however it gets done, is important is because consumers most want to hear from other service users about their experience to guide their decision-making and however we do that. In the emerging next 10 to 15 years with the baby boomers moving from the children of residents to being the residents, that's going to be a much stronger perspective. We need to be ready for consumers to have much stronger voices and be more vocal about what they want and how they want it.

Ms SHARKIE: Mr Rooney, in your opening statement you talked about the role of volunteers and how places with a number of volunteers could possibly give the wrong reflection with respect to staffing ratios. It intimated that perhaps places with a high number of volunteers have less staff. I'm just wondering if you could clarify your comments there, because I found them a little concerning.

Mr Rooney: That wasn't my intention. The point I was making is that volunteers can complement the existing staff and extend some of the activities that happen in those facilities, because you're drawing on the goodwill of the community that want to support the older Australians in their community. But they're not a substitute for staff; they are a complement to staff.

Ms SHARKIE: Could you just clarify how that would mean that that having volunteers would affect staffing ratios?

Mr Rooney: We've all discussed the quality-of-life aspects, and if you look at how facilities are funded and staffing levels are funded under the ACFI, there are other activities that contribute to the quality and the experience of the resident that don't get covered under a staffing requirement because they're complemented by a whole range of other inputs, such as volunteers or, as others have said, allied health professionals that are not staff that come in and provide additional services. Schoolchildren coming and visiting residential-care facilities—those types of activities basically play out to contribute to the quality of the experience of the resident but wouldn't be captured under a reporting of the number of staff.

Dr FREELANDER: Thank you all for coming today. It's been terrific to get so many of you here in the one room. I have a couple of questions. First of all, I'd just like to address nurses, midwives and COTA. No-one is suggesting that staffing ratios is the only measure of quality, but to me it seems that there is this nexus between staffing ratios and acuity. I wonder if you have looked at any way of measuring those two together to get some better way of looking at provision of care?

Ms Butler: I presume the question's to me?

Dr FREELANDER: And also to COTA.

Ms Butler: Thank you very much for the question. Yes, indeed we have. The Australian Nursing & Midwifery Federation have conducted a major piece of research looking at the current acuity profiles of residents in residential aged-care facilities—let's call them 'nursing homes'—across the country and identified varying typical-resident profiles with varying levels of acuity and subsequent care needs. We've also then looked at the interventions that would be required to produce what we would regard as safe and best-practice care for each of those residents within those profiles. We've quantified that into a number of hours of care per profile required across a 24-hour period and who should be delivering which particular care intervention. We have that information available. It's a complex discussion to have.

When we talk about ratios, what we're talking about—as is supported by the AMA's submission—is setting a mandated minimum staffing level, setting a floor, that can be flexibly and innovatively applied across a facility, or a range of facilities, to ensure care needs are met. Some of people's concerns about ratios are that suddenly this harsh, blunt thing will be implemented. That is not what we mean. Obviously, these things take time. In the jurisdictions in the country where we already have nurse-to-patient ratios they have taken several years to implement. You do it in a particular staged way. You also need to meet workforce supply and development. We would not deny for a moment that we need to ensure there are the right qualifications. With the ratios, there need to be the right qualifications and the right number of staff, appropriately distributed.

The other point we'd make is that people have had concerns that to meet this blunt ratio we'll suddenly want to see numbers of unqualified staff throughout the system. Not remotely! In fact, it's exactly the opposite, which is why we would want to take a tiered approach.

I would like to take the opportunity, while I have the floor, to say numbers do matter. They really, really matter. I note our colleague from Estia said that other things are important. Of course they are. Corporate culture—I couldn't agree more. Something that I think has been strongly acknowledged by John Pollaers, in his report, is that there's a terrible workplace culture and attitude towards aged care, the aged, ageing et cetera at the moment. We do not deny that that needs to be addressed. He made a comment that it's not the number but their approach to their work that matters. Of course their approach to their work matters, and so many people working in the sector are only there because they still care so much about their residents. But if you're one registered nurse and you've got 160 residents, numbers matter.

Dr FREELANDER: Thank you.

Ms Gregurke: In the report *Keep fixing Australia's aged care system* we had a substantial appendix, which was a summary of the research we did on staff ratios. I would draw your attention to the fact that, in our view, the result of that research was that the jury is still out. Some of the international research certainly shows that, when minimum staff ratios were introduced, the services and facilities that had above the minimum level reduced their staff in those categories and, for some consumers, care levels dropped as a result of the introduction of a set limit.

COTA strongly believes that some way of categorising providers by care needs, so that the staffing matches the needs of the residents, is the critical factor. A number of people have talked about that today. I think generally we're in agreement that we must find a way—whether it's the quartiles of ACFI or, as other submissions talked about, something at the ACAT assessment level—of indicating the care needs of residents and also the broader needs of residents, such as special language needs, palliative care needs, dementia care needs. All those things actually affect numbers, the kinds of qualifications needed and who the right people are. It's been said a couple of times—including Annie's mention then of John Pollaers's report—that one thing that comes out really strongly around workforce in aged care is that consumers want people who want to talk to them. They want people who are actually interested in working with older people, not just people who need a job. It is finding a way to make a good fit between a workforce, however qualified, and people who love talking to older people and engaging with older people. And that applies across the whole workforce from the receptionist to the office people in facilities or bigger organisations, as well as the care staff who are on the floor and moving around and dealing with residents.

Dr FREELANDER: Thanks very much. I'd like to ask the geriatricians in the AMA: do you feel that mandated staffing levels will improve care in aged care?

Dr Torvaldsen: I think that the important thing, as the previous speakers have said, it's a necessary but not sufficient requirement to have adequate staff. In other words, if you don't have adequate staff, it is impossible to deliver good quality care, but having adequate staff alone—particularly if they're not well trained or the corporate culture's not good or they're staff who just don't want to be there—doesn't guarantee good quality care. So it's only the first step in the journey. But, to illustrate the point, I've been talking to the nurses and the staff who work in the facilities that I visit. Earlier in the week, when I spoke to one of the nurses and said that I was going to have to

change my normal time of visiting on a Friday morning because I was giving evidence to this committee and we were looking at what could be done to improve staffing ratios, she burst into tears and she thanked me for standing up for what was so desperately needed. And this comes from the people who are working there. They want to give good care.

Dr FREELANDER: Thank you very much. I'm sorry, we're a bit short on time.

Dr Torvaldsen: My second point is that we would support a measure which is a weighted measure. I think we talked about the ACAT assessment. The problem is that that's a static assessment on entry and I think, on reflection, it would probably be more appropriate to use an ACFI tool, so that it is not raw data but a weighted staff ratio, a little bit like the bank comparison rate, so that it actually relates to a nominal resident who is adjusted for ACFI acuity, and that would also reflect the funding that the institution is getting, so it would be a fair measure. It has to not be the raw data; it has to be somehow weighted.

Dr FREELANDER: Thank you. Let's hear from our geriatricians.

Prof. Strivens: Briefly, we'd back up what the AMA is saying and what Annie is saying as well in terms of numbers do matter. We know that in acute care and we know that in subacute care. There is a minimum level which guarantees safety. It's going to vary according to the models and it will vary according to acuity, but a minimum number does matter.

Dr FREELANDER: Good. I have one last question for the providers and maybe I'll start with Mark from Estia. Do you think that mandated staffing levels have the potential to increase costs?

Mr Brandon: I think the answer to that question would lie in looking at each nursing home. Some would presumably be above the mandate; some would be below the mandate.

Mr Buhagiar: In terms of the kind of levels that are described in the nurses association work, yes, absolutely they would. Providing the funding was there, we'd all be comfortable with going that path, but the funding needs to be there.

Dr FREELANDER: Correct.

Mr Buhagiar: So I think there's a fundamental problem here. We're talking about a bill about transparency and we're mixing it up with conversations about minimum staffing levels which is a different conversation. And unless we hold those two conversations together, like your report did that was released the other day, it makes no sense. We will hurt this industry if we don't hold those two conversations together. But this is a different one.

Ms Emerson: The costs may not be only financial; the costs may be the loss of innovation, the loss of diversity in our workforce, the loss of our capacity to have student participation, and the loss of being able to provide these essential supports that are not necessarily clinically and medically oriented. Residents see themselves as people first. They move in and out of ill-being, but wellbeing is their primary driver. They look for quality-of-life experience. They need good medical clinical nursing support—and I'm here today for the College of Nursing and I absolutely believe that, for living well and dying well we need nursing. I think the costs would be financial but also might just potentially impact our capacity to add value. We support—in my organisation, Helping Hand—more than a thousand students a year, and they add value to the client's experience.

Also the care of older people is not just the remit of the people on the ward, on the day—'in the ward' or 'on the ward'; that's a very clinical term—in the home. It's a whole-of-community responsibility. If we're reporting against these numbers, it's not counting the medical support—the really valued inputs of geriatricians, the supports of the mental health teams that we often have and the people we draw in from palliative services. There is this extraordinary complexity of quality contribution that happens. I think we have to really take that into account. How do you value that? How do you price that?

I really strongly support co-design with older people themselves in considering this strategy. I think that having individual conversations to ask what's essential to them might be quite surprising. It may be the person who puts the cover on their canary when they're going to sleep at night who adds as much value as me as a nurse who might be supporting a complex care assessment. Sometimes the value I add is the smile and something I'm wearing as much as my nursing skill. In fact, that is part of my nursing skill. People are living lives in aged care; we don't want to lose that. They're not hospitals. They're not input based and measured in the same way, nor funded. These are homes where people are living, and I think we need to think of that continuum as they move in and out. On the day you're very well, it may be the person who supports you to go to the garden, to catch the bus or to visit the art gallery.

Ms Sparrow: Can I just refer the committee to some work that was done through Professor Pollaers's report and also through Stewart Brown, which goes to the question of funding and does some calculations about what it

would actually cost financially across the system overall. There is some work there. I'll have a look and see if I can find it for you in the break; I can't find it right at the minute. I also want to back up what Susan's saying. I have been doing some reading around quality lately, and one of the things that comes through is around pets, social connections and access to the outdoors. I do think it's a much broader conversation and I've tried to focus today on talking about the actuality of this bill, which is about transparency. I think we need to make sure we have both discussions, but today is around the transparency.

Mr Rooney: If I can just add to that, the workforce task force strategy does speak not so much to staffing numbers but to contact hours of staff, per day, per resident, and it has found that the staffing contact hours, per resident, per day, are below what you would expect across the OECD average, and that that gap, if I recall, in terms of funding to meet that gap, was about $3.5 billion.

CHAIR: Thank you. So at this stage I think we might just plough on, because I think we're going to get an early mark today. I'll go to Mr Zappia.

Mr ZAPPIA: Thank you. Thank you all for your comments. I have two questions. Firstly, given that we're talking about staff, staff and staff familiarity with the residents is important. Can someone tell me what the staff turnover rates are in your sector and, in particular, the nursing staff turnovers? If you can't, if someone could come back with some information, that would be useful information.

Mr Rooney: I think the aged-care workforce task force strategy said that at any one point in time it's something like 20 per cent.

Mr ZAPPIA: Is that higher than industry turnovers generally?

Mr Rooney: As I understand it, it's high for an industry. With regards to a care industry, I'm not sure. But it was certainly identified as an issue for our industry and a productivity cost to the industry. That was quantified, I think, in the report.

Ms Harding: Can I add to that? It really depends on the setting where that care is being delivered. Certainly, in metropolitan areas the turnover is greater. If you look at smaller rural and remote communities, where people don't have opportunities to travel, they have a lesser turnover, and it's significantly less.

Mr Buhagiar: I'd absolutely support that. Also, you need to account for the difference between permanent and casual turnover. That 20 per cent figure, based on our numbers, would include both. You need to think about the nature of the workforce and you need to think about rural versus metropolitan settings to understand that number properly.

Mr ZAPPIA: What proportion of staff are casuals?

Ms Harding: It's individualised for individual organisations.

Mr McGothigan: Yes, across the sector.

Ms Butler: The NILS data does make some estimation of that but, again, like many of the reports we talked about not every single facility is included in that kind of information. I would just add to what has been said that nurses are generally a mobile profession. They tend to move jobs to gain different experiences or in working towards—as doctors would—becoming specialised in a particular area. From our understanding from reports by members and information that is available, such as NILS, there is increasing casualisation in the workforce and there is increasing turnover and reliance on agency staff. That really contributes to the sorts of things we are talking about. One of the important things in working in the aged-care sector is for staff to know their residents very well, so that is creating additional problems.

Further to what Sean said: John Pollaers also estimated that currently there is approximately $400 million of wastage in the system because of staff turnover and related issues. We're talking about the 3.5 in terms of looking at staffing the gap that has been identified. For a government, that's not really accounting for offsets that would be gained. So John Pollaers could instantly identify that $400 million, but there are the offsets by preventing ambulance transfers, by unnecessary hospital admittance et cetera.

Mr ZAPPIA: I understand that, yes.

Mr Mersiades: I'll give you some data here from the NILS survey on staff turnover—

Mr ZAPPIA: I'm happy for you just to table that formally and I'll read it.

Mr Mersiades: Okay.

Mr ZAPPIA: Given that you've all heard each other's comments, does anyone wish to comment about someone else's comments, in terms of taking issue with something that has been said to this committee?

Prof. Parker: There is an issue around linking staffing ratios to something like ACFI or the ACAT assessments. For us in palliative care, only about five per cent of residents are currently classified as palliative under the ACFI questions. There are reasons for that, in that people are classified differently. Sometimes it's not worth doing it because of the acuity level of the person approaching that. So you have to remember that it's unlike in the United States, where they have a minimum data set that has a three-monthly reassessment of every resident in every facility. ACFI doesn't do that, so my ACFI assessment may be quite dated. Therefore, how does that reflect the ratios required?

What's most important for us, given that 60,000 people die in residential aged care a year, is skill mix. We need the registered nurses 24 hours a day, seven days a week, to be able to provide that care. Ratios won't necessarily answer that. So the ACFI issue is a problem.

Mr ZAPPIA: Fair enough. Anyone else?

Dr Torvaldsen: Perhaps I can respond to the ACFI comment, because I think we are muddling staffing ratios, funding and training. Certainly, I agree with the comments regarding palliative care. I think that palliative care should be regarded as an integral function of aged-care facilities. It's a fundamental part of what we do and what we should be doing. I think that that is most properly addressed by looking at the training and the skills mix, and just emphasises the fact that we were talking about earlier: that ratios alone without proper skills and adequate training don't give the whole picture. I guess the difficulty is that we have to use some kind of instrument to adjust for case mix and needs and so forth. If someone has a better suggestion than ACFI, then we would be only too happy to hear it and to discuss it.

Ms Ward: Separate to this, the Australian College of Nursing will table the International Council of Nurses' 'Evidence-based safe nurse staffing' statement for you to read outside of this, so you can look at international standards.

CHAIR: We've had a number of exhibits provided to us, being those from COTA, from Catholic Health Australia, and from the College of Nursing. Is it the wish of the committee that those documents be admitted as exhibits? There being no objection, it is so ordered.

We will wrap up for the day shortly. To my mind, there are four substantial issues that have been raised during the course of the day. The first is a broader one about whether reporting on staff ratios should be done as a standalone exercise or whether it should be done as part of a broader reporting framework/dashboard looking at a range of indicators. The second is, if you did go down the path proposed in this bill, where should the balance be struck in relation to reporting requirements, so that they are not onerous in a way that actually creates a red tape burden that some aged-care facilities would struggle with? The third is the issue of the descriptors used to describe staff, and we've had that concern expressed about categorising a whole lot of people as 'other' where they might actually be performing very important and relevant functions within a facility. The fourth, which is arguably the most significant in relation to this proposal, is: how do you construct a system that compares like with like? What we've heard suggested is that you might be able to use, for example, the ACFI system, as a way of banding aged-care facilities. I'm not quite sure how that interacts with just simply reporting on the staff numbers, in a way that consumers will understand. I suppose there's also an argument about whether, in any reporting, there can be the opportunity for an aged-care provider to have some type of textualised descriptor which might actually allow them—for example, to use Mr Brandon's example, if HammondCare is trialling or using a particular model which is unique; for the system to be able to actually describe that. They are the four substantial issues, as I see them, in relation to the bill that we have before us.

The two things for this committee to consider are, firstly, whether the bill is of merit and therefore should proceed—and that's the conceptual merits of the bill; and then, secondly, if we tick that box, are there amendments that we want to recommend to the bill that will make it both more effective for consumers and also more workable for the sector?

I know that a number of organisations have already put in submissions and we thank you for those. If there are very specific proposals that organisations have about ways in which you think the bill could be improved, maybe addressing those four issues that I raised—and I'm very interested in the 'comparing like with like' issue—then feel free to make an additional submission, or an initial submission if you haven't lodged one already. Does anyone else have a burning issue that they think needs to be considered at this stage before we wrap up in conclusion?

Mr Sewell: Can I suggest the fifth item might be that it needs to work for consumers. Some of the discussion today was about what the government, providers or peak bodies might need. But, ultimately, this is for consumers, and something that's simple and meaningful that consumers rating services on behalf of consumers, or

a measure that works for consumers to choose, is the ultimate aim. There are many other systems in practice that providers are engaging in. This is a diverse sector with a lot of companies and charities and churches picking other products. There are lots of them out there. But one standard measure that is mandated, that consumers have confidence in is the challenge, and it's the ultimate aim, I think.

CHAIR: I agree with that, but I think that's in some ways wrapped up in the issue of how you compare like with like and how you contextualise, effectively, raw data. The other factor I should note is the fact that, obviously, the government is heading towards some type of rating system, and there's a legitimate debate about whether you wait until that's concluded. I think that's mid-2020, and it may not include an indicator which does look at staffing numbers and ratios. So, it's about whether you wait for that process to conclude or you do this as a standalone measure, knowing that something else is coming down the line in future.

Mr Sewell: Chair, can I suggest that consumers may not want what the government develops and consumers may not trust a government system that's imposed. They may much prefer to hear other consumers' voices and to see other consumers make comment, which is what most other consumers in most other sectors rely upon.

CHAIR: Yes.

Mr Sewell: They're usually based on feelings and customer experience and the quality of all those factors wrapped into single measures. Most providers will count all those things forever more. We must compare everything: staffing and acuity and quality and culture. We will keep doing that till the cows come home and have it available should a consumer wish to see it. But simple, public consumer measures won't be driven by providers or the government; they'll be driven by consumers.

CHAIR: And they may not be driven by legislation either.

Mr Sewell: Yes.

Ms Gregurke: That's why co-design with consumers, which someone else already mentioned, is a fundamental aspect of whatever we do. If we're expecting it to meet consumer needs for information, transparency and differentiation of providers, which is already the framework that we're working on with government, then we need consumers in the room, at the table—not just consumer representatives but consumers.

CHAIR: There are always different levels of consumer—

Ms Gregurke: Correct, yes.

CHAIR: testing in some ways anyway. Consumers want the label on their jar of Vegemite to tell them what's in the Vegemite, but the government's not going to tell them whether they like it or not—but they want to know what's in it.

Mr Sewell: No.

CHAIR: Any other final reflections? Was someone on line wanting to say something?

Dr Lim: Yes, that's right. I did just want to make a final comment from our association, and that is that we do recognise this is just one element. It comes under this question about what the purpose of measurement is. If the purpose of measurement in this case is the combination of accountability and transparency, which are important from a consumer perspective, we do also need to consider the element of improvement. The measure which has been suggested here is the staffing ratio. If we follow the Donabedian model of quality improvement, it's actually a structure measurement. There are three elements to measuring: structure, process and outcomes. If you choose just one of three only, the problem is that we are always going to end up having, well, perverse outcomes. It's useful to consider this as a foundational element but also useful to consider that this is probably not going to be the final thing, and it's not the complete measurement but just part of it. For there to be informed accountability and transparency from a consumer perspective, this needs to feed into process and outcomes measurements as well.

CHAIR: Good. We'll take that point.

Mrs Grieve: Could I make one last point as well, please?

CHAIR: Yes, certainly.

Mrs Grieve: I just wanted to stay that, when you're looking for a care home, quite often—in fact, most of the time—it's in the middle of a crisis. Choosing a care home is not like choosing a hotel or a restaurant around a five-star or a four-star rating as such. A lot of the things that we think and that have come out today about what consumers want, I concur with, particularly living a good life once you are in a care home. But the reality is you don't enter a care home now until you have high care, complex needs. I think we would be well served to really recognise and respect that this is an area of speciality in which we need to know that we have enough staff and the

right mix of skills, that the home is able to support meaningful and supportive relationships, and then we have a skill mix that can look after the whole-of-person health. That's different from the organ paradigm, the whole-of-person paradigm, particularly in the area of dementia care and people reaching the end of their life. As is being discussed, that really does call for a wide range of staff—good staffing levels, enough staffing levels—and the right mix of staff, and a recognition, via registration, that this workforce matters. It matters to be part of a wider healthcare and caring profession, therefore looking at registration and those sorts of things put a value statement on the whole workforce as well as the registered workforce. If I could just leave that last point on the table, I'd be glad.

Dr O'Sullivan: Thank you. Dr O'Sullivan.

Dr O'Sullivan: Thank you. I'm just coming back to one of the issues that the chair raised around the descriptors for staff roles. Something that has been addressed in a few of the written submissions, but has really only just barely been touched on in the discussion, is that not only is that 'other staff' descriptor a problem but so is the descriptor of 'allied health staff' and lumping all allied health staff into one category when you're covering disciplines as diverse as physiotherapy, occupational therapy, speech pathology, nutrition and dietetics. They're all very distinct specialties that do very different things, and I think there are problems with lumping them together. But also, in terms of disclosure of staffing, some recognition of availability of medical professional input as well, whether it be primary care or specialist medical care.

Mrs Harding: I'd like to say one thing—actually a couple of things. One is that we haven't taken into consideration the new aged-care standards that are coming in, and I believe the shift to consumer focus in the new aged-care standards is going to be very telling on organisations when that data is published for each individual site.

The other indicators that we've got at the moment are the consumer experience surveys that are being conducted. They are published as mega data and not identified for individual organisations. I believe that if they were published alongside accreditation reports, it would give a much better indicator to the general community about the services that are provided in that home. I would also like to add that I'd like to table our submission.

CHAIR: Any last observations? Good. I thank everyone for participating this morning. It's actually been a really useful discussion, and I thank you for the spirit in which it has been conducted. All of you will be provided with a *Hansard* transcript of today's proceedings, so if there are any errors in that or we've attributed the wrong statement to the wrong person in such a large crowd, please come back to the committee secretariat by 2 November. Also with any supplementary information or supplementary submissions along the lines I spoke about, please feel free to do the same. Thank you again for your time today. We just had one submission—who had a submission that they're going to give us?

Mrs Harding: Me.

CHAIR: You haven't put that submission in before?

Mrs Harding: No.

CHAIR: Okay, can I have someone move that the submission from Aged Care Quality Association be authorised for publication?

Dr FREELANDER: I'll move that.

CHAIR: As there is no objection, it's authorised. On that note I declare closed today's hearing. Thank you very much.

Committee adjourned at 11:24