Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Friday, 15 November 2024 at 10.00am

(Day 060)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr Hilbert Chiu SC with Ms Joanna Davidson for NSW Health

THE COMMISSIONER: Good morning.

DR WATERHOUSE: Good morning, Commissioner.

Today we'll be hearing from the third clinician panel and this panel will consider the issue of patients who no longer need acute hospital care but cannot be discharged because of barriers in obtaining the aged care or disability supports that they need.

The Inquiry has been told that this is a common scenario with impacts on the patients themselves, the staff involved in caring for them and bed flows throughout the system, with the result that other patients or potential patients can also be affected.

Many of the obstacles are seen as beyond control of the local health districts and reflect challenges with Commonwealth Government funded aged care facilities and the National Disability Insurance Scheme.

That said, there are innovative approaches being taken to manage local situations to the extent possible.

We have six clinicians participating in this panel today. In the room with us, there is Amy Okulicz, who is the nurse unit manager, rehabilitation and geriatric rehabilitation unit at Wyong Hospital, Central Coast; Melissa Pickering, the acting director of nursing and midwifery at Central Coast Local Health District; Brendan Shortis, acting nurse manager, community health, at Nepean Blue Mountains,Local Health District.

Giving evidence online, via AVL, all from the Illawarra Shoalhaven Local Health District, we have Professor Jan Potter, who is a staff specialist geriatrician and co-director of aged care and rehabilitation division for the district; Rachael Hawkins, the aged care nurse unit manager at Wollongong Hospital; and Ben Wakeling, director of clinical strategy and outcomes at the Illawarra Shoalhaven Local Health District.

Commissioner, I'm told that Rachael Hawkins and Professor Potter will be giving evidence under the oath and the remaining four witnesses will take an affirmation.

<JAN POTTER, sworn: **[10.03am]**

<RACHAEL HAWKINS sworn:

<AMY OKULICZ, affirmed:

<MELISSA PICKERING, affirmed:

<BRENDAN JOHN SHORTIS, affirmed:

<BENJAMIN WAKELING, affirmed:

<EXAMINATION BY MS WATERHOUSE:

DR WATERHOUSE: As there are three witnesses in the court and three online, I'm going to divide this into five broad topics so that you don't need to try to cover everything you might like to say in the first couple of answers to questions that might be asked.

The topics that we'll be covering today are: the causes of the delays in discharging aged care and NDIS patients; the effects on bed flow; the consequences and risks for patients; the impacts on staff; and the actions taken and other possible solutions to these sorts of issues.

To start with, though, I'd like to get a sense of the magnitude of the problem in your respective local health districts. Could I go to you first, Ms Pickering.

I beg your pardon, I haven't actually got you to state your full names for the record.

Ms Okulicz, could you state your full name for the record.

MS OKULICZ: Amy Okulicz.

DR WATERHOUSE: Ms Pickering.

MS PICKERING: Melissa Pickering

DR WATERHOUSE: Mr Shortis.

MS PICKERING: Brendan John Shortis,

DR WATERHOUSE: Professor Potter, could you state your full name for the record.

MS POTTER: Jan Potter.

MS WATERHOUSE: Ms Hawkins.

MS HAWKINS: Rachael Hawkins.

DR WATERHOUSE: And Mr Wakeling.

MR WAKELING: Benjamin Wakeling.

THE COMMISSIONER: I should just say that if Dr Waterhouse addresses a particular question to any of you, the rest of you should feel free to indicate, by any reasonable means, that you would like to supplement the answer or provide anything further. So please don't hesitate to jump in as appropriate.

DR WATERHOUSE: Ms Pickering, if I can go to you, can you tell me an estimate of how many geriatric and NDIS patients you have in Central Coast Local Health District facilities that are waiting there, not requiring acute care but just waiting for other reasons at the moment.

MS PICKERING: If I can start with the older population that are sitting across Gosford --

MS WATERHOUSE: I might just get you to move the microphone a little closer to you.

THE COMMISSIONER: All of you will need to keep your voices up, mainly for my benefit but also for others.

MS PICKERING: Thank you. In response to the older people that are sitting within our hospitals on the Central Coast, across Gosford and Wyong, I guess, on average, if I was to look at some of the data, September and October this year, we had between 60 and 70 older people awaiting residential aged care facility placement. And that's from the time of assessment to then time of placement, on average, the older people are in hospital for about two weeks for many reasons. Some of those reasons include family choosing a facility for their loved one, and often they will decline residential aged care facilities until they reach a facility that they feel is comfortable.

DR WATERHOUSE: We might come back to that as part of the causes that we're talking about in a moment.

MS PICKERING: Sure.

DR WATERHOUSE: So that's the aged care numbers. And what about the NDIS?

MS PICKERING: Unfortunately I probably don't have that number to be able to share today across the district. Yes.

DR WATERHOUSE: Mr Shortis, do you have a sense from Nepean Blue Mountains of the numbers that you are looking at that are in hospital without needing acute care?

MR SHORTIS: I work in the community section so I'm only aware of when they come to the community.

DR WATERHOUSE: Is it something you can speak to anecdotally in terms of how frequently this is happening?

MR SHORTIS: Reports that I have is that it is a significant hold-up, but I don't have the numbers. It's not in my role.

DR WATERHOUSE: Mr Wakeling, are you able to speak for the Illawarra in relation to these numbers?

MR WAKELING: Yes, thank you, Dr Waterhouse. As of 11 November, which was Monday, there were 38 NDIS patients at Illawarra Shoalhaven that were suitable for discharge but awaiting NDIS acceptance and support, and that's 40 per cent of our mental health bed base and 60 per cent of our sub-acute bed base. The average length of stay, once suitable for discharge, was 43 days, and at that point in time, the amount of people awaiting NDIS and that length of stay totalled 1,700 bed days.

As of Monday 11 November, patients awaiting a residential aged care facility at Illawarra Shoalhaven was 122. 15 per cent was in our ED accessible bed base and the rest, 85 per cent, was in our sub-acute bed base. The average length of stay, once suitable for discharge, was 19 days, and the volume and the length of stay totalled 3,500 bed days in Illawarra Shoalhaven. Thank you.

DR WATERHOUSE: Thank you.

Professor Potter, maybe if I could start with you, can you outline what you see as the key causes of the delays in being able to discharge aged care patients in particular, given your background?

PROFESSOR POTTER: Okay. So in the last three years, since the Royal Commission and COVID, we have lost 600 aged care facility beds, permanently lost them from our district, with no plans within the aged care sector to rebuild these beds.

There's lots of reasons for that, which I can go into if you want me to. So we've lost 600 beds, and that has resulted in us having the numbers that Ben has already spoken to waiting for placement.

Although he has given you the length of stay from acceptance to placement to discharge, I would have to add to that that specific groups of patients, in particular the dementia patients with behavioural disturbance, can wait up to a year for a bed, and there are no dementia-specific bed vacancies at all in ISLHD aged care, and none of the providers are proposing to build new dementia-specific beds. So that's that particular issue for our patients within hospital, waiting placements.

DR WATERHOUSE: When you say you've lost those beds, what exactly do you mean by "lost"? Is it that the facilities have closed or they can't --

PROFESSOR POTTER: The providers have closed --

DR WATERHOUSE: Sorry?

PROFESSOR POTTER: Yes, the providers have closed the beds permanently - for a variety of reasons to do with the Royal Commission, a perception that these beds are not good quality for patients, and the local council provisions on what sorts of buildings can be built - a whole load of different factors like that.

Also, during COVID, Illawarra Shoalhaven had a high dependency on overseas nursing for aged care facilities and, of course, there was a long period of time where we couldn't have any overseas nurses coming in, so difficulty

staffing, difficulty making it work in terms of funding and a reluctance and a poor perception of what going into residential aged care means.

The majority of those 600 beds that have closed, providers are considering opening things like retirement villages for over 55s, not looking to provide the sort of patient groups that we've got now waiting for placement.

DR WATERHOUSE: Do you find that patients --

THE COMMISSIONER: Sorry, I don't know whether Mr Wakeling has his hand up, perhaps, to respond to that?

DR WATERHOUSE: Yes, Mr Wakeling?

MR WAKELING: It is, thank you, Commissioner. Thank you, Dr Waterhouse. Just to support Professor Potter in regards to the numbers on patients with severe behaviours or aggression, at the moment at Wollongong Hospital, the longest delay is 192 days, supporting Professor Potter's "almost a year". The average at Wollongong is 19 days. In our dementia-specific hospital where these patients are awaiting residential aged care, Coledale hospital west wing ward, which has 16 beds, their longest delay currently is 155 days, and the average wait there is 43 days, a significant challenge for ISLHD. I just thought I would add that to support Professor Potter. Thank you.

DR WATERHOUSE: Thank you.

Professor Potter do you find that there are delays in actually having the patients assessed by ACAT teams or is it really that that process is quite streamlined and it's going from that point when they have been found suitable for placement?

PROFESSOR POTTER: Look, we've done a lot of work looking at this. Our ACAT teams are adhering to the KPIs for hospitalised patients, which is within 40 hours of referral. That's not to say there's not improvements that could be made in that. There's often delays to making the referral for aged care, and that comes down to the underlying cause of the numbers. So within Illawarra Shoalhaven, our population, we have a lot of people retiring from cities to this area. Our proportion of frail elderly is highest in New South Wales, in particular

Shoalhaven. We have approximately 5.7 residents who are aged 80 or over, compared to 4.8 in New South Wales in general, and that is really further exaggerated in Shoalhaven.

So we've got this increasing need, we've got this increasing dementia population, and at the same time, we're losing and have lost the beds in the community funded by the Commonwealth that we require to host those patients.

I think, going back to the delays to referring to ACAT, that's because in Wollongong Hospital, for example, which is our main tertiary hospital where we do most of our admissions, we have a bed base of 21 patients for acute geriatric medicine. We, at the moment, have a minimum of 60 patients in Wollongong Hospital at any one time. So those other patients are scattered throughout surgical wards, acute medical wards, where nursing staff and - also we have gone from having 20 consultations to geriatric medicine from other specialty teams, in the last two years, to 60 a week, you know.

So basically, a lot of these patients are under teams who do not have the expertise to manage them, do not have the interest in that group either, and so that leads to further delays in appropriate decisions being made.

DR WATERHOUSE: I'm going to come back to some of that if I may. Can I just go, while we're still in the Illawarra, to Ms Hawkins.

So do you find that patients - it's mainly in your wards that you look after, it's mainly about placements, obviously, but are there also patients waiting to be transferred out for other types of care, such as rehabilitation?

MS HAWKINS: Correct. So at the moment, between C7 east, which is an aged care ward currently, a temporary aged care ward, we currently have 15 patients admitted that are under the care of a geriatrician; B3 east, there are 24, which is our acute geriatric ward. So between the two wards, there are currently 39 patients admitted under the care of a geriatrician and there's nine --

DR WATERHOUSE: Just before you go on, can I clarify?

MS HAWKINS: Yes.

DR WATERHOUSE: When you say "under the care of a geriatrician", does that mean they need acute care or they just happen to be admitted under that person --

MS HAWKINS: They're admitted --

DR WATERHOUSE: -- but waiting transfer?

MS HAWKINS: Correct. So they're admitted under the care of a geriatrician and then we've got 19 patients currently under the care of a geriatrician that are outliers, and then five of those patients are currently in the emergency department.

In terms of C7 east aged care, we have five patients - or actually, sorry, six patients - currently that are awaiting Coledale hospital for nursing home placement. We had one transferred this morning, which was awaiting GEM, and the remaining patients are currently under an acute care type, so they're still under the medical management of the doctor.

DR WATERHOUSE: Thank you. Ms Pickering --

THE COMMISSIONER: Can I just ask, Ms Hawkins, were the wards you're talking about - I should really know this, but were they the wards that I had a site visit of? I think they were, yes.

MS HAWKINS: Correct. So B3 east geriatrics is our permanent 25-bed geriatric ward, and then C7 east is currently utilised as a surge ward for geriatrics, so you visited both those wards.

THE COMMISSIONER: Thank you for that.

MS HAWKINS: Just to add, in terms of the statistics of those patients, so we currently have - I have the statistics from yesterday, which was we had four patients bed boarded to Coledale - the length of stay for our longest length of stay was 212 days. On C7 east it was 34. That patient was bed boarded since 1 May 2024. The next patient is at 89 days' length of stay at Wollongong Hospital, with a total length of stay on C7 east at 31 days. That patient was ready for step-down from

16 September 2024.

The next patient is at 111 days, as a hospital length of stay. Length of stay on C7 east aged care is 36, and has been bed boarded since 14 October. And our last patient, as of the statistics for yesterday, 14 November, was at 47 days with a total length of stay on our ward at 28 days. They were bed boarded since 2 October and ready for transfer.

THE COMMISSIONER: My notes have a reference to "C7 west". Did I just get my compass wrong or --

MS HAWKINS: Yes. C7 west is a different ward.

THE COMMISSIONER: That makes perfect sense, if you knew me. The other ward I just wrote as "aged care ward". Is that one of the wards you're talking about?

MS HAWKINS: Correct. So C7 east aged care is our surge ward and then B3 east is our 25-bed permanent geriatric ward.

THE COMMISSIONER: Thank you.

DR WATERHOUSE: If I can go to the Central Coast for a moment, can you tell me, Ms Pickering, do you have similar experience there in terms of some of those causes of the delays?

MS PICKERING: Yes, we do. I think, as I started before, the family choosing a facility is probably one of the big areas that we find quite challenging and causing delays. Families will often go and inspect a facility and decide that, for whatever reason, it's not right for their loved one, and so then they go and look at a second and a third and sometimes a fourth.

Just to note that last month we did receive, via the ministry, some guidance to support trying to facilitate and empower families to make a decision with no more than two choices. That's something that we'll be empowering and working with our staff to work with families towards, with, I guess, the conversation around, with the family, that if they, on their second choice, are still not 100 per cent satisfied, that they transfer with the view of looking, and when the - once the facility that they're after is

available, that they can then transition across.

I guess the other challenges are those older people with challenging behaviours and facilities, I guess, accepting some of these older people into their residence.

Also at times we do have older people that have been assessed that then do become acutely unwell in that period, so then they become too unwell for transfer.

DR WATERHOUSE: Just on the family situation, are there any financial incentives, perhaps, to let an elderly patient just stay in hospital because it's going to cost them money to be able to move them out?

MS PICKERING: Look, I think that's potentially a factor that the family members consider. I think part of the guidance that has come out, as I mentioned, last month from the ministry also supports that care type change and letting families know that there will potentially be a cost attributed with an older person staying in an acute facility that is no longer acute care.

DR WATERHOUSE: That is something that - I hear it has come out last month, is that a new arrangement altogether --

MS PICKERING: No.

DR WATERHOUSE: -- or is that something that just hasn't been happening in a coordinated way perhaps?

MS PICKERING: It's not so much a new arrangement, it's something that's, I guess, providing more guidance and support from the ministry level for us to be able to enact and empower with our staff.

DR WATERHOUSE: In terms of how it plays out in the ward at Wyong, can you give an outline of the sorts of patients that you have there waiting for long periods of time, beyond the acute care they need, Ms Okulicz?

MS OKULICZ: Yes. It's mostly the behavioural patients, the patients with challenging behaviours. We have to try to medically treat them first and make sure that we can get the - can we modify their behaviours using medications to make them suitable because facilities won't take them

whilst they are having significantly challenging behaviours.

We've also got issues regarding guardianship, those delays as well. So if patients can't make decisions for themselves or don't have capacity and are refusing to go, then we need to go down the guardianship pathway and, unfortunately, in their best interests take their decision-making rights away from them, so it either gets allocated to a family member or it can be to a guardian.

DR WATERHOUSE: How long does that guardianship process take?

MS OKULICZ: It's significant. So we have to go through all the assessments first of what the patient - treat the patient first for what they're going through. Then we have to assess their capacity, which can either be like occupational therapist, social worker, neuro psych team, geriatrician. It sometimes takes multiple people to do those assessments.

Then once it is seen that they don't have capacity and we're going place them against their wishes, we then have to do all the letters and then that starts a seven-day process where all the doctors, the social worker and everyone who's involved write their letters.

Then that gets submitted to NCAT, the guardianship board. Then they receive it and then they can take three weeks before they give us a hearing date and then that could be three to six weeks before we get then a hearing date. Then we have the hearing, then it gets allocated, and then the process of trying to find a suitable residential aged care facility can start.

Then, once it's found, that goes back to the guardianship board with everything submitted for their recommendation for placement and then the guardian can then take seven to 10 days to accept that place and put - do all their paperwork. Then we can get given a transfer date, which can be another week. So you're looking at up to, like, three months from beginning to end for that patient.

DR WATERHOUSE: So to be clear, that is three months starting from when they cease to need acute care in a hospital?

MS OKULICZ: Correct.

DR WATERHOUSE: They are just in the ward?

MS OKULICZ: Yes.

DR WATERHOUSE: Are there ways that you can do some things simultaneously? Can you be looking for an aged care facility at the same time as they're going through the process on the expectation --

MS OKULICZ: Yes, some families can. Some families are willing to do that. But also it depends on what the outcome is, because they may find a facility but they need to work out is it an appropriate facility for them, because we also have lots that need specific memory support units going forward, and they have very limited beds, especially on the Central Coast.

I've had one lady recently, that was only discharged on Monday, she had been with me for about 150 days from beginning to end, and then we finally found a facility, but that was because the family were willing to consider other areas and she actually got transferred to Belrose, in Sydney, because we couldn't get any suitable bed on the Central Coast.

DR WATERHOUSE: How many patients would you have at any given time, going through that guardianship process?

MS OKULICZ: It can range from one to four, typically. Yes. It's very variable. But I think four or five, I think, is the most I've had at any one time.

DR WATERHOUSE: Mr Shortis, can I just ask you, from the Nepean Blue Mountains' point of view, do you have familiarity with the sorts of things that are keeping patients in hospital, aged care patients or the NDIS patients?

MR SHORTIS: Not enough to speak on, no.

DR WATERHOUSE: Did you want to make any comment at all in relation to that?

MR SHORTIS: No, thank you.

DR WATERHOUSE: I think, Professor Potter, you wanted to make a comment about this?

PROFESSOR POTTER: Yes, and just to say that in relation to what you were saying about cost, which might be a disincentive to families, there is a maintenance fee, so when a patient is type changed to maintenance, which means they no longer require acute or rehabilitation care, they're ready to be discharged, they are charged a weekly maintenance fee.

It's an absolute trivial amount compared to what a family would have to pay for a bond for an aged care facility. So you're talking around $20 a week compared to a minimum of maybe a 500,000 bond. So there's obviously an incentive, and particularly in Illawarra Shoalhaven, where we cannot offer any dementia specific beds within the region, so you're saying to a family, $20 a week versus 500,000, and you are going to have to travel to Sydney or elsewhere. So it's a huge disadvantage.

DR WATERHOUSE: Am I right in understanding that the amount that you can charge is set by --

PROFESSOR POTTER: Yes.

DR WATERHOUSE: Is that by the ministry or is that a Commonwealth rate or how --

PROFESSOR POTTER: I think it's a Commonwealth rate in negotiation with the ministry but it's an absolute fraction. It's really --

DR WATERHOUSE: Yes, understood.

Ms Okulicz, could I --

THE COMMISSIONER: Sorry. Professor Potter, when you are using the term "500,000 bond", you're referring to the RAD, are you, the refundable deposit?

PROFESSOR POTTER: Yes, yes.

THE COMMISSIONER: Yes, thanks.

DR WATERHOUSE: They still have to come up with that in

the beginning, even if they're going to get it back in the longer term, is that the point?

PROFESSOR POTTER: Yes, and if they get it back in the longer term, they're not - you know, fees are going to be taken out for how long they are in there. And again there has been a whole load of speculation in the literature and in the news stories about whether that's a fair and equitable process or not, and I couldn't really comment, but it's certainly debatable.

DR WATERHOUSE: Now, I'm aware that Mr Wakeling has his hand up but Ms Okulicz also wanted to add something, I think.

MS OKULICZ: Yes, in regards to the maintenance care, my understanding for Central Coast, it was $67 a day, potentially, that's charged for the maintenance period, but there are ways families can avoid paying that as well. There's a hardship form that they can submit as well. So we can go through the maintenance process and they get charged the daily rate, which is basically the same - like a respite bed daily rate, but families can submit a hardship form and not --

DR WATERHOUSE: And who decides whether that hardship requirement is met?

MS OKULICZ: That is decided by the cashier, sorry, the manager - sorry, I know her name but I don't know her role.

DR WATERHOUSE: Somebody in a management role within the district?

MS OKULICZ: A management role within the clerks. They work together with the finance department and determine if it is hardship and they meet the criteria.

DR WATERHOUSE: Thank you.

Mr Wakeling, you wanted to add something?

MR WAKELING: Yes, thank you, Dr Waterhouse. Just in support of the payment that Professor Potter raised and the representative from Wyong, the average cost per bed day for a maintenance patient at the Illawarra Shoalhaven is $1,014, so the payment that those maintenance patients are

paying is, as Professor Potter said, a very fraction of the cost of the LHD to run that bed.

DR WATERHOUSE: In other words, not only is it a fraction of what they would be paying if they had the person placed in an aged care facility, it's also a fraction of what it is actually costing you to staff that bed?

MR WAKELING: Yes.

DR WATERHOUSE: Understood, thank you.

Can I just touch on whether or not, in the Central Coast - do you know if you have lost beds in the same way as Professor Potter was saying, with COVID and so on and the Royal Commission, has there been the closure of a lot of beds there?

MS PICKERING: I am aware that there have been some facilities closed. I couldn't tell you how many beds, but I don't think we've seen a large closure compared to what others have.

DR WATERHOUSE: Mr Shortis, I think that one of the things that you said when we met recently was you referred to the fact that a lot of aged care patients may no longer be seeing their general practitioners. Can you just expand on why you feel that that's occurring or why you see that happening?

MR SHORTIS: In Nepean Blue Mountains, one of the issues that we have is there's not a huge number of GPs, so the GPs are actually hard to get into, the clients themselves can't attend, can't get an appointment, can't get one within a timely fashion. There's just not the GPs available to see there, and then combined with the mobility issues of some of our clients and the lack of availability of home visits, they just can't get to their GPs as often as they would like.

DR WATERHOUSE: What is the flow-on effect from the point of view of the district?

MR SHORTIS: From the point of view of the district, we have patients who potentially could have been treated in their home environment whose care isn't what's required, and so they become more unwell and they are admitted to

facilities.

DR WATERHOUSE: Are there financial impediments to them being able to see general practice as well or do they mostly bulk bill them?

MR SHORTIS: My understanding is that most of the general practices in the area I work in don't bulk bill the majority of their clients. They do bulk bill based on an individual assessment.

DR WATERHOUSE: Professor Potter, I was going to go to you next, yes.

PROFESSOR POTTER: Just to say in regards to GPs and fees, there's a huge financial disadvantage to general practitioners to go into aged care facilities. They can make, you know, far more for their practice by seeing patients in five-, 10-minute appointments within their surgery if the patients come to them, rather than going to an aged care facility to see patients where they could be there for many hours, they struggle to get nursing staff to accompany them, the prescribing systems and electronic writing systems are completely separate from their own. It's not a very streamlined system at all and there's a huge disadvantage to patients, and to GPs, for trying to go in there. In the Illawarra Shoalhaven, we have a number of facilities where the only GP input they can have is telehealth from Victoria, which in reality, if you're trying to assess a frail elderly patient with multiple comorbidities who you've never met before, it really can't be done very effectively by telehealth.

DR WATERHOUSE: In those circumstances where their only general practitioner is a telehealth service from Victoria, is there a lower threshold for just sending a person to hospital if there's anything wrong with them?

PROFESSOR POTTER: There is often no alternative. You now, in an acute crisis, you'll only be able to get the telehealth person at certain times, it's all very, you know, office hours, and so they feel - I think, you know, in terms of the aged care facilities, they feel as if they have no alternative. We have put in place, and we're trying to expand, a number of strategies to support the facilities, which we can talk about later if you wish.

DR WATERHOUSE: One thing I wanted to ask, is it a requirement, in order to be able to go into a residential aged care facility that you must have a nominated general practitioner?

PROFESSOR POTTER: Yes. Once you leave the hospital you're no longer under the care of any medical provider, so the aged care facility has an obligation to have a GP for you. So often, as they were saying for Wyong, if an elderly person has been with the same practice for 40 years but we're now having to place them in an out-of-area facility, that GP has even less of an incentive to see that patient if they're now many, many miles away from the practice. So often the facilities will try to have a contract with a local practice, or when they can't get that, this is where the Victorian telehealth system is occurring.

DR WATERHOUSE: So to be clear, it's the facility's responsibility to find a general practitioner for their patients; is that right?

PROFESSOR POTTER: I'm not 100 per cent sure whose responsibility, it's either the family or the facility, but it's not the hospital, but it's often a barrier to how we can get the patient out.

DR WATERHOUSE: Just one thing I want to touch on, and I know we'll look at some solutions a bit later, but I understand there is a general practice in aged care, an incentive that's been started recently. Do you have a view on whether that is likely to be successful?

PROFESSOR POTTER: Look, I don't know the details of it. I have followed this loosely, but I understand that the Commonwealth has recognised that there is a disincentive financially for GPs and that they are looking at trying to improve the fees for general practitioners to go into aged care facilities.

I know locally, we have a couple of practices, GP practices, who are very interested in the local facilities and have tried to organise a set roster and make it work. So there is goodwill out there, it's not a problem amongst our general practitioner colleagues; it's the structure and the functions and the policies that are surrounding them.

THE COMMISSIONER: I think it's a payment per patient that you have, of like $300 for each patient you've got as a GP on your books, for going to see people in aged care, rather than a - I could be wrong about this, but rather than a change to the item number when you actually - I think that's right.

DR WATERHOUSE: Yes, a bit like the bulk-billing incentives.

THE COMMISSIONER: Yes.

DR WATERHOUSE: Mr Wakeling, are you able to comment at all on general practice and the access for the NDIS patients that you have waiting long periods?

MR WAKELING: No, I cannot. Nothing further to add.

DR WATERHOUSE: If I can just look at the Central Coast aspect, is access to general practice or general practitioners, I should say, an impediment there in terms of some of the aged care patients that you see, and NDIS for that matter?

MS OKULICZ: Yes, absolutely. There is a significant lack of GPs on the Central Coast. There have been a couple of urgent care centres that have been opened by the government there, which has sort of helped the community but it hasn't reduced the ED presentations at all, and there is a significant amount of people presenting to the ED instead of a GP: one, because they can't get in; two, they don't have one; and, because this is a low socioeconomic area, they can't afford the GP fee because none of them consistently bulk bill, so then they do present to the hospital instead.

DR WATERHOUSE: Two things, is that talking generally about the population or is that specifically an aged care issue that you're referring to?

MS OKULICZ: Both. It is the population, but again, yes, the older persons on the Central Coast, they can't afford their GP services.

DR WATERHOUSE: Are these urgent care centres that are set up by the state or the Commonwealth Government?

MS PICKERING: So we have one that's state funded, that is under the governance of Central Coast Local Health District, and we have two Commonwealth funded urgent care services, and there are some other private sort of facilities that are popping up on the Central Coast also. But they charge.

DR WATERHOUSE: I just want to go back to what we were talking about before with the guardianship delays. Is that something, Ms Pickering, that's across the board in terms of Central Coast or is it a specific Wyong issue?

MS PICKERING: No. I would suggest it is across the board. I am aware that, even in our sub-acute facility down at Woy Woy, they also experience some significant delays with guardianship process, as Amy had described.

DR WATERHOUSE: Mr Shortis, do you know if this is an issue that's encountered in Nepean Blue Mountains?

MR SHORTIS: I believe so.

DR WATERHOUSE: What about on the Central Coast? Maybe Ms Hawkins, are you able to comment on whether you have a lot of patients awaiting guardianship applications?

MS HAWKINS: Currently between C7 east and B3 east, we currently have one patient awaiting a guardianship hearing. Based on the "waiting for what" for the B3 east patient, that's dated the 23rd of the 9th.

DR WATERHOUSE: Is that one patient an anomaly or do you normally have more than that? Is it a significant issue for you?

MS HAWKINS: Patients awaiting NCAT hearings, we do see a frequency of those. In terms of an exact number, I don't have that exact number, but there is a high frequency of patients that are requiring NCAT, and that's more for coercive orders regarding accommodation and/or finances.

DR WATERHOUSE: Do they tend to have the same lengthy delays that were described by Ms Okulicz?

MS HAWKINS: Correct, yes. That's in regards to the preplanning process to actually get them to the point of the NCAT hearing, and then also from the point of NCAT

hearing to a decision, there can be lengthy processes, yes. It can be weeks to months.

DR WATERHOUSE: Professor Potter, did you want to add something about that?

PROFESSOR POTTER: Yes. In the Illawarra Shoalhaven Local Health District, the two main acute hospitals are Wollongong Hospital, which Rachael Hawkins is referring to, and Shoalhaven Hospital. There are then five other sub-acute hospitals, and the majority of the patients waiting for guardianship have already left the acute hospital and gone to the sub-acute hospitals. So the numbers in the sub-acute hospitals are always going to be higher.

Wollongong is our main tertiary level 6 hospital, so once we've ruled out most of the acute things, we will try to prioritise them to go to one of the sub-acute sites, so the numbers there will be much higher than at Wollongong.

DR WATERHOUSE: Understood. And do you have a sense form your role about how many those are, or maybe I could go to Mr Wakeling about that, as to how many guardianship patients there are waiting in hospitals?

PROFESSOR POTTER: It comes and goes. It tends to come in runs, as these things do, but I would say on average it's around two to 10, but there's always the lengthy delays as well. You know, with guardianship, we've actually done some work with our local guardianship board and we have attempted to streamline this, but still, inevitably, with more complicated patients not in acute geriatric wards, scattered through the hospital, you've got teams and specialists and social workers who are not experienced in managing that type of patient, so that leads to delays in getting the recognition that they need guardianship and then delays in accessing the relevant reports to go to the guardianship tribunal. So I think because we've got such a big population not in the appropriate wards, it just exaggerates everything.

DR WATERHOUSE: Okay. Mr Wakeling, did you want to add anything in relation to the guardianship tribunal patients?

MR WAKELING: Yes. Before I - sorry, I'm just looking up the live system that might help. In regards to the way we

monitor guardianship delays, all of us in the room will use the patient flow portal, the NSW Health online system that is our primary operational tool to monitor access and flow, any delays, inter hospital transports, et cetera.

Currently at Illawarra Shoalhaven, according to our "waiting for whats", which we enter, and the likes of Rachael, being a NUM, will review every day, there are nine patients waiting a guardianship decision at Illawarra Shoalhaven.

If I could just go back to make a comment about the urgent care centres and how that support through the Commonwealth may help the aged care, it is my opinion - and I also work casually as a registered nurse at our local urgent care centre that's administered by the LHD - that that is not a solution for primary care for older persons who really need a detailed assessment of all their comorbidities, a medication review, et cetera, that Professor Potter could expand on.

The target audience for urgent care centres is the cohort in between a GP and the emergency department, and in my observation at our local urgent care centre, it's primarily paediatrics with bumps and bruises, potential fractures, et cetera, cellulitis that's not septic, a quick and easy assessment, or lacerations. So very much the minor injury cohort.

Those urgent care centres are not staffed by GPs primarily, they're GP ED VMO type models in our area who just want those minor injuries. That's the gap that's there to fill. Thank you.

THE COMMISSIONER: I don't think they were - they're not advertised, and I don't think they were set up, to be a substitute for primary care. If you actually look it up online, it's all what they describe as - it's an urgent service you need but not an ED service. You know, as you say, like a burn, a cut, after-hours, you can't see your GP - you may not go to your GP in any event for a cut, who knows - but it's certainly not got the - they weren't devised to have that continuity of care that you get from a GP providing primary care.

DR WATERHOUSE: Ms Hawkins, I think you wanted to say something; is that right?

MS HAWKINS: I just had further detail to support for the guardianship status. So across the district, we've currently - there is 11. At stage 1, which is guardianship 1 "waiting for what" we have three. We've got five waiting at guardianship 3, which is waiting a hearing date, and we've got three waiting a public guardian to be appointed, and that's only relevant to the geriatric patients currently waiting.

DR WATERHOUSE: And you've used the term "waiting for what", as have a couple of others. Can you define what that means for the court? Is that a term that is used consistently through the system?

MS HAWKINS: Benjamin will be able to probably comment a little bit more, but as a nurse unit manager, the way we use our "waiting for what" is as a part of an escalation process and also to map as a part of where that patient is currently waiting for certain processes within the hospital system. So "waiting for whats", in particular how we use it in aged care, could be for diagnostics, and that's typically when a patient is waiting 24 or more hours, and also more in regards to our NDIS, our residential care and also for transport, when they're awaiting a hospital bed elsewhere, and the transport for that.

DR WATERHOUSE: So is it fair to say is that, basically, it's a list that gives you oversight to know exactly why each patient is in hospital and waiting for something as opposed to having an acute procedure or whatever?

MS HAWKINS: Correct.

DR WATERHOUSE: Did you want to add anything to that, Mr Wakeling, before I go to people in the room?

MR WAKELING: Yes, thanks, Dr Waterhouse. So the "waiting for whats" are not just for the residential aged care or NDIS delays.

MS HAWKINS: Correct.

MR WAKELING: They are for all delays through the system to try and make it as operationally efficient as possible. So, as Rachael alluded to, it might be for an image, a test, a procedure, et cetera, something related to the

discharge process, a referral by someone or a consult, or a transfer or transport to another ward or another hospital.

At Wollongong Hospital - well, at Illawarra Shoalhaven more broadly, residential aged care or inter-hospital transfers, which I will expand on when we talk about the challenges and impacts in access and flow, is by far and away our largest delay. Thank you.

DR WATERHOUSE: We will cover that in a moment.

Ms Pickering, were you going to say something before?

MS PICKERING: I guess, just going back to the urgent care services, so the one that we have that's under the LHD governance on the Central Coast, as Ben mentioned, is for episodic care, really targeting those triage 4/5 type category patients I guess as an alternative to ED and not just for the older person.

We do have primarily probably GP VMO staffing in our urgent care service, and I guess that does help, although they - the transfer of care is certainly back to their GP, with a plan of care to try and encourage them to really link back into their GP for any further interventions and ongoing care needs.

DR WATERHOUSE: Okay. And just looking at barriers in terms of NDIS patients for a moment, I think you said something about the fact that they present to the emergency department to expedite regrading. Can you comment on that? Are you aware of that?

MS PICKERING: I don't think that was me.

DR WATERHOUSE: That's fine.

Mr Shortis, are you engaged with sort of delays with NDIS patients and familiar with the sorts of causes?

MR SHORTIS: I tend to the work in the community, so it is after their discharge. The "waiting for what" is part of the bed board, which is an inpatient system. So I'm aware of it, but it's not something I use regularly.

DR WATERHOUSE: When you get patients who are on the

NDIS - I assume you have some of those within your community health --

MR SHORTIS: We do.

DR WATERHOUSE: -- for what sorts of reasons have they been waiting some time before coming to you, do you know?

MR SHORTIS: It can be around providing staff to provide the appropriate care. So one of the common things that the service I work with does with NDIS patients is wound care and we tend to run into two issues with wound care. Some of the wound care can be funded underneath the NDIS, some of it will be funded underneath health, and we find that stuff that can be funded underneath the NDIS is often - they try to push it back to health, and the other problem that we run into is they don't actually have the staff that are able to do the dressings or provide the care.

DR WATERHOUSE: So what is it? Is it about the sort of dressings and things that are needed that are pushed back onto health or is it more about the skill set required to manage a complex wound?

MR SHORTIS: It's actually a bit of both. For some of the simpler dressings, we find that we're often training the NDIS care workers in how to do that, and for some of the complex wounds, there just aren't the staff in the community, other than NSW Health staff who have the skills to attend to that care.

DR WATERHOUSE: And who is doing the pushing back when you describe that between the two systems?

MR SHORTIS: Usually it is the NDIS care coordinators.

DR WATERHOUSE: Is that because they either don't have the budget or they don't have the skilled staff to be able to do it generally?

MR SHORTIS: That is my understanding.

DR WATERHOUSE: Do you have any patients on the NDIS that have difficulty getting out of hospital because of accommodation issues - ie, they have nowhere to go? Is that something that you encounter in community health?

MR SHORTIS: It's not something that I've encountered in my role but I do believe that is an issue in the district.

DR WATERHOUSE: I can see Ms Okulicz nodding to that. Is there something that you want to comment on there?

MS OKULICZ: I can speak to the two NDIS patients that have been on my unit. They are not geriatric, they were actually quite young, and the reason that they presented to hospital is that they had severe aggression and violence episodes towards their carers, where carers were significantly injured. So then they were brought in to hospital to be cared for, and then we had to sort of set up isolation areas and have security guards and one-on-one nursing to provide them care.

Then we had issues around where the care provider didn't want them back because of the danger that they were to their staff, and then there wasn't a suitable house because one particular person had done so much damage to the place that they couldn't go back.

So then you've got barriers of, yes, care providers not wanting them back due to the risk to their staff and they're not trained and they don't have enough funding to provide the staff and they don't have suitable accommodation.

Most NDIS patients are under the age of 65, so they're not actually aged care persons. If they're over the age of 65, there is usually a conversation about whether they will transition from the NDIS to an aged care pension and then into an RACF, because a lot of RACFs won't accept patients on the NDIS program because of the paperwork that's involved.

We have had one person that was the age of 70 who was on the NDIS and we were trying to get him to transition to an aged care pension but he refused to do so. So then we had delays trying to find a suitable aged care facility that would accept his NDIS plan and continue on that.

DR WATERHOUSE: So just to walk through that in a little bit more detail, you've got a person who has a behavioural issue of some sort, and they have injured somebody else, but they themselves are not injured. They themselves are not unwell.

MS OKULICZ: No.

DR WATERHOUSE: Their behavioural condition is not a delirium that is treatable, or something of that nature.

MS OKULICZ: Correct.

DR WATERHOUSE: But the default is to send them to hospital because they can't be managed safely in the --

MS OKULICZ: Their own home.

DR WATERHOUSE: -- residential facility, or sorry, the NDIS accommodation, or whatever that they are living in. So they send them to hospital.

MS OKULICZ: Mmm-hmm.

DR WATERHOUSE: What happens when they're in hospital? Are they admitted under someone? Do they get assessed or is it just a case of boarding them there, effectively, until an alternative --

MS OKULICZ: They're usually admitted under a general medicine physician and then sometimes we look at medications - can their medications be adjusted to modify their behaviours? Sometimes they just - it's just a matter of they lashed out because they were unhappy, so then it's like they have to get admitted because their care provider refuses to take them back and we can't discharge them if they're refusing to take them, so then we have to accommodate them in the hospital.

The two youngest ones with the most significant behaviours that we've had this year have stayed - both of them were about four months, because then we had to get a plan review, potentially increased funding, an increase in care providers that could be with them 24/7, then a new appropriate house had to be sourced, and then they had to do all their assessments, their OT assessments and - to make sure the house was suitable and - yes, so it takes - it took about four months for both of them.

DR WATERHOUSE: Do you know if any of the cost of their care while they're with you is being covered by the funding under their NDIS plan?

MS OKULICZ: No.

DR WATERHOUSE: No, it is not, or no, you don't know?

MS OKULICZ: No, it's not being covered.

DR WATERHOUSE: It's not being covered?

MS OKULICZ: Yes. And these patients have required 24 hours' security, sometimes two security guards 24 hours, and a one-on-one nurse as well. So one of the gentlemen that I had for about four months, his security bill alone was $100,000, and that came out of my unit's budget.

DR WATERHOUSE: Do your staff have any particular training to deal with these very complex behavioural disorders?

MS OKULICZ: They do have violence and aggression training. That is limited. They do attend a one-day session. But it is usually directed at an older person, managing those behaviours. But the gentleman that was in my ward, he was 6 foot 3 and about 120 kilos, so even that training, with my female nursing staff, wouldn't have managed much.

DR WATERHOUSE: To be clear, though, it doesn't need clinical training to do that, so the care workers in an NDIS accommodation home could do that training; it wouldn't require a nursing degree to do that?

MS OKULICZ: No.

DR WATERHOUSE: Thank you.

I might just go to Mr Wakeling. I think he had a comment to make about this.

MR WAKELING: Thanks, Dr Waterhouse. I can just expand on the NDIS patients that the person from Wyong gave evidence on from an emergency department perspective, being an emergency clinician.

So when these patients come in, they may or may not be scheduled under a Mental Health Act, either by the police or the ambulance, because they're unsafe to themselves or unsafe to the community.

What we would normally do is rule out any medical or organic causes that have triggered this abnormal behaviour, be it an infection, or looking for other tumours in the brain or anything else in the brain that's causing this abnormal behaviour. It would require blood tests, it would require a CT scan, a urine sample. We usually would do a urine drug screen, because it may be linked to substance abuse. And we require all that before we, as the emergency team, are able to refer to another specialty, be it general medicine or the mental health team, for them to make a decision on this patient's care.

They cause significant disruption in the emergency department because, as suggested, they do need one-on-one type care and they are scheduled under the Act so we need to look after them. They may or may not need sedation or restraint to make it safe for them and the other staff members to provide the tasks that I mentioned before a decision can be made. Thank you.

DR WATERHOUSE: I just want to follow up on something about that, and it sort of goes to the difference, I guess, between the aged care patients and the NDIS patients. Is my understanding correct, at least from the point of view of Illawarra to start with - and I will come to you as well - that when it comes to the aged care patients, most of them that don't need to be in hospital are there because they are waiting a first-time placement in aged care, but when it comes to the NDIS patients, a lot of them are already under the NDIS but they've come in because the system is not working for them in the community; is that correct?

MR WAKELING: That could be an assumption that I say is correct, yes, thank you.

DR WATERHOUSE: I think I might go first to Ms Hawkins.

MS HAWKINS: So it's dual. They're often waiting their first nursing home placement or they're patients that have been in a nursing home, have not been able to be managed in regards to their behaviours, that bed has then been declined by the facility and then they present to us for a period of medical management and then they're needing to be placed in a new nursing home. So it's both.

DR WATERHOUSE: And do you have a sense of the proportions of the two?

MS HAWKINS: It's more often that it's a new nursing home placement but there has been an emerging trend in terms of patients that are needing a second nursing home placement found because a facility is not able to manage their behaviours, and rightly so, the behaviours that we have seen that have come through, they are significant behaviours of concern that have needed to be managed as an inpatient.

DR WATERHOUSE: Understood. Professor Potter I think is keen to say something.

PROFESSOR POTTER: Yes, I would agree with Ben and Rachael. It's more often for the aged care patients that they are people who have not managed anymore in the community and there's nothing reversible, however, the group who come in from aged care facilities and those facilities are refusing to take them back - often for appropriate reasons - that group represents a much bigger use of our bed base because they are very much more difficult to discharge, in particular because, as I said, of the complete lack of dementia-specific beds in our district and the lack of any willingness to build any more of them. So that group is expanding all the time.

DR WATERHOUSE: Thank you.

Ms Okulicz, you were going to say something?

MS OKULICZ: Just in regards to NDIS, we do have a number of new NDIS applications, and they're usually related to our stroke patients or some of our rehabilitation patients who have gone through a process. So they've come in, had a cerebral event, they've now got a deficiency and so then they've got a disability and can no longer go home or need significant care to go home, so then a new NDIS application needs to be made and then that has similar delays as a plan review.

DR WATERHOUSE: So that's to become a participant as opposed to having a regrade, effectively?

MS OKULICZ: So we do have both. We have becoming a participant and a review of plan participants.

DR WATERHOUSE: In terms of your aged care patients, do you have a proportion, like Ms Hawkins, that are brand new placements as opposed to people that are just not coping or the nursing home can't cope with them?

MS OKULICZ: We have a mix of - like, come in from the community, families can no longer care for them, and then we're following down the RACF pathway, or they've been in an RACF, their care needs have changed and they've become - their dementia has progressed and their behaviours have become too challenging to manage, so they've come into hospital for us to treat and to find any reversible causes, and then look at a new facility that can manage their new ongoing behaviours if it seems that that's now their new baseline.

DR WATERHOUSE: And when you refer to "RACF", that's residential aged care facility?

MS OKULICZ: Correct, sorry.

DR WATERHOUSE: Okay, that's fine.

Ms Pickering, did you want to add anything to that?

MS PICKERING: No, I think what Amy has said is quite accurate.

DR WATERHOUSE: Do you find that there are families that don't cope with either - well, particularly with, I suppose, NDIS participants, they might already have a plan but the family is not coping because there's not enough supports in the community for them?

MS PICKERING: Look, potentially yes. I think what one of the challenges are in the community space in particular is an NDIS participant has an allocated budget for their care needs. What we find, and this is more from my community service experience, is we do have, I guess, providers reach out, where the budget has been allocated, and it may not necessarily have been allocated in a way that health may see that we might need some allocation.

So, for example, and as Brendan said, we do have a lot of wound management in the community that we support, where there's an NDIS provider in place, we really do need to be

providing that - the capacity building for that provider to be able to care for their participant, but often we do hear, "Actually, we don't have any budget left for that. We actually aren't able to provide that element of care." And that has become quite a challenge.

DR WATERHOUSE: So, effectively, they've got the budget for the 12 months, they've spent the whole budget --

MS PICKERING: Or it has been allocated in a way for that 12 months.

DR WATERHOUSE: And therefore it falls back to the hospital system to pick up - or the health system, I should say.

Mr Shortis, is that your experience as well?

MR SHORTIS: Yes. Yes, very definitely.

DR WATERHOUSE: Does it go beyond wound care? Is it other things too?

MR SHORTIS: It can be, but, yes, as Ms Pickering said, it's the client or the package chooses to allocate to not in a way that health would necessarily allocate, I'm thinking about a client at the moment who's having their dog walked but probably needs their dressing done more importantly.

DR WATERHOUSE: Do you have a sense that sometimes it's being allocated the way it is because they know that the hospital system can pick up whatever they don't allocate to, so they focus on other things that the person might want?

MR SHORTIS: My experience would be it's predominantly the client's choice, that's their goal, to have whatever it is done, and health care comes as a later thing and then, yes, it is often left to health to pick up.

DR WATERHOUSE: Mr Wakeling, I think you were going to say something, and then I'll move on to the other topics, but I'll give everyone a chance if they want to say anything more about causes?

MR WAKELING: Thanks, Dr Waterhouse. Just following

people's comments, I think the hospital system can't refuse care, whereas the residential aged care facility, the NDIS provider, they all have the right to say it's unsafe for their - for the care of the patient or the consumer that's in their care, so the fall-back position is always the local health district or the hospitals.

Similar to the example Professor Potter gave, where there's no incentive for the patient awaiting a residential aged care quality to leave the maintenance bed because the financial cost is so low compared to the capital that is required to move to a residential aged care facility. We are in, in my observation, a point where it's to our disadvantage, although we are happy to provide their care when it's required and appropriate. Thank you.

DR WATERHOUSE: Thank you.

So before we move on to the effects of all of this on bed flow, can I just check if anyone else wanted to make any other comment about the causes of the problem? Ms Okulicz?

MS OKULICZ: I would also like to raise the limitations of our available allied health staff. So we've had a significant reduction in the allied health capacity, like the social workers, occupational therapists and the physiotherapists, and if they can't do their assessments, then that hinders the progress through the hospital system. So if we need an OT assessment and a physiotherapist to determine whether the patient is safe to go home or do they need to go, and then they don't see that patient for three to five days due to delays, we've lost a week just waiting for occupational therapy to make that assessment.

And then, because we've had surge open in Wyong Hospital as well, so we've had, like, 24 to 26 surge beds open at any given time but there's been no increase in the resources for allied health to see those extra patients. I think last week they had three physiotherapists for the entire hospital, so that was a ratio of one to 30 patients for all their referrals. So when you're waiting on discharge plans or progress or patients' capacity to be able to go home or what their needs are, then you've got delays just waiting for allied health to come and see those patients.

DR WATERHOUSE: Just to make sure I understand that clearly, when there's an increase in activity, surge beds are opened, meaning temporary beds, effectively?

MS OKULICZ: Mmm-hmm.

DR WATERHOUSE: Those beds are staffed from a nursing perspective so that the patients have care at the nursing level?

MS OKULICZ: Through overtime and casuals. Like, they're not - it's not our --

DR WATERHOUSE: You don't appoint extra nurses, I appreciate that.

MS OKULICZ: No.

DR WATERHOUSE: But you have nurses counted towards those beds --

MS OKULICZ: Correct.

DR WATERHOUSE: -- or allocated towards those beds, but there's no change in your allied health capacity, so they're spread more thinly?

MS OKULICZ: Correct.

DR WATERHOUSE: Ms Pickering, I know there is casual --

THE COMMISSIONER: Just before you go to Ms Pickering, Ms Okulicz said there had been a "significant reduction in allied health capacity". What should I understand by "significant", and what is the cause of the reduction in the allied health capacity?

MS OKULICZ: There was leave. There has been maternity - from what I'm aware of, because it's not my department, but from what I'm aware of, there's been maternity leave, there's been people going off on, like, annual leave not back-filled, like, whenever somebody is on leave, they're not back-filled, there isn't a position for that. There's maternity leave that hasn't been back-filled as well, and then people leaving the district or leaving their positions that they've struggled to recruit to those positions as well.

THE COMMISSIONER: I see, thank you.

DR WATERHOUSE: Ms Pickering, just going to the allied health point, do you find that there has been a reduction in allied health people moving out into the private sector to work for NDIS?

MS PICKERING: Again, it's not my area, but anecdotally, I have heard that, that - well, not just the NDIS but even through aged care providers out in the community, there is a greater, I guess, financial incentive for allied health to go from NSW Health out to working in private.

DR WATERHOUSE: And I understand there is a casual nurses pool. Is there scope to have a casual pool for allied health staff?

MS PICKERING: Potentially. I think that is something that is being considered.

DR WATERHOUSE: Mr Shortis, do you have any comment in terms of the allied health staffing from the point of view of the community health?

MR SHORTIS: No.

DR WATERHOUSE: Okay. Professor Potter, you wanted to say something further about causes?

PROFESSOR POTTER: Yes. It's complicated. So as I said at the beginning, because, in our district, of the proportion of frail elderly people retiring into the district, we have higher numbers of elderly patients than other districts in New South Wales - in fact, we have the highest.

What that results in is that we have a lot of frail elderly patients in the wrong areas of the hospitals under the wrong teams, and what that then means is if you've an allied health specialist who has a particular expertise in orthopaedic surgery, we have a ward where up to a third of the patients are frail elderly people with other needs, so you've got the wrong skill set in the wrong places.

One of the other important things I think to put towards the causes of this is the training institutes don't

seem to have caught up with the population demographic. So the colleges, Royal College of Physicians, Royal College of Surgeons and the HETI, so the basic physician training, all of those groups consider geriatric medicine as a small sub-specialty, not as the majority of what's coming through the front door of the hospitals, and that leads to all sorts of incorrect - for medical staff, so you're not training the right number of people to become geriatricians. You're then ending up with geriatric patients under adult medicine sub-specialties and, even worse, in the surgical sub-specialties as outliers, and that just amplifies the whole problem.

Up to this moment, there is no - there doesn't appear to be any appetite for any of the colleges to change that fundamental structure.

I think one of the other things for regional areas in terms of training is we - I've been in this job here for 20 years and I have never been able to convince the colleges that Illawarra Shoalhaven could complete three years of specialist training for advanced trainees.

So what that means is we're allowed to do two years but not the third year, the final year. So you've got advanced trainees who are very keen to be geriatricians, who graduate, postgraduate now as opposed to undergraduates, so by the time they're in specialist training they are significantly older with family commitments and mortgages. They finish their time in the Illawarra Shoalhaven, they're not allowed to do their third year and have to go to Sydney, which is completely disruptive, and often if you finish your final year in Sydney, you will end up working in Sydney.

I feel as if there is an unfairness there, that we're still very city-centric and yet the population is not following that demographic. So the elderly population is coming out to the regions and rural, and yet we're not allowing the training to follow them, which I think is a significant contributor.

DR WATERHOUSE: Ms Hawkins, you wanted to add something, and I'm going to go on to you also about the effects on bed flows, et cetera, but can you just comment there?

MS HAWKINS: The only thing I was going to comment in

regards to causes is I feel that we're at the tail end of a much broader issue. Obviously what we're seeing now is the current state of bed block due to, in part, our NDIS-waiting clients and also our RACF-pathway patients. What we're looking at, and what I've seen as a part of my aged care nav and discharge planning experience is we've got patients who, they're - they've got no other choice but nursing home placement.

Oftentimes they come to hospital at a point of crisis, and that's usually as a result of carer fatigue or carer stress. There is a frequency of patients that come through the department as a result of social admissions, where their carer is no longer able to provide that level of care that they require to be safe at home, whether that be in their own home environment, supported by a carer, or supported by services.

I do think that in regards to patients, there is a high demand of community resources in terms of care planning. What we do see in hospital is there are delays in terms of families being able to access ACAT or RAS assessments, which then leads them to not being able to get access to the services that they require to remain safe at home.

There is an issue with families' ability to navigate the My Aged Care system, and to safely and efficiently get the service approvals for their loved one that they need, but also to have that service onset. There are delays in terms of home care package approvals, there are significant delays in terms of waiting for a 3/4, for example. That could be anywhere from six to 12 months, not to then mention the time of ACAT assessment to wait for that approval, which then leads families to make, I guess, a risk assessment in terms of, "Are we able to manage at the level of care that we are", which is more frequently on the responsibility of family.

When they reach that point of crisis, they then present to the emergency department and then, as they're admitted by a geriatrician or if they are a medical outlier, they require significant discharge planning in hospital, which increases their risk of a long length of stay and a complex admission, which then means that their only choice realistically is nursing home placement, because we're not able to get the services that they

require to discharge effectively home.

DR WATERHOUSE: You referred to a 3/4 taking six to 12 months, can you explain what a 3/4 is?

MS HAWKINS: What I'm talking about is the level of the home care package. Home care packages come in four levels, so there's a level 1, 2, 3 and 4. So you're looking at a level 1/2, which is a little bit of help at home, to a level 3/4, which is more the moderate to maximal level of service provided in the community to a patient. That also equates to hours and it also equates to the funding that supports that package.

DR WATERHOUSE: Is there a perception at least that it will be easier to traverse that process and get someone care even if they do go home, if they bring the person to hospital and there's sort of help to be able to facilitate the process? Is that what people believe? Is that why they present?

MS HAWKINS: Correct. I think that that would be an accurate statement. I think that it is sometimes easier for families and patients to rely on the discharge planning service and the multidisciplinary service that is provided by a hospital to be able to quickly and effectively coordinate that care to give them a resolution, to be able to say, "Yes, we can find you a service package", or "We can offer you an interim package", which is either an !TAX or a ComPacks package, over them having to coordinate that themselves at home.

DR WATERHOUSE: I'm mindful that I want to hear from others as well, obviously, but I wanted to clarify two things. You referred a moment ago to a "social admission". Can you just explain what you mean by that?

MS HAWKINS: Correct. Typically how I define a social admission is that a patient has come in not for a medical reason, it's more often because family are not able to cope with the level of care. What we would reference that to and what we're seeing typically is in regards to behaviours of concern, so wandering and exit-seeking from their home, or that the level of care in terms of ADL, which is activities of daily living, which means their personal care or their medication management or just an overlying level of supervision is required, which means that they need to

come into hospital because their family are not able to cope with that level, and more often than not, it's as a result of falls as well.

DR WATERHOUSE: You also said that you previously had been an aged care nurse navigator and a discharge planner.

MS HAWKINS: Correct.

DR WATERHOUSE: Can you explain in very brief terms what those roles involved?

MS HAWKINS: A discharge planner, as a discharge planner you are responsible for assessing patients, typically adults, so over the age of 18, that are admitted either to a surgical or medical ward in regards to service planning. So that's coordination of care, making sure that a patient has an appropriate discharge location. And within an aged care navigator, it's similar, but it also has a patient flow aspect of making sure that patients are going to the right hospital for the right care needs and that their care journey is monitored, but they are under the care of a geriatrician, so they're admitted under geriatrics.

DR WATERHOUSE: Thank you.

Ms Pickering, do you have aged care navigators and discharge planners working in the district?

MS PICKERING: We do. We have - we call them the supported transitioning care team, so they're our discharge planners, so similar to Rachael was describing but probably not just our medical and surgical, they'll go into older people's wards as well, but certainly more the adult population, to - I guess what they will look at is trying to identify whether they're already known to some of our health community service providers, and, if so, then communicate with those providers to see if there's anything we can do to support transfer back home. But again, if they are not linked, then they will look at what care needs they may have on discharge to try and work with the ward teams to support that transition back to the home.

DR WATERHOUSE: Okay. Mr Wakeling, I would just like to ask you, how does bed block in one facility in, say, one of your smaller facilities there in Illawarra, how does that have a back-flow effect and can you talk us through what

that is?

MR WAKELING: Yes. Thank you for the question, Dr Waterhouse. I usually look at the access and flow of a system from the back of the system more towards the emergency department. I think, first of all, the aged care patients, they're in their beds, they're maintenance beds, it's not the optimal environment that they should be because it should be their home that they're living in and enjoying the last days that they have. It's very much a hospital environment. I'll start with that.

When the patients are in the hospital environment for those long periods of time, they've got an increased risk of hospital-acquired complications by the nature of their complex condition, the facility they're in and the long length of stay because they can't get out. They've got a risk of deconditioning. They've got an increased risk of mortality as well. So that compounds that bed block, what we're talking about, in that maintenance type phase. And then --

DR WATERHOUSE: Are there back-flow effects into the ED and ambulances?

MR WAKELING: Yes. So the phase before the maintenance bed is usually from a sub-acute phase, so a rehab or a GEM, a geriatric evaluation and management bed, and so those beds, where we provide basically rehab care to try and get a patient's goals that they've identified back to a safe enough discharge or an outcome that the multidisciplinary team, patient and family have agreed, they get full of the maintenance type patients that are waiting NDIS or aged care.

So that blocks our ability to move a patient from the acute phase to the sub-acute phase. So there's a proportion of patients, as we described at the start, currently on Monday at Wollongong there were 25 patients awaiting a residential aged care in our acute beds. That inhibits our ability to provide acute care, so the patients that need acute care, back-flow back into the emergency department.

At Wollongong, for example, at any given day, there's around 30 admissions in the emergency department. Rachael mentioned that there are five geriatric patients today

under Professor Potter's team's care in the emergency department. I've just had a quick look, four are over 12 hours, there's one over 24 hours. The risk of hospital-acquired complication or extended length of stay goes up dramatically for those patients who are in the emergency department for that length of time, and ultimately, it's sad, but their mortality risk is increasing and their percentage of or their likelihood of not meeting their goals of care to be discharged home in the sub-acute phase goes down and they're more than likely going to go to a residential aged care facility.

DR WATERHOUSE: I want to come back to the effects on patients in a little while, but just so I understand it, in terms of the back-flow, so you've got patients that are in a sub-acute facility waiting to go to a nursing home, they can't be moved out, therefore the patients who no longer need acute care can't go into the sub-acute facility, therefore, the patients who are waiting in the emergency department can't go into the acute care beds and therefore, you get things like ambulance ramping. Is that basically a correct summary of what you're explaining there?

MR WAKELING: That's an exact summary, yeah. And then, to extend on that, we can't offload the ambulances if they require a bed - we try and provide the ambulances to the most safest place that patient can receive care. And then, increasingly, on my observation as an emergency nurse for the last 15 years, there's a tendency to provide care in the waiting room, which may not be optimal for all patients and may be unsafe in certain circumstances.

DR WATERHOUSE: Is there also an issue in terms of being able to, say, move intensive care unit patients out to a step-down ward when they no longer need intensive care because there is blockage in the acute beds?

MR WAKELING: That's correct.

DR WATERHOUSE: And are there cancellations of surgical cases because there is no ICU or no ward bed that they can go to postoperatively?

MR WAKELING: That's correct. So the other two scenarios, as you described, are once the patients have finished their ICU or HDU - intensive care or high-dependency unit - level of care that required, you know, higher nursing, allied

health and medical health requirements, there may not be an acute bed for them to step down into, so therefore they stay in that ICU/HDU bed, blocking access, where there might be a patient in the emergency department's resuscitation room that is on a ventilator or a breathing machine, they might be delayed moving up, but also that's in a very expensive bed type, ICU and HDU, to cost because of the higher labour costs, so the patient is not right in there, from a financial perspective.

If we don't have beds for a patient after their theatre to decant to, they'll either stay in recovery longer, therefore we might extend recovery opening hours - that will require overtime, there is an impact on burnout, wellbeing and fatigue - and/or like you said, if we know there's a crisis, and we measure that operational assessment every day in our short-term escalation plans, if we are in step black, our level four highest escalation, we might make a decision where operations for certain patients are cancelled because there's no safe space for them to go postoperatively.

DR WATERHOUSE: Thank you. I want to just move to see if that's very similar, or is at all similar, in the Central Coast Local Health District. Is what Mr Wakeling is describing what you see day to day?

MS PICKERING: Yes, it is. It is very similar. The only thing I would add to that is that it can also then result in us opening surge beds, as Amy mentioned before, which then sees us stretch our resources across the broader bed base, which then, from a nursing perspective has, for us on the Central Coast, been quite challenging to meet our minimum staffing requirements across many wards.

DR WATERHOUSE: When you say "minimum staffing requirements", you're talking there about nursing hours per --

MS PICKERING: I am. Nursing hours per patient day, yes.

DR WATERHOUSE: But I'm assuming that there is no change - well, there's no change, we've heard already, to the allied health staffing; they are spread more thinly?

MS PICKERING: No, that's right.

DR WATERHOUSE: What about the medical staffing?

MS PICKERING: Very similar; as like allied health, spread thinly.

DR WATERHOUSE: Do you take on locums and things to try to manage the load or do you try to do it with overtime and so on?

MS PICKERING: I'm probably not the best one to answer that one.

MS OKULICZ: I've only ever known locums to cover a specialist or VMO's leave, not as an additional team. We still only have a set number of teams.

There has been commentary from some doctors that when they are on take, that they've got 40 to 50 patients just for one team, so three doctors for 40 to 50 patients spread across the site that they're trying to equally see. So then you've got the added challenges of when you're trying to contact said team for a discharge summary or a discharge plan, they're on the other side of the hospital dealing with an acute sick person and they can't get to where they need to be or where we need them to be to progress a discharge.

Just in terms of sub-acute hospitals, like the Illawarra, we've only got one sub-acute hospital on the Central Coast, so there's two acute and one sub-acute, and that's at Woy Woy. Patients from Wyong don't go to Woy Woy, they would sit in Wyong because, one, it is too far and lots of families don't want to go down there, but also that is primarily a Gosford discharge site for sub-acute.

There was a sub-acute hospital at Long Jetty, but it was closed I think in 2020 or 2021, and that is now where the urgent care centre is, but basically all the sub-acute patients now sit within Wyong because there's nowhere else for them to transfer to.

DR WATERHOUSE: Do you have the same issues in terms of being able to move patients out of intensive care and have surgical cases cancelled?

MS PICKERING: Yes.

MS OKULICZ: Yes. We try very hard not to cancel surgical patients but unfortunately sometimes if the hospital is at capacity there is no other choice.

DR WATERHOUSE: What about flow within the ward, how many patients do - like, you're staffed for how many?

MS OKULICZ: I'm funded for 22 beds, but my average bed base since January has been 27 patients a day, and it can go up to 30, because I have 30 physical beds within my unit but only 22 of them are funded. So then my roster is only funded for those 22 beds and whatever nursing hours per patient day that looks like.

If I'm running at 30 beds a day, that's an extra six staff that I need to find across each shift, and so if we're running at 30 beds every day for - and I have done it for a month - that's a significant increase in work flow. I'm running, on average, anywhere between 350 to 450 hours of overtime a fortnight.

DR WATERHOUSE: And it's being done by staff that are already on your ward or by other --

MS OKULICZ: Majority of the overtime is done by staff on my ward. The casual pool and nursing support roster do the best that they can to fill in some of my gaps as well, but their main focus is to fill any unplanned leave, so if anyone calls in sick, then that is what they cover. If there's any surge or overtime required, then that's up to myself.

DR WATERHOUSE: Ms Hawkins, I just want to ask you a question in relation to I think you opened an extended ward specifically because of these bed numbers; is that correct?

MS HAWKINS: Correct, yes.

DR WATERHOUSE: And can you explain in terms of the staffing of that ward how does that function?

MS HAWKINS: C7 east aged care we opened on 26 June 2024. We are an 18-bed ward but currently this morning we had 16 patients. We have a staff profile of three patients - three staff on a morning, four on an afternoon and three on

a night. What further detail do you need?

DR WATERHOUSE: Just, I suppose, understanding what your standard staffing is and how you get additional staff and whether it's purely a nursing staff thing, do you get extra allied health, et cetera?

MS HAWKINS: We do have allied health that are allocated, but they are not permanent, they are shared between other wards. As a surge ward, we created a roster, when we opened and we were allocated staff, but our roster is made up of PRPs, which is permanent relief pool staff, agency and casual pool staff as well. We are very fortunate that we do have some casual pool staff members that do take regular shifts with us, but our staffing can be variable.

DR WATERHOUSE: When you say that it's a surge ward, has it just been opened for a limited period of time or is it indefinite or how does it work?

MS HAWKINS: So my current understanding, and Jan will probably be able to comment further, at the moment, it is a surge, temporary ward. We close on 22 December with a view that we are going to re-open in the new year, but for how long that is going to be, I am unsure.

DR WATERHOUSE: Okay. Mr Wakeling I think you wanted to make a comment and then if we go to Professor Potter.

MR WAKELING: Thank you, Dr Waterhouse. Following the surge comments at Wollongong hospital - thanks, Mel, for raising that from the Central Coast's perspective - Wollongong currently has 34 over-census beds opened. Normally what we would do in demand management is flex up and flex down. As Rachael and the rest said, they're unbudgeted, unfunded, unstaffed, it's usually through overtime, agency, et cetera.

You may have heard earlier that Professor Potter referred to B3 east aged care ward having 21 beds, but Rachael mentioned that they were 24/25 beds, that's because Professor Potter is responding to the funded/budgeted allocation of 21, but for the last two years, my understanding is Wollongong Hospital has operated and rostered to the 25 beds because we know that the demand is there.

Wollongong Hospital's over-census beds, since I restarted back in the district in April 2024, have been opened no lower than 34 over-census beds at any one time and we only safely have 35 over-census beds. So we are operating at capacity the whole time.

C7 east was a response to winter, because it was hard. I do not foresee Wollongong Hospital safely closing C7 east without having a dramatic back-flow impact, as we discussed before, on increasing the admissions in the emergency department, and that will have an effect on us to provide high quality and safe emergency department care and offload those ambulances. Thank you.

DR WATERHOUSE: I think you just mentioned the word "winter", so there is obviously a seasonal aspect to this, but by the same token, 22 December is a little after winter, so are you seeing a difference? It used to be more of a seasonal issue and it is now all year long, is that what you are saying?

MR WAKELING: From a seasonality, from a demand perspective, as Professor Potter mentioned, the Illawarra's demographic and Shoalhaven's demographic is increasingly old. It's growing at a rate above the New South Wales state average from a demand perspective.

From a seasonal perspective, it's not so much the demand changes, it's the acuity of the patients, therefore, they need more inputs and the length of stay is longer to get them to a safer place for discharge. That's my comment around seasonality.

DR WATERHOUSE: Thank you.

Professor Potter, you wanted to add something?

PROFESSOR POTTER: Yes, I think just to emphasise, so the B3 east, which is the geriatric unit, is funded for 21, is never below 24. C7 east is the temporary surge ward. That ward is funded for renovation for a completely different patient group, and because despite 24 beds being used for acute geriatric, we are never less than 60 acute geriatric patients in Wollongong Hospital, and because of the difficulties and the strain on junior staff and senior staff going into 13 or 14 wards to see these patients, we temporarily put them in C7 east and that gave us 40 of our

60 all in one place, which helped to some extent. However, as everybody has said, we're not going to be able to continue that ward beyond December, and my understanding is that although it will re-open probably in early February, it will not be for geriatric medicine, it will be for the purpose that ministry funded the renovations, so we'll be back to a situation with at least 46 outliers in acute geriatric medicine.

DR WATERHOUSE: Those in the room, does anyone want to comment on that seasonal aspect, winter and the growing numbers, et cetera?

MS OKULICZ: Previously we would see a seasonal - like, winter was always our busiest period and then it would calm down in the August/September, and then summer was generally okay, but we've seen a shift, especially from Christmas 2023. I would go down to about 18 beds across the holiday period. We only dropped to 18 beds for two days and then by 27 December, I was back up to 27 patients.

January was probably one of the worst Januarys I have ever seen in terms of patient requirements and admissions, and it hasn't stopped pretty much all year. That's why my average bed base is now 27, because we've literally been consistently at 30 or more, or 25 or more patients every week, with occasional drops back down to 22, but it would only last a day or two and it will spike back up.

But winter was definitely worse on top of that, so we were already seeing an increase in presentations, an increase in how unwell patients were, and also they're staying at home longer, they're coming in with far more comorbidities, requiring far more treatment and input, so they're staying in hospital longer.

And then on top of that we got winter, which saw an increase, and then COVID outbreaks and all the impacts of that as well was still ongoing. And then we actually had to open a surge ward temporarily, which was only supposed to be eight patients but was consistently running at 12, and that was purely staffed by casual pool and nursing support, which then left the lack of resources for the rest of the hospital because they were the priority staffed from casual pool and nursing support.

Yes, so seasonally we still had a bad winter but it

didn't stop from summer. It's just been consistently higher. We've had an increasing growth in the area, they keep building more homes. We're having more people move to the area coming from Sydney. Our ageing population is still significant. At one point, I think I had 30 patients and 45 per cent of them were over the age of 90; I had two over the age of 100. So they're definitely - like, they're there and they're older and they're staying at home longer and they're refusing to get the help that they need because they want to be at home. So it's just a compounding effect. But, yes, this year has been probably one of the worst years I've seen in terms of health in Wyong Hospital.

DR WATERHOUSE: And Mr Shortis, are there flow-on effects seasonally from your perspective to community health?

MR SHORTIS: Yes, we have increased demand over winter but we have a significant demand most of the year for our services. What we found over the last couple of years is the winter period has been growing out longer and longer, and instead of starting in May, we are now kind of planning in February for winter to start in early April.

DR WATERHOUSE: I'm going to come back, as I said, to the effects on patients, the effects on staff and some of the solutions and opportunities, or options, but did anyone else have anything that they would like to say specifically about bed flows? That might be a good time to take a break.

THE COMMISSIONER: We might take an adjournment until 11.50. To those of you online, I might just leave it with icourts, but we will be back at 11.50. Thank you. We'll adjourn until then.

SHORT ADJOURNMENT.

THE COMMISSIONER: Yes.

DR WATERHOUSE: Before the break I mentioned that I'd like to move on to some things about the consequences and risks for patients.

If I can start with you, Mr Wakeling, because I understand that you still work as a registered nurse sometimes in the emergency department; is that right?

MR WAKELING: That's correct.

DR WATERHOUSE: Can you tell me, from your perspective, what issues do you see? You have touched on these a little bit before, but what issues do you see, particularly in that setting, with geriatric patients coming in and being in the emergency department for long periods?

MR WAKELING: So as I said before, the length of stay of these patients has a detrimental impact to the outcomes of these patients, but these patients need - a higher likelihood of needing a bed to start the assessment. So not having a bed makes it very difficult, and it could lead to a situation where you're unable to offer the ambulance to a safe place, therefore, the ambulance delay is not just within the KPI, which is 30 minutes, but up to hours.

I think it starts with, you know, some of the risks of complications of these aged care patients on the ambulance stretcher, which might result in pressure injuries, because the stretchers are designed to be hard; if there's a CPR required, et cetera; the bright lights in regards to risks of delirium, it's just an unsafe environment.

Certainly care does begin while they're on those stretchers, et cetera, but sometimes the care that you're trying to provide, ie, it might be a blood test, a cannulation, to give intravenous fluids, it might not be in the correct setting or location that's safe for the patient or safe for the staff member.

So in a corridor, that's not a good environment. If it's in a chair, for example, before a bed becomes available, there's a whole range of - you know, that's not best practice in regards to cannulation, the bending-over movement, there's some occupational health and risk behaviours for the staff member.

I think they're the main risks. And then, from a privacy perspective, these patients, the environment we've put them in, it might not be the most dignified location for an assessment that you're making. If it's a heart test, you need to remove the clothes and expose the body to get access to stickers and labels, so the impact of not having a bed there, because of the downstream impact we spoke to before, you might not be able to do a heart test for the patient if they're in a corridor, a busy corridor

there, because of a privacy perspective, and other tasks that require access to the private areas of a patient. Thank you.

DR WATERHOUSE: Do they tend to need more supervision in the emergency department environment and it's supervision that can't necessarily be given by the staff available?

MR WAKELING: That's correct. So especially if the patient's in the waiting room while we wait for an acute bed. Currently, the emergency departments attempt ratios of one to three, if it's an acute bed, for a nurse, or one to one in a resuscitation bed, if that's the case.

There are no ratios that occur in the waiting room. It fills up and your ratio might go to one to 20, and that certainly was the case in my last ED shift on Wednesday, where the waiting room was quite full, and there's no way a nurse can safely monitor, assess, treat or provide medications or things that the medical officer has ordered for 20 patients, let alone aged care patients.

DR WATERHOUSE: And to your point about privacy, is part of the issue that hearing deteriorates with age and therefore you might have to speak quite loudly to be asking some quite sort of intrusive questions in a very loud voice to be understood by the patient?

MR WAKELING: That's a good point and I would agree with that point. Alongside the other senses, if they've got osteoarthritis or other comorbidities that they are likely to have, a chair or a hard chair or a position might not be comfortable for that patient. Certainly Professor Potter and Rachael would be able to expand, but pain is a stimuli that triggers things like a delirium, et cetera, and vision might be impaired so they might be in a busy room with other patients or a location of chairs that might not be safe. I think that's a great point.

DR WATERHOUSE: Ms Hawkins, can I just turn to you. What are the risks in the ward environment for these sorts of patients who either can't be - they may not need acute care but they are sort of there for extended periods?

MS HAWKINS: So I guess acute conditions, obviously, compound generalised frailty of our aged care patients, but I think that - are we relating this to in terms of nursing

home patients' inability to step down to a peripheral site or to their nursing home? Is that what we're asking?

DR WATERHOUSE: That's right, yes.

MS HAWKINS: I guess the impacts on patients are that they, in our ward, require a high level of supervision, and that's because with generalised frailty they're often requiring assistance with tasks, whether that be generalised showering, medication management. I think that the compounded issues are deconditioning and physical decline, as well as a risk of delirium or acute confusion.

I guess the other issues are isolation, because they're not in their home environment, and ability for family to visit regularly, as well as risk of hospital-acquired infections and then obviously that delay in their length of stay as a result of the care needs that would result in that.

DR WATERHOUSE: What sorts of infections are you referring to there?

MS HAWKINS: More often in terms of COVID or - predominantly, it would be COVID.

DR WATERHOUSE: And what about falls? Is that a risk that occurs in the ward?

MS HAWKINS: Correct. So obviously patients, because they are not in their own environment, there is a level of supervision that's required. Due to the nature of our ward, we do have two-bedded rooms and single rooms, but we risk-manage our patients when they come up to us as to where we place them, but they are - falls is an issue, yes.

DR WATERHOUSE: Before I go to those in the room, Professor Potter, did you want to make any comment in relation to the effect on patients?

PROFESSOR POTTER: Yes, look, there's very, very clear literature around frail elderly who often all of their senses are not working to the extent that a younger fitter person would be, so that's vision, hearing, cognition, continence, speech. So in the emergency department, if you are there for a prolonged period of time, it can often even lead to completely inappropriate interventions. So if

a patient who might, if you had been able to get an environment that you could have a sensitive conversation with them about whether they wished, you know, invasive tests, whether they wished comfort care, whether they wished to be palliated at home, if you simply can't have those conversations because of the environment, they end up on a conveyor belt going through all sorts of things that they wouldn't otherwise have gone through. They might not be able to indicate that they need the toilet, they might not know that they need the toilet, whereas in their own environment, they were able to recognise these things, but there are so many external stimuli going on.

The literature is really clear: the longer you are in an inappropriate high-activity area as a frail elderly person, the higher your morbidity is in terms of infections, falls, pressure areas, but also the higher your mortality is. So if you stay in an emergency department as a frail elderly person for 12 hours, you're much more likely to die in the next week than if you didn't. So it's really quite stark. It's distressing.

As a geriatrician, that distresses me for the frail elderly people, but I've also been in the emergency department where younger people are distressed by frail elderly people calling out all the time. You know, if you're there with an acute MI, somebody yelling at you all the time is incredibly distressing, and it's incredibly distressing for the staff, who are trying their best to do the best by everyone and yet, you know, attacked on all fronts.

So I think as this problem gets bigger, it certainly has enormous impact for patients, staff and other patients in the emergency department.

Then as Rachael said for the few, you know, the small percentage of our acute geries - patients that we get to an acute geries ward - there are still challenges there, but you have to remember the vast majority are scattered throughout the hospital. They're in every ward apart from paediatrics and obstetrics. Every other ward has two or three frail demented elderly people, where the staff have no - and I don't mean this critically, their expertise is in surgery or cardiology, they have no knowledge or comfort in dealing with this patient group, and as a result, the outcomes are much worse.

We know this. We have analysed this. We have looked at this. The outcomes for our outlier patients are far worse than for the patients in our own wards. It's not just the patients and the relatives; it's the other patients in the ward who are distressed by this, the number of complaints we get about, "Why was there a demented person in the surgical ward? My surgical father was very distressed by this, there were people intruding" - and for the staff.

So I think at every level of the hospital, it just creates such additional stress, such additional burnout, and certainly I'm sure Ben will testify to this, we have lost - since COVID and since the numbers going up because of aged care facilities closing, we have lost so many staff who were elderly - well, not elderly, they were approaching retirement age but had no intention of retiring, but so many of them --

DR WATERHOUSE: Sorry, I want to come back to staff if I may, because I know that the people in the room are keen to be able to tell their experience as well. So just talking specifically about the patients and the effect on patients, can you tell me from your point of view, Ms Okulicz, what do you see as being the risks in the ward to patients?

MS OKULICZ: Well, especially if they have come in with acute delirium, they're at significant high risk of falls, they're very impulsive, they can't follow instructions. A lot of these patients, we then attempt to manage in what's called a Hi-Lo bed, so a bed that goes right down to the ground so then the patient can't get up, so if they're not supervised, they can't get up.

The issue being around that is that then if we're having a long time to review, get on top of their delirium or their confusion or work out a plan for them, they spend a lot of time in that bed, so then they become deconditioned and then they've lost their ability to walk as they did previously. So we've had people come in walking and then unable to walk again because they decondition quite quickly, and it's very hard then to get those people reconditioned, because if the delirium resolves and their confusion is ongoing, they can't follow instructions, they're not rehab-able, and then, therefore,

they end up in a nursing home because of basically what we've done to them in terms of trying to keep them safe from falls, they've now had this complication that they can no longer walk.

You've also then got patients that are spending extended periods of time in bed who are at high risk of pressure injuries, we try to do their personal care and keep them moving as much as possible, but then you've also got complications of hospital-acquired pneumonias if they're staying in for a long time as well, because they're not up moving around.

You've got increased behaviours because you don't have any diversional therapy. They're just bored. They're sitting looking at four walls all day with no source of stimulation or activity, so therefore, they go into other people's bed spaces, you're trying to redirect them, you've got no capacity of trying to provide that, and then if you've got someone that's in hospital for four months, they haven't been out in the sun, they haven't been out in fresh air, they've got that sort of impact on them as well. So they're very - they end up depressed, they've got all sorts of complications from being stuck in.

DR WATERHOUSE: In terms of the deconditioning, are you talking there about loss of muscle mass and so on?

MS OKULICZ: Yes.

DR WATERHOUSE: Is that partly a function of the limitations in terms of allied health staff relative to your surge beds and so on?

MS OKULICZ: Potentially as well, it is. Like, sometimes if you are waiting for somebody to do that, but if somebody is in acute delirium, a physiotherapist isn't going to be able to get them up, it is not safe for the patient, it's not safe for the staff, they can't follow instructions, they could be combative. So starting physiotherapy at that point isn't ideal for anybody.

DR WATERHOUSE: Ms Pickering, can you tell me about the consequences and risks that you see across the district more broadly for these types of people?

MS PICKERING: I think probably most things have been

covered, to be honest. I guess the result of all the things that have been mentioned so far is that increased length of stay and I guess then the challenges, particularly for those older people that have become deconditioned, the challenges of then finding the services that can support them if they are at a point when they can go home, because they are - I guess, as was mentioned before, they may have been walking when they came in but then they have some limitations on their mobility and aids and things are required. So then it becomes a challenge trying to match those services in the community that can actually meet their care needs if they're not at the point for a residential aged care facility

DR WATERHOUSE: Mr Shortis, by the time they get to community health, what do you sort of see about these people who have been for prolonged periods in hospital without any acute care?

MR SHORTIS: As has been discussed, we see clients that are deconditioned, they don't have the mobility that they used to, requiring increased allied health services in the community to try and maintain that. We also often see other complications of being in hospital, like pressure areas that require care and as Melissa just mentioned, difficulties in navigating their increased care needs and finding the providers to actually provide that care. There are significant waiting lists, if you are on a level 3 or 4 package, to get funding to get the assistance with your gardening, your cleaning, your nursing care, your allied health care.

DR WATERHOUSE: Would it be fair to say that if they had, perhaps, been discharged sooner, if that had been an option, then it may be easier to find carers for them in the community that have got the skills required?

MR SHORTIS: Potentially because they'd more likely be less deconditioned and more mobile and more able to resume their previous care-at-home levels prior to admission.

DR WATERHOUSE: Professor Potter, can I ask in terms of the outliers that you mentioned, just talking about the effect on those patients, can you give us some examples of the sorts of outcomes you have concerns about for those - when I say "outliers", I'm talking about patients that are in non-geriatric wards.

PROFESSOR POTTER: Can I check, can you hear me all right?

DR WATERHOUSE: Yes.

PROFESSOR POTTER: Look, they have a higher incidence of being sedated inappropriately. So where there are all sorts of behavioural strategies and specific geriatric medicine guidelines over how to safely treat dangerous behaviours or behavioural disturbance, that doesn't happen in wards where the staff are not familiar with this patient group. So, for example, the sorts of doses of a calming agent you may give to somebody who is a young person experiencing perhaps a psychosis or an alcohol or drug withdrawal, it would be about a 10th to a 20th of the dose that you would use in a frail elderly person, and we have had numerous episodes and complaints and processes and, you know, committees that we have had to form to review these things, because it's not a fault, it's not complacency amongst the staff; it's a simple fear and lack of understanding of how to treat this patient group.

That happens far more in the peripheral units. Each time an inappropriate sedation happens, you're more likely to have a fall, you're more likely to have a pressure area, you're more likely to miss a treatable medical problem. So, for example, a geriatric patient might display aggressive behaviour because they are in severe pain, they might be having a coronary event, whereas if you just run in and sedate them, you're not addressing any of the underlying problems, and that happens far, far more in the outlying wards, and that's despite attempts at education, consulting, and it's not a criticism of the staff in the outlying wards, it's an inevitability.

DR WATERHOUSE: Understood. I mean, they have their own expertise, obviously, the patients they're used to dealing with. Do you see more medication errors for the patients that are on the outlier wards?

PROFESSOR POTTER: Yes.

DR WATERHOUSE: Can you elaborate?

PROFESSOR POTTER: Along the lines of what I said, we see inappropriate use of PRN medication, so that's as required. We see the wrong doses being given. We see them being

given far too often, when it should have been given once and then the whole team called to help.

The other thing that is very clear, and this happens to our outliers a lot, because the ward they are in are struggling to look after them safely, they request that the patient - that we move them, but because there is a shortage of acute geries beds, they might move them somewhere else. Every time a patient moves, particularly if they move hospitals, you triple the likelihood of a medication prescribing error.

Every time something has to be rewritten or re-prescribed, you increase the likelihood that there's going to be a problem. Unfortunately for this patient group, they're the group that have the most ward changes, the most hospital changes, and they're usually the group who are on the most medications, so there's an increased risk at all aspects.

DR WATERHOUSE: What about in terms of having those multiple moves around a hospital, does that further disorientate people who might have dementia already?

PROFESSOR POTTER: Absolutely. Basically a dementia patient will do best in a very familiar environment with a very familiar routine and very familiar staff. So even if they stay on the same ward, the staff changing every shift creates problems. But if you move them to different wards, they don't know where they are. They can't work out where the toilet is, they can't work out where the buzzer is, and, you know, you compound that with deafness, cognitive impairment, visual inability, it just - every time you move, even if you move beds, it creates additional stresses for the patient.

DR WATERHOUSE: So, to be clear, you've got a patient who is in a hospital, sort of as a safety net, effectively, because there's nowhere else for them to go, but they don't need acute care, but they're in a setting where they're at increased risk of behavioural disturbance; is that correct? If you can just say and agree with me rather than nodding because the transcript needs to pick it up.

PROFESSOR POTTER: Yes.

DR WATERHOUSE: And they are at increased risk of falls

and pressure injuries and other hospital-acquired complications like that?

PROFESSOR POTTER: Yes. Absolutely.

DR WATERHOUSE: Are those outliers also at increased risk of different types of infections?

PROFESSOR POTTER: Yes, they are. So if you are not familiar with a person's bed, bladder and bowel routine and you are not then toileting them in the way they were being toileted, they end up with more soiling incidents, more constipation incidents, which leads to more urinary tract infections, which leads to urinary retention, which then leads to kidney failure. So it just goes on and on and on.

If you're not familiar with somebody's swallowing capabilities and they've moved wards, the modified diet they were supposed to get is much more likely not to reach that patient, so they will be given a different meal by somebody else, they will feed themselves and are more likely to aspirate and have a pneumonia. So it just happens at every level.

I think the other thing that has been documented, and is very sad but true, every time you move wards, you're more likely to lose your dentures, you're more likely to lose your hearing aids, and so all of these things just compound a frail cognitively impaired person's ability to cope within the environment.

DR WATERHOUSE: A lot of those things that you're talking to there are about a loss of dignity, et cetera. Do you see mental health conditions like depression developing in some of these elderly people who are being moved about?

PROFESSOR POTTER: Absolutely. The depression - the incidence of depression in frail elderly, in the first place if you take them from their home environment and have to admit them, it goes up. But the more moves they get the more disempowered they feel, the higher the depression rates are.

In addition, unfortunately, frail elderly never present in a typical way and, as I said, it's very difficult for a changing staff to actually pick up subtle differences in a person, and so not only are they more

likely to get depressed, it's less likely to be recognised.

DR WATERHOUSE: Now, I may have misheard you before and please correct me if I did. Did you say that if somebody waits for 12 hours in an emergency department, they are more likely to die in the following week? Is that correct?

PROFESSOR POTTER: Yes. There's good literature that your incidence of delirium goes up the longer you're in the ED. This is for patients with underlying cognitive problems. Your risk of pressure areas goes up - as Ben pointed out, the trolleys are not designed to be pressure-relieving mattresses, they're designed to allow treatments to occur. The risk of falls goes up and the risk of continence episodes goes up, and all of those carry a morbidity with it and carry a delirium risk with it, and all of those things increase your mortality.

DR WATERHOUSE: But, to be clear, they are not dying necessarily from the acute condition with which they may have presented --

PROFESSOR POTTER: Oh, no.

DR WATERHOUSE: -- they could be dying from one of those other hospital-acquired factors, if I can put it that way?

PROFESSOR POTTER: They are, and the longer they're in the wrong place, the risk of hospital-acquired complications goes up and the risk of mortality goes up.

DR WATERHOUSE: Does anyone else want to make a comment about that aspect, not specifically to the 12 hours in ED, but more generally about the effect on patients that you see?

Maybe if I could start with those online, Mr Wakeling or Ms Hawkins?

MR WAKELING: No further comments from me, thank you.

MS HAWKINS: No further from me, thank you.

DR WATERHOUSE: And from those in the room, anything else on the effect on patients of these issues?

MS OKULICZ: No, I think everything has been covered.

DR WATERHOUSE: Okay. If I could then move on to look at the impacts on staff, and I might start with you, Mr Shortis. Can you talk us through about what you know of the impacts on community health staff of these patients that they're having to deal with who are very deconditioned and very - perhaps have been set back through the long time they've spent in hospital?

MR SHORTIS: So with the patients who are deconditioned, they'll often, as we've spoken about before, have pressure injuries and wounds like that that the nurses are treating, but to treat the deconditioning they will often need a rehab program, Rehab in the Home, by some of the allied health staff.

Allied health is, predominantly in my district, for the Kinder community funded through the federal My Aged Care system, and there are significant wait lists for that. So clients will be discharged. They'll have needs. They might wait up to a year to get to see a physio or an OT to start the rehab program to get them back up to their previous mobility. The staff triage and monitor the patients as best they can and prioritise them but there are significant waits for these clients to get the care that they require.

DR WATERHOUSE: Do you find it difficult to recruit staff into these sorts of positions?

MR SHORTIS: We do find it difficult to recruit staff. We find that for part of the way that NSW Health manages these contracts, they're actually contracts for staff. So as a nurse prior to coming into community, most of the nurses that I worked with were not on contract positions; they were permanently employed. In community, a proportion of my nurses are on contracts and a significant number of the allied health staff are on contracts. What that means is they come and stay with us for a while, they get the skills, then they're looking for a permanent position, so we end up having a bit of a turnover in staff wanting that security of a permanent job, so it does affect our recruitment and retention.

DR WATERHOUSE: What about burnout, is that an issue within your staffing?

MR SHORTIS: Not an issue that I have noticed. We tend to have quite a supportive environment and the staff are able to - when they see the clients, they always provide the care that is required.

DR WATERHOUSE: So when they're leaving, it's more because they're looking for a permanent position and you can't offer those; is that correct?

MR SHORTIS: Yes.

DR WATERHOUSE: And why can't you offer those permanent positions?

MR SHORTIS: My understanding is it's a district/ministry decision that as the contract is temporary, the positions attached to it are temporary as well.

DR WATERHOUSE: So when you say "the contract", that's the contract from the Commonwealth Government paying for the service; is that correct?

MR SHORTIS: Correct, yes.

DR WATERHOUSE: Ms Okulicz, can you tell me about the effect on the staff in your ward? You have already mentioned having some fairly challenging NDIS patients in particular, and I suppose some of the aged care ones as well, and needing security, but for your nursing staff, what is the effect on them?

MS OKULICZ: Well, the burnout and - because they are doing significant amounts of overtime. I've got some staff that are doing, like, 40 hours of overtime a fortnight each. Then you've also got the psychological impact of turning up every day knowing that there's behaviourally challenged patients that have been physically violent towards them. Many punch, kick, slap, scratch. I've been punched multiple times this year myself. I've got a staff member that's off on workers comp after being punched in the face by a staff member - sorry, by a patient.

DR WATERHOUSE: I think that might be a different issue, if it was by a staff member.

MS OKULICZ: No. She's off on workers comp at the moment after being punched in the face and having her arm pulled.

I have another staff member that just last week had significant scratches down their chest because of a patient, and they just have to consistently go in and deal with these and try to verbally deescalate where they can, because these patients still need washes, they still need their pads changed, they still need their medications given, they need their observations attended to. They just still have to go in there and - they work out whether they need a buddy system, whether they need two people. Some patients require four staff to do their personal care, so we rely on the patient support assistants to come and support, because you can't have four nurses in one room because then that's away from there.

So, yes, recruiting to geriatrics can be challenging because everyone knows it's not the glamorous one and it is challenging. But I've been thankful with the staff that I have got and they sort of just get in and get it done. But the sick leave has been consistent as well because they are tired, they are burnt out, and their families are taking the toll as well because they're doing so much overtime and that. But yes, it is a challenge.

DR WATERHOUSE: Do they express to you concerns about the fact that, "This is not nursing, this is not what I was trained to do and spent all of those years studying to do", the types of care they're having to provide?

MS OKULICZ: Not so much. More the issue is about being staffed appropriately. So consistently having to work short, that's their main concern, because again, trying to find six staff a day isn't always feasible, so you are consistently working one to two shifts down, whether that's one nurse or two nurses down. So that's their main concern, is being staffed appropriately.

Then if you've got those extra challenging patients, then they require a one-on-one nurse, so then you've also got the psychological impact of having to sit with this patient by yourself and having to be prepared to call for help, because these patients are a danger to themselves and others. That's why they need the one person with them, so they've got that challenge as well.

If you've got one confused patient, then you only get - you don't get any additional staff, if you've got to provide that one to one, so that then takes nursing hours

away from the rest of the patients. But if you've got two or more, then you can request additional staff, if two or more patients require one to one.

DR WATERHOUSE: When you're having those patient specials or the one-to-one nursing, does that tend to be an assistant in nursing or a more junior nurse?

MS OKULICZ: Typically, yes. Sometimes there's a clinical reason that you have to put an EN or an RN with them because they've got a higher skill set, but usually it falls to the AIN, unfortunately, because the RNs and ENs need to be freed up to do all the medication administration and all the other technical stuff for the rest of the patients.

DR WATERHOUSE: Obviously, it would be a terrible thing to be punched in the face by a patient, or by anyone, but by a patient, which is the concern we're talking about now. Do the staff report feeling supported by the system and by the hospital generally in terms of the way that they are enabled to deal with something like that or the scratches or other injuries we've discussed?

MS OKULICZ: Not always. I think they feel supported by me, because I do my best to support them and they know that I will go out there and get in the thick of it with them, but I think they don't feel supported when, like, you've got multiple challenging patients and then they want to admit another one, but then you don't have the staffing or the resources to manage that as well, and so you request that one to one or you request the additional staff because of the increased behaviours, and you are told, "No, there's no resources. You have to take this patient. We're not giving you any further staff to deal with it."

DR WATERHOUSE: Okay. And with the fact that you don't get additional medical staff, I'm thinking junior medical staff in particular, do you find that by them being more stretched across a larger cohort of patients, it means they have less time to give on the ward helping you to manage some of these issues?

MS OKULICZ: Yes. So we have a system where you can request a JMO consult through the computer system and they're supposed to regularly check their tasks. But it could be hours before a doctor is free to come and do that

or if the medical team is rounding with all their patients, then you're paging them, going, "We've got an issue, you need to review these medications", or "This patient has an issue", it could still take a time before they come to you. They try to review as best they can over the phone and give instruction if they can't get to you, but, yes, there can be limitations on getting medical support.

DR WATERHOUSE: Before I go to those online, Ms Pickering, did you want to add anything?

MS PICKERING: I was just going on add from a community perspective, with the effect on staff, we are seeing more complex patients being discharged out into the community, and I guess it's a shift from probably what was five, 10 years ago. Patients that would have received a certain type of care in the inpatient setting are now being pushed much earlier into the community context because of the bed pressures, and we are now seeing our community staff are needing to be trained and receive education in areas that they have previously been unfamiliar with, and I guess with that, it takes time.

We're also seeing, I guess, a larger number of referrals coming through, through to the community, and what that results in is the teams having to reprioritise almost on a daily basis to ensure that they have a reasonable workload each day to meet the demands of the patients they've got on their books, but as a result, some patients are being put off or being encouraged to self-care, with the nurses a phone call away, which is not always ideal, depending on their care needs.

THE COMMISSIONER: Just pausing there, I think I know by now, but just to be sure and for the transcript, when you say, "we're seeing more 'complex patients' being discharged out in the community", can you give me some examples of what you mean by "more complex patients"?

MS PICKERING: Multiple comorbidities, multiple care needs. It may no longer just be the simple wound care that the nurses are going in to provide care for. The nurses are also identifying the decreased mobility, the other factors that are a risk factor for someone in their own home, and so they're needing to reach out to many services to ensure there's care wrapped around that person to try and prevent a hospital presentation.

THE COMMISSIONER: So a mix of various illnesses but also risks?

MS PICKERING: Absolutely.

DR WATERHOUSE: Given they're being moved out more quickly than perhaps they used to be, and obviously with the community support, do you find there is an increased risk of readmissions with people bouncing back because they weren't quite ready?

MS PICKERING: Yes, there is. We do try, on the Central Coast, we do have a follow-up phone call service. So for people over the age of 65 that have been discharged from one of our hospitals, we do have some enrolled nurses that will conduct follow-up phone calls within 48 hours, and the purpose of that is to, as much as possible, try and ensure that our older people have managed to get an appointment with their GP as a follow-up, and that they've actually managed to get to a pharmacy to get their medications that are required, and so if that has - if the answer is no to those, then health will come in to try and help facilitate and ensure that those things have occurred.

DR WATERHOUSE: Sorry, Ms Okulicz?

MS OKULICZ: Just in terms of readmission, in terms of our older persons, the impact of that, so we have a lot of patients that again refuse - even though it's identified that you probably won't manage at home and you should probably have 24-hour care, they're adamant they're going to go home, so it's called a high-risk discharge. We explain all the risks to them about going home. We try to put as many services or supports in place to give them the best chance of being at home, but they will go home and within two to five days, they haven't coped and they will come back to hospital. So then we've got to start the whole process again, because they - they're just adamant they want to go home and they have no interest in going into a nursing home, and they have capacity. So therefore we have to honour their requests, but it just means a re-present.

We can be doing this with one person multiple times a year because they're adamant they're not going to go into care. They will go home for a few days, they'll come back

to hospital for a three weeks, they'll go home for a few days, they come back to hospital for three weeks. Like, it's a vicious cycle.

DR WATERHOUSE: Do you ever try like a gate leave approach whereby you see if they can manage at home but they're still technically admitted to the ward, they haven't been discharged?

MS OKULICZ: Not so much from my ward. I know rehabilitation do that to assess them in their own home, but not from us. We try to do as many assessments as we can in the hospital, like simulating their environment in terms of how many stairs they've got, how wide their hallway is, can they have a four-wheel walker, do they need a stick, making sure - going through all of those assessments, that's more what we do.

DR WATERHOUSE: And that again would depend on having operational therapists and so on to make those assessments.

MS OKULICZ: Correct.

DR WATERHOUSE: Yes, Ms Pickering?

MS PICKERING: If I can just add to that, we do have on the Central Coast a transitional care unit. So for some of those older people where there is a goal that's quite achievable to try and help them to return to home safely. There's that 12-week program that could either be in the home as a package, but we actually have an inpatient area and they will do some gate leave or support an older person to go home for a period to see how they manage with the view if they need to return and it's still within that time frame, that they can return to the transitional care unit.

DR WATERHOUSE: Thank you. If I just go to those online, Ms Hawkins, can you tell me what is the effect in your wards, on the staff, that is, of these patients, particularly those with the challenging behavioural issues that you've mentioned but no acute need?

MS HAWKINS: I believe that there have been quite a few things that have already been touched on, which would be relevant to our area as well, but I think for our aged care patients, the majority of the time, what they're needing is time. They're needing time and assistance. And what that

means is that those additional duties or additional tasks, which may result in needing assistance with feeding or to assist in terms of equipment or additional staff to perform that care, in terms of if there's incontinence and additional toileting needs, there's additional time that is taken and required, and that's notwithstanding in terms of behaviours of concern and the appropriate care that results from that. I think that there is, obviously, the emotional and physical demands that result in that, and there is - sometimes where there's a one-to-one need, we have what's called a - there are forms that we need to submit to be able to get nurse specials.

Oftentimes, the behaviour needs and requirements of our patients don't meet the triaging tool that would mean that a nurse special would be indicated, so we're having to look after those patients within our numbers.

At the moment we have a few patients that are requiring one to one care. What that means is that the, I guess, emotional and physical demands can increase fatigue.

There are also the concerns in regards to, you know, sick leave and staffing shortages. We do try and manage that as best we can, but it's also - notwithstanding on our core patients that we have on our ward, but it's also the impact on staff on our outlying wards, having to look after patients that they're not familiar with in terms of the behavioural and nursing management needs of those patients, but also on the medical staff, when, from an environmental perspective, you've got your patients on our wards, for example, that are under geries, and then on outlying wards it is the physical distance that our doctors are having to travel to be able to round on those patients and the delays in time from having to travel over a wider footprint, for example, at Wollongong Hospital. Doctors may need to travel between, you know, six or seven wards to be able to see all of their patients so that's obviously resulting in delays then, which may impact in terms of doctors' abilities to complete all their tasks within their work time. I think that covers that.

DR WATERHOUSE: Do you find that the staff on those wards where there are outlier patients are reaching out to you and your colleagues for advice about how to manage some of these complex behaviours?

MS HAWKINS: Yes, so we've also got our aged care CNC that's on site as well, so in terms of complex behaviour management they do defer to our aged care CNC in that regard, given the fact that I have worn a bit of a dual hat in terms of nurse unit manager of the aged care ward and also the aged care navigator, I do get contacted from time to time in regards to the care planning of those patients and the intricacies about care pathways - so whether they are going to be discharged home with service packages or whether they're going to go to residential care. Often nurse unit managers and/or core staff will give me a phone call, and I can chat through them, and I'm happy to do so, but yes, I do get contacted.

DR WATERHOUSE: Thank you.

Professor Potter, you're the sort of doctor in this space and a senior doctor and you obviously see the effect on staff. You've touched on this before a little, but can you just go into more detail now about what it is that you see as the impacts on both medical staff and other clinical staff?

PROFESSOR POTTER: Okay, particularly with medical staff, the junior medical staff in the last three years, as this problem has been mounting, are completely distressed. I regularly have staff, young doctors, who are just coming into medicine, in tears at the end of shifts, doing lots and lots of overtime. They ultimately have more sick leave. They feel discontented. Our senior doctors have great empathy towards them but feel that they're getting an awful experience of what geriatric medicine is.

So if you're in a particular geriatric medicine ward with a multidisciplinary team and a NUM and nurses who understand geriatric medicine, your experience as a junior doctor is one of empowerment. You understand how to look after these people.

Our poor doctors are trying to see their cohort of 20 patients and they're going into eight, nine, 10, 11 wards, where they're trying to find a nurse unit manager who can't really tell them anything about the patient, they're seeing terrible outcomes. They feel like failures and they don't want to do geriatric medicine anymore, and given the majority of the admissions are an ageing

population, that's an awful thing.

For our senior doctors, that's incredibly distressing as well. They don't like that our junior doctors see other medical teams sitting having a coffee and a debrief with the staff, where we're still going round at 7 o'clock in the evening.

So that's terribly demoralising both for the specialty going forward but particularly for these young doctors where this is their first experience. You always hope that having done a term in geriatric medicine you will feel empowered to deal with these challenging patients, and that's what we aspire to, and, unfortunately, that's getting more and more difficult to guarantee.

So that's the main thing, is the terrible burnout and distress amongst the juniors, which, as a senior doctor, that's a horrible thing to deal with. You really don't want to be responsible for your service creating that in a junior.

But I also would extend that to the nursing staff, the allied staff, the visitors, the other patients where these patients are not being looked after in a way that meets their needs and amps up the distress, because everyone else in the ward feels that. Everyone else in the ED feels that. It just creates a sensation of distress throughout the hospital.

DR WATERHOUSE: With the junior doctors and, I suppose, senior doctors as well, do you have consultation with colleagues in other hospitals and districts to see whether they're having a similar experience, and is it similar, or is this a particular issue in Illawarra?

PROFESSOR POTTER: It is particularly an issue in the Illawarra. I don't doubt that 10 years from now, if something drastic doesn't change in the Commonwealth residential aged care system, it will be the same for everyone, and I sincerely hope that this Inquiry actually results in some sort of change, but at the moment, it's particularly a problem for the Illawarra.

Nowhere else - and I have looked - nowhere else has had anything like the aged care failure, market failure, that we've had. It's really quite remarkable. As I say,

at the moment we've lost more than 600 permanent beds and the projections are that that's going to go up to 1,000, and nobody's looking to producing those beds again. So it really is a stalemate and a real sharp focus in the Illawarra.

Hopefully, we can use that to the good and actually become an area where we might be able to show what we can do differently, and we're definitely trying very hard to do that. But definitely, I don't think it's as much of a problem elsewhere, and that combined with what I said before about the college not recognising that you could do all of your advanced training down here. If you've had two years down here under that that level of pressure, even if your kids are at school down here, and you go up to Sydney and everything's so much calmer, you're not going to come back, you're going to stay there and move your kids.

As somebody who came out here from Scotland 20 years ago to build up geriatric medicine, we were doing brilliantly up until four years ago and we're just going backwards rapidly, which is really disappointing.

DR WATERHOUSE: When you refer there to "the college", do you mean the college of physicians?

PROFESSOR POTTER: Yes, HETI and the college of physicians. Royal College of Physicians, we recently had accreditation. We get accreditation every five years. When I first came here we had no accreditation for geriatric medicine. We now we have accreditation for training up to eight advanced trainees in geriatric medicine.

However, despite the fact that we've got 15 supervisors, nine sites, we cover things like Aboriginal communities, we've got a vast difference between rural, regional, urban. You know, we can offer everything and we have the supervisors. The college still don't see that, you know, the difference between a term in Sutherland at St George is not - that that's different enough to count as a separate term, whereas the difference between Nowra and Wollongong is no different at all.

That's very disappointing to get that sort of city-centric view. Given that the population are retiring to the rural and regional areas and that they're ageing

faster there, I would have thought that we could look at that and come up with something. So we keep trying. We're constantly, you know, lobbying and asking and explaining what we can offer down here, and the feedback from our trainees, despite the stress, is overwhelmingly positive about what we're giving them. But we haven't as yet been able to change that mindset.

DR WATERHOUSE: Given that there is ageing of the population, do you think that this is something that should be a focus for other colleges as well, not just those that train geriatricians.

PROFESSOR POTTER: Absolutely. As I pointed out earlier, patients who go to surgical specialties, all specialties apart from paediatrics and obstetrics, they are now taking much older patients than they did 20 years ago. Twenty years ago, if you presented to hospital with a cardiac event and you were 90, you would have no chance of getting into a coronary care unit. Now you'll get every chance of getting into a coronary care unit.

However, what happens then is the coronary care unit fixes whatever needs fixing in your heart but they then cannot deal with any of the rest of the patient. So our consult numbers in the last four years have gone up from about 25 a week, to other teams, to over 60 a week. We're asked all the time to solve this patient who is in the cardiology ward, solve this patient who is in the respiratory ward, and particularly the surgical wards, you know, our surgical trainees - it's becoming more and more operation specific, you know, procedure specific, not holistic as in the whole patient. But unfortunately, as they're doing these procedures in older and older patients, the patients' needs are multifactorial with multi-comorbidities that the surgeons are not trained to understand and nor do they choose to.

I think the problem is developing and I have no doubt it will become an all-of-Australia problem if we don't change what we're doing at the moment. But as I say, I'm eternally optimistic that we will.

DR WATERHOUSE: So to give an example, perhaps, if a person comes in with a fractured neck of femur, an elderly person, with perhaps a number of comorbidities, is it the case that the surgeons will fix the fracture and

then want to hand it over to the geriatricians to patch up other things and improve medications and so on and so forth?

PROFESSOR POTTER: Yes, that's a particularly good example because that has been the case and been recognised as the case for more than 10 years now. As a result of that there is now an established - the whole of Australia and New Zealand have a hip fracture registry where it's a best practice, and recognised best practice, with audited results, that you have formal shared care for fractured neck of femur in elderly people.

The other thing that's happening in Wollongong Hospital is we have formal shared care with surgeons and pain specialists for blunt - with rib fractures for elderly. So that's been recognised in those areas, and it's been staffed in those areas and it's working well and it is audited and peer reviewed. However, we now see patients having vascular procedures, you know, abdominal aortic aneurysm ruptures in their 90s being operated on where that wouldn't have happened before.

I'm not saying it shouldn't have happened, but we need to have the staffing and the mix of skills to be able to look after those patients, not just get them off the operating theatre alive. That's not the goal. We need to actually get them well enough to leave the hospital, otherwise we shouldn't be doing the procedure.

So I think there's a lag. It has been recognised in orthopaedics but it really has not been recognised yet in any of the other specialties.

DR WATERHOUSE: I know Ms Hawkins wants to say something but I want to ask you one other question about junior doctors. Is it fair to say that even though a lot of these patients are no longer requiring acute care, the junior doctors still need to be very actively involved because they have to deal with medication errors, assess them if they fall, and so on and so forth? So they're still having to be very involved even though the person is not acutely unwell; is that correct?

PROFESSOR POTTER: That's absolutely correct. So although they're not acutely unwell and they've got over their acute problem, as long as they're in a hospital environment

that's not appropriate to their needs, they have much higher hospital-acquired complications, so they have medication complications, they're more likely to fall, they're more likely to have urinary infections, continence issues, so the junior doctors are still having to do as much work with that patient group as they would be, and in fact, in the acute phase it's actually much more straightforward because you've got a protocol to follow, whereas it's all these other little comorbidities that are popping up that cause these other problems.

DR WATERHOUSE: Ms Hawkins?

MS HAWKINS: I was just going to say in support of Dr Potter when she was talking about the demand on the consulting service of geriatricians at Wollongong Hospital, typically when a patient not admitted under the care of a geriatrician is requested to be consulted, at times it's when the presenting problem of that patient is complete and it is more so for the complex discharge planning care needs of the patient that is over the age of 65, the geriatrician service is then requested to consult.

Typically, they will accept that patient, which then will result in that patient needing to be bed boarded for GEM, which is geriatric evaluation and management, and that will typically result in a patient being bed boarded peripherally for either Shellharbour Hospital or for Bulli hospital for that level of service, which then obviously results in bed block of those patients within the acute wards.

DR WATERHOUSE: Sorry, is bed boarded when they're put on a list to go to another bed or another hospital?

MS HAWKINS: Correct. It's when they're requested to go to another hospital, yes.

DR WATERHOUSE: I'm going to move on to some of the other actions that have been taken and the other possible solutions, but before I do, are there some more things to be said? Sorry, Mr Shortis?

MR SHORTIS: I just wanted to go back to something that we mentioned before. We spoke about whether I had seen burnout in my staff, and that's not something I have actual experience of, but listening to the conversation, the

environment that I work in is different, and Melissa has mentioned this, we have some ability to rearrange our workload to some extent. So I suppose whilst I don't see burnout, what I see is different. As a manager I'm often trying to manage my staff to get out of work on time because they're wanting to provide the gold standard care and ensure everything's been done, whereas what I'm doing is making sure that the care that's required, that's absolutely required, is provided, not the stuff that makes everything else better for the client.

DR WATERHOUSE: Anything else you wanted to add? No. Okay. Looking, then, at some of the actions taken, I might start with Mr Wakeling.

Can you talk us through any actions you know of, particularly about NDIS patients, obviously we'll come to the aged care but I want to make sure we don't lose sight of those types of patients. So what actions are being taken by the district in relation to those delays?

MR WAKELING: Specifically for the NDIS, I can't comment. I'm more focused on a broader comment. So the first thing that we would be doing is we've changed the bed base of the hospital or the layout of the LHD, if that's - is that relevant back to your question?

DR WATERHOUSE: Yes.

MR WAKELING: Then I will continue. Yes?

DR WATERHOUSE: Yes, sure.

MR WAKELING: I will say Illawarra in particular has a large amount of hospitals. A lot of those are, you know, historical, because of the coal mining that occurred in the area, they are all 100 years old. Linking back to some of the other comments of the other panel members, including Professor Potter, moving patients between these very small hospitals is detrimental to the patients' outcomes, and from a financial perspective, a lot of these hospitals are at a bed base of, you know, 40 to - some are 20, they just do not make economical sense from a bed-base perspective.

But what we've done is we've turned Coledale Hospital - in 2022, we converted that from a rehab hospital to purely a maintenance hospital that specialises in aged

care and specifically for patients that are awaiting aged care, with dementia, that are wandering or aggressive, like the panel members have mentioned. So that's a 38-bed purpose-built unit for those patients.

In November 2023, we had further bed block occurring, so it was increasing, like Professor Potter said over the last four years, so then we outsourced more transitional aged care beds, 20 more, to Figtree Private Hospital, and then a further six to 15, where we flex up and down with Shellharbour Private Hospital. So Figtree, a Ramsay Health Care provider, Shellharbour a Healthe Care provider.

Then in June 2024, similar to what Rachael mentioned, we had to respond to the winter, where we ran out of surge capacity, and that was impacting our emergency departments to function and our offload of ambulance. So we opened further surge beds at C7 east at Wollongong Hospital, the ward that Rachael manages, a further eight beds at Shoalhaven Hospital, just for residential aged care maintenance patients.

I think, really importantly, these beds aren't funded, they're not planned, they just had to occur, and they're heavily reliant on casual staff. So the plans would be to change - to close those surge beds if the external factors improve, but at this case, I don't see that happening in the short term.

Other changes that we are making are bed-base changes where a specialty may not need as many beds with the footprint that they've been given and the staffing cohort that has been allocated, and increasing the bed base for specialties like geriatric medicine, like Professor Potter said, to cope with that influx of demand that's occurred over the last few years. That would be my comment on what we're doing in regards to bed-base changes.

DR WATERHOUSE: Do you meet with resistance from those specialties if you try to take away part of their bed base because they want to preserve it?

MR WAKELING: I would agree with that and I would say that behaviours may occur to retain the occupancy of that bed base, so the discharging may be prolonged to make sure that the occupancy stays the same. We would benchmark that length of stay compared to similar specialties across

New South Wales or Australia, to see if that is an inefficient service from a length of stay perspective or an efficient service, but, yes, we would encounter challenges.

DR WATERHOUSE: Just to make sure I understand that correctly, what you're saying is if another specialty feels that they may have beds taken away, they tend to make sure those beds keep patients in them and they don't discharge people so that it will make them look busier but that, in fact, is inefficient relative to their peer hospitals; is that what you're saying?

MR WAKELING: That's correct, yes. What we would encourage is innovation or new models of care. So the one thing that they might be worried about is the funding of their specialty. They may not want a physical bed footprint but they would want to maintain the budget that's provided to that specialty, so we would encourage a different model of care, and that certainly is a focus at Illawarra Shoalhaven, models of care that don't have a hospital bed footprint.

DR WATERHOUSE: So what you will say to that department or specialty is, "The budget is ring-fenced. We've removing some of the inpatient funding. We'd like to divert it to some sort of innovative non-inpatient type arrangement or model of care"; is that what you mean?

MR WAKELING: That's what I mean. So we would encourage the movement to more outpatient clinics, for example, or more home-based services that might still be managed by the LHD and that specialty, alongside primarily allied health or nurses as well, but it's just outside the hospital environment.

DR WATERHOUSE: Professor Potter, I understand that for the outliers you do regular ward rounds across the hospital to try and help manage those, which is obviously a model of care. What other sorts of innovations have you tried to introduce to deal with the challenges?

PROFESSOR POTTER: There have been quite a few, actually, and some more successful than others. Right up-front I would have to say that our chief executive has been incredibly supportive, so much so that we put up models of care which we were promised funding for, which we have not seen the funding for, which is having a negative effect on

our bottom line, which we're still persisting, because they are having good clinical outcomes. So the main one about that is we developed an aged care outreach service, so that - like a flying squad. So we've got a nurse practitioners, geriatricians, ordinary level registered nurses and AINs, and we are now - we've had that running for more than a year now. In the first year - and that's purely to support residential aged care and we focused on preventing ED presentations.

So for the first year of that team - we've only got it in the Illawarra, we don't have it in Shoalhaven yet. The first year of that there were 7,000 referrals to the service from residential aged care of which we were able to give advice to maintain patients in the facility for 5,000. We actually physically went out and visited 2,000, and for 90 per cent of those patients, we prevented an ED presentation. In the 10 per cent that still required to come to hospital, for 2 per cent of those, we were able to negotiate a direct admission and bypass the ED, so we're preventing that 12-hour spell where the patient will deteriorate.

That model of care is fantastic. We're getting great feedback about it. The staff members are getting great satisfaction out of doing it. The families are loving it. What we would like to do is expand the funding for that so we could support aged care facilities at the early discharge from hospital and with difficult behaviours rather than just focusing on ED. We would also like to roll that out to Shoalhaven. That's probably the main thing. We've also put an ED --

DR WATERHOUSE: Sorry, I just want to ask you a little bit more about that outreach service. So the referrals are made by aged care facilities to the service?

PROFESSOR POTTER: Yes.

DR WATERHOUSE: Are they patients that they just have queries about or is it somebody that they're about to call an ambulance and send them to hospital?

PROFESSOR POTTER: Originally we worked with our extended paramedic ambulance as well. Originally the criteria was somebody you're about to put in an ambulance and either the aged care facility would call us or the extended paramedics

from NSW Ambulance would call us.

In fact, as they realised that we were responsive, and we're running seven days a week until 10pm at night, so as they realised that we were actually a lot more responsive and available than the GPs that they might be able to access, they started calling us about everything.

So the first year, we had to really do a lot of counselling and things with that, and say, "That's not" - you know, "We're a limited resource, we're focusing on ED." So we worked with them over the year and it's got a lot better, the referrals have got a lot more appropriate, and as I said, the feedback has been really good from families and patients.

We tried to link in with the GP as much as possible but one of the things that became apparent with that service is there really is a problem out there with GP provision to residential aged care which, as I said, there are new models coming through from the Commonwealth that might improve that. So we do want to try and expand that further down to Shoalhaven and also expand the remit further so that we can support other things. So that's been a great success.

Will I go on to other initiatives?

DR WATERHOUSE: Yes, please do.

PROFESSOR POTTER: So we've also put an ED navigator, so a bit like Rachael being the aged care nurse navigator, we have an emergency navigator in the emergency department at Wollongong Hospital, and they have expanded to working with our outreach team, our flying squad, so that if there's somebody who has actually got into ED that is from an aged care facility, they will liaise with the flying squad in the morning and say, "Could we take them straight back to the facility and you will support them there?" So again that's helping, that's working as well and that's been a good thing to do.

As Ben mentioned, we've expanded our Commonwealth supported places into the private hospitals, so we've got some extra beds there, but it's a drop in the ocean. There is, on average, 150 patients waiting for placement, and that's 20 beds. It's not really going to solve it.

The Bulli urgent care centre, which Ben spoke about earlier, is predominantly VMOs and a nurse practitioner model of care. It's helpful in that it is preventing other things attending ED. So it doesn't help our frail elderly people but it does help the whole picture.

We've also got - the things that Ben was talking about with virtual care, we have encouraged other departments to expand that so that their inpatient requirements are less.

We're trying to do some collaborative commissioning work with the private health care network looking at specific diagnoses of discharge to see whether we could support them in the community with specialists liaising with GPs, and that's working for things like chronic obstructive pulmonary disease, but I see that, in the future, that could work with dementia or frailty or falls risks, so that's something we're trying to explore.

We've had a lot of high level meetings with state and Commonwealth which - we're not getting there yet but we're floating things and we're trying to. We recognise that there's a lot of Commonwealth funded initiatives lying in residential aged care where, although the funding sits with the Commonwealth, they don't actually have the means, you know, if the aged care providers are not going to open homes there's nothing very much the Commonwealth can do to force that.

We're trying to suggest that perhaps we could open some facilities. There's a disused facility that has not been knocked down or sold in our area. We said, "If we could staff that, would you fund it?" So we're looking at things like that. Is there some other way to get some aged care beds? We've asked whether we could look at some of our current hospitals, our peripheral sites, where we are just full now of dementia-specific patients, could we actually get the Commonwealth to give us the funding for that so that we could open the acute beds that we've lost elsewhere, as part of the planning for new builds?

These are the sorts of things we're trying to do. Varied success with our flying squad, success with some of the other models in and out of ED, not yet definitely seeing the funding for those, but we will keep pushing, but other models that we want to try and support the

Commonwealth to act together, where the Commonwealth provide the funding but we actually make the thing happen, you know, we're optimistic that we might get somewhere with these things but as I say, at the moment because Illawarra Shoalhaven is usually at the pointy end of this problem, we're trying to turn that around from a disaster to an opportunity to see whether we can actually get Commonwealth on side to say, "Well, this is the amount of money we're not spending on aged care facilities in the Illawarra. What can you do with it to make it work for the rest of the hospital and for that patient group?" And I think that's the main things that - oh, there's one or model that the Commonwealth is funding, that's called special care dementia funding, and that's now running for nine beds in the HammondCare in our district.

So Commonwealth fund HammondCare to provide the service. HammondCare contract with Illawarra Shoalhaven and we provide a geriatrician and we provide specialist training for - actually forensically disturbed dementia patients. So where the behaviours are terrifying and so awful, we work together with HammondCare to train HammondCare, to train the nursing staff and to look at trying to get some of these patients well enough to go into mainline residential.

I've also floated an initiative for the future with the University of Wollongong to see whether, because of all these models that we've got, could we look at opening a training centre to empower GPs, nurses and allieds to know how to work with dementia patients. Again we haven't got off the ground with that, but we're trying to put all these initiatives out there.

DR WATERHOUSE: I want to hear from some others.

I'm mindful of the time, Commissioner, are you happy for me to continue? I probably just have a few more minutes, I think.

THE COMMISSIONER: Yes.

DR WATERHOUSE: Just one thing before I move to the others, can I clarify in terms of your conversations with the Commonwealth, how have you actually been able to facilitate those? Has that been done sort of at an executive LHD level, paving the way, or have you just

approached the Commonwealth directly? How does it work?

PROFESSOR POTTER: No, we've been working very closely with our CMO, - what's the word - CE, our boss, Margot Mains. We've been working very closely with Margot and she's very on side with everything we're attempting to do. She's taken it up via the ministry, the ministry have approached the Commonwealth, and we've now got a series of workshop type meetings.

We keep doing one step forward, two steps to the side, so we're not quite getting there yet but at least we've opened a door, we've got a dialogue going, we've floated some suggestions. So, you know, we remain optimistic and we're trying very hard and as I say, I think from a NSW Health perspective, if we don't do something about this problem, we've audited what we're doing, we're not creating the problem, the problem has been created, so if we don't start doing something differently, this is going to become a problem for all of NSW Health. So I think, you know, we need to keep this dialogue going and see what we can do, but we've been very well supported by our CE.

DR WATERHOUSE: Thank you.

Ms Pickering, I'm just interested to know what sorts of strategies, like outreach, for example, have been done in the Central Coast?

MS PICKERING: Sure. On the Central Coast, there's a number of strategies that we have put in place. We do have what we call the virtual care and triage service, which has two functions, one is a monitoring function and that's more for those patients that may - not just older, but it may include older patients, that can be discharged but the medical team or the nursing team are just not quite sure and might think they just need some follow-up, so it's a virtual care component of care.

We also have the intake line, and the intake is primarily for residential aged care facilities, GPs and NSW Ambulance. The majority of calls that come through are from residential aged care facilities, and similar to Jan was saying, it will then link the caller through to the aged care response team that we have on the Central Coast for those facilities.

The aged care response team consists of - we have two nurse practitioner positions, although one of those is vacant at the moment, and registered nursing staff. They work from 8am to 7.30pm seven days a week and they will respond to those calls that are what we call priority response, in that if we don't respond on the same day, they're likely to present to hospital. So we will, as much as possible, do the same-day response, although if it is a care need that can wait until the next day, we will do that as well.

Similar stats to what was being described earlier, of those calls that come through that are a priority response, we do avoid hospital more than 90 per cent of the time, with a timely response. Given it is a nursing model of care, the team do have connections with geriatricians, our palliative care staff specialists as well as our Hospital in the Home medical staff. In those instances where they think they can avoid a hospital presentation, the nurses are unable to contact the GP, but they just need some medical, I guess, guidance, we do have those relationships in place.

The other thing, I guess, the aged care response team do is a lot of capacity building within the facilities. So they will look at trends of the types of calls that they're getting. A recent example would be a facility where there were often calls for blocked catheters, so then we will focus some education on catheter management, how to do catheter changes with the nursing staff that are there.

We are cognisant that there can be a high turnover of staff in facilities and there is also a high proportion of agency staff used in facilities, so it's often not just a one-off education. And we have, I guess, more recently recorded the education to make it available for the facility, because of the staff there being so fluid.

DR WATERHOUSE: Just before you go on, does that translate in your experience to a reduction in those calls, that these staff are empowered at those facilities?

MS PICKERING: It has in that facility, yes. The other thing is we have our Hospital in the Home service which I guess more recently we - and again, this has been funded by the district, it wasn't through additional funds, we have got at the moment temporarily the 10 additional beds

that have got a real focus on the older person, and is primarily allied health led, still under the admitted medical model of the HITH staff specialist.

That's something that's working quite well where we are able to wrap allied health support and assistance around the older person in the community whilst still under the admitting medical officer which is either a geriatrician or our HITH staff specialist.

We also have our alternate ambulance pathways, so with NSW Ambulance we've got agreed pathways in place that they can contact our virtual care and triage line for older people either in the community or in a residential aged care facility, where together we can actually work out, I guess, the best care location for them, rather than presenting to a hospital, where it is safe to do so and where we have the resources available to respond to their care needs at that time.

The other, I guess, thing is we've got quite a good relationship with our PHN, so our primary health network, on the Central Coast. They did some work, probably just post COVID, looking at the virtual care capacity within our residential aged care facilities and supporting the facilities with, I guess, their virtual care capacity, so we do have a lot of virtual care.

So where if a nurse practitioner is unable to go into a facility right at that moment, we've got the capacity to be able to provide the care virtually and also link in to some of our other specialist nurses including our wound management nurse practitioners, for example.

DR WATERHOUSE: Do you find that there are financial barriers to introducing some of these initiatives or is there generally support for them because they're recognised as having downstream benefits?

MS PICKERING: I think it's probably a combination of both. There definitely is financial barriers. You know, the example I've just provide with our older people within the Hospital in the Home service, it was time-limited funding; the funding sort of is no longer there. As a district, we can see absolutely the benefit of it, so it is continuing at the moment, but we will be evaluating that particular program, in combination with other programs that

we introduced, to look at whether they will be continuing into the future.

DR WATERHOUSE: Ms Okulicz, is there any particular initiatives that you've tried on the ward that have been successful to manage the challenges that you've been describing?

MS OKULICZ: For a while we, through COVID, were given additional funding for what's called a health care worker, so they were an additional person. They weren't an AIN, it was just a person who was willing to come in and work and work with the patients, they were across the hospital.

What our health care worker did was really good at building therapeutic relationships with some of our patients, especially when they had been there for a long time. She would take them for walks, she would sit with them and play card games with them, ensure that their menus were ordered correctly or, like, have they lost their teeth or the dentures. She would also do all their washing. We had a washer dryer on site in our unit, so she would go through and make sure everyone's washing was done and she would keep track of that.

She was very instrumental in building our activity trolley. It has diversional activities within the trolley that we can use, but again it's having the time to sit with the patients to use those and she was very much the person who did that.

She definitely helped alleviate some behaviours because of that, because she would really get to know them and she would know what their triggers were and she could intervene, and it also just freed up a lot of the nursing time to go and deal with some nursing allocated tasks. So she was great. But, unfortunately, COVID funding ran out and all the health care workers no longer have positions within the hospital. So we've lost that resource.

DR WATERHOUSE: Thank you.

Mr Shortis, are there actions being taken in a community health setting to deal with some of these things, initiatives you've tried, and so on?

MR SHORTIS: Similar to the other districts, we provide

education into nursing homes and we certainly have nurse practitioners that go in there.

One of the things that I haven't heard mentioned that we've done at Nepean is we've employed some geriatricians in our primary care and community health service. What that allows is the primary care and community health staff to refer directly to the geriatrician, to get them reviewed, to get their care needs addressed and make sure that they're on the best possible treatment.

Other work that we've been doing around aged care is ensuring that we're tracking the patients appropriately so that the clients who we're providing - the clients who we're providing care to with home care packages, we're in negotiations with the home care package providers to make sure that they're either providing the care or we're doing the care or we're providing them support for the care, similar things like that.

DR WATERHOUSE: Thank you.

And Ms Hawkins, do you have anything to add about initiatives you have tried at a local level on the ward or just within the hospital?

MS HAWKINS: Specific to C7 east aged care, it would be diversional therapy cover at Wollongong Hospital. It's not something that we've experienced before, and from what I've observed in terms of the effects that it's had on our patients, irrespective of their behaviour, I feel it has been significant.

Others which may have already been touched on that I'm aware of at a district level is the transitional aged care beds at Figtree Private Hospital, which is the 20 beds there. What has been trialled over the last three years, also which Dr Potter's touched on as well, is the aged care nurse navigator role, which had an overview and oversight of all geriatric patients at Wollongong. They're what I'm aware of.

DR WATERHOUSE: Thank you.

I suppose I just want to finish with an understanding from each of you. There's obviously a lot of really good initiatives already happening --

THE COMMISSIONER: Can I go back just to clarify something with Professor Potter. Also, I can see Mr Wakeling has his hand up, but if I can just go back just so that I understand something that was said a bit earlier on this topic. For anyone following, it is at 6227 at about line 20 of the transcript.

You told me, Professor Potter, that you've - well, "we've", that is the LHDs, had a lot of high-level meetings with state and Commonwealth, and you said:

> *We've had a lot of high level meetings with state and Commonwealth which - we're not getting there yet but we're floating things and we're trying to. We recognise that there's a lot of Commonwealth funded initiatives.*

And then you go on to say:

> *If the aged care providers are not going to open homes there's nothing very much the Commonwealth can do to force that. We're trying to suggest that perhaps we could open some facilities. There's a disused facility that has not been knocked down or sold in our area ... so we're looking at things like that.*

What should I actually understand by that? That's a discussion, is it --

PROFESSOR POTTER: Yes, so the --

THE COMMISSIONER -- between the LHD, the ministry and the Commonwealth about the Commonwealth providing some money for the state to run an aged care facility or the LHD to run an aged care facility? Is that right?

PROFESSOR POTTER: The state. Yes, that's correct. So it is for the state to actually run it, for us to provide the medical staff, the nursing staff, and for the Commonwealth to transfer the funding to the state to allow us to employ those people, and to also renovate that building because it's an old building. That's the same model that we've asked them to consider.

So one of our hospitals currently is now full of patients waiting for aged care facilities, particularly dementia disturbed patients, and we've said to the Commonwealth, "Can we just get the funding that if that was in a nursing home in the Illawarra, can we get the funding into the state and we will open the beds that we've lost at part of our planning initiatives for new builds, for example, in Shoalhaven, et cetera". So that's where we're going with that.

There has been some success. I said there hadn't been any great success with all of them, but the other group spoke about the new policy from the Commonwealth about you're only allowed to offer a place - relatives can only refuse two places in the nursing home, and that's a new policy from the Commonwealth. We wrote that policy with them.

THE COMMISSIONER: So nothing's been decided yet. This is still in discussion; correct?

PROFESSOR POTTER: Absolutely, yes.

THE COMMISSIONER: Just another thing you said. Dr Waterhouse asked you to clarify some of the conversations with the Commonwealth, and about whether that 's been done at the executive LHD level, and you said, this is at 6229, 8:

We've been working closely with Margot --

your chief executive --

she's taken it up via the ministry, the ministry have approached the Commonwealth, and we've now got a series of workshop type meetings.

Are those workshop type meetings to discuss the thing that we have just discussed?

PROFESSOR POTTER: Yes. It's to look at what can we possibly do different to what we're doing at the moment that would alleviate the problem.

THE COMMISSIONER: And those workshop meetings involve

people from the Commonwealth as well in those discussions?

PROFESSOR POTTER: Yes.

THE COMMISSIONER: All right. Thank you. And they're ongoing, are they?

PROFESSOR POTTER: They are.

THE COMMISSIONER: Okay, thank you. That's what I wanted to ask, thanks.

DR WATERHOUSE: Just developing that --

THE COMMISSIONER: Sorry, Mr Wakeling had his hand up.

DR WATERHOUSE: Yes, sorry. I'll come back to you, Professor Potter.

But, Mr Wakeling, sorry, you've been waiting. Do you want to say something?

MR WAKELING: Thank you, Commissioner, thank you Dr Waterhouse. Just a point, the question "What are the initiatives we're taking", and everyone responded in more, more, more things. Of course, for the record, all hospitals, including Illawarra Shoalhaven, are particularly focused on creating efficiencies in the length of stay to open up the capacity. There's daily operational meetings or, you know, four times a day, where we're really trying to identify each little task of inefficiency that might stack up to a few days of wait.

I hope today showcased just how complex the healthcare system is, in particular the aged care, because there are increments of little delays that add up, and it is very hard, using appropriate project methodologies like Lean, to try and nut out all those inefficiencies, but we are trying our best, thank you.

THE COMMISSIONER: Don't take this the wrong way but we have discovered the healthcare system is complex before today, but you're certainly reinforcing it.

DR WATERHOUSE: Maybe if I could just go a little bit further, actually, into that point while I have you, Mr Wakeling. So I appreciate the value of finding small

inefficiencies and resolving those so that you can be as efficient as possible, but obviously there are some fairly major inefficiencies, if you like, with some of what we've talked about this morning.

What would you like to see changed in relation to something like the delays for the aged care? Obviously, theres other things, we'll talk about those, too, but in particular, also the delays with the NDIS patients, what would you like to see done differently that would be big savings in terms of efficiency, in your mind?

MR WAKELING: The most successful program that Professor Potter spoke of that would get the most success for us from an innovation perspective would be expanding the aged care outreach service. That would make immediate impact on reducing the demand to come in. That would be within our LHD's control. I see a lot of the solutions from an external, outside of the LHD's perspective. Fast-tracking the ACAT assessments that Rachael mentioned, fast-tracking the access to those level 3/4 home care packages which are currently, you know, six to 12 months is not ethically correct, and then opening up the ability of the aged care beds.

Currently Illawarra has 122 waiting and the impacts that we talked about, if they weren't there, we would have nil impacts offloading ambulances, we would have nil impacts of admissions in the emergency department. I am sure our hospital-acquired complication rate would go down, and we probably wouldn't need as many services that we're running in regards to Coledale Hospital, which is a complete residential aged care facility. We could repurpose it for something else and/or we could probably close it and save some funds. So that's all I'd like to say, thank you.

DR WATERHOUSE: Thank you.

Professor Potter, just on the points that you were being asked about by the Commissioner, are you aware of other states where they have been able to secure funding for the state to run an aged care facility in the sort of way you're talking about with the Commonwealth?

PROFESSOR POTTER: Yes, NSW Health actually has a facility at Garrawarra, which is, I think, South Eastern Sydney

Local Health District, so - and that is specifically running under that model where it's Commonwealth funding but state run. I don't know the details of how the funding model runs for that, and I know that there has been concern because of the accreditation standards for aged care facilities, particularly around dementia management, that has made that whole model very challenging and it may even be in doubt. But I suspect these are the sorts of things that we're going to have to do. We're going to have to get good at looking after this patient group in suitable accommodation, however we staff it and however we run it.

The problem is not going to go away. There is no cure on the horizon for dementia and the numbers are getting bigger and bigger. So we need to do something. So I am aware of that model. I don't know the fine detail of how the Commonwealth fund it or what the relationship status is.

DR WATERHOUSE: With the outreach model that you have running at the moment - Mr Wakeling said a moment ago that it would be good to have it as a standing outreach service - does that mean it's sort of cobbled together just prevailing on borrowing people at the moment, effectively and it's not an ongoing thing?

PROFESSOR POTTER: No, this is a great thing again to praise our chief executive. Even though the funding has not come through, she has had promises that it will come through, so she said, "Put the staff on permanently." If you put them on temporary, it won't work, it will fall over. So we're running this, I think, at a loss at the moment, but the benefits to the patients, the benefits in building relationships at aged care facilities, is immense, and I think we really truly could expand on that so it wasn't just ED avoidance, it was supporting early discharge, it was supporting training nursing home staff in how to manage this group.

I think that's a great model, it's having great success. From what our other colleagues were saying, it's working in Wyong as well. I think we could go a lot further with that model and really build our links with the community and with our facilities and GPs which would be a great starting point and could expand.

DR WATERHOUSE: Are there other things - I mean, you're,

obviously, talking in the workshops about different things that would work with the Commonwealth, but in an ideal world, are there other things you would like to see as solutions to some of the challenges we've discussed?

PROFESSOR POTTER: Yes, I think a very simple - well, I say it's simple, I'm just a doctor, but I think a very simple thing would be if we just look at how many patients are sitting across our acute and sub-acute beds, that would be being paid for by the Commonwealth, why can't they simply just transfer that funding to allow us to enact all these other models that we're trying to do to make everything else more efficient?

It seems to me we're charging a small amount of money that's nothing like what it would cost, and yet where is the money that would be paying for those 600 beds if they hadn't closed? I feel as if there must be - there's lots of innovative ideas that people come up with and we are doing that, but if there was - we're sitting with a very unfavourable bottom line with our relation with the ministry. If we could get round that and fix that and allow all the new ideas and the new models of care to come out, I think that would give a sense of optimism and hope going forward. So that would be a thing I would like to see explored and, as I say, it's not my area of expertise, I'm sure it is very complicated, but I think that could be something.

DR WATERHOUSE: Thank you.

Ms Hawkins, did you want to add anything in terms of what you would like to see change?

MS HAWKINS: I think it's more what people have touched on in terms of community-based measures, in terms of supporting our patients before they get to a point of crisis, or at a point of needing the acute care. I think it would be more around service-based activities in the community.

DR WATERHOUSE: Just one point I wanted to clarify, you mentioned earlier, and Mr Wakeling supported the point, about the level 3/4 community care packages sometimes waiting six to 12 months. How often do you see a person deteriorate in that time such that they now do need an aged care facility and they cannot be managed at home? Is that

a common phenomenon?

MS HAWKINS: Frequently, yes, and I can comment that as both a nurse unit manager and within a discharge planning phase where they're not geriatric-admitted patients, as well as my aged care navigator role. It is highly frequent, yes.

DR WATERHOUSE: So that six to 12 months delay is actually not just an inconvenience; it is actually resulting in a deterioration that means that they need a higher level of care than they would have needed?

MS HAWKINS: Correct, and it's a twofold impact in terms of the impact and the stress that it's also causing the family and also the demand that it's actually causing on the hospital system.

DR WATERHOUSE: Thank you.

Ms Okulicz, what would you like to see given an ideal world, apart from the health care worker back?

MS OKULICZ: For me personally and for Wyong, I'd like if there's a bed in the hospital, it should be funded. I have 30 beds, fund the 30 beds, then I've got the staff to run it. But then you would also be able to increase the allied health recruitment to actually be available for every bed. Then we'd get proper referrals and proper reviews in a timely manner to make decisions quicker and be able to move people through, because our area is consistently being developed.

There are more and more houses coming up. There is nothing but growth happening in the Wyong area that we're going to need those beds if - there's no ifs and or butts, and we haven't had aged care facility closures, we've actually had more opening, but they just don't have capacity and half of them don't have memory support units either. So I say fund every bed that's available in Wyong hospital and then look at increasing memory support units for the Central Coast.

DR WATERHOUSE: What about the guardianship tribunal aspect that you spoke of before? Are there ways that you see that that could be streamlined and improved?

MS OKULICZ: If you had the allied health referrals quickly, then we could get those reports sooner, so having the allied health services available. But then looking at the guardianship processes, like, why does it take three to six weeks to get a hearing date? Could they not be expedited for somebody who is in hospital, looking at those processes? I mean, ACAT already get expedited for in hospital, so they are 48 hours KPI, but in the community it's like six weeks. So can we look at things that are prioritised for hospital patients to get them out and can we streamline that process?

DR WATERHOUSE: Thank you.

Ms Pickering? If you had an ideal world, what would you like to see?

MS PICKERING: I think right care in the right place, and I guess I'm coming from the community context of we know that there's a lack of GPs and that's not an easy fix. We have a number of non-admitted models of care in the community that don't have - the medical governance sits with the GP, and often when we are unable to get hold of a GP, then we don't have another avenue to go where we think we might be able to actually avoid that hospital presentation.

I touched on some of the linkages that we do have, but those medical officers that I touched on before already have a workload as well, so I think linking some medical support at an LHD level into the non-admitted models of care in the community to really try and help prevent those hospital presentations.

I also think we need to look at the hours of operation of some of our community services, because, you know, for the vast majority of our community services we go down to one or two staff over a weekend or public holidays, but we're not seeing the reduction of the patients that are needing our care in the community. So I think that's an opportunity to really - and I guess out of hours, I participate in on call out of hours, so I see some of the presentations that are coming through, sort of after that 8.30 at night. There are some that are preventible that if we had the services operating later into the evening, potentially that would avoid some hospital presentations.

DR WATERHOUSE: Mr Shortis, from a community health point of view what would you like to see?

MR SHORTIS: Similar to what has been said. With the increasing complexity of people in the community I'd like to see more supports both pre and post hospital, so from a medical point of view to avoid admissions, from a medical point of view to get them out quicker, and from the supports for the people living in the community to enable them to function in the home, and stay in the home longer.

DR WATERHOUSE: Commissioner, that concludes my questions.

THE COMMISSIONER: Can I just ask all six of you whether there's anything further of real importance that didn't get raised today?

MS PICKERING: No.

MS OKULICZ: No.

THE COMMISSIONER: Anyone online?

PROFESSOR POTTER: There was just one thing, sorry, I know I'm talking too much. One of the other things we mentioned with the Commonwealth was we have level 1, 2, 3 and 4 packages. We asked could we look at level 5 packages, could we look at something that's closer to an actual residential aged care facility? And, again, we were willing to work with them to be the providers of that.

That's just another thought, that, you know, let's get the packages timely but actually let's go above and beyond so there's something between a level 4 and an aged care facility.

THE COMMISSIONER: Okay, thank you.

Mr Chiu, was there anything?

MR CHIU: No questions, thank you.

THE COMMISSIONER: Thank you for that?

DR WATERHOUSE: I just, sorry --

THE COMMISSIONER: Go ahead.

DR WATERHOUSE: We've had the benefit of your lyrical brogue today, Professor Potter, but I have been asked by the stenographers if you could please state your name clearly for the purposes of the transcript.

MS POTTER: Okay, it's Clinical Professor Jan Potter, P-O-T-T-E-R, as in Harry.

THE COMMISSIONER: To all six of you, thank you very much for your time. We're very grateful for the assistance you have given the Inquiry. So thank you again.

We will now adjourn and I'm told it's 2 o'clock on Monday. So we'll adjourn until 2 o'clock on Monday. Thank you all.

<THE WITNESSES WITHDREW

AT 1.28PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO MONDAY 18 NOVEMBER 2024 AT 2PM

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