TRANSCRIPT

PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Hospitals and Care Facilities Pandemic Order

Melbourne—Tuesday, 1 March 2022

MEMBERS

Ms Suzanna Sheed (Chair)
Mr Jeff Bourman (Deputy Chair)
Mr Josh Bull
Ms Georgie Crozier
Mr Enver Erdogan
Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

WITNESSES *(via videoconference)*

Ms Tina Hogarth-Clarke, Chief Executive Officer, Council on the Ageing Victoria; and

Mr Corey Irlam, Deputy Chief Executive, Council on the Ageing Australia.

The CHAIR: I would like to welcome you both. Thank you very much for coming today to provide evidence to our committee.

I will just introduce you to those committee members who are here. I am Suzanna Sheed, the Chair. We have Georgie Crozier, Kim Wells, Josh Bull, Harriet Shing and Mr Erdogan on Zoom.

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I welcome our witnesses and invite one of you to make an opening 5-minute statement, and then we will have questions following that. Thank you.

Ms HOGARTH-CLARKE: That is great. Thank you. And thank you for having me today. I would like to read a statement if I may. So, first, I am thanking you for the opportunity to present to this committee on the inquiry into the impacts of the visitors to hospitals and care facilities orders.

Before I commence my statement I would like to also acknowledge that I am joining this inquiry on the lands of the Boon Wurrung people and pay my respects to their elders past and present and those who continue the journey.

COTA Victoria really appreciates the leadership that has been shown by the Victorian government during the past two years as well as its willingness to engage with the community services sector to work through some of the key issues affecting older Victorians. It is our hope that the feedback provided today in this statement will equip the committee with greater insights into the future measures that may be needed to ensure the human rights and dignity of older Victorians continue to be met during the COVID pandemic and also beyond.

It is important to note that our statement has been informed by the lived experience of older Victorians, and this is based on analysis of the trends that have emerged through calls made to our seniors information helpline and also our Seniors Rights Victoria helpline from March 2020. It is also from feedback relayed to us by the frontline staff working within local councils, community organisations and others that are supporting older people. It is also informed through our involvement in fortnightly visitor directions meetings that have been chaired by the commissioner for senior Victorians, Gerard Mansour, and has involved the aged care COVID preparedness and policy team; Elder Rights Advocacy, who represent the OPA Network in Victoria; and Dementia Australia. I also refer the committee to COTA Australia's industry code for visiting residential aged care homes during COVID-19, which requires residential aged care providers to allow an essential visitor at all times, which I will discuss later.

It is important that this committee understands the impact of social isolation and loneliness in the context of residential aged care and in the acute hospital settings and the vital role that support people play. Let us be clear: older Victorians are not in residential aged care or in hospital for social reasons. They are there separated from their loved ones because they need care. Visitors not only provide the social interaction humans need to live healthy lives but also provide informal care and act as a check that the residents have been looked after and had their needs met. In a hospital situation the same occurs: a family member or a friend is there to support the patient when they are at their most vulnerable, providing comfort, but they are also there as an advocate, ensuring their rights and dignity are respected and met. This is especially true for older Victorians who live with dementia. We have been told of tired and overworked aged care staff berating older people in their care when they step outside of their rooms, even though some of them who are living with dementia cannot remember that they are supposed to stay in their rooms and do not have any idea that there is a pandemic going on.

We hear from families that loved ones with dementia have declined faster than expected and are losing their capacity to recognise family sooner because they are not only locked out but, if they are allowed in, can only see that person in a mask and they are kept at a distance. Residents being locked in rooms has seen a decline in mental and physical health that has led to falls and subsequent hospitalisations, and in some cases the older person has contracted COVID-19 in hospital, not to mention the decline in mental health. Desperate families report listening to their loved ones on the phone begging to go home or wanting to die. They are confused and they are lonely. There have also been reports that health decline has resulted in the older person moving into palliative care, end-of-life stage, perhaps sooner than anticipated by family members.

But before I talk about aged care, I want to talk about older people in Victoria. I want to acknowledge the genuine fear that they have had about COVID and recognise that they have created their own self-imposed isolation rules. We are often told that they have reduced or denied themselves social visits for weeks and months after the changes to public health orders have indicated that they can return to those activities. So when this committee investigates not only the words on the pages of the orders I urge the committee to consider the lived experience impact as well, which, as I say, has consequences for weeks and months or, as we may find out, for years after the order has been changed.

There is a critical need to strike a balance between protecting residents in aged care and patients in hospital from infection and ensuring residents have the visits and freedoms that are essential to their wellbeing. Older Victorians must be afforded the dignity of risk, allowing them the opportunity to have their rights respected regardless of where they live. It is a wicked problem to have to balance the psychosocial, nutritional and physical impacts of not allowing loved ones in on one hand versus the impact of COVID entering the facility on the other. It is understandable that providers who are often led by medical professionals will focus on clearly documented infection control procedures of the past, when residents were isolated for shorter periods during a flu outbreak. But, as we know, COVID is different. COVID has a longer term impact and is not just a one-off for a few weeks. We have had reports that residents are locked in their rooms for over a week with bare minimum human contact. One gentleman's daughter told us that her father had not been showered or washed for eight days because showers spread COVID through the facility, which we know is not actually true.

Over the past two years we have seen a shift in state government acknowledging that residential aged care facilities are not institutions but are people's homes. What has flowed from this is a different way of thinking about visitor access that is more consistent with household visit orders applied to the community. Victoria has attempted to take a least restrictive approach compared to other jurisdictions. Few residents have more than five visitors a day anyway, so the Victorian benchmark of allowing up to five visitors, which at the time was comparable to the community position, is really appreciated.

Just as there is debate in the broader community about the most appropriate balance of COVID restrictions, so too there was debate amongst residents and families about how to approach COVID in a shared living environment such as residential aged care. Some argued for the shut-the-doors approach while others argued for 'Let me out to see my family' or 'Let my family in to see me'. The omicron wave's wider spread of COVID in the community, media reports of successive outbreaks and lockdowns, the fact more people were vaccinated—though not necessarily boosted—than in previous waves and the fact it occurred around Christmas time saw that most people were arguing for the 'Let them in' rather than the 'Lock them out' approach. However, COTA has received multiple reports that providers are not allowing visitors in. This is either due to non-compliance with the industry code based on the organisation's own individual risk assessment or because the local primary health unit did not allow the visitor in during an outbreak. This was exacerbated by successive outbreaks or exposures in particular facilities during COVID, with around 40 per cent of Victorian aged care homes estimated to have more than one outbreak or exposure, and this compounds the residents' isolation and impacts the residents' quality of care and wellbeing.

On top of the lack of visitors, obviously over the Christmas period PCR tests took a long time to come back, and we have heard of multiple examples of older people being asked to stay isolated in their rooms while they waited for those test results to come back, which amounted to more than a week, maybe seeing someone for about 15 minutes a day when that person dropped a meal tray off. Consumer stakeholders still report ongoing barriers to residents receiving visitors and that there are quite a number of aged care providers who continue to impose more severe restrictions on visitor access. We are also told that providers are telling families that they are just implementing public health orders, although we do know that there is a bit of a mix of both of those

scenarios. This example highlights the critical importance that the orders are accompanied by guidance notes to providers to ensure that the providers understand the orders but also how to implement them in practice.

Based on the reports COTA received we have been calling for a legislative mandate that every resident has at least one visitor at all times. We call these the essential visitors, and they should be able to visit a resident even during periods of outbreak on site, even when the resident is required to self-isolate in their room. An essential visitor may be a partner in care who comes in daily to assist with psychosocial support, and in the case of some residents experiencing dementia the family member is the only person who they will allow to feed them. If a resident does not have a partner in care, we ask that they be allowed to nominate one visitor. We call this named visitor after the term in the UK. It is basically the same as the Victorian Mental Health Act's nominated representative, which the pandemic orders for mental health care facilities recognise as a class of people who are exempt from visitor restrictions.

A few weeks ago the Australian Health Protection Principal Committee, which includes Dr Sutton as a member, endorsed interim guidance for a change in how to manage outbreaks and exposures. Part of this change included recognising essential visitors as outlined by the industry code and what I have just explained. Since that time we have seen public health units across the country change their stance on how to allow or not allow visitors, but this only removes a block that providers who wanted to let visitors in faced. The current approach does not mandate access or require providers to let visitors in. Providers are inconsistent in their application of the Australian Health Protection Principal Committee guidelines and the visitor code, having restrictions to visitations beyond those directions.

Restrictions being placed on visits include not allowing visitors or severe limitations even when there are not outbreaks or exposures, not allowing end-of-life visits, not allowing any visitors access when rapid antigen tests are not available, and then charging visitors up to $15 a day for a rapid antigen test, which effectively makes it cost prohibitive for regular visits. As well as providing an important social connection, many visitors continue to want to provide essential care and wellbeing to the residents. Many families are concerned they have lost line of sight about the wellbeing of their loved ones, and many providers have still not set in place a system to identify essential visitors, including partners in care. So we would like to see essential visitors recognised in the care facilities pandemic orders in such a way that mandates their recognition by aged care providers and provides them a legislative or a regulatory mandate to access. If there is not a federal recognition in the *Aged Care Act* or a state recognition in the pandemic orders, residents of aged care homes will continue to be beholden to the individual sites' risk assessment.

Given the coronial inquiry into aged care deaths and the Victorian WorkCover inquiry into aged care management of the pandemic, it is understandable that some providers would be apprehensive about increasing their risk to their facility, no matter how small a risk that might be once you mitigate it with PPE, infection control and prevention training and other measures. In short, if these orders are not updated to include a mandated access for essential visitors to aged care, we will continue to see visitors excluded from their loved ones at the behest of a possibly well-intentioned, risk-averse aged care provider who is concerned that a regulator like WorkCover or the coroner will interpret their inclusion of visitors as a contributing factor to an outbreak that may unfortunately result in deaths.

In the hospital setting we are hearing that carers are not permitted to attend appointments with a patient or indeed a support person is not permitted into a hospital even if the patient has dementia. One caller to COTA, a gentleman who was hearing impaired, was not allowed to be accompanied by his wife, who usually attended medical appointments with him to ensure he heard the information being discussed. Masks of course exacerbate this issue, and the gentleman had trouble hearing information during an eye exam. The exam was usually bulk-billed, but he was charged $290 for a consultation and a test. He paid the bill, thinking it was the usual small amount because he could not hear, and now the couple do not have any money to live on until the next pension, hence their call to our service. Another person, who is vision impaired, was not able to take their registered carer into a hospital-based appointment. If carers are unable to attend appointments, it will compromise the patient care and tend to result in additional costs, as this example shows.

For two years, older Victorians have been told that COVID can kill them—they are at the greatest risk. Now as they struggle to take on the self risk assessment, particularly if they have an underlying health condition, which is common for older people, the messaging has shifted to, 'Go out; omicron is a different variant and not as serious'. But the statistics that are still being reported state that the majority of hospitalisations and deaths are

still in older people. We are informed that this does not seem to be as prominent an issue for older people in other states, where the messaging and extended lockdowns have not been as traumatising as in Victoria. It is important that this committee understand that a lot more work is required to change the messaging directed at older Victorians to encourage them to re-emerge into community. There is a complexity of issues for older people and not enough long-term plans and thinking to provide reassurance, confidence and hope.

I am happy now to take some questions, but I may defer to Corey Irlam from COTA Australia, who has also been coordinating our engagement on the industry code and various other aspects of COTA policy work on COVID and aged care, or we may have to take some questions on notice.

The CHAIR: Thank you very much for that presentation. I think one of the things that you identified for me is that wicked problem of balancing the two issues, obviously. If I take you back to the time of March 2020, with the *Ruby Princess* and Newmarch House and then the hotel quarantine situation here, no vaccines, disease spread, virus spreading, a lot of fear, a lot of anxiety and then moving on—but not until around about October last year did we have people getting to critical numbers with two vaccinations. I just wonder now whether if you took us back to 2020 you would still say, 'Under any circumstances have that essential accompanying person with an elderly person'.

Ms HOGARTH-CLARKE: The benefit of hindsight, I suppose: back in March 2020 I do not think any of us had any idea that we would still be here in March 2022, still in the midst of the COVID pandemic. I think there has been a massive learning curve for everybody with that. To answer your question: if this was March 2020, at the beginning, we would have been, as everyone else, testing those boundaries and testing the theories and testing what impact certain things would be having, but I think that as the lockdowns, particularly in Victoria, went on and on and on and then we came back out again, even when the lockdowns did lift there were still heavy restrictions in aged care and on visitors in aged care, including the wearing of PPE. The reality here is you have people that have basically lived for two years without seeing somebody's face. I mean, that is the reality.

The CHAIR: So could I just take you to—

Mr IRLAM: Sorry, Chair, could I just add to that?

The CHAIR: Yes.

Mr IRLAM: If you go back to May 2020 when the industry code was first created, the partners in care who were delivering support to individuals that had dementia were coming in and feeding them and washing them and those sorts of things. That was included. The sector called for it in May 2020. It was not until November last year that that got expanded to include 'one resident, one visitor' by introducing the main visitor under that concept of essential visits. So that gives you some information there—always partners in care right the way through the pandemic, but since we have had the double vaccination figures you talked about, in October, then we have expanded that to say every resident, regardless of whether they are providing care or not, should have access to one main visitor.

The CHAIR: So I guess we have learned a lot over the last couple of years, obviously, and we can see the terrible impacts that all of this has had on so many people and particularly those in aged care. If we were to move to a situation where we have another variant, we have the flu and we have a very volatile and dangerous situation, knowing everything that we know and understanding the risks associated with a situation such as that, would you still say to have that essential carer with an aged person?

Ms HOGARTH-CLARKE: Yes.

Mr IRLAM: What I would say to you, Chair, is that the pandemic orders can be changed rather quickly in response to what happens. So we would argue the pandemic orders under the current settings, the current risk profile today, should include essential visitors of both types. If we came to having a drug-resistant strain, if we came to having an unforeseen risk that increases the risk specifically in aged care, specifically for older people, specifically living in congregate locations, then we would revert to that May 2020 position of just those persons providing essential support and care under that partner in care definition. That would be my guess as to where the industry code would go. I would have to speak to 12 different organisations to confirm it, though.

The CHAIR: Do you have a sense that during the course of the pandemic and during the making of the orders, and more particularly in recent months during the making of the current orders, your organisation has been consulted and had an input into these sorts of issues that you have talked about?

Ms HOGARTH-CLARKE: We do, yes. So particularly in the last couple of months towards the end of last year—and we are continuing; we are having fortnightly meetings with, I cannot remember the title, one of the public health departments that are working on the preparedness for aged care—we have had a lot of consultation, certainly with the Department of Families, Fairness and Housing and the commissioner for seniors, throughout the pandemic around a lot of different issues that involve older people. So, yes, it has been quite extensive.

The CHAIR: Just earlier we heard in evidence from Shepparton Villages about a strong advocacy for, 'We just need one agency to deal with aged care', because they had that tension of directions coming from the commonwealth, orders coming from the state and local public health units and issues around interpretation of orders. Clearly that has been very challenging, and as you have said, so many of these organisations are interpreting them in a way that is not consistent with the way you, for instance, would see the orders being interpreted. Do you see a better way forward in terms of dealing with these sorts of issues and getting some consistency?

Mr IRLAM: Do you want me to take that one?

Ms HOGARTH-CLARKE: Yes. Go for it, Corey.

Mr IRLAM: I think there is a difference between—two different things: does the order prevent something from happening, or does the order require something to happen? And this has been the tension in aged care regardless of whether it is federal regulation or state, because we put the onus back on the aged care provider to conduct their own risk assessment on their own site. So we had up until recently the AHPPC position in other states—not so much in Victoria but a little bit—that there was a block through the public health orders, not the written orders but the direction from the public health official, about whether visitors could come in or not. Largely that has now been resolved and there has not been reported to us in the last couple of weeks public health units saying, 'Don't let visitors in'. But the orders do not go so far as to mandate to a provider to let the visitor in. So you are pushing back on the provider again in the context of a coronial inquest, in the context of a WorkCover investigation into how they managed it, even in the context of media reporting about deaths in aged care, to make a risk assessment as to whether or not they should marginally increase their risk by allowing a visitor in. Now, there are workforce complications as to how they safely do that, but there is also a general risk aversion amongst many of the people who lead aged care facilities to not want to increase this very clearly understood scientific calculation. And so often the weighting they put on the psychosocial, the nutritional and the physical ailments that happen as a consequence of not letting visitors in is given a lesser weighting in their risk profile than the very clear black-and-white risk of introducing COVID.

Given that context of regulatory investigation by WorkCover, we think the only way you are going to shift the provider's risk profile analysis is by mandating that they have to recognise essential visitors and look to do it safely. That will send enough of a cover signal to them to look at that better balance of how to do it rather than whether to do it. So that is why we are advocating that we should see the change to the order to the next round that actually mandates essential visitors in there.

The CHAIR: Thank you very much, and I have to finish at this point. So I will hand to Ms Shing.

Ms SHING: Thanks very much, Chair. Thanks, Mr Irlam, Thanks, Ms Hogarth-Clarke. I am interested in something you have just said, Mr Irlam, around striking that balance on the one hand between risk management and what you have referred to as the marginally greater risk of somebody having COVID coming in. We have heard evidence today that it just takes one to have one case and an incursion and an individual case and then a cluster and then an outbreak. One of the things that we have seen, particularly in private aged care, has been the ongoing examples of that actually happening, and I think there has been a lot to learn out of that.

But I am keen to understand, particularly, Tina, from your evidence earlier, how that fits with what you have described as distinct between private and public aged care, because a lot of what you have said seems to bundle aged care in as a job lot where in fact there are quite distinct and different processes, protocols, staffing, surge, PPE, RATs and other sorts of supports and resourcing in place. So can I take you back to your earlier evidence

and just ask you to create that distinction and perhaps give any views and perspectives you might have on how we can improve the system overall, including by reference to cherrypicking the good bits from each sector as you might see fit. Thank you.

Ms HOGARTH-CLARKE: Thanks for that question. Yes, there have been some distinctions, and I mean it is also very clear that the public sector RACFs definitely have a staffing profile that is higher than in the private sector and even the not-for-profit residential aged care. I do not have the data here in front of me, the comparisons between the outbreaks between them, and I think that even with that staffing profile one of the biggest issues that a lot of providers have been saying to us throughout the pandemic has been that they do not have the staffing profile to enforce or to support visitors coming in. So there might be a distinction there. Corey, do you have—

Mr IRLAM: I foreshadowed this question and asked our staff frontline staff and our colleagues just what their thoughts were, and they said to us that the state-run services do better mainly due to two things: having more qualified staff on site and having an existing ratio. Having said that, though, every single public-run facility in Victoria failed in allowing visitors. They did not manage that well at all, and many private providers better managed that risk balance. So there seemed to be a much more command and control approach out of public health facilities in no visitors, not happening, even though they had a better capacity within their staffing mix of skills and the numbers of staff to actually manage that process going through.

Ms SHING: But there is a direct correlation, though, then, isn't there, surely—

Mr IRLAM: Can I just also pick up one thing—

Ms SHING: No, no, just a moment, Mr Irlam. Is there not a direct correlation between visitation on the one hand—and I am not saying this is causation, but it is correlation—between the visitor availability that you have talked about in the private setting and the case numbers and the incursions within private sector settings as far as aged care is concerned?

Mr IRLAM: No. We saw before omicron a number of cases that were happening because of staff bringing it in. We saw an increase in the number of visitors bringing it into aged care during omicron commensurate to the number of increases in the community. So—

Ms SHING: Private sector or public sector?

Mr IRLAM: the issue is about when you bring a visitor in, how do you support them to do it safely? Have you trained them, such the having the partner in care training that teaches them about PPE correct wearing? Are you screening them to make sure either they know how to fill it in themselves—correct all the questions, do the temperature gun properly, make sure they understand the full gamut of symptoms as to why you should not come into an aged care system—or do you have a staff member on site to be able to do that for them when they come through? Once they are in the facility, are they aware of where they can and cannot go? Are they staying in a person's room that is only a single room? Are they staying in a dedicated visitation location because the person shares a room? These are the things that mitigate that risk that I referred to, and that is not directly related to whether you are public or private. That is related to the individual provider's risk mitigation strategies they do in how they facilitate visitors going in, and we would argue you can balance that by doing those things.

Ms SHING: I would like to understand a little bit more about the way in which aged care has actually managed the response to COVID in balancing out the proportionality of risk and damage; on the one hand, potential risks to life and to physical health and wellbeing, including as it might relate to long COVID for people over the age of 50, and the risks, the incursions and the disadvantage occasioned by the introduction and implementation of orders. There is a tension here which the orders are trying to accommodate, which the public health team tries to accommodate and which this committee is charged with looking at, so I would like to understand the extent to which you see that balance being struck, noting what you have just said about the primacy of visitors, as against the risk to life and safety for people particularly in aged care.

Mr IRLAM: I think the first thing to note is whether there are five visitors in the orders or whether there are 10 and there are no restrictions, the reality is many people in aged care do not receive visitors on a regular basis or a weekly basis even. So when we are talking about the numbers that might increase by mandating the recognition of 'essential visitor', by and large the numbers will not increase much on what the orders say now.

The difference is that for those specific sites that are saying 'no visitors at all' it sends them a message to change that, so that those residents in those facilities can have access to what you might assume the orders are facilitating in the way they are written and the intention of how they are to be interpreted.

The question as to how you measure the balance of risk between the impact of bringing COVID in versus the psychosocial, nutritional and physical impact of not allowing visitors in is going to be something that is going to be researched for years to come. I am not so sure that long COVID is going to be a factor in it, apart from people with disability living in a residential aged care facility, but what we have seen often reported is cognitive decline—irreparably going. There is some emerging international research coming out showing that because of that lack of consistently seeing my carer that I have seen day in, day out, I now no longer recognise them, I no longer communicate with them and I am no longer talking to them. We do not have hard figures on what that is, but we do know 50 per cent of people in residential aged care have dementia, and that could affect that half-population that is in there.

Due to a combination of not wanting anybody other than their family member, along with staff shortages during the omicron wave and generally not having the right skills in a facility, we see people not going for as many walks and therefore their muscles deteriorating. We see people not being fed and therefore the nutrition going down. These things can be corrected with some intervention after they start letting people in, but often due to staff profiles we do not see that happening. So the question then becomes: what is the individual's choice about raising those risk profiles of 'I've got all these physical ailments in the final months of my life' versus the risk of COVID coming in, and how do you then take that individual's risk profile decision and apply it to a congregate living situation? As we said in the opening statement, it is a wicked problem, and there is no clear answer, black or white, one way or the other.

Ms SHING: Thanks very much.

The CHAIR: Thank you, and we will go to Ms Crozier.

Ms CROZIER: Thank you very much, both of you, for your very interesting testimony this afternoon. You talked about the analysis of trends, Ms Hogarth-Clarke, at the start of your opening. Is that analysis public?

Ms HOGARTH-CLARKE: No. So they are the trends, the themes and the conversations that are coming through two of our phone lines. COTA runs an information line, and we also have a community legal centre that specialises in elder abuse and they also have a helpline. We do analysis across those phone lines just to understand what the themes are and what the issues are that older people are experiencing at any given time but particularly during COVID.

Ms CROZIER: And just some clarity on that: the numbers to those phone lines, those helplines, have they increased markedly?

Ms HOGARTH-CLARKE: Yes. Our family violence—so our elder abuse, which is a form of family violence—has followed the trends of other family violence phone lines and helplines. During lockdowns our

For the other information line, because we have not been able to access community face to face, the phone line numbers did go up.

Ms CROZIER: Thank you. I just want to go back to some of the evidence we heard this morning, and the Chair referenced Shepparton Villages. Some of their testimony was the voice of the residents, and they said their residents were telling them things like 'I'd rather be dead', 'End of life never meant to be like this', 'I've been cut off from my family', 'We're shut in our rooms' and 'I couldn't walk around'. So they were very limited. They were very heartbreaking stories to hear—and worse, I might add. They spoke about some of those pleas, and you talked about the 50 per cent of aged care residents having dementia and the decline with that.

Now, the aged care standards allow for unannounced visitors, I am of the understanding. With the lockdowns and with the orders, that clearly did not happen because of the interpretation by various aged care facilities and how they were dealing with that. We also heard just how the orders changed; it was very difficult to interpret some of the orders and they were wanting to do the right thing. I am just wondering from your perspective—and I have seen the mandates for the essential visitations that you announced in December around this—as a

direct consequence of all of these issues that I have just spoken about and your advocacy on behalf of people in aged care, what response have you received from both the federal and state governments in asking for those mandated essential visitations?

Ms HOGARTH-CLARKE: Just a point of clarity: COTA is not a part of the Older Persons Advocacy Network. It is another organisation, Elder Rights Advocacy, who facilitate that in Victoria. Their role is to go into aged care facilities and work with residents et cetera and their families in negotiating issues that they have with a provider. We have never done that role, and obviously we did not perform it, but what we did hear—

Ms CROZIER: But you would hear back from those organisations that are listed on your site that have been providing the advice, I presume, because they are the providers of this service.

Ms HOGARTH-CLARKE: Correct.

Ms CROZIER: Yes. Great. Thanks.

Mr IRLAM: Sorry, could I just clarify? You talked about unannounced visits. That is a term referring to the Aged Care Quality and Safety Commission turning up on site. That is not the same as the aged care essential visitor we are talking about. At the moment there is an interpretation as to whether standard 1 allows for visitation as a requirement, and we are seeking advice from the quality and safety commission about how they interpret standard 1 in relation to visits. To date they have not provided any commentary in their comments on visitation that says it is a mandated requirement. We have then spoken to the minister for aged care saying, 'Well, there's a bill before Parliament. We think that you could amend the bill and provide a mandated legislation in aged care'. And then we have now seen the AHPPC come out with the interim guidance that directs state and territory chief medical officers to consider that guidance in how they implement their orders, hence why we are saying to this committee, 'Update the orders to recognise essential visitors'.

Ms CROZIER: Thank you for that clarity. But just on the unauthorised visitations by the authorities, did that happen throughout the—

Mr IRLAM: I would have to go back and take numbers. There were some numbers that happened. There was some decrease that we saw compared to previous years. It depends on which part of the pandemic you are talking about. There certainly were not a lot of onsite visits happening during the first wave of the outbreak, as I understand it, because the resources were allocated to doing daily telephone conversations with facilities that were having an outbreak as part of their outbreak management teams. So there still was a level of oversight, but it was remote, not physically there. There was still a level of understanding of whether the regulations were being complied with or not, but it was not deemed an onsite unannounced visit physically happening; it was done by telephony and videoconference et cetera. There was a smaller than anticipated number of unannounced visits during the omicron wave over the Christmas period, which I believe the commissioner has made some public comments about, but I would have to take that on notice to come back with accuracy.

Ms CROZIER: Good. Thank you very much, if you would not mind, because I do think that is important to understand—you know, two years from the first outbreak and that first wave to where we have come from the omicron. Just again to go to those impacts, and you spoke about that and the essential visitations, I think that that is what we have been very concerned about. We have heard a lot of evidence in relation to the restrictive nature of the orders and how that has impacted not only just those residents but their family members and how that has had a flow-on effect too. So it is not just those people, those elderly residents, but also their family members. So just finally if I could—

The CHAIR: Quickly.

Ms CROZIER: I am out of time, I can see. Did your analysis take into consideration those impacts to the broader family members too, or was it just to the residents?

Mr IRLAM: We know the role of some people as the primary carer for a person living in residential aged care is a very important role to their sense of self, the sense of connection to their husband or wife, family member et cetera, but in the context of whether or not there is a right for somebody to be visited, it is about the rights of the resident. We argue they should have a right to be able to choose or not to choose to receive visitors

on an individual basis, not have that decision made for them by a facility doing a risk profile worried about a WorkCover investigation, for example.

Ms CROZIER: Thank you.

The CHAIR: Good. Thank you. We will go to Mr Bull now.

Mr J BULL: Thank you, Chair. Thank you, Tina and Corey, for your representation, advocacy and support and care for those that are over 50 and for the really comprehensive and thorough introductory statement. I wanted to go to the very first line that was within that statement, where, Tina, you mentioned that you appreciated the leadership of the Victorian government through the course of the pandemic. Can you explain what you mean by that?

Ms HOGARTH-CLARKE: Yes. I think what we have discovered during the pandemic has been a collaborative approach with the sector and particularly when it comes to senior Victorians. I am not sure if anybody in the room is aware: we have a very ageist society that we live in, and it does make it very difficult sometimes to bring older people's issues to the attention of not only government but also the community. So what we did find—if we want to look for a silver lining—during the pandemic is that older people's issues and older people in general in Victoria were put into the spotlight, and media and general society were interested in what was happening. As a reflection of that, we have had an extremely good relationship certainly with the Department of Families, Fairness and Housing and the office of seniors. We are in regular contact with Gerard Mansour, the commissioner's office, as well as Anthony Plummer and, previously, Jackie Kearney, interacting with their teams on a regular basis and being asked to consult around what are the issues that we are hearing and having that feedback and instant feedback, so it has been greatly appreciated in that leadership response.

Mr J BULL: That is wonderful to hear. Both Anthony and Gerard are excellent people, and from my interactions with Gerard he is certainly someone who is committed to all of those points that you raised. It is incredibly important that that work continues. Just on the situation around public and private aged care, we heard evidence earlier today around some significant concerns that were within a federally run aged care facility in this state and particularly in relation to vaccines and the lack of PPE, and it builds on some questions that the Chair, I think, asked earlier around: how do you see that split around federal and state-run aged care, and what is the model that COTA fundamentally supports?

Mr IRLAM: I think the first thing to understand is that there are no such things as federally run aged care facilities. All aged care facilities are federally regulated, but either they are run by a not-for-profit private provider, a for-profit private provider or the state government in Victoria, which is one of the few states that still run directly aged care services, so I am not quite sure what you meant by federally run.

Mr J BULL: Public and private delineation.

Mr IRLAM: Yes. Thank you. Sorry, I just wanted to clarify.

Mr J BULL: No, that is fine.

Mr IRLAM: So I think that as we alluded to before, there is no neat, easy thing to be able to point to between publicly run by the Victorian government and other aged care providers other than those two points that I made earlier about the skills mix—high qualifications often found in staff and the ratio numbers of staff that are mandated under the Victorian legislation. So we see slightly more staff in public compared to most privately run aged care facilities, but not all. There are some that are equable to it, and some actually exceed it. We certainly see a skills mix that is more often higher level qualification in publicly run aged care facilities compared to most privately run not-for-profit or for-profit facilities in Victoria.

So they are two variants that we see, but what is perhaps more important, regardless of whether you are public or you are private, is what your policies and procedures are, what the training that you are providing people that come through is and what the level of PPE and RAT testing that you have got access to is—and we all know there were problems during omicron in just getting the RATs even if you wanted them, let alone the issues of whether you are charging the residents' visitors or whether you are collecting the money back from the commonwealth government grant fund. These are the sorts of things that, irrespective of whether you are public or you are private, were making the difference as to whether or not you were managing well. In our opinion the

outbreaks were happening. As I said before, in some cases we have seen bad outcomes happen in private, and in all cases that we have had reported to us in public the issue of managing visitors is one area that the public system in Victoria could improve upon.

Mr J BULL: One final one. I have got the green light again from the Chair. Thank you, Chair. Can you just touch on vaccine mandates for me and your position on those, please?

Mr IRLAM: The position of the industry code is to support mandating of vaccination, both for influenza and for COVID. It has not tried to complex the definition of what is fully vaccinated to talk about boosters and say whether they should be mandated or not, but I think that sends a very clear signal that we are supportive of mandating across both of those, including as we are now seeing for workers what we are calling 'fully up to date' by having a booster but still fully effective vaccination if you have got two. It is getting a little confusing out there, but there is general support that we should do that, particularly given that we see evidence with the extra booster of a different kind of risk profile in residential aged care when you have got it versus when you do not.

Mr J BULL: Thanks, Corey. Thanks, Tina.

The CHAIR: Thank you. We will go now to Mr Wells.

Mr WELLS: My questions have been answered.

The CHAIR: Good. Okay, then in Mr Erdogan's absence, back to Ms Shing.

Ms SHING: Thank you very much. I would like to touch on a couple of things around staff retention in the aged care sectors. We have heard evidence that it is a really difficult road ahead, as it has been previously. We have also heard evidence that pay increases and additional training and opportunities for advancement within the profession, along with lifting the recognition of work in this context, are important. I would like to get your take on that and any priorities that you would identify for reflecting and recognising this workforce and making sure that this cohort is able to not just perhaps stem the flow of people from the sector but also build itself back up over time. Then I would like you to touch very briefly on technology and engagement and how that is actually being used to create connections that perhaps have not been there before, and from that, what lessons have been learned and what you can take to retain, now with the benefit of hindsight, as practices that do in fact create, foster and preserve connections and also the quality of life for ageing Victorians.

Ms HOGARTH-CLARKE: Thank you. I will let Corey address the national take on the workforce issue, if you want to, and then I can talk about digital inclusion.

Ms SHING: Thanks, and ratios too, if you are in a position to address that, around staff. Thanks.

Mr IRLAM: Yes. So just very quickly, 24/7 nursing, ensuring there is a nurse on site every time, every hour of the day. There is a whole question of whether you should have more than one nurse, for example, for beds more than 100, but let us start with actually making sure there is a nurse on site at every point. There are a lot of challenges about finding that workforce. There are not enough nurses, they are not paid enough compared to other sectors they can work in, but we are yet to see a commitment from the federal government to mandate 24/7 nursing; we would like to see that. There is a Fair Work case to work out the value of how much somebody should be paid. Unions have put forward the proposition that should be a 25 per cent increase. There is a consensus statement that COTA was happy to be around the table and make sure it happened between providers and unions. That gave the Fair Work Commission a basis of where people could agree to help progress that case. We are yet to see the government commit publicly that it will fund 100 per cent of whatever comes out of that independent umpire's process, and we would argue that that should occur because it is a very important signal to Fair Work as to whether or not we are going to find sectors that are increasingly in the red and are going to have to fund the difference themselves or whether the tab will be completely picked up by an aged care funded sector.

Ms SHING: You are talking about the award system federally? The award system?

Mr IRLAM: Well, it is the award system we are discussing, but we also know that often people are paid by EBAs above the award system, so it will all flow through eventually in both. What was the question, sorry?

Ms SHING: I was talking about staff retention, pay increases, training and workforce development opportunities and how we in fact build the system and confidence and morale back up again after what people have experienced in the last couple of years.

Mr IRLAM: Yes. So I think training is largely covered. There is a lot of promotion for people to become trained in a certificate III, a certificate IV, as an enrolled nurse, a registered nurse. I do not believe that we have got an undersubscription in those courses at TAFE to be able to do it, but we have not necessarily got the pipeline of people wanting to go into the sector, and if they are qualified as a personal care attendant, they are often finding the extra $3 or $4 an hour in disability to be more attractive than working in aged care—hence we are wanting to fix that. We are also finding the workload and the ratio element—you know, how many enrolled nurses to registered nurses, how many personal care workers, how many people are under the domain of control for a nurse—that it can be quite more attractive to work in the primary health system rather than the aged care system. So there are some things that need to be resolved in those first points. But then there is going to be generally, after—what is it going to be?—two or three years of COVID, lots of media reports of death, dying and doom in aged care, a need to actually conscious bring the community back to respecting the role of workers in aged care, to actually support it as a good industry to work in once these pay and conditions settings have been fixed, which will not happen until June next year after the Fair Work Commission inquires into it, and possibly thereafter.

Ms SHING: Thank you. And just finally, the tech and engagement—what has worked? How have there been able to be connections created with people who are within the aged care residential setting or at home, for example, to offset to some extent that isolation and loneliness? And what are the things that can be captured and retained as good practice to address the social and wellbeing consequences of orders which are there for the intention of protecting life and safety?

Ms HOGARTH-CLARKE: That is a very interesting question. I mean, earlier on in the piece we—not just COTA but several other organisations—had a really concerted effort in getting as many people as we could across the line and engaging in this sort of forum and ensuring that they did have the technology to be able to engage in Zoom or Teams or some sort of virtual forum. So we moved a number of people across, you know, using that encouragement and obviously giving them a reason now to engage in this sort of forum, and we are quite happy particularly with COTA. Many of our volunteers, for example, are now seeing the benefits and are wanting us to continue. But let us not forget that there still is a large cohort that are not able to choose not to engage in a digital form—and it is still quite large numbers. I do not have the numbers with me at the moment but it is still quite large numbers of people, particularly those from culturally and linguistically diverse—those that do not speak English, for example—as well as those that have medical conditions that make it difficult for them to engage with a tablet or with a computer, sight impaired. A lot of these digital formats are not accessible for people that are sight impaired et cetera.

Ms SHING: But with those caveats, it sounds to me as though there have been improvements as far as connection and a reduction in that feeling of isolation because of the way in which you have been able to adapt using technological platforms and opportunities that are available to you. I mean, that is certainly the evidence that we are getting from elsewhere.

Mr IRLAM: The Australian Digital Inclusion Index, if you compare 2020 to 2021, only showed about a 3-point increase in digital ability amongst people over the age of 65—I will come back on notice with exactly what those figures are—so it has only been a marginal difference in their ability to do it. I think the issue comes back to whether or not people choose to do it. They might have the ability to, but they choose not to. That has pivoted to people choosing to do so because they have had to, but we also would forecast that it is likely it will pivot back to them choosing not to when they do not have to.

Ms HOGARTH-CLARKE: Yes. And it also takes into consideration, particularly in an aged care facility, that we are talking about 50 per cent of residents within aged care facilities having some form of dementia, and depending on what stage they are with their dementia they cannot engage on a digital screen. They do not recognise that the picture on the screen is their family member. There is a big difference between that touch and that personal contact.

Ms SHING: Yes, absolutely. Thank you very much.

The CHAIR: Thank you. Just one final question: as an advocacy organisation, do you get access to a lot of statistics and information? Does the government share a lot of information with you and other agencies and other advocacy bodies?

Mr IRLAM: We do not, because we do not provide direct services to people on the ground going through those processes, but other organisations, such as OPAN, being part of that state response centre to aged care, would have access to other data. I think, though, whenever we have asked for information as a one-off we have been able to get that information very helpfully from the public health unit through those fortnightly facilities, but it is not a regular thing that we receive, Chair.

The CHAIR: Okay. Thank you very much. There being no further questions, I would like to thank you both for appearing before the committee today and giving evidence. You will receive a transcript of the hearing within the next week for you to review and a list of any questions that were put on notice to you.

That concludes today's hearings. I thank everyone for providing evidence and all those who have attended and those who have watched proceedings today. Thank you.

Committee adjourned.