HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP (virtual)
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP
Mr TJ Watts MP (virtual)

Staff present:
Mr R Hansen—Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE PROVISION OF PRIMARY, ALLIED AND PRIVATE HEALTH CARE, AGED-CARE AND NDIS SERVICES AND ITS IMPACT ON THE QUEENSLAND PUBLIC HEALTH SYSTEM

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 10 FEBRUARY 2022

Southport

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The committee met at 2.14 pm.

CHAIR: I declare open this public hearing for the committee's inquiry into the provision of primary, allied and private health care, aged-care and NDIS services and its impact on the Queensland public health system. My name is Aaron Harper, member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples whose lands, winds and waters we all now share.

With me today is Mr Rob Molhoek—we are actually in his patch—deputy chair; Ali King, member for Pumicestone; and Joan Pease, member for Lytton. We have Trevor Watts, member for Toowoomba North, who is substituting today for Mark Robinson, the member for Oodgeroo. Stephen Andrew may join us later on via teleconference.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. However, what we have done in public hearings in other areas is open it up to members of the audience should they wish to provide some contribution. These proceedings are being recorded. Please turn off any mobile phones or switch them to silent.

BURRETT, Ms Sara, Executive Director, Allied Health and Rehabilitation Services, Gold Coast Hospital and Health Service

SPENCE, Ms Karen, Acting Program Manager, Integrated Care Services, Gold Coast Hospital and Health Service

CHAIR: Thank you both for being here. We will move to an opening statement and then go through to questions.

Ms Burrett: Thank you for the invitation to speak today. The Gold Coast Hospital and Health Service strives to provide excellent care to our patients. That care includes reviewing the entry into and planning for the discharge from our services, which at times can be challenged by the availability and accessibility of aged-care and disability services, the timeliness and appropriateness of NDIS assessments and the way the primary care system is set up. These challenges create pressure on our health system to manage the increasing demand on our inpatient beds evidenced in part by a 14 per cent increase in ED activity over the last five years.

Our hospital currently has over 100 patients whose discharges have been delayed for various reasons, including awaiting a NDIS plan approval or review, awaiting a supported accommodation living vacancy, a residential aged-care bed or a variety of supports that would help them to live at home. These patients can remain in hospital for days, weeks and sometimes months while eligibility for services are determined and then while those services source suitable supports, for example, personal hygiene, wound care, domestic assistance or allied health care for patients.

In many instances health is the facility of last resort, particularly for patients with complex medical and/or behavioural needs that require more specialised care in the community and at times when external supports are not available or equipped to care for them. We at Gold Coast have good relationships with our partners and we work hard with them to get the best outcomes in the most timely manner for our patients. Despite this, the systems often work against us all. Queensland Health has provided additional resources to support the safe and timely discharge of patients and to prevent admissions in some cases. For example, in this financial year alone Queensland Health and Gold Coast have paid nearly $300,000 to support patient discharge safely to more appropriate accommodation than hospital with equipment, overnight supports or rent, as examples. In addition, we do have services designed to hold patients for a week or three while external supports, including Commonwealth home support packages, are sourced.

We have a GP advice service, for example, that allows GPs to discuss the care of their patients with specialists prior to sending them to ED or outpatients. In the last quarter of last year this resulted in 33 patients avoiding ED presentations and outpatient appointments. We have many more examples that we are happy to provide and we welcome the opportunity to explore these themes more fully today. Thank you.

CHAIR: Thank you very much, Sara. I think you paint a pretty frank picture. We have heard similar in other parts of the state this week as we have travelled. One hundred patients is a great burden on the Gold Coast Hospital. I am out of my patch of Townsville and I do not know what the Gold Coast HHS incorporates in terms of hospitals. How many beds do you have available down here?

Ms Burrett: Around 1,000 between the two hospitals. We have the Gold Coast Hospital, which is around 650 beds, and Robina Hospital, which is around 350 beds. It does differ according to staffing availability and other factors.

CHAIR: Some of the data we heard in our very first briefing was that there was anywhere between 550 and 600 beds across Queensland taken up by exactly what you have talked about here, that is, when people cannot be discharged. We have heard of long stays. Can you give us an example of the length of stay of these people in hospital and what the negative effects of that might be?

Ms Burrett: We have a report that we look at fortnightly with patients who are in for over 35 days. We can see that we have a range of patients from 35 days up to and including sometimes two years. In the last three years we have made great efforts to reduce the length of stay so that we are not having patients in for 12 months or 24 months. However, we do continue to get some patients like that.

CHAIR: We have heard that people staying in hospital for long periods of time is not a healthy thing.

Ms Burrett: That is correct. There is evidence to suggest that a patient's condition can decrease the longer they stay in hospital when they are not required to be there. Particularly for aged patients we know that when they spend longer than they need to in hospital their muscles can become deconditioned. We also know that their nutrition can sometimes be impacted and that causes issues with them going back home. That means we require more services to support them when they go home.

Ms Spence: To add to that, the research does show how quickly that actually occurs. You would think it would take longer, but it can be as little as three or four days, and the patient starts to lose the condition of their muscles, especially in the older age group. It is really surprising.

CHAIR: There is no doubt there are very similar stories. I am going to move to questions. Deputy Chair?

Mr MOLHOEK: Thank you for coming today. Sara, I am wondering if you could elaborate a little bit more on the long-stay patients. What is the average number that you would have in the hospital and health service and what is typical in terms of length of stay? I know you said you had one person in there for up to two years, but what are the averages that we are looking at?

Ms Burrett: We have around 100 long-stay patients at any one time. I have to say that there is a range of reasons for those lengths of stay. When we say 'long-stay' we mean 35 days or more. Some of those patients still require medical care so they fall out of this particular discussion because they require rehab or further investigations or a mental health consultation—something like that. They require medical care so they still are long-stayers but are not part of this discussion.

Mr MOLHOEK: I am conscious that the Gold Coast hospital is something of a hub in terms of servicing parts of Southern and Western Queensland. Are they all Gold Coasters or are some of them from Goondiwindi and Stanthorpe and places west of here?

Ms Burrett: I do not have the statistics on where our patients come from, but certainly you are correct. We do have a number of specialised services at the Gold Coast and as such we do receive referrals from elsewhere. I do know we also receive some patients from Northern New South Wales, particularly trauma patients, rehab and brain injury patients—from New South Wales and from broader Queensland.

Mr MOLHOEK: Perhaps as a question on notice it would be interesting to see some sort of a breakdown of those figures in terms of how many from New South Wales, how many from outside of the Gold Coast, how many are NDIS. You made the distinction that some actually quite legitimately are still there because they require medical care. I think one of the things we are trying to get to the

bottom of with the inquiry is deficiencies in the NDIS program and home care packages and other federally funded programs around aged care. It would be good to understand the breakdown of that data so that we can get a better picture of that real impact on the health system.

CHAIR: Anything taken on notice we need to have back by 17 February. Member for Pumicestone?

Ms KING: Thank you for coming in today and for your contributions to the health and wellbeing of your community here on the Gold Coast. I wanted to ask a couple of questions about aged care in the region in particular. Before we go there I will note that of the 550 to 600 long-stay patients in Queensland at any given time it sounds like the Gold Coast Hospital and Health Service cares for a large proportion of them. We know that some of them will be people who are awaiting discharge to a suitable aged-care place. Is it your view that this region has enough aged-care beds in residential aged care to meet the needs of the community?

Ms Spence: Patients are staying longer in nursing homes now. There are less beds that are becoming available. We make up for that by having beds in a nursing home called our interim care beds. At the moment we have 16 or 17 beds there. Those patients are actually cleared by the medical staff and are just awaiting a nursing home position becoming available. It could be that the patient themselves wants to choose a particular nursing home and so they are waiting or it could be that there are some financial things going on with them from families involved and things like that, but mostly that is about waiting on a nursing home becoming available within the Gold Coast.

Ms KING: What did you say that accommodation was called?

Ms Spence: It is called interim care. It is in one of the nursing homes close by to here. We use it because the patients are still governed by ourselves in Gold Coast health.

Ms KING: Is their care funded by Queensland Health while they are in that interim care?

Ms Spence: Yes.

Ms KING: While they are awaiting a suitable place to come up, Queensland Health is funding their care?

Ms Spence: Yes.

Mr MOLHOEK: We should probably point out also that the Gold Coast health service contracts out many other beds amongst private hospitals and providers to meet the shortage of overall beds.

Ms KING: Could I continue my line of questioning, please, member?

Mr MOLHOEK: Sure.

Ms KING: I am sorry: you were about to add something.

Ms Burrett: I was going to add that I have the February data in relation to NDIS and RACF patients. Patients waiting to be discharged—we have currently 25 patients who are waiting for an RACF bed.

Ms KING: Thank you for providing that. Was it in the last financial year that Gold Coast HHS had contributed nearly $300,000 in equipment, overnight support and even rent? Did I hear 'rent'?

Ms Burrett: That is this financial year.

Ms KING: This financial year so far?

Ms Burrett: So far.

Ms KING: To make it clear, the Gold Coast HHS, funded by Queensland Health, has contributed that money to meet a cohort that are nominally meant to be cared for and their care funded by the federal government?

Ms Burrett: That is correct. We have a gap in NDIS funding for one patient for overnight supports, and we provided a significant amount of money to engage overnight supports so that the NDIS could then see that those supports were required. Often there is a disconnect between what the hospital sees as supports that are required in order to discharge, acknowledging that in the first few weeks they may need more and then become less over time versus what they may need further down the track. Often that is a cause for delay because there is back and forth around opinion and around what the NDIS will fund. If they are saying they are only going to fund a certain amount, that patient would be stuck in hospital without that additional funding. In order to discharge them so that they can start their lives again outside of the hospital environment, we do pay for rent, equipment and sometimes care workers to support that discharge.

Ms KING: I will briefly note before I hand back to my fellow members that the Queensland government cashed out to the NDIS very significant amounts of money that were previously spent supporting people with disability. In effect, we are paying twice for the care that these people absolutely require and deserve?

Ms Burrett: Yes.

CHAIR: That is a really good point. We have heard and received some data around people waiting for assessments and then that being questioned. I was interested to read—I think it was PricewaterhouseCoopers—where someone reported there was some $17 million in litigation against people applying for NDIS. I thought that was amazing. That is a huge amount. The problematic issues that arise from that in relation to people getting the funding—it was all about choice and control, to actually go home and get out of the beds. There must be a huge impact at the front end as well.

Ms Burrett: Yes.

CHAIR: There has been a fair bit of media attention around ambulances trying to get in. Obviously there is increased pressure and demand for service with COVID. Talk to us about the practicalities of that. If you cannot get people out at the back end, what is happening at the front end?

Ms Burrett: As I said, we do have increasing demand on the hospital through the front end. We have had a 14 per cent increase in activity through emergency over the last five years. Roughly, that is a three per cent increase year on year for the last three years. The data is similar across both sites—Gold Coast and Robina. That is both ambulances arriving and walk-ins as they come through the door.

CHAIR: That is a very good point. In Townsville we had figures of 250 a day. About 70 per cent walk in because they cannot get access to a GP. That is where I wanted to go with this question. Can you talk to that?

Ms Burrett: Yes. For ED arrivals in January 2022, our figures show we had over 15,000 presentations to emergency. Just over 4,500 of those presentations were ambulance arrivals, which means roughly 11,000 were walk-ins.

CHAIR: Wow!

Ms Burrett: That is for January.

Mr MOLHOEK: That is across Robina and—

Ms Burrett: That is the total, yes.

CHAIR: Is there a problem accessing GPs on the Gold Coast?

Ms Burrett: I think it has improved. Did you want to answer that?

Ms Spence: There were problems over Christmas and the New Year. I think everyone was experiencing those problems. I think we have reports of people not able to access the GPs, and out of hours as well becomes a problem for them. That comes through in our figures as well. You can see the different times that patients actually arrive. We categorise them as they come through and you can see our category 4s and 5s as well over the years. Those are ones that would traditionally be dealt with in the general practice arena.

Ms Burrett: In addition to that, I am not sure about the numbers of GPs that are out there, but I think one of the challenges that has been described by—we have a GP liaison officer in our service who does a great job of building those relationships with the GPs. She has talked to her colleagues and described that the way the system is set up with 10- to 15-minute or 20-minute appointments means that it is difficult to have those longer time frames to assess a complex patient or even just a patient with a condition that requires a little bit more time. Where they might otherwise spend that time and send for tests out in the community, if they do not have that time, they might then send them to the hospital to get those assessments done.

There was also a comment that GPs have varying levels of confidence in dealing with the undifferentiated symptomatology and many seek support or assurance to exclude where or not-to-be-missed conditions. I described before our GP advice line, which has been really helpful in allowing those GPs to have those conversations with specialists to try and prevent those admissions.

Ms Spence: May I add in here as well: the other part about the GPs is that the Medicare, the fee-for-service, does not include case management. With a lot of the work that we do at the back end from the chronic disease perspective and managing this cohort of patients, the best way to manage would be a collaboration and a joint working together because a lot of the time it is allied health and

nursing that can actually deliver this care for the chronic disease patients. However, because of the way that the system is set up, there is no incentive for them to actually be a part of that. That is another area that could do with being improved.

Mr WATTS: How many patients do you have in the hospital who are claiming medical cover, as in using their private insurance, I am assuming?

Ms Burrett: I do not have the statistics for that. I do not have the data for that here, but I can take it on notice.

Mr MOLHOEK: They are taking that on notice, Trevor.

Mr WATTS: Thank you.

Ms Burrett: I do know that as a general theme there is a reduction in private health.

Ms Spence: I think it was about 40 per cent or something across the state. We just need to check that to see how it correlates here.

Mr WATTS: I am curious to understand what sort of percentage could be used of that private health cover in a private hospital to then open up a public bed, rather than a private claim being in a public hospital. I know that is the practice that public hospitals are engaging. I want to get the figures again on your emergency department. I think you said it was 4,000-and-something. I did not hear all of that. Could you repeat that for me?

Ms Burrett: For January 2022, we had 15,720 total presentations to our emergency department. Of those, 4,669 were ambulance presentations, which means roughly 11,000 were walk-ins.

Mr WATTS: Of those walk-ins—I am trying to understand what it is they are walking in for. Is it a category 1, 2, 3 or 4? What sort of triaging are they requiring?

Ms Burrett: I am sorry I do not have that information with me today. I can take that one on notice, too.

Ms KING: I think we would like to have that, not just for the walk-ins but for all ED presentations if that is possible.

Ms Burrett: The question is for all ED?

CHAIR: Yes, including the QAS category. If you can give us a breakdown of 1 through to 5, that would be good.

Mr WATTS: I am trying to understand how many of them should be in hospital. That is the principle of the question. My next question relates to specialist services and where a GP might be referring someone and the on-boarding of those people and the integration of that. Obviously one way to keep people out of hospital is to get specialist appointments done early so that they can receive whatever treatment they might have and/or be managed by their GP. I am trying to understand what the process is there and where we might be able to make some changes to have less siloing. Obviously one thing is to keep people out of the hospital and appropriately back into GP care, and one strategy may be to try and get specialist appointments done so that they do not have to go to hospital.

CHAIR: I will take that as a comment.

Mr WATTS: I am trying to understand what your process is for somebody seeing a specialist and then being passed back to their GP?

Ms Burrett: We have a centralised referral process system. GPs refer into the hospital and health service. Those referrals are categorised and then appointments are made according to that categorisation. Once they have seen the specialist, they will then either be provided with an intervention or sometimes they are referred from the specialist or from the categorisation to allied health for models of care and primary contact. We also have nurse-led clinics, so we see those patients with a variety of different professionals according to the presenting problem and the skills of the professionals. Then we would discharge those patients back to the GP or, if those investigations have shown something more serious, then we might book them in for surgery, for example.

Ms PEASE: Like my colleagues, I would like to acknowledge the great work that you do in providing services and support to the people of the Gold Coast, but also to your staff for the great job that they have done during particularly trying times. Thank you.

CHAIR: Hear, hear!

Ms PEASE: I am interested to hear more about the specialist GP program that you run. At our earlier hearing this morning we heard from a general practice at Inala. They spoke about the ability to speak to a specialist at a public hospital to determine what they need to do with a patient: is it worthwhile referring them to the hospital or could some advice be given to the doctor on the ground so that they might not be referred on. Is that the sort of service that you are—

Ms Burrett: Yes, I will get Karen to speak about that in a second. The other thing that would answer that question is the HealthPathways process. That is a relatively new program. It has gone around the rest of Queensland. We were late to the game, but we do have HealthPathways now and that is a really great resource for GPs for these kind of questions. If somebody comes in with symptoms of diabetes, for example, they can follow that pathway which asks them to send them for particular tests; then if it goes this way or that way, you might manage it as the GP in the community or you might need to refer in. We have HealthPathways and we have a number of other programs that Karen is able to speak to.

Ms Spence: On from that is the Smart Referrals, where the GP puts the referral in and it has a clinical prioritisation criteria there which, if the patient is presenting with X, Y and Z then this is what happens. As Sara says, it could be HealthPathways and it could be into one of the clinics within the hospital to a specialist. The other part was the GP advice. It has been a trial that we have trialled under our community services redesign work that we were doing. It has been going since we started really—September this year—and it has been wonderful. It has been a really good service. With COVID as well, GPs were phoning in for advice for that too, so other good things happened in that space too.

We tried to have it where the GP could speak directly to the specialist, but that is hard to manage because specialists are not sitting around and neither are GPs. We have to organise that, link them up, get the information—get the two of them together at the same time. Sometimes that is best dealt with by a phone call to the GP liaison officer who can then liaise with the consultant. Sometimes it is about bringing them together.

I think for us and for Sara it is about the vision for that service and what we actually can do with that. In the past we spoke about whether we could ever have the specialists working in general practice and having that cohort of patients seeing them when they were there. As you know, specialists are such a precious resource it is hard to manage that, but perhaps some way through this GP advice function or service we could do that using our virtual care so we could end up having these three-way consults with the GP and the patient into the general practice.

Ms PEASE: Thank you, Karen. One of the things that we heard about today was the problem for the GP on the ground is that there is no way that they can recoup the time.

Ms Spence: Correct.

Ms PEASE: So there is no Medicare rebate that they can make.

Ms Spence: No.

Ms PEASE: Any time they spend on that takes them away from a patient where they can earn money so that they can pay the overheads, pay their staff et cetera.

Ms Spence: Correct.

Ms PEASE: Who would you go to? Would you go to your PHN? Who would you go to to see if there would be any capacity to advocate to create a rebate through Medicare for this sort of service? Would you go to your PHN?

Ms Burrett: Yes, absolutely, you would go to the PHN. We have a partnership with our PHN already. That has been ongoing. We have regular monthly meetings with our PHN to talk about our combined patients.

Ms PEASE: So that is a role that a PHN could effectively play, to advocate on behalf of the GPs to make sure that they are being remunerated effectively for providing primary care to their patients?

Ms Burrett: Yes.

Ms Spence: There is the GPGC as well. On the Gold Coast, I think it is about 50/50. Half are part of the PHN so they do not cover all of them, but between the two, the GPGC and the PHN, they are covering the whole of the GPs apart from one—

Ms PEASE: What is a GPGC?

Ms Burrett: It is a particular group of GPs who are not part of that PHN.

Ms PEASE: Why are they not part of the PHN?

Ms Burrett: I do not know. I am not sure.

Ms KING: They choose not to engage with the PHN.

Ms Burrett: I cannot speak for them, sorry.

Ms KING: I understand, sorry.

Ms Spence: The other way we have of getting around that is we do have a GPLO, our GP liaison officer, who targets everyone, goes out with the communication, feeds back to them all and makes sure they are all part of what is happening within the HHS, so that there is a conduit to everyone. But there would not be the one advocating for everyone.

CHAIR: What is the population down here: 600,000 or 650,000?

Mr MOLHOEK: Six hundred and eighty thousand.

CHAIR: With that comes an ageing population, which means people living longer with chronic conditions. I do not know how many residential aged-care facilities you have, but I would imagine—

Ms Spence: Fifty-nine.

CHAIR: That would be about right. Everyone wants to come to the Gold Coast to retire. If there was a better level of care to keep people out of hospital, so care in place through home care packages or in a residential aged-care facility—and be mindful that we did an aged-care review and made several recommendations about increasing nurse practitioners and a number of other things in the private space. It is up to the federal government to implement that. If there was a better level of care, be it nurse practitioners or GPs who actually go to these places and deliver that, do you think that would keep a potential number of those presentations out of hospital?

Ms Spence: Yes. Probably the worst part is before the patients actually get into the nursing homes. They have the Commonwealth home support programs, the basic service, and then they go up to the packages and the levels. As they get up to level 2, level 3, level 4—these are really hard to get. Some of these take 18 months. With the time the patients have been waiting on these programs, not getting the regular care that is required at that level, they end up getting admitted into RACFs or end up with us as well. The patients want to stay at home as long as they can.

CHAIR: We heard that from palliative care. Some people died waiting for their home care packages.

Ms Spence: Yes, they do. It is sad.

Ms Burrett: On the point about nurse practitioners and doctors being able to visit the nursing homes, we do that from the Gold Coast perspective as well, so we know that that works.

Ms Spence: Similar to other comments that I have seen in some of the papers, we have the same service. We have a RaSS service and a RACF acute support service that is staffed by nurse practitioners, CNCs and CNs, also with the support of a GEDI doctor, a geriatric emergency department initiative doctor. The way that that works is that it is intended to make up. In the nursing homes there are RNs mostly. The CNs, CU level—that higher level of nurse with triaging experience—can liaise back in with the GEDI doctor to see if there is anything they can do to help keep the patient in the RACF. The other service that is part of that is medical imaging. We can do remote medical imaging and remote ultrasounds as well so that patients do not need to get trundled in here just for a bladder scan or—

CHAIR: Via an ambulance—another ambulance stress.

Ms Spence: Via ambulance for hours and hours and hours. We can mobilise that. That has been an amazingly successful service. Probably across the Gold Coast it would be 26 times a month for that. That is effectively 26 patients who would otherwise have been trundled in here to get that type of diagnostics done.

CHAIR: Very quickly, do you have a private hospital and does it have an ED?

Ms Spence: We do not have our own, but there is one here.

Ms Burrett: We do not have our own private hospital, but there is a private hospital on the Gold Coast and there is one at Robina as well.

CHAIR: Do they have emergency departments?

Ms Burrett: Yes.

CHAIR: Do you know the percentage of people on the Gold Coast who have private health cover?

Ms Spence: I do not. I think 40 per cent, but I do not know.

CHAIR: We have some data that around 60 per cent do not have private health cover and 40 per cent do. The gap is so big they go to the public system

Ms Spence: Yes. The other part of that is that, even for the ones who do, it seems to be that a lot of it does not actually cover all of the things that they want and so they end up coming here.

Mr MOLHOEK: I understand that in an ideal world we would not have long-stay patients in our hospitals. Would it be fair to say that one of the reasons the Gold Coast University Hospital and Robina Hospital have developed so many innovative programs around external care has been because the health services have been under enormous pressure across the board?

Ms Burrett: Yes.

Mr MOLHOEK: In terms of the Gold Coast University Hospital, I understand it has the busiest emergency department in Australia now.

Ms Burrett: Yes.

Mr MOLHOEK: So a lot of the innovation and the outsourcing of services has come because the system has been under enormous pressure, hasn't not?

Ms Burrett: That is correct. I will add that the population statistics obviously grow with our tourist population as well. Our particular hospital is faced with those challenges through the emergency department, often around schoolies, school holidays and that sort of thing.

Mr MOLHOEK: And that is not always accounted for in the planning funding either?

Ms Burrett: It is absolutely not, no.

Mr MOLHOEK: I wanted to ask some questions around the local area needs assessment, the LANA process. It would be interesting to get your commentary around the capacity of our hospitals currently, particularly around beds, where we are at with planning and what we see as being future demand. I think they are important figures for us to be considering as part of this inquiry. I understand that Robina, for example, is already running at about double its built capacity and I think we are well past capacity here from its opening 10 years ago.

Ms Burrett: Yes.

Mr MOLHOEK: Where are we at with our local area needs assessment?

Ms Burrett: It is safe to say that we do not have enough beds across the HHS. We are engaged in a number of different processes and planning activities in order to address that need. One of those, for example, is the Coomera hospital and health precinct. In recognition of the need for more health facilities on the Gold Coast, $3 million was provided by the Palaszczuk government to develop a plan for a new hospital and health precinct at Coomera. We are currently working through that planning process and, given the size and scale of the proposed facility, it will likely be five or more years before it is operational. We are planning for a hospital and health precinct. I do not think we are at the stage yet of firmly determining what services we will have up there, but we are still in that planning stage. We also have a secure mental health unit that is well on its way in the planning process, and the Tugun satellite hospital project as well that we are—

Mr MOLHOEK: What is the time frame for that to be operational?

Ms Burrett: With the Tugun satellite hospital project, we are up to talking about what kind of taps we need so I think it is not too far off—12 months, I would suggest, but I would need to confirm that.

Mr MOLHOEK: I understand the health service currently contracts out beds to the private hospitals.

Ms Burrett: Yes.

Mr MOLHOEK: Can you tell us a little bit about how many beds we would like to contract out and what the challenges have been around that with the fact that the private hospitals have been at capacity as well?

Ms Burrett: I did not bring exact numbers on what we are currently outsourcing. Prior to COVID, we had the Surgery Connect program. We were outsourcing some numbers to the private hospitals for particular conditions. During COVID, we used private hospitals significantly for our hospital patient care. We did move inpatients to the private facilities so that we could have beds available for our COVID patients. We had, I think it was, four wards full of COVID patients at Gold Coast alone during that surge period. Most patients were transferred to the various private hospitals across the Gold Coast in order to do that.

Mr MOLHOEK: Perhaps as a question on notice we could have the statistics around that outsourcing and the actual numbers involved.

Ms Burrett: Surgery Connect, yes.

CHAIR: I know part of that was managing COVID and having capacity for surges. The same thing happened in Townsville. It was a good partnership, actually. We have a supplementary question from the member for Lytton.

Ms PEASE: My question might be a little bit longwinded. We heard in other evidence about the allied health and wraparound services that people should be offered in the community and that should be available to one and all. We heard about the difference that means for the ongoing management of chronic disease and potentially preventing it getting to that point. We might run out of time, but we have heard anecdotally that rather than try to source a physio or OT themselves, a lot of patients will come to the hospital because they know that all of those services are going to be on tap, whereas if they try to visit their GP—if they are fortunate enough to get a GP appointment—some of them may be eligible for the package of five visits. However, if they have a chronic condition those five visits are not going to solve anything. Could you comment with regards to what I have said there?

Ms Spence: What you have said is what is happening for us. In terms of numbers, we have chronic disease and post-acute programs, and about 700 new patients every month are referred there. That is where we add value, where we do have these wraparound services. It is very patient centred and provides what people actually need. Within that there is a whole lot of programs including for heart failure, cardiac rehabilitation and all of those respiratory programs. That is what is happening there.

Ms PEASE: That is an amazing impact and it would be a huge drain on your ability to provide services—700 referrals a month—for what is potentially a low-care referral. It is not a chronic or an urgent referral; it is just people wanting to get into the system because they do not have health cover and those allied health services are not covered by Medicare. That is a huge number.

Ms Burrett: I would also say that the allied health services in the private hospital are not equipped to manage the complex patients that we do see in the public system. Sometimes we will get a call from a patient who has been in a private facility and then comes to us because they are suffering due to not receiving particular allied health services whilst an inpatient. That is one of our challenges, and that occurred during COVID too. We found that the private facilities, as much as it was a fantastic partnership as we described, did not have the numbers nor the expertise of allied health professionals that is required for those particularly complex cases.

Ms Spence: They also did not have some of the equipment. It is quite specific to the patients.

Ms PEASE: That deserves to be explored much more than that one question allows. I am sorry, I would have loved to have more time to ask you more questions. Thank you very much.

CHAIR: Thank you both very much for attending today and giving us some insight into what is happening on the Gold Coast in terms of demand on the public health service. I commend you for a lot of those initiatives you are undertaking. I have the view that a lot of that could be fixed by the primary care models that should be adequately funded, such as the NDIS initiatives and getting people out of hospital and into the home. They are just my observations. Thank you both. We appreciate your time.

OCKHUYSEN, Ms Annaleese, Member, Queensland Nurses and Midwives Union

ROGERS, Ms Paula, Community Campaigns Coordinator, Queensland Nurses and Midwives Union

STRINGER, Mr Scott, Member, Queensland Nurses and Midwives Union

CHAIR: Thanks very much for being here today. We will start with an opening statement and then move to questions.

Ms Rogers: It is great to be here. My name is Paula Rogers and I am the stakeholder engagement and campaigns coordinator with the Queensland Nurses and Midwives Union. With me today is Annaleese Ockhuysen, a clinical nurse consultant with Queensland Health's emergency substituted service. Annaleese is also a QNMU delegate and workplace representative. Annaleese will discuss the shortcomings in aged care and their impacts on Queensland's public health system.

I would also like to introduce Scott Stringer, an emergency department clinical nurse consultant and nurse practitioner candidate. Scott is also a QNMU delegate. Scott will present shortcomings in the provision of primary health care, aged care, NDIS and private health care and how they place pressures on emergency departments.

Ms Ockhuysen: Approximately seven years ago my service was a pilot site in Metro South and we developed a hospital and emergency substitutive care service for residential aged-care facilities. We currently service over 100 aged-care facilities in Metro South and it is looking at about 10,000 beds at this point in time.

People living in residential aged-care facilities present to emergency departments at a rate of 0.1 to 1.5 transfers per residential bed per year, and 40 to 60 per cent of these presentations are admitted to hospital. Prior to the initial COVID outbreak in 2020, smaller equivalent services called RaSS services were rolled out to each of the HHSs to assist with the redistribution of clinical care out of the public sector. We were able to provide aged-care residents with a choice of where they received their emergency care. During the Royal Commission into Aged Care Quality and Safety it was recommended that a service likes ours or similar should be rolled out federally, but this is yet to occur. It is only in Queensland that this has happened.

CHAIR: Was it 'RAD'?

Ms Ockhuysen: RaSS, residential aged support service. Our service will often be required to attend to simple presentations such as catheter changes or simple wound care because either the facility is understaffed or the staff do not have the ability or confidence to complete these general nursing tasks. Some of the facilities have developed internal policies where they restrict their registered nurses from completing tasks such as indwelling catheters or male indwelling catheters. These facilities are receiving additional funding for lines and devices and, as such, they should be providing not only the care to the patients but ongoing education to their clinical staff to maintain their competencies. If the facilities are unable to complete these tasks and there is not a service like ours, the default setting is for them to ring QAS and send the patient to the emergency department. This is already putting stress on our hospitals that are under the pump and on our QAS departments.

During COVID our service has had to flex up our staffing to be able to meet the needs of the facilities. This has been due to not only the increased complexity of the patients but also the inadequate staffing, skill mix and projections of the facilities despite having almost two years to prepare in Queensland. Currently, our little service is taking 450 triages a month, which is potentially 450 avoidable presentations to the hospital.

We understand that often the registered staff in the nursing homes are very junior and have been put in a leadership role with little to no training. When we attend to provide emergency care we always encourage the registered staff from the facility to be with us and to complete the tasks under the supervision of our nurse practitioners or doctors. We will often enter the nursing home and spend 20 minutes trying to find the staff who rang us in the first place, and then they have no time to participate in the task due to the high numbers of patients they care for on any given shift. In some of the facilities in Metro South this can be one registered nurse to anywhere up to 120 patients. This is currently further complicated by the additional requirements of PPE donning and doffing and the numbers of staff currently in isolation.

At times, residents cannot be released from hospitals back into their nursing homes because there is not a registered nurse to coordinate and complete this transfer—this is a registered nurse in the aged-care facilities. This overwhelms our already stretched public health system. Many of our

facilities in Metro South—our nursing homes—have no registered nurse from 4 pm every afternoon until the next morning. We have a small group of facilities that do not have a registered nurse from Friday afternoon until Monday morning. This means that any patient who is currently occupying an acute care bed cannot be transferred back into the nursing home over the weekend, and then this fills an acute care bed unnecessarily.

For safe and effective nursing care, there needs to be at least one registered nurse for every 10 to 12 patients in an aged-care facility—around 30 per cent. Tasks such as medication administration take approximately one hour, and that is twice per shift. Wound care, catheter insertions, registered nurse feeds for patients that are at risk of aspirations—all of these take approximately one hour each. Having registered nurses with numbers of patients higher than this puts the patient at risk of suboptimal care, tasks not being completed or patients being sent to hospital because it is easier for somebody else to complete the task when the RN has no time to do it themselves.

Currently our facilities that are in lockdown have had to reduce the total number of their staff interactions to a bare minimum and in some cases to dangerous levels. They have normalised aged-care staff doing 12- to 14-hour shifts to accommodate the reduced number of available staff during lockdown. We must not allow this to become normal into the future. Instead, we should designate this kind of activity as extraordinary and a sign of workforce crisis.

GP availability is diminishing at a catastrophic rate. Currently there are some facilities in Metro South that have not had a GP since October. We are hearing every single day that it is no longer financially viable for our GPs to attend and they cannot look after aged-care residents anymore. This leaves our nurses in the facilities with no clinical governance for their decisions and no medical decision-maker. This results in the default transfer to hospital or contacting my service, which again impacts the public health system. This is also not federally funded. Allowing nurse-led models such as nurse practitioners to practise to their full scope and in the aged-care setting could mitigate the need for some GP decisions and allow residents to receive the majority of their clinical care in their home environment.

CHAIR: Thank you very much for your passion and dedication. I will make some observations before we go to Scott. In its former iteration the health committee conducted reviews into aged care, palliative care and end-of-life care and we made 77 recommendations. We were able to get the Queensland government to increase nurse-patient ratios in the 16 state-run facilities, but of course the 469 other facilities are run by the federal government and it is entirely up to them to try to increase it. It is in the national spotlight right now. As someone who comes from North Queensland and is used to disasters as we only call the Army in after cyclones and floods, I cannot believe that the Army is now being requested to help out in residential aged-care facilities. Thank you again. Scott, welcome.

Mr Stringer: Thank you for the opportunity to speak. The COVID pandemic has placed unprecedented demand on health services across the world. QNMU has joined with other health unions and our 'Health Needs Urgent Care!' campaign to highlight pressures on health systems and how frontline workers such as nurses and midwives need to be at the table to work on solutions. Unprecedented demand on emergency departments such as mine are being exacerbated by the following. There is an increased number of NDIS patient presentations, particularly those with mental health issues, who must face extended wait times in a chaotic and busy environment. These patients often face transportation difficulties, especially at night when the only option left is to admit them as a social admission or tie up the QAS to transport them back home.

There is an increased number of aged-care facility patients. We have noted within the ED that these patients are coming in with more pressure sores, more falls and more presentations related to simple nursing tasks. I dare say that these patients would likely not have presented if there was adequate registered nursing care coverage in aged-care facilities to provide basic care and prevent harm. These patients also bog down the QAS as they await transport to and from public hospitals. The increased workload imposed upon the QAS extends to the wait times that the community faces in emergencies.

In the COVID environment we have seen both NDIS and RACF facilities refuse to accept COVID positive patients back into their care and/or they request PPE for these patients from the public health system. There are increased emergency lengths of stay and patient off-stretcher times due to the increased constraints that are worsened by patients presenting that could be treated by their primary care provider or within the community. Lastly, there is bed block, which is intensified by the competition for beds from patients in the above scenarios.

The lack of primary care in my region has impacted our ED. A delayed focus on primary care results in patients becoming sicker and often turning to the emergency department for their health needs when they are unwell. In the background of reduced primary care, our catchment is also a low socioeconomic area. It includes a significant First Nations population and spans a wide rural area and is also experiencing some of the fastest population growth within the country.

In relation to primary care, general practitioners are limited in our region, which increases wait times for those who can wait to see a primary care provider. Bulk-billing options are scarce, which poses a problem for families unable to pay to see a primary care provider, and private facilities provide limited support. Patients with private health cover still come to the public health system, they still come to the public ED, due to the significant gaps that they are forced to pay or the limitations in service provision at those facilities.

Lastly, autonomous nurse practitioner models are largely excluded from primary care, which again denies our public patients the opportunity to have their primary healthcare needs managed outside of the hospital. Both registered nurses and nurse practitioners are excluded from the COVID vaccine rollout. NPs do not replace GPs; rather, they provide opportunity for meeting unmet needs. Changes are needed in both the MBS and PBS at a federal level to facilitate work that NPs do.

In terms of solutions, what do we do? There is a huge opportunity to endorse the innovative and immediate public healthcare solutions both at a state level and a federal level. One would be statewide endorsement of the nurse practitioner model of care in places such as primary care, aged care, NDIS, emergency departments and urgent care clinics. We have seen some success in the ACT with NP-led urgent care centres. To reiterate, the NP model has proven safety profiles and cost efficiencies demonstrated in multiple countries around the world. Nurses and midwives need to be at the table when solutions are discussed and to be in charge of budgets funding nurse- and midwife-led models of care.

In terms of supporting the workforce, our state has some of the best RN and NP programs in the country—the University of Queensland and the Queensland University of Technology just to name a couple. Huge opportunity exists to integrate the students from these facilities within the public healthcare system by expanding the educational opportunities for them in the clinical setting and by increasing new graduate positions for these individuals when they graduate. Thank you.

CHAIR: Thank you very much for your work. I should have asked both of you where you work and how many years experience you have in this space.

Mr Stringer: I am in Ipswich, West Moreton Health, and I have been a nurse for 21 years.

CHAIR: Congratulations. Well done. We cannot do it without you. What about yourself, Annaleese?

Ms Ockhuysen: Close to 20 years as well and I am currently in Metro South and previously West Moreton as well.

CHAIR: Thank you very much for your work. Deputy Chair?

Mr MOLHOEK: I echo my colleague's sentiments of appreciation for the work that you do and the service of you and your members to the residents of Queensland. It has been a very trying couple of years, I am sure, for all of you. Annaleese, I was having trouble keeping up with a little bit of what you had to share. I think you said it is the RAS—residential aged service?

Ms Ockhuysen: Residential aged support services or RaSS.

Mr MOLHOEK: Can you explain a little bit more how that works.

Ms Ockhuysen: The RaSS service was rolled out statewide just before the first COVID lockdown in March 2020. I think we went statewide at the end of 2019. We take telephone triage by senior nurses, clinical nurse consultants, of deteriorating patients in aged-care facilities and make determination on what the best appropriate care for them based on their wishes and goals of care for the patient as well. In combination with GPs and family decision-makers we decide on whether the patient is suitable for emergency care in the nursing home, if that is their wish to have that, or whether they need to be transferred to hospital or if it is something that the GP is able to manage.

Mr MOLHOEK: Is that funded by Queensland Health?

Ms Ockhuysen: Yes.

Mr MOLHOEK: How many people would that involve?

Ms Ockhuysen: We are the biggest because we were the pilot site. We have currently expanded. I think I have roughly just under 20 FTEs. That is including nursing SNOs and allied health.

Mr MOLHOEK: That is for—

Ms Ockhuysen: That is Metro South. The other HHSs are obviously size dependent given the size of their HHS.

Mr MOLHOEK: I thought you said that you support a thousand aged-care facilities.

Ms Ockhuysen: One hundred aged-care facilities, 10,000 beds.

Mr MOLHOEK: I was trying to understand where the chair got 469 services across the state.

CHAIR: I know that well after our aged-care review.

Mr MOLHOEK: So 10,000 beds.

Ms Ockhuysen: Ten thousand beds, yes.

Mr MOLHOEK: You mentioned some figures: 0.1 to 0.5 per cent.

Ms Ockhuysen: It is 0.1 to 1.5 transfers per bed per year and then 40 to 60 per cent of those are admitted.

Mr MOLHOEK: For the sake of a number, about one per cent of the 10,000 beds would end up being looked after by your service?

Ms Ockhuysen: That would be presenting to ED. These were statistics when we were researching for our project in the beginning phase. I would hope, given our service impact, that we have reduced that number significantly.

Mr MOLHOEK: It is about one per cent per bed per year. I do not know where I got the thousand aged-care residents from.

CHAIR: That is because you are typing and I wrote it down. The figures QAS gave us in December were of some 35,000 transports in the last year out of those 469 residential aged-care facilities.

Ms Ockhuysen: I think some of the QAS numbers get inflated necessarily because they include some of the retirement villages in there and there are some retirement villages that we do not service like Freedom, Tall Trees, Aveo. They do not fall under the aged-care act so they are not funded to receive our service unfortunately. We look after the ones that have had an ACAT assessment.

Mr MOLHOEK: How long has the trial been running?

Ms Ockhuysen: We are now permanently funded.

Mr MOLHOEK: When did it start?

Ms Ockhuysen: We have been permanently funded for five years. It started seven years ago.

Mr MOLHOEK: I gather it was established by a diversionary service away from ED and to better manage—

Ms Ockhuysen: It was established by an emergency physician who had seen the escalating numbers of aged-care residents and saw that there was a need.

Mr MOLHOEK: Scott, I want to talk to you about nurse practitioners for a minute. I was invited to their conference about two years ago and was given a fairly sound education around the value of nurse practitioners. From what I understand and from all accounts they do fantastic work. What is involved in qualifying or gaining status as a nurse practitioner? Why do we only have about 1,800 to 2,000 in Australia and how could we get more in the system? Are there legislative changes or other systemic changes that need to occur to make that a possibility?

Mr Stringer: All of the above. Firstly, the NP model in Australia is new. It is only about 20 years old. I think that speaks to the limited number. Number two, I think the implementation of that role within public health and certainly private health has been limited by both policy and funding. NPs face a lot of scope challenges in some systems just with people who do not understand what they can do. You asked what it takes to be an NP. Most universities in Australia require that a nurse be an experienced RN with a number of years experience behind them. I am going through the University of Queensland's program. They also require a postgraduate certificate in an area before you can apply.

Mr MOLHOEK: It is an advanced level of study.

Mr Stringer: Yes, sir. It is a masters level qualification and a significant number of clinical hours are required.

Mr MOLHOEK: Is it policy or legislation that would need to change?

Mr Stringer: Both.

Mr MOLHOEK: What sort of changes would we need to make?

Mr Stringer: If we look at policy specifically related to Queensland Health, I think you are in a fantastic place to implement this model to address some of these needs within these communities. For example, if we could envision something to address the population in her cohort, NPs empowered to work within those facilities could prevent the transfer of those patients; that would be one solution. Primary care—largely excluded from primary care. We do not have the facilities like they use in the ACT.

Mr MOLHOEK: They do not have a Medicare number. You cannot charge an NP on a Medicare number either, can you?

Ms Ockhuysen: You can. They are very limited. I was saying outside just before that I was an NP candidate prior to my role now and I actually withdrew from the course because as a gerontic NP—there are about four of us in the state and there are only two Medicare billable items. If I go out and do that I would earn less than I am earning now—significantly less than I am earning now in the private sector. With only two Medicare billable items I would then have to pay my public indemnity insurance, I would have to pay rent and I would still have to find a clinical governance. It just was not going to be financially viable with another $40,000 debt for a university degree on top of it.

Mr MOLHOEK: I think I heard from some of the NPs that what they are paid in respect of what they have to offer is quite disproportionate as well in terms of experience levels.

Mr Stringer: It is. To add to what Annaleese has said, I think lobbying the federal government both on MBS and PBS would be an important first step. I know the QNMU has been involved in that, but certainly for the state to support that would be fantastic.

CHAIR: I will move to questions from my right. Member for Pumicestone?

Ms KING: Thank you so much for being here. Thank you for the work that you do standing up for your members and thank you for the clinical work that you are doing. It is very important and we all recognise that. I want to go back to the time during the COVID pandemic before there was widespread community transmission in Queensland. Over and over again in my own community and in other electorates, according to some of my colleagues in parliament, we had reports made to us about private residential aged-care facilities cutting staff hours during the COVID lockdowns. Can you please let us know whether your members who work in RACFs were reporting those cuts to you?

Ms Ockhuysen: I honestly can say categorically that in Metro South that is not the case at all. We had the same amount of staffing until recently and it has mainly been because of isolation that we have had issues.

Ms KING: I am actually speaking to private residential aged care. Were your members working in those facilities reporting that their hours were being cut by their RACF management?

Ms Rogers: I might answer that. Yes, definitely, we have experienced widespread cuts across the last couple of years. Our members have reported that, we have been investigating that as a union and we have also reported that.

Ms KING: Do you have any sense or do your members report any reasons behind those staffing hour cuts for nursing staff in residential aged care?

Ms Rogers: Mostly budget pressures and because, as you are probably aware, we have been after nurse-to-patient or carer-to-patient ratios over many years. In terms of the cuts, employers can just make those cuts. It was really budgetary driven.

Ms KING: Were your members reporting that that led to worse care or more hospital presentations for the residents that they care for?

Ms Rogers: Overwhelmingly. Our workloads were ramping up. We have reported that. We have reported it through the royal aged-care commission and through the ANMF. It has been an ongoing issue and it has been quite harrowing for our members.

Ms KING: What has the federal government done to prevent that denial of care to vulnerable people?

Ms Rogers: There was the report from the royal commission, but as far as we have seen those have not been really implemented at this stage. We are still continuing our campaign and still continuing to ask for nurse-to-patient ratios across aged care and some improvements in workforce so that they can attract and retain staff.

Ms KING: Today I read an article on the *ABC* website about a really tragic incident at the Jetta Gardens facility in Metro South. A resident fell from a balcony. There were reports of one registered nurse to 160 residents at that time. I would like your comments on that.

Ms Ockhuysen: That is absolutely correct, and it was not falling—she jumped. There is a significant underreport of her mental health background and some recent deterioration. The poor lady is in a big bind at the moment in the PA Hospital. The staff at Jetta Gardens—it is very unfortunate. Up until probably June last year, it was run like an absolute ship. It was beautiful. It was run fantastically. About June last year, there was the sale of the actual building and the owner left. He had such beautiful visions for it, utopian visions of this place, and when he left all of the staff went with him. They lost about 75 per cent of their staff. They are mainly run now by either agency or very junior enrolled nurses. It is not through lack or want. The ones who are there absolutely care. They work their butts off. I can ring them at any hour of the day and it is still the same staff really, unfortunately for them. They are doing what they can with what they have; they just do not have a lot. It is one of our biggest facilities in Metro South. It is very hard for them. We are trying our best to support them from our service but, again, we are a very little service too.

Ms Rogers: Ali, I might just comment on what you said about the impact of staff being cut across aged care. Our members are saying that cares are missed, medications are missed, people are not getting fed on time. There is a whole raft of services that are just being missed. Our members—assistants in nursing, enrolled nurses, registered nurses, everyone—are just so incredibly stressed when they are seeing our elderly suffer and put in these circumstances. It is just a shame. The workloads have just been onerous and horrendous.

Ms KING: We are talking about a human cost both to residents and to staff who are trying their best to care for these very vulnerable people?

Ms Rogers: Yes, absolutely; very emotional.

Mr ANDREW: Thank you all for the work that you do for Queensland and the hospital system. You talked about workload earlier. Has losing many nurses over the current mandate period made the workload heavier for you or for the nursing staff of the hospital?

Mr Stringer: We have certainly been operating with a reduced number of staff. Staff are now at the point that some of the things that people are having to deal with are career breaking. Yes, we have lost nurses due to the stresses.

Ms KING: Just to clarify, I think the member's comment was slightly different in its intent.

CHAIR: I have spoken to the member for Mirani about this. It is outside the scope of this inquiry. We are talking about primary and allied health.

Mr ANDREW: I am just worried about the delivery of the service, that is all, and if it affects it generally at the moment.

CHAIR: Do you have another question?

Mr ANDREW: No, not at this stage. I am thinking about something at the moment.

CHAIR: Member for Toowoomba North?

Mr WATTS: I do not have anything specific at the moment apart from expressing my thanks to the witnesses there and their members for the service they have given to Queensland.

Ms PEASE: I really appreciate all the work that your members do. I have very good friends who are nurses. I acknowledge the great work that they have done not only during the COVID pandemic but day in, day out. Anecdotally, I have spoken to one of my constituents, who is also a neighbour of mine. She mentioned that they have seen a huge increase in foot traffic at the hospital she works at. Can you confirm if you have seen a big increase in presentations to the ED, given you are at Ipswich Hospital? Are you able to comment on that at all?

Mr Stringer: Certainly with the increase or the surge right after or during Christmas, we saw increases initially in the Omicron infections both as walk-in patients and QAS presentations.

Ms PEASE: What I am asking for is not necessarily COVID related; I am talking about general foot traffic increases of category 4s and 5s. We have heard from other HHSs that they are coming in. Are you able to give any commentary on that given you are at the coalface?

Mr Stringer: Absolutely. One of the biggest surges we saw in that period that I can recall would be the referrals from doctors, from primary care physicians in the community, who could not or would not see these patients. That added to the workload. The category 4 and 5 patients that you mentioned initially probably dropped off. We have now gone back to the pre-COVID levels with those patients.

Mr MOLHOEK: I want to go to the submission from the Nurses and Midwives Union. On page 4, I note one of the recommendations of the Queensland Nurses and Midwives Union was about the need to establish a health performance commission back in 2017. Is that still your view and has any progress been made towards that goal in discussions with the current government?

Ms Rogers: I will take that question on notice and get back to you on that, if that is okay?

Mr MOLHOEK: Okay. I turn to some of the recommendations. There are a number of recommendations from the QNMU to the government. One of them was around addressing nursing and midwifery workforce shortages through the development of a comprehensive health workforce plan for Queensland. Has any progress been made on that? What discussions has the union had with Queensland Health and the government, given the acute shortages that we are seeing right across Queensland in terms of labour force demands for nurses, not just in the health system but also in aged care and in every area of health across our state?

Ms Rogers: I am not across the detail of that so, again, I will take that on notice and get back to you.

CHAIR: That sits in workforce planning. I am pretty sure the DG gave us an update on workforce planning at the original hearing in December, but I will have to check *Hansard* for that.

Mr MOLHOEK: It would be interesting to hear what feedback you have had and whether there has been a response from government to the recommendations of the nurses' union over the past couple of years. The other thing I wanted to discuss with you or perhaps seek some broad comment on is the issue of health equity. You talked quite a bit in your submission about health equity for all Queenslanders. There is also a section that talks about health equity for First Nations people. You also talked about the unique characteristics of Queensland: it is a large state, it is geographically big, 95 per cent of the population is concentrated in larger centres. How do you see us meeting some of the challenges in some of the really far-flung regional and remote parts of the state in terms of delivering better health care and better allied health and specialist services?

Ms Rogers: Again, I will take that question on notice and get back to you. I do know we have been pushing for nurse-led and midwifery-led models of care to fill in some of the gaps, particularly in regional and rural areas in aged care and across some of the primary health care settings. That is something that we have been talking about for a long time and putting into our submissions at a federal level as well.

Mr MOLHOEK: I suppose it would be interesting in that context, looking at the challenges around nurses and nurse numbers but also some commentary around the role of midwives. Some birthing facilities have closed in some Queensland hospitals, probably some for good reason, and alternatives have been put in place. It would be interesting to find out a little bit more about responses to midwifery needs in some of those areas as well. Finally, I think there have been some trials around Hospital in the Home. Annaliese, you have been talking about strategies around diverting people from the EDs. Have you had any experience or exposure with your team?

Ms Ockhuysen: Absolutely. We partner with them quite frequently. Hospital in the Home, certainly in our HHS, is at all of our hospitals. Each of them run slightly differently, again based on hospital size and the complexities of the patients. My services are emergency substitutive. We will go out and do an initial visit. If the patient is requiring further care, we can refer directly to the Hospital in the Home team and avoid essentially the entire hospital admission if the patient is only requiring something such as a few more sessions of wound care, a week's worth of IV antibiotics or something that the facility is unable to do. Again, this is sort of something that I think is a downfall of the aged-care facilities. I do not understand why the registered nurses there are unable to provide IV fluids, IV drugs. It is a registered nurse task. We have all done the same degree.

Mr MOLHOEK: Have you done any sort of research or study into perhaps why there are not more?

Ms Ockhuysen: It is all policy driven for the facilities. They can do it. We all come out of university with the same degree and we can all do those tasks, but it is policy driven and they are not allowed to do those tasks. They are absolutely squashed. Their competency is not maintained and these poor nurses become unskilled very fast.

Mr MOLHOEK: When you say 'policy', is it because the facilities have become risk-averse?

Ms Ockhuysen: Yes.

Mr MOLHOEK: Is that as a result of state or federal legislation or the insurance industry? What is driving this sort of risk aversion in our aged-care facilities?

Ms Rogers: In terms of private aged care, the bottom line is making profits. The ANMF has commissioned a number of surveys into the big providers. In terms of workforce, you were asking questions around that. Registered nurses in private aged care earn approximately over 30 per cent less than they do in the public sector so attracting and retaining quality staff is really hard. I have personally come across a couple of new graduate registered nurses, young women new to nursing, who are looking after 100 residents by themselves.

Mr MOLHOEK: Just for clarity, because I do not know a lot about the sector so this is a bit of a journey for me in terms of understanding, when we talk about a minimum requirement of having a registered nurse in every facility, and then the ratios—I understand what you are saying about ratios—would they be required to have a registered nurse or registered nurses there currently just during the day or 24/7 or seven days a week? What would you suggest are the appropriate standards of care to have in those facilities?

Ms Ockhuysen: Registered nursing needs to be at a minimum of 30 per cent in an aged-care facility.

Mr MOLHOEK: Of staffing?

Ms Ockhuysen: Of staffing, absolutely a minimum of 30 per cent.

Mr MOLHOEK: And 24\7?

Ms Ockhuysen: At least, absolutely. Care is 24 hours a day. The patients do not change whether it be day or night. Quite often these facilities have demented patients, cognitively impaired patients or patients who require around-the-clock care. We have patients who need peg feeding. That cannot be provided by an enrolled nurse or a carer; that needs to be provided by a registered nurse. They need to be able to have people on-site for the lines and devices that they manage.

Mr MOLHOEK: Are you saying that 30 per cent of all the staff should be registered nurses?

Ms Ockhuysen: Yes, clinical staff.

Mr MOLHOEK: I thought I heard you say earlier that there should be—I cannot remember the figure—at least one registered nurse for every—

Ms Ockhuysen: One to 10 to 12 patients roughly.

Mr MOLHOEK: If there were 100 patients then you would have eight registered nurses at any one time at the facility?

Ms Ockhuysen: Yes.

Ms Rogers: We have made recommendations to the royal commission and we can provide you with those recommendations.

Mr MOLHOEK: It would be great if you could provide us with a copy of those.

Ms Rogers: Just to let you know further, we were successful in having the state government implement nurse-to-patient ratios across the 16 aged-care facilities across Queensland Health. We are after a similar model at a federal level.

CHAIR: People deserve the very best of care.

Ms Rogers: Absolutely.

Ms PEASE: The member for Thuringowa and I did the inquiry into aged care. We heard a lot of stories around the nurse-to-patient ratios, particularly registered nurses, in some of the residential aged-care facilities. It was terrible to hear what was happening out there. Thank you for your great work, and keep up the advocacy.

Ms KING: I wanted to go to the issue of workforce retention. We have received significant submissions through the course of this inquiry about nurses being an ageing workforce, it being difficult to retain new nurses after five years and a whole range of workforce challenges for nursing. This is probably primarily a question for Scott. If there were better workforce pathways for nurse practitioners and, in particular, if we could see those nurse-led clinics having access to proper Medicare item numbers that could be billed so they become a primary care funds generating centre, how do you think that would impact on workforce retention into the future?

Mr Stringer: I certainly think it would attract more nurses. Twenty-something years ago when I started my nursing education we were dealing with these same issues. In fact, I sat in front of a guidance councillor and asked, 'What can I do with my science background for the rest of my life anywhere in the world?' and he said, 'Nursing.' It was certainly a financially driven motivation that took me to my first facility. I was offered a sign-on bonus in North America. Those are things we do not see so much in Australia. Financial incentives would certainly be something to look at. The awards that nurses attract would be a good place to start.

Ms KING: I suppose my questioning is around career progression opportunities and also career satisfaction and whether it is your view that your members would be more likely to stay in nursing if they could work to a higher scope of practice.

Mr Stringer: Absolutely. It is quite satisfying to see the work that you do and the positive impact that has on people. That is quite rewarding to see and watch. The MBS and PBS items you mentioned are going to be key.

CHAIR: I am interested in the data. You spoke about the ACT model. I think they call it the walk-in clinics. Can you speak to how many people it has prevented from going into emergency by accessing that? The second part to that is: how are they funded? I think that is a place where primary care could be provided. Would you surmise that under a PHN type model they could fund a clinic where nurse practitioners could operate to reduce the burden on public hospitals? I have looked into some of this online and I am sure there are thousands of people who have not had to go to hospital for minor suture removal or ear examinations. Can you give us a practical example? How would that best work in Queensland? How could we set the model up?

Mr Stringer: I can speak directly to that. I do not have the lens so much about the ACT model, but I was involved in writing the model of care for the urgent-care facilities—the satellite hospitals—with the pledge from the government for seven around the state. I was involved in the Ripley model which does include nurse practitioners. It is coming; it is just not here yet.

CHAIR: Can anyone talk to the ACT model or can you take that on notice?

Ms Rogers: We will take it on notice and give you some information.

CHAIR: We would be interested to see what the reduction was.

Mr MOLHOEK: I am almost certain that Yeppoon hospital runs a nurse practitioner led walk-in service. They have three nurse practitioners there. They set up like an outpatients centre when it was built. The original intent was to have some GPs working in there but they were not available. It seems to be a very successful model and is diverting a significant number of people away from the ED. It would be good to get some comment on that as well.

CHAIR: I am of the view that we are inquiring into the primary and allied space. The burden keeps going back to the Queensland government to do this. If you have a great example of a good model of care that would help. For us as a committee it is about making recommendations. Clearly we are hearing that expanded scope of role works. It is how that model might work as a supplementary to reducing the thousands of people who are turning up. What did we hear this morning—I cannot remember the figure? It was thousands of people walking into the Logan Hospital—

Ms KING: It was 14,000, I think.

CHAIR: You are right, member for Pumicestone. I think it was 14,000 through January 2022—4,000 came with the QAS and 10,000 or 11,000 walked in because they could not get access to a GP. If people are having problems accessing a GP, what is the best model? For us it is about getting that data and making recommendations.

Ms Rogers: We will definitely provide you with some analysis of it.

CHAIR: That would be fantastic. We really appreciate it.

Ms Ockhuysen: There are NP-led clinics in the emergency departments of most Queensland Health hospitals. The problem is that they are still taking up a Queensland Health bed. They are still coming through the triage system. They are still going through everything. The NPs are seeing category 4s and 5s—correct me if I am wrong. In Metro South they are certainly doing that. We have some of our staff who work across all of the hospitals as well as my service which does that. It does take that away from a doctor having to provide that care, but it does not reduce the bed. We need the NP-led clinics external to the hospital for it to be effective.

CHAIR: Absolutely. If people cannot access a GP for two or three weeks—and we have heard that throughout this week—my observation is that the burden goes back onto the Queensland Health model. What have we heard time and time again this week, members: the door of last resort; the public emergency department. This is for services that could be provided outside in a far more practical and efficient manner. I am of the view that it sits in the primary healthcare space and that is for the federal government.

Mr MOLHOEK: I just want to ask about the NDIS. Is it better with the NDIS now and are more people getting access to services than were previously? Should we go back to the old way or should we push forward with the NDIS, as a general observation?

Ms Rogers: I think we might take that on notice.

Ms Ockhuysen: We will take it on notice, please.

Mr MOLHOEK: It would be great to get some kind of guidance on the success, failure or otherwise of the NDIS and how it sits. We have heard from one of the service providers that they have gone from 40 to 160 clients in the last two years. Their challenge is not so much that there is not cash available but rather that there are not allied services to support that. We are seeing a massive increase in demand on our EDs and on the public health system. Has there been any analysis done of the decline in GP availability versus population demand and then overall trends as a result of the impact of the NDIS, more money being available and a range of other things? Has the union done any sort of analysis or is it aware of any analysis that shows where the shortfalls are and what the challenges are?

Ms Ockhuysen: I know in the aged-care space that the PHN is doing work on GP availability because they are the ones that are unfortunately getting stuck when our GPs walk out and say that it is no longer financially viable for them. The financial viability for GPs in the aged-care space has been due to the fact that we have facilities with 100-plus patients but the Medicare rebate is for up to only 10 patients per day that they can see and their money starts going down after that. If they have 20 patients on a list to see and they only get paid a little bit of money after the 10th patient, they are just not bothering. They will say, 'I will come back to tomorrow,' but in the meantime that poor patient has deteriorated. The PHN is definitely working on doing more data. They are also working on trying to get us some GPs at the moment.

Mr MOLHOEK: It has almost been a perfect storm. We have had the pandemic—and we are still dealing with that—we have had significant population growth, we have seen an increase in demand around aged care and aged-care packages and support and community expectations and now we have people getting money for NDIS services looking for services. I wonder how all that looks in terms of the impact on the public health system and obviously the challenges around federal funding. I understand that that is an issue. Then there are labour force challenges with us being so dependent on overseas people to fill the gaps.

Ms Rogers: In terms of aged care, we have been lobbying the federal government for at least eight years around improving the situation in residential aged care. We predicted that there would be workforce shortages and stresses on the system. No-one could predict the result in terms of COVID. We have been lobbying extensively for years and years. Even during COVID we said that there needed to be a lot more pre-planning. We were concerned about workforce issues. It has proven true over the last year or so. It was an issue that we were bringing to their attention constantly and through various forums as well.

Mr MOLHOEK: I appreciate that you have been doing that and that is important work—

Ms Rogers: Even after the aged-care royal commission and the handing down of the recommendations, that response has been slow and not enough. We knew that the workforce would become the issue because attracting and retaining staff is hard.

Mr MOLHOEK: I guess what I am looking for is some commentary around the confluence of issues. Yes, the aged-care system is certainly under stress—and I am not here to argue against you in that respect; I think we can all see that—but I would suggest that based on some of the testimony we have heard, some of the material we have already read in submissions and also previous reports of the Queensland Audit Office around planning for services, when you look at all the factors that need to be considered in the overall health system we have a much bigger health crisis on the horizon than now. I am not suggesting that is just Queensland Health. I am suggesting that is something that all of us need to be turning our minds to. It would be interesting to hear further from one of our peak bodies—the Nurses and Midwives Union—about how you see we need to meet some of those challenges.

Ms Rogers: We might take that question on notice and respond to that as well. I am not across all of it.

Mr MOLHOEK: In one of the submissions we have received there has been some commentary around the need for local area needs assessment to be conducted in each health and hospital service across the state in partnership with the PHNs. Does the Queensland Nurses and Midwives Union have any input into that process? Have you been called on to make submissions or contribute to LANA—the local area needs assessment—for each health and hospital service across the state?

Ms Rogers: We will get back to you on that as well.

CHAIR: We thank all of you from the QNMU for your very insightful contributions on this important topic. We look forward to getting that data off you. There is a bit of it. Any questions on notice need to be back to the secretariat by 17 February. We appreciate your time today. I declare this public hearing closed.

The committee adjourned at 4.00 pm.