T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the Victorian Government's Response to the COVID-19 Pandemic

Melbourne—Thursday, 27 August 2020

(via videoconference)

MEMBERS

Ms Lizzie Blandthorn—Chair
Mr Richard Riordan—Deputy Chair
Mr Sam Hibbins
Mr David Limbrick
Mr Gary Maas
Mr Danny O'Brien
Ms Pauline Richards
Mr Tim Richardson
Ms Ingrid Stitt
Ms Bridget Vallence

WITNESS

Adjunct Professor Stephen Cornelissen, Group Chief Executive Officer, Mercy Health Aged Care.

The CHAIR: We welcome Mercy Health Aged Care to the second series of public hearings for the Public Accounts and Estimates Committee Inquiry into the Victorian Government's Response to the COVID-19 Pandemic. The committee will be reviewing and reporting to the Parliament on the responses taken by the Victorian government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic.

We advise that members are attending these hearings remotely from home and from their electorate offices, and we ask that people note that members are not required to wear a face covering if they are working by themselves in an office under the stay-at-home directions, 6 August, part 2, section 7(i).

We advise that all evidence taken by this committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you repeat the same things outside this forum, including on social media, those comments may not be protected by this privilege. You will be provided with a proof version of the transcript for you to check, and verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

Thank you for joining us today. We invite you to make a brief opening statement of 5 minutes, and we ask that for the Hansard record you state your name and position and the organisation that you represent. This will be followed by questions from the committee. Thank you.

Adjunct Prof. CORNELISSEN: Thank you. I am Stephen Cornelissen, the Group Chief Executive Officer at Mercy Health, and we are a not-for-profit Catholic provider of health, aged and community care services in various parts of Australia and particularly here in Victoria.

We are in the midst of one of the greatest pandemic threats seen in our lifetime. Our focus, especially in Victoria at this time, must be on how we collectively respond to this threat and ensure the safety of those at greatest risk of this insidious and devasting virus. As a hospital and aged-care provider we have seen the impacts of COVID-19 from a variety of perspectives. The settings, the operational models and the clients of hospitals and aged care are vastly different; however, COVID-19 possesses similar threats to services, has similar entry patterns and has similar impacts on staffing and presents the same risk to the highly vulnerable people. Once inside any facility the impacts of COVID-19 are material, due to not only the risk of exposure to all but the ability to safely staff a service. For example, one staff member affected by COVID-19 could result in up to 20 to 40 staff being furloughed due to close contact. Earliest intervention is our best defence to contain further spread. Upon notification of exposure or the immediate isolation of a COVID-19 person occurring, contact tracing, personal protective equipment or PPE implementation and furloughing of close contacts are critical. Of course, notification of exposure is sometimes not timely due to numerous unavoidable reasons, and this is when the virus can take a much greater grip on the service.

No one service is singularly equipped to deal with the virus, and the reliance on trust between providers, government and others is critical. On that note, our experience with government to date has been mainly positive. The provision of required PPE has on most occasions been timely. Clinical first responders, especially in the early days, were responsive, informative and provided consistent advice. They worked in collaboration with our onsite managers and our incident commander, and there was a collective response between all to finding solutions to those very complex cases and complex issues. Our experience of Sonic onsite diagnostic testing has been positive, and when there were minor issues, again, we had these quickly resolved.

There have also been learnings, particularly as COVID-19 cases have grown and the workload of all of the agencies has increased. Multiple agency involvement at times has resulted in inconsistent advice being provided, which has the potential to confuse staff and result in practice variation. A small number of directives were provided, then changed shortly thereafter, complicating their implementation and also creating some confusion. Again, I must say though, when we raised these issues with the agencies concerned, senior staff were both responsive and supportive and, in the main, issues were resolved.

Providing information and/or access from homes to multiple agencies remains a challenge. A manager of an aged-care home can communicate with up to 10 different agencies essentially wanting similar information and/or access to the site. This is time-consuming and superfluous against the immediate requirements of managing an outbreak. Agencies have shown some flexibility; however, a centralised and single-point case manager approach going forward may alleviate this concern.

Some public announcements regarding changes have not had the associated lead times required to implement practice change, resulting in some confusion in the community and less than optimal implementation. Workforce challenges have presented material difficulties. The implementation of the surge workforce by government must be commended and has been instrumental for providers in dealing with this current wave. Whilst critical, it has also, though, not been without issue. Given the need for surge staff to move between multiple homes with outbreaks, the simultaneous implementation of policy to restrict aged-care staff to one employer and one site, whilst valid, has also created challenges. Although logical and sensible, it does seem rather counterintuitive to furlough site-specific staff as potential close contacts and accept surge staff who have worked at homes where other COVID-19 cases are.

Finally, the unintended consequences of comments or criticisms of the sector as a whole cause more fear, confusion and concern and exacerbate many issues that we know already require redress in the current system. Our collective focus at this time should only be on trying to get ahead of this insidious virus and ensure the imminent safety of our community. When we reach that goal we can then partake in thoughtful [Zoom dropout]

The CHAIR: Sorry, we seem to have frozen. Sorry.

Adjunct Prof. CORNELISSEN: That is okay.

The CHAIR: Are you with us, Professor? Thank you.

Adjunct Prof. CORNELISSEN: I am indeed.

The CHAIR: Excellent. Sorry, we just lost you on the tail end of your final remarks there. Would you like to repeat them, or would you like us to just go—

Adjunct Prof. CORNELISSEN: Was that just from when I said 'finally'?

The CHAIR: Yes. It was just about from when you said 'finally'.

Adjunct Prof. CORNELISSEN: My main point there was that the unintended consequences of comments or criticism of the sector as a whole do cause more fear, confusion and concern, and they exacerbate many of the issues that we already know exist in the current system. I think our collective focus at this point should be on trying to get ahead of this insidious virus and ensure the imminent safety of our community. I think it is when we reach that goal that we can then partake in thoughtful, considered and enabling discussions on how to address our weaknesses and all that we have learned to date.

The CHAIR: Thank you very much. I will pass to Ms Ingrid Stitt, MLC, for the first questions.

Ms STITT: Thank you, Chair. Good morning, Professor. How are you?

Adjunct Prof. CORNELISSEN: I am well, thank you.

Ms STITT: Great. Thank you for coming along to the hearing this morning. Now, given the large number of aged-care services that Mercy run across metropolitan Melbourne, I am just wondering if you can take us through, in a little bit more detail, what the most effective steps have been that you have put in place to keep residents and staff safe during the pandemic.

Adjunct Prof. CORNELISSEN: Absolutely. Look, I think at a system-wide level for Mercy Health, putting our incident command system in place has been a critical step. It is a command and control system with senior staff overseeing our response to COVID-19. We put that in place in March this year. That allows us to look not only proactively but also reactively when we do get a case and how we manage that. It also means our managers can move into day-to-day operations, which is a critical component of keeping people safe. We have an infectious diseases physician who is on that incident response team as well as a dedicated infection control

consultant. It means that our approaches can be tested by experts and they can give advice as to what is a good preventative strategy but also what is some of the reactionary stuff that we may need to put in place.

I think we have been lucky to have some of the resources from the government given to us in SCORM files and to be able to put those into our own learning management system, and then we have been able to monitor the effectiveness. For example, we know exactly our hand hygiene rates and who has done them and who has not, and we have been able to insist that people who have not done them are not to come to work. Those little things are about keeping people safe. We have also been able to get those things onto mobile devices to make them easier for people to use.

I think the other two points are the pre-emptive stocking of what we would call outbreak kits. So in March we put forward a pre-emptive stock on every site of ours across Australia of an outbreak kit, which would give us 24 hours to 48 hours of PPE supply should that need be required urgently, and then we were not reliant on the stockpile to initially get it there within an unreasonable time frame but to get it there within a reasonable time frame. The final one would be contact tracing. I think we have been very successful in our contact tracing efforts, both in hospitals and in aged care. In the main we have been able to do this mostly within about 6 hours of notification because we have a dedicated contact tracing team, and we have a surge capacity contact tracing team in case things go horribly wrong. I think that has been very helpful. They have also been able to be our communicators with residents and relatives on COVID.

Ms STITT: Thank you. I was going to ask you a little bit about PPE. In March the plan for the Victorian residential aged-care sector was developed by DHHS, which required providers to have an adequate stock of PPE to be accessed directly from the national stockpile, as well as obviously the active pandemic and infection control plans in place across the facilities. How have you found the process of accessing PPE? You just mentioned that you have got your own sort of back-up emergency system, but obviously that has been working in with the other processes. Can you talk a little bit about your experiences with accessing PPE?

Adjunct Prof. CORNELISSEN: Yes. Look, you are 100 per cent correct. I think that we did put that pre-emptive one in so that we would have those 24 hours covered. But our access in using the PPE stockpile has been very good, and I think it has become better streamlined as the crisis has gone on, which is probably a bit counterintuitive, because one would think it might become more difficult as the crisis went on, but it has become better streamlined. We have had excellent responses. We have even had proactive responses where people have contacted us when they knew that we had a potential outbreak and asked proactively whether we needed PPE and what we needed and how much we needed and how could they assist. So I think from the government's perspective, we need to commend them there. It has been, I think, very useful.

The only issue we have had is particular items of PPE that have been in short supply. But they would be in short supply everywhere, and it might be a particular preference of PPE that we are finding is as difficult to find in our hospitals as it is to find in aged care. They have been the only issues. But again, they have sourced most things very, very readily, and we have got enough stock and it is always on site and well delivered, so we have no real complaints about that at all.

Ms STITT: Great, thank you. You are obviously aware that the Victorian government has paused all non-urgent elective surgery across the state, just to create that additional capacity within the health system. That has obviously been incredibly important in the response to the aged-care outbreaks. How have you found working with your linked hospital? You can maybe take us through in a little bit of detail how those transfer arrangements have worked, if there has been a need for you to do that to move vulnerable residents from your homes to a hospital setting.

Adjunct Prof. CORNELISSEN: I should say that as a provider of hospital and aged-care services we are actually a linked hospital to aged-care facilities—

Ms STITT: Of course, yes.

Adjunct Prof. CORNELISSEN: as well as being linked with other hospitals. I should also say that one of our aged-care facilities is in the catchment of our public hospital as well. We have only transferred one person there who was clinically required to be transferred, after being transferred and deteriorating from another hospital, so it was a quick movement. And other than that, we have not transferred any people to our own hospital—just so people do not think we are sort of taking advantage of a situation that others may not have.

In the other hospitals that we have dealt with, though, we have certainly been well supported. I think the cluster hospital approach has been very supportive. It is a little bit on a tangent to what you have asked, but I think the cluster hospital process has been very supportive. The in-reach service that has been provided in aged care when required has been excellent and required. I think that expert support from hospitals to aged-care providers is critical. I do think that has been quite a successful thing.

The only thing I would have to say, I guess, if I had to look at cluster arrangements and transfer—because we are a large provider we are working over eight clusters, so we do see the variance in requirement of information, the variance of process, the variance of how they each want to approach it in their own nuanced way, and that does create more work at a level for us. But having said that, again, when I have spoken to the senior staff in all those clustered networks they have been exceptionally responsive and have been very, very flexible to make those work as best they could for us.

I think the cluster hospital approach is excellent, and I would certainly recommend it. We have only transferred people that are clinically indicated to be transferred, and in all cases they have been accepted. We have not been pushed back for people who have got clinical indications for transfer.

Ms STITT: Thank you. In terms of the Victorian Aged Care Response Centre, which has been established at the State Control Centre in Melbourne to coordinate and expand the resources to manage this pandemic—it is a commonwealth-led body and it is based at the State Control Centre in Melbourne—do you think this is a useful model in terms of any interaction that you have had with this State Control Centre, and do you think that it is something we should consider recommending to other jurisdictions, other states?

Adjunct Prof. CORNELISSEN: If I am brutally honest, I think it is a little too early to say how effective it has been because it is still relatively new, and we are in the midst of a pandemic. But I have said that we have got our own incident control centre, so I am a believer in crisis in command and control and it is a good way. So I think the centre has every likelihood that it will succeed and be great.

In the little involvement we have had with it, and they have coordinated a number of services, we have seen better coordination occur. What I would really think if we are going to going to adopt this model, the thing that would be most helpful—and the centre may yet get to this because we have to remember it is in its infancy—is how it could bring together all of the agencies that require services and input from an aged-care facility, bringing them into one and running them as a coordinated case management approach. So if they had one person per home that could coordinate all those agencies and take away all the communication and be one central point of truth, I think that would really bolster the success of the agency from a provider's point of view.

Ms STITT: Okay, thank you. During this second round of hearings we have had some witness evidence that has argued, basically, that the government's approach to driving down case numbers is actually causing more harm than the virus itself. I am interested in your response to that, given the very vulnerable cohort that your organisation is responsible for the care of. What do you say about balancing the need between protecting vulnerable Victorians and some of the measures that have been put in place to do that versus this notion that the lockdown and the restrictions are actually causing more harm than the virus?

Adjunct Prof. CORNELISSEN: Look, I am not an epidemiologist and I am certainly not an infectious diseases physician, so I cannot comment on the specifics of that. But from a health professional running a health organisation, I have to say that we are seeing firsthand the devastating effects of this in our hospitals and we are seeing the devastating effects of this in our aged-care facilities. The first entry point is community transmission—there is no doubt about that—and the more we can do to drive down community transmission, from my point of view, the better.

Ms STITT: Thank you. It has obviously been very distressing for residents and their families, and there has obviously been a need in some settings to restrict visitation from families to residents. Have you got any examples of innovative contact that has helped reduce that isolation of residents during this very challenging time? I imagine that you have probably got a few different examples of what you have been able to put in place.

Adjunct Prof. CORNELISSEN: Look, I have got examples. I am not going to say they are innovative, because I think that is a big word to use, and I would not say that they are any different to what most providers are trying. Many people will have all sorts of ideas. We have certainly tried the window visiting concept where residents and families can visit through a window and talk on their mobile phones. We have encouraged letter

writing and letter faxing particularly younger members, like great-grandchildren or great-great nieces or nephews, but also we have encouraged that from schools for those that may not get visits. So they are writing letters and sending pictures in, and that brings great joy to a resident when there is not a lot else going on in a lockdown situation, particularly that they can have those letters and pictures come in. We have put in mobile devices in all of our sites, and we put Zoom in there obviously. We have free internet access so that people can use their own device or can use ours, but we also need to remember there are a lot of people that are non-verbal or have cognitive issues that do not actually respond well to that medium.

Obviously we have done all the usual issues in the home of trying to create as much activity as possible within the realms of keeping people in their rooms, particularly where there is a COVID outbreak or a COVID threat in a home. We have also got a few groups that have come in and agreed to write letters, besides schools. So a couple of Christian groups have come through and said that they would write letters to our residents. Letter writing is part of that era—a very important part—and even if they cannot read them themselves, our staff have a pod to be able to interact with them and give them some personal interaction on something a little bit different to what they would have. They tend to be the bigger ones, but I would not think they were innovative or what most providers are not trying.

Ms STITT: Okay. Thank you. Obviously with family members in a facility where there is an outbreak it is a very distressing time. Could you talk about the things that you have had to do in those circumstances to keep families abreast of what is going on with their loved ones in these very difficult circumstances?

Adjunct Prof. CORNELISSEN: Look, this is probably the hardest thing I think: to lose contact with someone you love, particularly in aged care, and not be able to visit them, particularly knowing that aged care is often the end-of-life journey for people. So to know that could be any time, anywhere and 'I have little control of it' and/or the threat of a COVID infection and what that might mean is devastating. So I think the only thing we can do in these times is really improve communication. That has been a massive focus of ours. We have our director of communications on our incident command team and there is a role for a communicator.

I will start with the general sites. We do send letters about what might happen if COVID came into a facility. So all of our residents and families have had a pre-emptive letter about what might happen and what that would look like. We think preparation is important so that the shock factor of how it might go is not as great, even though it is still personally traumatic. We also undertake when we do have a COVID exposure—I call it COVID exposure because sometimes it is just a staff member that may have been on the site during an infectious period, although at other times it might be bigger than that. But when we have had a COVID exposure we do SMS everyone and then ring them and check that we have their email details. We speak to everyone. We try to do that within the first 6 to 12 hours. To give you an idea, that is about 22 hours worth of phone contact in a general site, and we have that for every single family member and obviously we are doing that with our residents.

We also undertake to write to them daily. We do provide daily written material giving them very open and honest information about what is happening on the site, including infection rates, including infection numbers and, if there are deaths, we will include deaths of COVID-related disease as well. We then do that verbal phone call for the next two days as well. So we do it on day zero and day one and day two, and then we verbally ring everybody twice a week from then on whilst we are still in an outbreak zone. If anyone does have COVID, then they are rung daily as well. That communication is really important.

Prior to that issue we did allow visitor entry. We were a site that believed that visitors, particularly a specific loved one, were critical, and that our relationships are very important. These in fact are often more important to our elderly residents when we survey them than their medical care. We did try to keep visits going.

In non-COVID sites we still have people coming in with the Victorian directive under the essential carer category. Those people actually sign a contract. The contract is about two and a half pages, and it does detail all the things they will do, including at home and coming to our site to keep themselves and our residents safe. In the whole, our people who have been doing that both before the visitor restrictions and now have been very responsible. We never saw visitors as the major threat. Usually with the life they live and where they live and how they live, they are usually very cautious and are not usually in large social situations, whereas our carers often have families and other movement in their homes, which obviously gives them greater exposure points. I do not know if that answers your question.

Ms STITT: Yes, very well. Thank you, Professor.

The CHAIR: Thank you. The member's time has expired. I will pass the call to Mr Danny O'Brien, MP.

Mr D O'BRIEN: Thank you, Chair. Good morning, Professor. Thank you, Ms Stitt. You have just asked all the questions I had pretty much. But I will follow up on a few of them, starting with the issue of people at end of life, particularly palliative care. Can you give a bit of an overview of what that has been like for families in particular who, I assume, 100 per cent have not been able to visit?

Adjunct Prof. CORNELISSEN: Look, there has been an issue. I think even if you are able to visit at that last end-of-life part, not being able to have the regular contact beforehand is still very concerning, because I think people have felt quite robbed of that last part of the opportunity and also have all those questions like, 'If I was there, would it have been different?'. I think they are natural questions we would all ask ourselves, so we have to be very aware of that.

We have pastoral care services in all of our sites, and I think that has been of critical benefit for us. Our pastoral care have developed a number of resources. Some of those have not been able to be on site because of the risk factors to themselves as well, being in a high-risk, vulnerable group. But we have developed resources for our staff, for our families about what it is like when someone is facing an end-of-life pathway and an end-of-life journey and what are the sorts of things that might be going through their mind. It is one of the things going through your mind as a staff member but also as the family who may not be able to visit.

We do the same for the death and the dying process and then for the after death and how we can manage and support people. We obviously ring people and communicate with them, and our pastoral carers do follow up all families of any deceased person, irrespective of how they died. I think the important part for us is we have never talked about death rates in aged care being a number. We have always talked about an individual who is loved and is deserving of respect, and I think we are also trying to make sure that stays in place in COVID. We are advising people of COVID-related deaths in their homes, but we are only doing that in their homes, because we do not want to make those people only a number when in fact they are a loved person, and we want to make sure that is respected.

Mr D O'BRIEN: Very difficult. Can I just go back to again a question Ms Stitt asked about alternatives to the current process that we are under in terms of lockdowns. It has been suggested to the committee and indeed wider in the community that what we actually need to do is protect the vulnerable—you know, look after our aged care homes in particular—and effectively have minimal restrictions elsewhere. Is that feasible? Is it possible that you can increase the level of surveillance, if you like, and alertness at aged care to allow the virus to run perhaps a bit more freely in the community and protect the vulnerable?

Adjunct Prof. CORNELISSEN: I will take the hotspot out of it, because I think that that has been a challenge in itself, and whilst we would have probably preferred not to see visitor restrictions in place in all places as a mandate, I think in the hot zone there was little choice. So I have to say that, as difficult as it has been, there has also been little choice. I think there are ways of managing visitor restrictions. And when you are not required to wear full PPE, then you are not also draining resources. I think when you have to wear gowns, gloves and masks, that does change the whole way we have to be able to manage visitors in there. We did require that all of our visitors obviously had the influenza vaccine. We did require that all of our visitors had evidence of completing the Hand Hygiene Australia online course and were able to demonstrate that, and then we did require that our visitors showed us hand hygiene on entry. So they had to come in; they were only allowed to be in for, I think, 60 minutes a day; and it was only one designated visitor, it was not all visitors—and that is an important middle ground I think we can get to. They did have to be thermal checked, even though we know that is a latent sign and symptom of COVID-19, and they did also have to sign an agreement or state that they had satisfied a whole number of criteria about visitation, about where they had been, that they had changed their clothes—all those sorts of things.

Mr D O'BRIEN: Do you think that that sort of regime is feasible going forward?

Adjunct Prof. CORNELISSEN: I do. I do. I think it is, and again I go back to the sort of people that visit their elderly parent. They are the person that is mostly going to be very worried about taking the disease in there, they are going to be taking all those precautions at home and they are not likely to have the level of risk that others would.

Mr D O'BRIEN: Yes; fair enough. That is good. Can I just go to the issue of staff? What sort of support has the state given you to manage that issue of covering for staff that may have been previously going across different locations and sites?

Adjunct Prof. CORNELISSEN: We did a bit of a survey early in the piece to find out where our staff worked besides with us, and we have been working on reducing the casualisation of our workforce for some time, so we had quite a high degree of permanent, albeit part-time, staff. We did recognise that about 19 per cent of our staff did have other positions in other places, and over time we have tried to restrict those to our site only, of which about 55 per cent have stayed with us and the rest have opted to go to another provider where they have got more hours. So the surge workforce has been the biggest component, but as I said, the surge workforce has not been without its own problems, because obviously it is coming from agencies and agency staff by default have to work across multiple sites, and that does open up exposure points. Whereas part of our entry criteria is that people have not been in a hot zone or been in a site that has got COVID-positives. So it actually almost restricts half the surge workforce when we go that way, but we could not survive without it.

Mr D O'BRIEN: Yes. How much assistance was the state government in providing that surge workforce? Or was it more the federal government you were dealing with?

Adjunct Prof. CORNELISSEN: No, it has been the state government in our case more so, and absolutely very good. As I said, we have had the odd person who has come and tested COVID-positive several days later, but that is one of the concerns we have. But all in all we could not have survived without them either and/or the cluster services that helped us out as well at times.

Mr D O'BRIEN: And going forward, this is probably a question across the aged care sector, so I appreciate you cannot comment that broadly, but is it feasible to have a restriction on staff not crossing between sites for a longer period of time, going into the future? Or is it just that the set-up is that there are many casuals and part-timers who are going to work across different agencies?

Adjunct Prof. CORNELISSEN: Look, I think the evidence internationally is telling us that this is a key consideration. The issue is, though, we would probably need a whole workforce reform platform in aged care to really look at how we do this properly. So I think it is very easy to anecdotally say that that would be the case, but the entire workforce reform agenda would need to be looked at for that to be successful.

Mr D O'BRIEN: Okay. And in terms of preparation for what ended up being the second wave, did you have much discussion with the state government on preparation for another outbreak as we came out of the first wave?

Adjunct Prof. CORNELISSEN: Look, we had already submitted preparedness plans, both to the commonwealth and to the state government—so yes, we had. They were never going to be foolproof, of course, but they were there and I think they were a good thing and we should do it. I guess the problem was that again with the preparation plans it seemed like we were asked by at least five or six different agencies to provide the same document, albeit nuanced in a different way, whether that be WorkSafe, the department of health, the Department of Health and Ageing, the public health unit, Safer Care Victoria, the quality agency—all people asking the same. Again, when you have got managers, aged care is a very thinly managed organisation, with one manager responding to all of those, that is a concern. So again, if that could be coordinated, I think that would be an improvement going forward.

Mr D O'BRIEN: Would that be one of the areas of biggest failure in terms of stopping the second wave into aged care, how it worked? And what was—if there is anything else that you could say—the biggest issue?

Adjunct Prof. CORNELISSEN: Look, it is far beyond me to say what is a failure because we have never had this before, so I think it is really difficult to point the finger and say what is a failure. We are responding to something we have never responded to before. We are an evidence-based practice in health and also in aged care, and yet we do not have an evidence base here—we are going on best base knowledge. So I think to point the finger is rather unhelpful at this point in time.

I do think, though, that in terms of how we have responded I think in most cases we have done the best we can. The issue has been that as community transmissions have gone up, that is the entry point. Our people work and live in the community, and if they come into a home without knowing and without symptoms—I want to be

clear: I do not think I have got many workers that came to work sick. They were very concerned about what they might bring into the site and they were very aware of the risk they posed, but most of them were asymptomatic—and when they found out or became symptomatic, they let us know straightaway and then we got the test.

If anything, maybe some of those first test results might have been a bit slow getting to them, and that may be because aged-care workers were not seen as healthcare workers or did not identify themselves as a healthcare worker. And doing those two to three days of first response and contact tracing, that is the difference between catching it early or it catching you early, and once it is in front of you it is a hard chase.

Mr D O'BRIEN: Yes. Thank you very much, Professor; I appreciate your evidence.

The CHAIR: Mr David Limbrick, MLC.

Mr LIMBRICK: Thank you, Chair. Thank you, Professor, for appearing today. It is very impressive, the management systems and protections that your organisation has put in place. I would like to just follow up on a couple of things that you mentioned during your introduction. You mentioned something about unintended consequences of comments about the sector. Would you mind explaining what you meant by that? Because I am not sure what you were actually talking about there.

Adjunct Prof. CORNELISSEN: Look, I think that sometimes—and this has been in media; it has been in a range of areas—people have made a comment about one issue and applied it to the entire sector. And those general comments, in a sector that is already struggling with the royal commission and trying to find a whole heap of issues, are not helpful in a crisis. There have also been, I think, some small public announcements or decisions that have been made that have all the right intentions, and I understand them, but the unintended consequences of the way those decisions have been made have been felt quite negatively by the workforce. For example, if I look at the concept of permits being available for healthcare workers but not for aged-care nurses, with the registered nurses we already struggle to attract registered nurses into aged care. They are the same professional body with the same professional regulation requirements, and one can get a permit and the other cannot get a permit and gets stopped on the way to work and has to give evidence as to why they are out and about, whereas the other is permit free. I think it is very small, but the impact our people report of that is, 'Yet again, we are less than the other registered nurses. Why would I want to work in here?'. So there are those unintended consequences of what is good policy but has those issues behind the scene that no-one would have ever thought of.

Mr LIMBRICK: One of the whole points of this inquiry is to look at the response and try and come up with recommendations for how to do things differently. For that particular situation, what would be a better way that that could be managed, do you think?

Adjunct Prof. CORNELISSEN: I think we have to get down to: if we are saying a hospital is an essential service and a registered nurse is critical—if I just stay with that example—how can a registered nurse that might be one of only two in an aged-care facility looking after 40, 50, 100 people not be critical and essential as well? So I think it is just saying—if we are applying things to a hospital—as I said before, the residents and the people we look after are vastly different but the systems, processes and issues are the same. We should just remember that aged care is not an inferior service; it is a very different service, and I think we have just got to be very careful.

Also with the single-provider failures—and look, there have been some abhorrent reports of single-provider failures—they are not necessarily synonymous with a system failure. And I think we sometimes sit there and in necessarily commenting on one we assume that every one is the same. And for a workforce that is minimally paid—and we have to remember that most of our workforce are minimally paid—they are coming in at entry-level salaries and are required to do complex, complex care, I think, that is well beyond those pay grades. I think we have got to be very careful not to make them feel further down the food chain than they already are.

Mr LIMBRICK: I understand. On these comments that have been made about single providers, you are sort of saying that, you know, there is a diversity of service providers and there are problems in some places and not problems in others, and this idea that they are all the same and have all got these problems is wrong. Is that sort of what you are getting at?

Adjunct Prof. CORNELISSEN: That is absolutely right.

Mr LIMBRICK: Okay. Thank you. Another thing that you mentioned that I wanted to explore a bit more was the idea that close contacts of staff members that were positive needed to be furloughed and then replaced by someone else, and you mentioned that there were some problems there. Could you maybe elaborate on that a little bit, please?

Adjunct Prof. CORNELISSEN: Look, there is no doubt that we have taken a conservative approach to furloughing, and I think there is no doubt you have to. We have done that in our hospitals, and we have done that in our residential aged-care facilities and in home care indeed as well. The issue is when you furlough someone—and I do not have any answer to this, by the way—it just seems counterintuitive to furlough someone because they may have been exposed to COVID-19 and therefore be at likelihood of getting it and then take a staff member from an agency or from a surge workforce that has worked on COVID-positive sites and also has been exposed but has not been identified as a close contact. It is just a bit counterintuitive, and I do not know what to do with the conflict, but it is one that we live through every day as we try and balance that and the need to staff a service.

Mr LIMBRICK: Yes. It does sound like a challenging situation for staffing. On that issue of staffing, I guess you must be doing things like having separate roster groups and things like this. How does that affect your organisations, like financially? Because there must be a large financial impact of doing this sort of unusual staff management.

Adjunct Prof. CORNELISSEN: One hundred per cent. I think firstly if you are going to run the incident command centre, there is a cost in that, and we try to absorb most of that. But absolutely when you have a site where you have got furloughed staff, clearly you are paying those staff in terms of sick leave or whatever leave they are on. You are paying that; then you are replacing them. And if you have got COVID in your resident cohort as well, then you are also moving to what we would call, sort of, segregation, or you move into colour coding—you know, red, green and orange zones. But if you move into those zonings, you have then got staff that cannot move across any of the three zones, so therefore your single staff roster turns into three staff rosters. So the number of staff you then require to do it effectively can triple for every shift, because you do not want your staff moving between those three areas because of the risk of transmission.

So it is very difficult, and that has obviously got a huge financial impost. Our issue at this point has been that we need to wear this. Look, I think we have been given good assurances at both the state and the federal level that costs will be supported where possible, and we are just moving for the safety aspect now. That is what we are firmly on.

The CHAIR: Thank you, Mr Limbrick. Yes, your time has expired. Thank you, Professor, very much for appearing on behalf of Mercy Health Aged Care for our committee deliberations today. The committee will follow up on any questions which were taken on notice in writing, and responses will be required within five working days of the committee's request. The committee will now be taking a short break before consideration of its next witness, but thank you very much for your time here today. Thank you.

Adjunct Prof. CORNELISSEN: Thank you. Thank you very much for the time.

Witness withdrew.