It's too early to tell how the royal commission will handle different agendas

AS I WRITE, the aged care royal commission has completed its first two weeks of formal hearings and is a couple of weeks away from its second round. It has also already run its first expert roundtable and conducted two public forums.

It is early days yet in the journey of a commission that will run till April 2020.

However, some early areas of focus have emerged that are not surprising. They include:

- funding models
- funding quantum
- levels and mixes of staff
- increasing consumer choice and control
- new models of care, especially in residential
- the lack of real transparency from providers about services, prices, complaints and quality issues
- how aged care and other parts of the human services fit together, or not, especially the health care system.

The first two weeks of hearings were more exploratory than interrogatory as the Counsels Assisting sought to use witnesses to describe the aged care system and identify major issues.

Understandable, but it raises the question as to how the commission will make judgements between competing views and assertions, coming from different sets of interests.

These do not always lend themselves to an evidence-based conclusion, as the same evidence can be taken to mean different things by different interests.

How does the commission come to a definitive view about what aged care should look like in the future and how that is achieved?

Ian Yates, chief executive of COTA Australia

COTA has also strongly made the point that all providers currently operate within the same regulatory and funding environment but produce quite different outcomes in terms of consumer safety and quality.

This has been illustrated for example in the overuse of medications by many providers, including to the point of abuse, while other providers use them only sparingly and appropriately. Food is another area of major difference.

Exploration of why such differences occur is critical to the achievement of the commission's terms of reference.

If funding was increased in residential care, for example, without that question having been answered, then the poor behaviours of a significant number of providers, and the inefficiencies of many, will be rewarded, and taxpayers' funds will be expended without an increase in quality and safety.

And the good guys get no recognition or reward. ■

Reversing frailty needs early identification and action

WHEN SOMEONE says the word frail, we can all imagine a frail older person.

Roughly 25 per cent of the older population are likely to be frail, though different definitions and lack of data collection means this figure is not well established.

Over the next few years we are likely to see frailty increasingly recognised and measured as a mixed physical and psychosocial geriatric condition.

Frail or prefrail older people have higher levels of comorbidities, such as heart failure, ischaemic heart disease, chronic kidney disease, osteoarthritis, dementia or other cognitive impairment and diabetes mellitus.

Social isolation and cognitive frailty are increasingly being recognised as contributing to frailty as society better understands the link between mind and body.

Frail older people are vulnerable to increased dependency, lower quality of life, hospitalisation, falls, disability and death.

Associate Professor Christine Stirling, president of the AAG

This means that early intervention to reverse frailty is beneficial for the individual and the health system. There is a move towards research and reablement interventions focused on this.

Activities with proven benefits include resistance training and increasing protein and Vitamin D in the diet. But there is also some evidence that social activities can also help reverse signs of frailty.

> "Social isolation and cognitive frailty are increasingly being recognised as contributing to frailty as society better understands the link between mind and body."

People in the pre and early frailty stages of deterioration are most likely to benefit from the promotion of healthy behaviours and social activity but how do you recognise them?

There are several useful and validated frailty tools that can be used by frontline staff including the Edmonton Frail Scale.

Key signs that should raise suspicion include unplanned and unexplained weight loss, using five or more medications, decreasing functional or cognitive capacity and social isolation.

A time-limited program (six to 12 weeks) with individualised exercises, additional protein in the diet and reablement to return some or all recently lost functional independence should be the intervention target.

With better knowledge about the warning signs of frailty and access to validated frailty measures, it is possible to identify an older person in the pre or early stages of frailty and to intervene promptly. ■

AAG Australian Association of Gerontology