SUBMISSION TO THE ROYAL COMMISSION INTO AGED-CARE QUALITY AND SAFETY

September 2019

Recommendations

- Support university-aged-care service partnerships to build learning cultures and expand clinical placement capacity into aged-care. Research supports such collaborations as key drivers for improved workforce and other aged-care outcomes.
- Develop an aged-care workforce policy and planning forum as an enduring structure that brings all relevant stakeholders including government, aged-care industry and higher education providers together regularly.
  - As a first step, support a national roundtable that brings universities and aged-care service providers together to showcase effective models, identify barriers and work out next steps.
- Expand the Rural Health Multidisciplinary Training program to extend aged-care placements and grow aged-care workforce in rural areas across all disciplines.
- Support universities to gather national clinical placement data to map aged-care placement capacity.
- Refocus aged-care towards preventative, restorative approaches to keep older Australians out of hospital/residential aged-care and in the community for longer.

INTRODUCTION

Universities Australia (UA) welcomes the opportunity to make submission to the Royal Commission into Aged-care Quality and Safety. UA is the peak national body representing Australia's thirty-nine comprehensive universities. UA has a keen interest in aged-care workforce policy and the way in which universities can support healthy, positive ageing. UA previously made submissions to the Aged-care Workforce Strategy Taskforce. UA is also represented on the current Aged Services Industry Reference Committee (IRC) and its Tertiary Education and Pathways Sub-Committee.

This submission focuses predominantly on the aged-care workforce and we have addressed the Commission's Terms of Reference (TOR) pertinent to this area (see Appendix 1 for the full TOR). This submission has been developed in consultation with our Health Professions Education Standing Group (HPESG) which comprises senior university sector representatives from all health professional disciplines and jurisdictions (see Attachment A for further information).

Our specific focus is on the education and training of health professionals – nurses, doctors, dentists, pharmacists and allied health professionals – and the contribution they can make both as students and as qualified health professionals to enhancing the quality of care for older Australians. Universities play a major role in educating such health professionals. All universities deliver health professional education and

most offer multiple courses. Such education relies on close interaction with health, aged-care and disability services, particularly for the clinical education (or placement) component.

Clinical placement experiences are mandatory in all pre-registration health professional courses. Where and how health professional students undertake such placements – and the quality of these experiences – provides notable benefits to clients and services. They can also have a profound effect on where students choose to practice once qualified. The service settings within which placements occur therefore play an important role in workforce distribution and can support workforce growth and skill development in needed areas such as aged-care. However, most clinical education continues to be in acute-care. Collaboration between universities and aged-care services can develop the learning environments in which placements and other skills development can occur. Any aged-care workforce formation must necessarily consider these aspects in developing its education and training pipelines. The challenges of developing such approaches and placements and proven ways to support them are outlined in the following responses. Many of these points have been made previously in UA's submission to the Aged-care Strategy Workforce Taskforce and UA refers the Commission to this submission (see Attachment B).

Throughout this submission, except where otherwise qualified, "Aged-care" is used to include both residential facilities and those aged-care services provided to older people living at home receiving community-based support.

RESPONSE TO SELECTED TOR:

TOR C: the future challenges and opportunities for delivering accessible, affordable and high-quality aged-care services in Australia, including:

i. **in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and**
ii. **in remote, rural and regional Australia;**

Australia's older population is growing rapidly. The proportion of Australians aged 65 years and older has almost doubled in the last fifty years (now 15 per cent) with predictions it will be almost a quarter of the population in another fifty[i]. Australians are not only living longer, they are also living with more years of ill health[ii]. This simultaneously:

- reduces older people's options to remain living at home; and
- increases the need for a health care workforce oriented towards aged-care.

To address this, we need to build a healthcare workforce that helps older people stay independent and well while also providing appropriately for those experiencing significant ill-health or unable to care for themselves. However various challenges exist:

- The aged-care workforce itself is ageing. The median age of such workers is 46 and 52 years in residential and home-care respectively[iii]. This raises issues of workforce sustainability.
- The use of technology and artificial intelligence (AI) is growing across all workplaces, including aged-care. High-touch, high-skill jobs that can work alongside technology are predicted to grow, arguably requiring a differently skilled, more educated and professional workforce[iv].
- Health promotion approaches help people age well and remain living independently. All health professionals play a role in this, especially the allied professions that support functional independence as people age. However, our current health system is not well geared towards this[1]: allied and other health professionals are underutilised in the aged-care sector, especially in rural and remote areas.

[1] Only 1.34 percent of our health spending is on prevention[1] despite about 31 percent of our disease burden attributable to modifiable risk factors – including up to one third of dementia cases[1 1].

- For multiple reasons[2], working with older Australians, especially in the aged-care sector and particularly in residential aged-care, is not seen as a first choice for many, including healthcare professionals.
- Training courses do not always include adequate experience in the aged-care system to support future health professionals best prepare for working with older clients or realise the rewards of doings so.
  - There is an educational and workforce imperative for students to learn about people outside of the acute hospital setting where most clinical education still occurs[v].

If unaddressed, the impact of these factors on the quality of care for older people is likely to be substantial. What is required is leadership, career pathways and a health professional workforce that is better enabled to provide preventative care and to work with older Australians both in and outside of the aged-care sector.

One way to address this workforce issue is through learner development approaches. This approach involves supervised opportunities in aged-care settings for all learners (students and staff) to learn the skills, knowledge and attitudes that provide high-quality and safe services to older people. The mechanism for students is supervised placement. Learner development approaches build safe learning environments and allow for career pathways to be embedded in aged-care workforce development. The path begins with a learner at the beginning of their journey and then supports them toward competence and independence in aged-care service delivery.

Within this framework, there is a particular benefit in increasing the number of health professional students across all disciplines who undertake supervised placements in aged-care services. Clinical placements bring the following benefits to services:

- increased staff up-skilling and professional development;
- increased workforce capacity;
- the promotion of service innovation; and
- improved client perceptions of services.

Multidisciplinary student placements in aged-care bring the following specific benefits:

- enhanced client care;
- better prepared health professionals to work with older people; and
- increased student likelihood of choosing to work in an aged-care domain once qualified.

However, there are challenges in developing learning environments and expanding clinical placements in aged-care. A key barrier is the lack of clinical education and supervision capacity within many services. While some aged-care services do this well and a number of effective models exist (see Attachment C for examples), national coverage is patchy (see Box 1 below) and evaluations have identified significant need for expanded education and development opportunities in aged-care[vi].

Box 1: The exact proportion of aged-care services providing clinical placement opportunities nationally is not known despite the identified need to expand capacity. Clinical placement data used to be collected through Health Workforce Australia (HWA) as part of universities receipt of the Clinical Training Fund (CTF). The data collection was very involved and took each university significant resources to collate, especially those with a large number of health courses. However, this data collection ceased after HWA was abolished. Re-establishing national clinical placement data collection would be extremely useful.

Residential aged-care in particular is relatively under-developed in relation to supporting a range of placements and broader learning environments. Various barriers exist including the following:

- Many aged-care service providers operate within the private and NGO settings. This has an impact on placements in several ways:

[2] Lack of career progression and pay levels that are not comparable to working in acute care also contribute to this situation.

  - business viability and commercial imperatives can deter services from employing a broad range of health professional staff. This reduces their general ability to provide environments within which student placements and other learning can occur. It presents particular problems for multidisciplinary placements, especially where health professional accreditation standards do not allow cross-disciplinary supervision.
  - services may take students but will charge universities to do so – despite the benefits students bring. This can deter universities from placing students into aged-care services – especially in the current higher education environment of reduced funding.

- Casualisation of the workforce. An increasing number of staff in aged-care services are employed under casual contracts. Such contracts generally do not stipulate teaching so even where a staff member is qualified to supervise students, they are not allowed to do so under their contract.
- Limitations of the Aged-care Funding Instrument (ACFI). The ACFI allocates government funding to aged service providers based on assessed resident care needs. Tightly specified use of the ACFI can constrain what services students can provide, limiting the student education experience and potentially limiting the benefits to clients of broader-based student services.
- Lack of awareness of the benefit of student placements to clients and services. Many aged-care and health services are unaware of the benefits that students can bring. There is a misconception that students are a burden, add pressure to already busy staff schedules and take time away from staff that could be spent with clients. While universities do need to work closely with aged service providers to determine which particular supervision models will work for them, this is often not the case.
- Perceptions that aged-care is an unattractive career choice. Myths and misconceptions about aged-care exist among health professional students. This can deter students from electing to undertake placements in aged-care services.

Evidence shows that many of these barriers and misconceptions can be altered through strong university-aged-care service partnerships. However, these partnerships often need time and sustained resources to develop. Department of Health and HWA funding was previously provided to support such partnerships through pilot trials and the former CTF. However, this funding is no longer available despite evaluations showing positive outcomes[vii] [viii]. Some effective local models still exist (see Attachment C) but policy support and further work is required to implement these more broadly. Ways to address this situation are provided in responses to TORs D and F.

Rural and remote issues

People aged 65 years and over are disproportionally represented in regional, rural and remote areas[ix] and the above issues are even more pronounced in these communities. Difficulty accessing services and an appropriately skilled health workforce generally increases with increasing rurality[x] [xi], amplifying the challenges. The Rural Health Multidisciplinary Training (RHMT) program is a Commonwealth Department of Health (DoH) funded program that supports universities to increase multidisciplinary health student placements and experience in rural areas. It offers a foundation from which health professional workforce and student placements can be increased in rural areas to support a range of services, including aged-care. The program is currently under review. UA refers the commissioner to this review and to the UA response (see Attachment D) and recommends that the Aged-care Royal Commission gives consideration to expanding the RHMT program to include an additional aged-care focus as part of addressing rural aged-care workforce issues.

There is also currently work underway by the National Rural Health Commissioner looking specifically at how to increase allied health workforce in rural locations. As outlined in UA's submission to that review (see Attachment E) this must necessarily consider clinical education and placements. This could include consideration of approaches that expand learning environments and placements in rural aged-care services.

The Commission may also wish to consider ways in which additional service options, such as telehealth, can support aged-care in rural areas. Health professional education will increasingly need to embrace technology across urban and rural settings. However, the infrastructure to support technological advances in health care delivery is still inconsistent across rural Australia. This presents challenges to fully incorporating the required education and service delivery approaches.

TOR D: what the Australian Government, aged-care industry, Australian families and the wider community can do to strengthen the system of aged-care services to ensure that the services provided are of high quality and safe;

Investment in the aged-care workforce and specifically in education experiences that promote aged-care to future health professionals is required. As noted in the Wicking project work: *"Population demographic changes and aged-care workforce capacity issues provide a strong impetus to develop aged-care facilities as centres of education and innovation with evidence-based practice the focus"* [xii]

Aged-care-university partnerships are an effective way to achieve this. However, such partnerships are not common across Australia and take time and resource to establish. Dedicated staff positions from both aged-care and university providers are required to support the following:

- development of clinical supervision capacity;
- identification and implementation of clinical education models that best suit each aged service provider; and
- promotion of the multiple benefits of student placements in aged-care to both students and providers.

Policy and resourcing to develop these partnerships is needed. This view is supported by research and was included in the recommendations from the Teaching Research Aged-care Services (TRACS) evaluation [v vi viii xii xv xiii xv]. TRACS found multiple benefits to clients, providers and students from supporting the development and strengthening of aged-care-university partnerships. Models varied with each site. Common to all however were opportunities to build multi-disciplinary clinical education and research capacity in aged-care to improve client care and student education. Similar findings have also been shown in the Wicking projects which are more specifically focused on dementia care. TRACS specifically recommended a hub and spoke model to build on existing university-aged-care provider relationships; and support capacity building to other aged-care providers through the spread of innovation and good practice.

Developing these approaches is important in building the supervision, clinical education and action research/continuous quality improvement (CQI) capacity required more broadly across aged-care services that will:

- increase the likelihood of health professionals deciding to work in aged-care;
- better prepare all health professionals for working with older clients; and
- address the need for a more skilled workforce in aged-care. This is particularly important as the care needs of residential clients becomes increasingly complex and to support a digitally-enabled workforce as the role of technology in health and aged-care delivery rapidly increases.

TOR F: how best to deliver aged-care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged-care workforce and capital infrastructure;

"Teaching Aged-care Facilities across Australia have the potential to facilitate high quality care to residents with increasing levels of frailty and dementia and to develop evidence-based practice… to drive high performance, attract a new generation of health professionals into aged-care and enable a reconfiguration of the aged-care workforce." [xii]

The Teaching Nursing Home (TNH) model acknowledges the learning opportunities offered by an aged-care clinical placement, the need to grow health and aged-care workforces, and the importance of creating specialist teaching aged-care services (in the same way as the health sector system includes dedicated teaching hospitals [xiii].

University-aged-care partnerships embed learning and CQI cultures within aged-care services that support ongoing innovation, research and education. They are key to achieving improved workforce retention and enhanced outcomes for clients, aged-care providers and students. Positive results have been achieved

across a range of aged-care services including in more challenging areas such as dementia [viii] [xiv]. Partnerships help build learner development environments within which dedicated educators can develop sustainable, coordinated learning opportunities. Student placements are a key part of this. While predominantly educational in focus, placements also contribute workforce and other benefits (see Attachment C). A summary of measured results include:

- decreased experience of social isolation in aged-care clients;
- workforce benefits both during and after the student placement. Some service providers report using the placement as a "long recruit" which assists in staff recruitment and retention post qualification;
- reduced client falls, greater functional independence and increased cognitive functioning where relevant student programs have been implemented;
- increased service capacity and the confidence of enhanced care;
- increased social interaction and facility vibrancy overall. Residents often report that health students bring "a new breath of life" to the service[xv];
- increased student interest in participating in further aged-care placements;
- greater student interest in pursuing a career in aged-care once qualified;
- better developed student knowledge, skills and attitudes required to work collaboratively within the aged-care sector to improve the overall quality of care for residents;
- greater understanding of sensitivity and vulnerability in older people and the vital skill of "learning to care";
- greater development of clinical skills in working with older adults making students more "job ready" for working in aged-care; and
- increased opportunities for inter-professional education and practice.

Some specific models have been developed. However, iterative processes are generally required that facilitate ongoing, university-aged-care service provider collaboration [vi] [viii]. This enables differences in staff and organisational capacity at each facility to be taken into account. More customised models can then be implemented that best suit each facility and the needs of clients, while also providing high quality teaching and learning experiences for students and staff.

Gearing the workforce for greater preventative care

There is a need to increase the emphasis on prevention and primary care with the aim of keeping older people out of hospital and in the community for longer. Greater opportunities for health professionals to implement preventative approaches are also needed.

From an education and training perspective, enabling students from all health professional disciplines - nursing, medical, allied health, dental and pharmacy - to undertake placements in aged-care is critical. This is particularly so for the allied health professions who focus specifically on restorative health, rehabilitation and functional independence. Allied health student placements in aged services have been shown to achieve greater resident mobility, decrease falls and aid cognitive functioning. Including placements as part of a broader learning, development and research environment enables health professionals, staff and students to input into preventative/other approaches to inform aged-care policy and practice.

From a workforce perspective, health professionals need to be enabled to deliver mitigation strategies to avoid client hospital-admissions (hospital avoidance approaches). The number of hospital admissions from aged-care can be reduced with greater access to appropriately qualified health professionals. One model that has application to aged-care is to expand the use of multidisciplinary health teams and "flying squads". These teams undertake expanded clinical roles and provide early intervention and/or crisis care within the community to prevent hospital admission where possible. Hospital admission can be distressing for older people, especially for those with dementia, and can exacerbate health issues. While aged-care providers will need to consider broader health professional roles in future workforce planning, policy support and

commitment from all levels of government to a greater national focus on prevention within the health system overall is required.

Other considerations for aged-care providers in future workforce planning include skills mix, the role of technology, new models of care and client needs and preferences. Teaching and research collaborations between universities and aged-care providers can help identify and implement these across the education and training pipeline.

TOR G: any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.

There is significant other work currently underway in health, aged-care and disability workforce (see Appendix 2). While this is encouraging, this work largely occurring in isolation from each other. Yet the same health professional workforce is shared across the three domains and there are many education and training requirements that are common to each.

It is UA's strong view that as part of a broader national health workforce planning mechanism, a national Aged-care Workforce forum should be convened where governments, industry, education providers and other key stakeholders meet regularly under an enduring structure to:

- plan strategically for the sector's future workforce, education and skills needs;
- share best practice and innovation; and
- identify workforce pressure points, duplication and gaps.

Health workforce planning mechanisms that link health, education and other relevant agents are endorsed by the World Health Organisation (WHO) as good practice[xvi].

The role of the new Aged Services Industry Workforce Council is yet to be made clear however this could take a lead role in overseeing such work. Clearly there would need to be strong connection with the higher education and VET sectors and with other relevant work on health and disability workforce. Some initial ideas for this body of work have been suggested in UA's submission to the Aged-care Workforce Strategy Taskforce (see Attachment B, response to question 2). As a first step the university and aged-care sectors could be brought together in a small national roundtable to showcase effective partnership models, understand barriers to their expansion and identify the steps required to address these and implement effective models more broadly.

A growing consideration in all workforces is also the rapidly increasing role of technology and artificial intelligence. This is an emerging area in aged-care in Australia. UA is engaging with the Digital Health CRC and the Australian Digital Health Agency to look at how digital knowledge can be better embedded into health professional education and training. UA also refers the Commission to the Digital Health CRC which includes a specific focus on aged-care as a flagship program: https://www.digitalhealthcrc.com/research-themes-and-settings-of-care/

REFERENCES

[i] Australian Institute of Health and Welfare 2018: *Older Australia at a glance*: https://bit.ly/2rNWa47
[ii] Productivity Commission 2017: *Shifting the Dial Report:* https://www.pc.gov.au/inquiries/completed/productivity-review/report
[iii] Australian Government Department of Health 2017: *The Aged-care Workforce 2016.* https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/03_2017/nacwcs_final_report_290317.pdf
[iv] A. Charlton. UA conference 2019: *Enterprise Skills and the future of Work.* https://bit.ly/2KxLy1Z
[v] R Saunders, K Miller, H Dugmore et al. *Demystifying aged-care for medical students.* The Clinical Teacher 2017; 13: 1–4 1. https://www.ncbi.nlm.nih.gov/pubmed/26749340
[vi] K Barnett, C Moretti and S Howard 2015. *TRACS to the Future - National Evaluation of Teaching and Research Aged Care Service (TRACS) Models: Final Report*. https://agedcare.health.gov.au/tracs-to-the-future-national-evaluation-of-teaching-and-research-aged-care-services-tracs-models-final-report
[vii] ibid
[viii] Wicking Teaching Aged Care Facilities Program 2017: Multiple published journal articles available from the Wicking Dementia Research and Education Centre
[ix] Australian Bureau of Statistics: 2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016: https://bit.ly/2EmLH4a
[x] Australian Government Department of Health: Health Workforce Data – Summary Statistics 2019: https://hwd.health.gov.au/summary.html
[xi] National Rural Health *Alliance Health Workforce*: https://www.ruralhealth.org.au/book/health-workforce-0
[xii] A Robinson, C See, E Lea et al 2015: *Wicking teaching aged-care facilities program: innovative practice.* https://journals.sagepub.com/doi/abs/10.1177/1471301215603846
[xiii] M Corlis, K Barnett, H Loffler et al. 2019. Partnering to provide interprofessional education in aged-care. Journal of Interprofessional Education and Practice. https://bit.ly/2lL3Fq2
[xiv] Teaching and Research Aged-care Services (TRACS) http://bit.ly/2DCEXeL
[xv] K-E Elliott, M Annear, E Bell et al. 2015: *Residents with mild cognitive decline and family members report health students "enhance capacity of care" and bring a "new breath of life" in two aged care facilities in Tasmania.* https://www.ncbi.nlm.nih.gov/pubmed/25041246
[xvi] World Health Organisation (WHO) 2013. Transforming and scaling up health professionals education and training: WHO Guidelines 2013. http://www.who.int/hrh/resources/transf_scaling_hpet/en/

APPENDIX 1: ROYAL COMMISSION'S FULL TERMS OF REFERENCE

The Commissioners were appointed to be a Commission of inquiry, and required and authorised to inquire into the following matters:

a. the quality of aged-care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response;
b. how best to deliver aged-care services to:
    i. people with disabilities residing in aged-care facilities, including younger people; and
    ii. the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged-care services;
c. the future challenges and opportunities for delivering accessible, affordable and high-quality aged-care services in Australia, including:
    i. in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and
    ii. in remote, rural and regional Australia;
d. what the Australian Government, aged-care industry, Australian families and the wider community can do to strengthen the system of aged-care services to ensure that the services provided are of high quality and safe;
e. how to ensure that aged-care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters;
f. how best to deliver aged-care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged-care workforce and capital infrastructure;
g. any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.

APPENDIX 2: CURRENT HEALTH WORKFORCE AND EDUCATION INITIATIVES / REVIEWS

- Medical Workforce Strategy.
- Consultation on the Rural Allied Health Workforce and distribution pathways.
- Review of the Rural Health Multidisciplinary Training (RHMT) program. The Program provides DoH funds to universities to enhance rural health workforce through clinical education/placement pathways.
- Boosting the Local Care Workforce Initiative. The initiative is examining NDIS workforce needs.
- Aged-care Workforce Strategy Report – including the development of the Aged-care Industry Workforce Council and the Aged Services Industry Reference Committee
- Digital Health Cooperative Research Centre (CRC)
- Digital Health Agency – Workforce and Education Roadmap
- Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) tool. The tool is under development. Its initial focus is medical primary care workforce and service data. Clinical placement data is not currently collected through the tool.
- Rural Bonded Medical Scholar program—new legislation passed. The program supports a rural return of service obligation for bonded medical scholars.
- Accreditation Systems Review. Review of accreditation/registration governance of the fifteen health professions regulated through the National Registration and Accreditation Scheme (NRAS)
- Nurse Education Review
- DHA's Education and Workforce Roadmap development.
- Medical Workforce Reform Advisory Committee (AMRAC)
- Nursing and Midwifery Education Advisory Network (NNMEAN)