# SUBMISSION TO THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY: WORKFORCE

December 2019

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### Recommendations

- 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.

- Support university/aged-care service partnerships to build learning cultures and expand clinical placement capacity in aged-care. Research supports such collaborations as key drivers for improved workforce and other aged-care outcomes. As a first step:

  – support a national roundtable that brings universities and aged-care service providers together to showcase effective models, identify barriers and establish next steps;

  – 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.

- Develop sustainable funding models that support health professionals, especially allied health, to work in aged-care.

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## BACKGROUND AND INTRODUCTION

Universities Australia (UA) welcomes the opportunity to make a submission to the Royal Commission specifically on Aged Care Workforce, further to the Commission's third Melbourne hearing in October 2019. UA's current submission focuses on:

- link between health professional education and training and aged-care workforce;

- contribution that university/aged-care service partnerships make to aged-care workforce and client outcomes; and

- need for aged-care and broader health workforce planning.

Universities play a major role in the formation of Australia's entry-level health professional workforce and are well positioned to work in partnership with aged services to contribute to relevant workforce development. Much information and evidence about these important links has been provided in UA's previous submissions and statements to the Royal Commission. UA refers the Commission to these documents for more detail. However key points are reiterated below in response to relevant terms of reference (TOR). The Commission's full aged-care workforce TOR are at Appendix 1.

# RESPONSE TO SELECTED TERMS OF REFERENCE

**TOR 1: Methods for determining and implementing the minimum staffing levels and appropriate skills mix for aged care services, including for nursing, personal care, allied health and others**

Establishment of a national aged-care workforce forum is required where governments, industry, education providers and other key stakeholders meet regularly under an enduring structure to:

- plan strategically for the sector's short, medium and longer-term workforce, education and skills, with a major focus on workforce sustainability within a dynamic environment;

- take into account likely workforce change as technology evolves;

- undertake workforce forecasting under different scenarios incorporating technological/digital health advances, potential new workforce roles, changing skills mix/scopes of practice change and student contributions to care;

- share best practice and innovation;

- gather, link and analyse relevant data[1] that includes workforce and workplace inputs, outputs and outcomes – including student clinical placements/other education experiences; and

- identify workforce pressure points, duplication and gaps.

As aged-care is intrinsically linked with disability and mainstream health services which all draw on the same health professional, care and support workforce, this forum should be part of a broader national health and disability workforce planning mechanism.

This type of workforce planning, including in aged-care, was previously undertaken to good effect by the former Health Workforce Australia (HWA). HWA's work included:

- development of a national workforce planning statistical database;

- workforce redesign funding;

- workforce scenario planning and forecasting

- innovation, funding and expansion of clinical education; and

- supervision capacity-building.

There is already some work currently underway in aged-care, health and disability workforce development (see Appendix 2). While this is encouraging, initiatives largely occur in isolation from each other. A broader, overarching mechanism is needed that draws applicable work from individual groups together into a meaningful whole. This would help to connect aged-care with the multiple other stakeholders involved in health, aged-care and disability workforce formation. More comprehensive whole-of-system health and aged-care workforce planning would help to pinpoint its workforce, skills-mix and clinical education needs/gaps and provide a basis for further policy development.

> **Box 1: According to the Productivity Commission's recent report , while Australia does reasonably well in some areas of health and aged-care, its lack of a systems approach, jurisdictional barriers and other service disconnects impede improvement. Many opportunities to advance the system could be addressed through better system integration in all areas, including health workforce planning.**

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[1] The Commonwealth Department of Health is currently overseeing the development of an aged care workforce data framework.

A structure that connects the multi-sectoral participants, funders and tiers of government is definitely needed to bring a sustainable systems approach to aged-care workforce planning and overcome its current patchiness – especially given the divided responsibilities for aged-care, health, and disability policy, regulation, funding and delivery. Workforce planning mechanisms that link health, aged-care, education and other relevant agents are endorsed by the World Health Organisation (WHO) as good practice[i]. An example of a similar structure which is used to good effect in the UK is Health Education England[ii].

More detail about a national aged-care/health workforce planning mechanism is provided in UA's submissions to the Aged Care Workforce Strategy Taskforce (attached), the APS Review (attached) and to the Royal Commission on Aged Care Quality and Safety[iii].

> **Box 2: A growing consideration in all workforces is the rapidly increasing role of technology and artificial intelligence. This is an emerging area in aged-care in Australia. The Australian Digital Health Agency (ADHA) is developing a Digital Health Workforce and Education Roadmap which incorporates Aged Care. ADHA and the Digital Health CRC are also undertaking work looking at how digital knowledge can be better embedded into health professional workforce and education. The Digital Health CRC includes a specific focus on aged-care as a flagship program: https://www.digitalhealthcrc.com/research-themes-and-settings-of-care/**

### TOR 6: Any institutional changes needed to ensure that the Commonwealth fills its role as the system steward and exercises leadership in workforce planning, development and remuneration

Policy, regulation and funding oversight of aged-care services are predominantly the responsibility of the Australian Government[2]. However, oversight of health and disability services is shared across multiple tiers of governments [iv] [v]. The actual delivery of all of these services (aged-care, health and disability) occurs via an extensive array of public, private and NGO providers. Multiple other stakeholders (such as professional bodies, educators and accreditors) are also involved in workforce development. All of these agents need to work together for effective, sustainable, aged-care workforce planning.

This requires a commitment from all Australian governments, industry and others to work together. However, the Commonwealth government could take the lead on bringing relevant parties together, connecting across portfolios and sectors for more integrated aged-care workforce policy formulation. Several bodies, such as the Aged Services Industry Reference Committee (IRC) and the National Aged Care Alliance already bring together multiple groups with an interest in aged-care. These groups provide an initial foundation for such discussion. The role of the new Aged Services Industry Workforce Council is yet to be made clear, however, this could also be a key contributor and advisory body in such work.

Clearly there would also need to be strong connections with the higher education and VET sectors (only the Aged Services IRC currently includes tertiary education representatives) and with relevant work on health and disability workforce. Some initial ideas for potential areas of focus have been suggested in UA's submission to the Aged-care Workforce Strategy Taskforce.

The Commonwealth government, in conjunction with jurisdictional governments, could also take a lead role in refocusing the health system towards greater preventative and primary care. Implementing preventative health programs will help keep older people out of hospital and in the community for longer. Policy to support health professionals to implement these approaches is also needed, especially sustainable funding models for allied health professionals to work in aged-care. A number of the allied health professions have a specific focus on restorative health, rehabilitation and functional independence which can bring benefit to aged-care clients. Supervised allied health *student* placements in aged services have also been shown to

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[2] About 97 per cent of government funding to aged care in Australia is though the Commonwealth government.

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. However, there are currently very limited funding options to support viable allied health models of practice in aged-care. Without sufficient qualified allied and other health professionals in aged-care services, supervision of students is also restricted. Further detail is provided in the response to TORs 4 and 5 and in UA's previous submissions and statements to the Commission.

## TOR 4: How to raise the overall skill, knowledge and competencies of all care staff (existing and new entrants) in working with vulnerable people, especially those with age related conditions and illnesses; and

## TOR 5: how to ensure service providers develop a culture of strong governance and workforce leadership

UA reiterates the important role that university-aged care partnerships play in building the skills, organisational culture and learning environments needed to support health and care staff to work effectively with older people. Work such as the Teaching Research Aged Care Services (TRACS) initiative and the Wicking Teaching Aged Care Facilities Program have provided good evidence about the beneficial difference such partnerships make to clients, services and students [vi, vii]. This has been outlined in our previous submissions to the Commission [iii] and to the Aged Care Workforce Strategy Taskforce (attached).

A key aim of such partnerships is to help build learner-development approaches. Through these reciprocal relationships, the knowledge and skills of those within aged-care contribute to students (including, but not limited to, those in the health professions). Students and universities reciprocally contribute to the learning and skills development of aged-care staff and services. Approaches involve 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 (including clinical placements for health professional students). 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 supports them toward competence and independence in aged-care service delivery.

Within this framework, there is 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 general 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.

There are challenges in expanding clinical placements in aged-care. These have been outlined in detail in UA's previous submissions. University/aged-care service partnerships can help overcome these challenges and have been shown to deliver multiple workforce and other benefits, including in challenging areas such as dementia. (A list of benefits is outlined at Appendix 3). However, such partnerships are not common across Australia and they take time and resource to establish.

Department of Health and HWA funding was previously provided to support such partnerships through pilot trials and the former Clinical Training Fund (CTF). However, this funding is no longer available despite evaluations showing positive outcomes[vi][vii]. Some effective local models still exist (see UA's previous submissions and Attachment A for examples) but policy support and further work is required to implement these more broadly. 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, identify the steps required to address these and implement effective models more broadly.

> **Box 3: 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.**

With suitable policy support, universities can also play a role in gathering national data on the number and type of placements undertaken in aged-care – see Box 3.

Policy and resourcing to develop these partnerships is needed – as an investment in the aged-care workforce, in education experiences that promote aged-care to future health professionals and as a way to help embed continuous quality improvement (CQI) processes into aged-care services. Further detail is available in UA's previous submissions to the Commission.

In this submission UA has offered evidence of approaches that have been shown to work in:

- developing a health professional workforce that has the skills and knowledge to work with and deliver good outcomes for older people; and

- developing aged-care workforce planning linked to broader health, disability and education/training needs.

These approaches make a difference. Models for their implementation have been used previously and are available. However, it is important to emphasise that these are one part of a broader context within which aged-care services and workforce operate. Other factors, such as workforce remuneration, worker recognition/value, career progression and the like, also have an impact but are outside of UA's remit. These factors must also be taken into consideration, alongside workforce planning and university partnership approaches, to effectively address aged-care workforce needs for quality care delivery.

## APPENDIX 1: AGED CARE ROYAL COMMISSION WORKFORCE SUBMISSION COMPLETE TERMS OF REFERENCE

Following the third Melbourne hearing, which focused on workforce issues, the Royal Commission seeks written submissions on policy issues relating to:

1. methods for determining and implementing the minimum staffing levels and appropriate skills mix for aged care services, including for nursing, personal care, allied health and others
2. who should be covered by a registration scheme for non-clinical staff in aged care, and how such a scheme might be implemented, administered and funded
3. options to resolve low remuneration and poor working conditions, including how the remuneration and working conditions of aged care workers can be aligned with their counterparts in the health and disability sectors
4. how to raise the overall skill, knowledge and competencies of all care staff (existing and new entrants) in working with vulnerable people, especially those with age related conditions and illnesses
5. how to ensure service providers develop a culture of strong governance and workforce leadership, and
6. any institutional changes needed to ensure that the Commonwealth fills its role as the system steward and exercises leadership in workforce planning, development and remuneration.

Submissions should be made to ACRCWorkforceSubmissions@royalcommission.gov.au

## APPENDIX 2: CURRENT HEALTH, AGED CARE AND DISABILITY WORKFORCE INITIATIVES

- 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)

- Australian Digital Health Agency – Digital Health 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. Aged Care and 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

- Medical Workforce Reform Advisory Committee (AMRAC)

- Nursing and Midwifery Education Advisory Network (NNMEAN)

- Health Workforce Planning Framework - under development

- Aged Care Workforce Data Framework

## APPENDIX 3: BENEFITS OF UNIVERSITY-AGED CARE SERVICE PARTNERSHIPS TO AGED CARE WORKFORCE / CLIENT OUTCOMES

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 [vi, vii] 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 A). 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[viii];

- 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, vii]. 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.

# REFERENCES

i 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/

ii Health Education England: https://hee.nhs.uk/

iii UA submission to the Royal Commission into Aged Care Quality and Safety available at: https://www.universitiesaustralia.edu.au/policy-submissions/submissions/#area=health

iv Report on Government Services (ROGS) 2019. Chapter 14. Aged Care Services: https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/aged-care-services

v ROGS 2019 Chapter 15. Services for people with disability: https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/services-for-people-with-disability

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 Wicking Teaching Aged Care Facilities Program 2017: Multiple published journal articles available from the Wicking Dementia Research and Education Centre

viii 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