

SUBMISSION TO THE CARE WORKFORCE LABOUR MARKET STUDY

June 2021

Recommendations

- **Develop policy to enable:**
 - **greater employment options for health and social care professionals in care services; and**
 - **higher education-service provider partnerships and flexible industry approaches to building learner-development cultures in care services.**
- **Establish an enduring, comprehensive workforce planning structure that gathers data, undertakes scenario planning and technological impact modelling across different sectors and scopes of practice in the care workforce**

INTRODUCTION

Thank you for the opportunity to make submission to the Care Workforce Labour Market Study - Discussion Paper. Universities Australia (UA) is the peak body for Australia's thirty-nine comprehensive universities. We undertake advocacy on issues of national relevance to the university sector as a whole. This includes health professions education and workforce formation. The majority of Australia's health professionals are educated in Australian universities and all member universities provide health professions education courses.

The whole care workforce is large and broad. It is defined in the discussion paper as including those occupations:

- which are shared across, and involved in the direct care and support of people within aged, disability, veteran and mental health care; and
- where a significant number of workers are employed in residential, in-home and/or community care and support.

Unpaid carers and care roles undertaken predominantly in medical and hospital settings are largely out of scope.

Health professionals across medicine, nursing, allied health, dentistry and pharmacy, are a significant part of this workforce and often work closely with other non-professional care and support personnel. However, the primary focus of this submission is health professionals and other care workforce staff who undertake university-based education.

RESPONSE TO DISCUSSION QUESTIONS

UA has responded directly to many reviews regarding the care workforce, including providing submissions and testament to the Aged Care Royal Commission, the NDIS Outcomes Strategy and multiple health

workforce reviews. We are represented on the Aged Services Industry Reference Committee (IRC) and its Tertiary Education and Pathways Special Interest Advisory Committee (PATSIAC) and provide substantial input to these committees. We have responded to many of the issues raised in the Labour Market Study discussion paper in previous submissions. These are attached for further detail. We reiterate the following key points about the care workforce in relation to the current discussion paper:

WORKFORCE OBSERVATIONS; AND WORKFORCE ATTRACTION RETENTION AND DEVELOPMENT

There is a need for greater access to health professionals in the care workforce and an upskilling of unqualified care/support staff.

The need for increased health professional workforce in the care sectors has been highlighted in a number of recent reportsⁱ. The increasing complexity of clinical and care needs in clients within the sectors of interest, especially in aged care, requires:

- greater access to health professionals, including direct employment of more health professionals by care services; and
- an overall uplift in skills and knowledge in unskilled or minimally qualified support workers.

Clients in the care sectors of interest often have complex clinical and care needs. These are best addressed by a multi-disciplinary, multi-professional team, led by health professionals working closely with management and support staff. This type of approach can improve clients' clinical, social and care outcomes. Access to health professionals in care settings also opens up opportunities for health student and care worker/trainee supervision (see below). However, cost considerations and other barriers often prevent services employing sufficient, appropriately qualified health professionals. Lack of access to qualified health staff can result in clients receiving reduced levels of clinical care and/or aspects of clinical care being delivered by staff who are not appropriately qualified to do so.

Learner-development cultures cultivated through partnership approaches build durable workforce capacity.

UA has previously presented evidence about the benefits of learner-development approaches in addressing care workforce issues, especially in aged care and disability services. These approaches involve supervised opportunities in aged-care and disability settings for all learners (students and staff) to learn the skills, knowledge and attitudes that provide high-quality and safe services to clients. Learner-development approaches build safe learning environments and allow for career pathways to be embedded in workforce development. The path begins with a learner at the beginning of their journey and then supports them towards competence and independence in their respective care service delivery. There is good evidence that services which are set up around learning cultures produce better client outcomes, lead to better workforce attraction and retention and support staff upskilling. Further details are outlined in [UA's submission to the Royal Commission into Aged Care Quality and Safety](#).

To deliver this approach, policy support is required to enable:

- greater employment options for health and social care professionals in care services; and
- higher education-service provider partnerships and flexible industry approaches to building learner-development cultures in care services.

TECHNOLOGY

Telehealth, digital hospitals, wearables and monitoring apps are already changing the way care is delivered and their use is set to increase. Other innovations are also likely to be introduced as developments in technology and AI progress. There is significant scope for such advances to further change the way care is delivered, how people access services and associated workforce requirements. It is important to differentiate where technology will replace, be used by and/or augment the care workforce.

Current research suggests that while some lower skill, routine occupations are being replaced by automation, high skill, high touch occupations, management and leadership are workforce growth areasⁱⁱ. These are already critical skills in many health professionals and care workers. As technology and AI broaden their reach, the overall care workforce will need a greater focus on both:

- technology and working *with* machines; and
- areas of ability where humans dominate, such as critical thinking, creativity, consumer service, social perception/judgement, and communication.

How these factors translate overall to the volume, skills mix, advanced practice scopes, distribution and education of health professionals, managers and care/support workforce needs careful consideration. It involves ongoing communication, planning, data gathering and linkage between the multiple stakeholders and tiers of government who work across the health, social services and higher education sectors. Some elements of digital health and workforce are currently being assessed and progressed through the [Digital Health CRC](#) and the Australian Digital Health Agency, particularly its [Digital Health Workforce and Education Roadmap](#). However, what is really needed is a more comprehensive workforce planning structure that can gather data, undertake scenario planning and model the impact of changing technology on care workforce requirements (see also response to the section below). UA continues to recommend the establishment of an enduring mechanism that brings these elements and stakeholders together on a frequent basis to determine Australia's evolving health/care workforce and associated education and training needs.

MONITORING FRAMEWORK AND DATA GAPS

There is a need to establish a comprehensive workforce planning structure that can gather data, undertake scenario planning and technological impact modelling across different sectors and scopes of practice in the care workforce

There is a pressing need for a dedicated planning mechanism to look across the whole care workforce, including health professionals. The mechanism would gather, collate and analyse relevant data, look at workforce innovation and undertake modelling to assess workforce and skills mix needs under different models. This would include looking at the impact of technology, pandemics, scope change etc. on care workforce and education needs.

In relation to health professionals: data sources exist for some of this workforce however it is patchy, public access is limited or prohibited and data sources are often several years old. Existing national data sources include:

- The Australian Health Practitioner Regulation Agency (AHPRA) data - for those health professions registered under the National Registration and Accreditation Scheme (NRAS);
- Commonwealth Department of Health data used to inform their Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) tool and workforce fact sheets
- The NDIS Demand Map
- The Labour Market Information Portal
- Australian Institute of Health and Welfare and Australian Bureau of Statistics workforce data

Data also exists at local and jurisdictional levels. For example:

- Primary Health Networks (PHNs) are required to undertake population health planning which includes an understanding of workforce need; and
- Local Hospital Districts (LHDs) also undertake aspects of workforce planning.

Again, this data is often patchy and inaccessible publicly.

Data gaps include:

- allied health professional workforce data for those disciplines not registered through AHPRA. This includes many of the allied health disciplines relevant to aged, disability, veteran and mental health care such as Audiologists, Dietitians/Nutritionists, Speech Pathologists/Therapists; and Social Workers.
- clinical placement information. Given the relationships between clinical placements and future workforce choice, having a national data base, analysable at the state and local level is important. Universities used to be funded to gather this data – it is intricate, time-consuming data to gather – through the Clinical Training Fund (CTF). However, the CTF ceased in 2015 and this data is no longer collected nationally.

OTHER INFORMATION

Other relevant UA submissions are attached as follows:

- Submissions to the Royal Commission into Aged Care Quality and Safety.
- Response to the Aged Services Industry Reference Committee discussion paper on the Reimagined Personal Care Worker
- Response to the NDS and NDIS Outcomes Framework – Introductory Paper
- Submission to Educating the nurse of the future - The Independent Review of Nursing Education

ⁱ E.g. Final Report of the Royal Commission into Aged Care Quality and Safety ; NDIS National Workforce Plan 2021-2025 ; Labour Market Information Portal Employment Projections

ⁱⁱ Enterprise Skills and the future of Work. Dr Andrew Charlton. UA conference 2019: <https://bit.ly/2KxLy1Z>

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 fiftyⁱ. Australians are not only living longer, they are also living with more years of ill healthⁱⁱ. 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 respectivelyⁱⁱⁱ. 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 this¹: 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 prevention¹ despite about 31 percent of our disease burden attributable to modifiable risk factors – including up to one third of dementia cases¹.

- For multiple reasons², 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 doing 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 disproportionately 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/>

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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)

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

December 2019

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.

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 data¹ 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.

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 practiceⁱ. An example of a similar structure which is used to good effect in the UK is Health Education Englandⁱⁱ.

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 Safetyⁱⁱⁱ.

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 Government². 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

² About 97 per cent of government funding to aged care in Australia is through 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 Commissionⁱⁱⁱ 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>

Response to the Aged Services Industry Reference Committee discussion paper on the reimagined personal care worker

Introduction

Universities Australia (UA) is the peak body for Australia's thirty-nine comprehensive universities. We undertake advocacy on issues of national relevance to the sector as a whole. UA's interest in health, aged care and disability is in relation to university health professions education, including clinical education and workforce formation in these domains.

A reimagining of the Personal Care Worker (PCW) role is welcomed, if somewhat overdue. PCWs make an essential contribution to the aged care workforce through their provision of direct care to clients. PCWs are currently an unregulated workforce with no minimum qualification or ongoing staff development requirements. Most of the questions posed in the discussion paper are therefore out of scope for UA. However, we have responded to questions where relevant to health professions education and workforce development. Additional comments on the introduction of potential minimum qualifications for PCWs, how these might articulate with other qualifications and/or feed into career progression will be made, where relevant, in relation to the linked discussion paper on pathways.

Response to selected questions in the discussion paper

Section 1:

Q 3. How should a PCW meet both the social and health needs of care recipients?

The importance of clinical and social care delivery for aged care service recipients and the need for PCWs to have an understanding of these aspects of care is recognised, as is the foundational contribution that PCWs make to the aged care workforce. However, UA does not support the provision of clinical care – or more complex social care - by an unregulated, non-clinically educated/trained workforce. A range of regulated, appropriately qualified health and social care professionals¹ already exist to provide this care. Greater use of this workforce within aged care is recommended. More extensive use of such personnel would help better meet the increasingly complex needs of aged care clients. It would also provide much needed opportunities to supervise and mentor PCWs, health professional students and other aged care staff/trainees.

The discussion paper references recommendations² that PCWs should “...*be regulated with nationally consistent nomenclature and titles, a code of conduct, professional standards and scope of practice to ensure nationally consistent minimum education and CPD requirements.*” Relevant education and training is recommended as a useful first step towards this. The level at which such vocational education should occur is a joint matter for the VET sector and industry. From a health professions education perspective we recommend that minimal knowledge requirements of a PCW include a solid understanding of:

- client-centered approaches;
- specific issues of ageing including frailty and dementia;
- scope of the PCW role;
- when and how to communicate with/implement instructions from health and care professionals; and
- infection control.

The last point has been highlighted in the current pandemic. It further underlines the need for greater employment options for health professionals in aged care. Health professional education and training deeply embeds such knowledge within everyday practice so that it occurs as a matter of course. Health personnel not only model this practice in their regular work but are also on hand to teach other staff so that good practice is integrated across the workforce – not just provided as an “add-on” in times of crisis.

The paper also suggests that the aged care sector “...*cannot wait for regulation to ensure that PCWs have the skills demanded in a consumer-directed system...*”. UA has previously presented evidence about the benefits of learner-development approaches in addressing aged care workforce issues. These 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. Learner-development

¹ “Appropriate” refers to relevant health/social care qualifications provided across the tertiary education sector in both VET and Higher Education.

² As recommended by the Australian Nursing and Midwifery Federation (ANMF) and the Australian College of Nursing (ACN).

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 towards competence and independence in aged-care service delivery. Evidence suggests multiple benefits of this approach to aged care clients, service providers, students and staff. Further details are outlined in [UA's submission to the Royal Commission into Aged Care Quality and Safety](#).

Such an approach would go a long way to upskilling PCWs and others while issues of regulation were determined. To deliver this approach, policy support is required to enable:

- greater employment options for health and social care professionals in aged care; and
- higher education-service provider partnerships and flexible industry approaches to building learner-development cultures in aged care services.

Section 2:

Q 5. How do you think we should build skills around continuity of care and the transition of care from one setting to another, regardless of the model of care, such as:... “ b. General duties versus more specific duties (such as palliative care, swallowing and meal assistance, disability services and dementia care)... ?

It is unclear if this question is referring to building such skills in PCWs or in general in the aged care workforce. If the former, UA reiterates its view that clinical and/or complex social care must be provided by appropriately qualified health professionals – or, where health professional students/trainees are involved, under appropriate health professional supervision.

Section 3:

Q 7. What broad knowledge of ... other disciplines would PCWs need ... to be able to: a. Work with these other skills groups; b. Be more aware of identifying needs, issues or problems; c. Refer their recipients towards to the right professionals; and d. Make the right decision in the moment?

See also response to Section 1 Q3. Educating PCWs on the complexity of client needs, the scope of their role and when/how to engage other health and social care professionals is a good start. Integrating PCWs into a multi-professional team so that all team members can learn about their respective roles and contributions is also useful. Supporting learner-development cultures in aged care, where the workforce is viewed as a collective group and models for complex, holistic care are developed, is an effective way to achieve this. If PCWs became a regulated profession, as has been recommended, the above could be integrated into their theoretical and practical education and training.

Q 9. If entry-level PCWs have little or no authority or responsibility, and the Taskforce has called for more supervision of them, how can we ensure that supervision is able to be provided, especially in home and community care?

Government and industry support is needed to:

- increase education and employment of health/social care professionals in aged care services; and
- implement learner-development approaches (see response to Section 1 Q3).

Increased employment of health professionals across all disciplines in aged care would:

- support improved outcomes for clients;
- extend supervision opportunities of PCWs and health professional/other students; and
- help develop the learning cultures that enrich aged care services, boost client outcomes; enhance overall aged care workforce recruitment and retention; and improve knowledge in future health and aged care workforce of working with older clients.

Q 10. How much responsibility and autonomy is it reasonable to give to an unregulated, entry level worker, especially as recipients' medical needs and conditions become more acute and complex?

PCWs make an important contribution to client support as part of a multi-skilled aged care workforce team. Given the increasingly complex clinical and social needs of aged care clients however, an autonomous role for PCWs is not supported - especially while they remain an unregulated entry level workforce with no minimum qualification or ongoing staff development requirements. In such circumstances it is recommended that PCWs continue to work as part of a multi-disciplinary aged care workforce team under the supervision of suitably qualified and experienced health care professionals.

RESPONSE FROM UNIVERSITIES AUSTRALIA TO THE NDS AND NDIS OUTCOMES FRAMEWORKS: INTRODUCTORY PAPER

December 2020

Thank you for the opportunity to respond to the draft framework: *"Improving outcomes for people with disability under the National Disability Strategy (NDS) and the National Disability Insurance Scheme (NDIS)"*. Universities Australia's (UA's) interest in this work relates to the Framework's proposed outcomes in the following two domains:

- Health and wellbeing; and
- Learning and skills.

Further detail of these two domains is provided at Appendix 1.

UA supports the inclusion of both of these domains and associated outcomes/indicators in the framework and makes the following comments relevant to universities contribution to these areas.

Health and wellbeing:

Many of the framework's outcomes, sub-outcomes and indicators relating to the health and wellbeing of people with disabilities rely on access to a sufficient, adequately skilled and disability-cognisant health workforce. However, a recent evaluation report of the NDIS identified significant unmet health workforce need within the NDIS, particularly for allied health professionals¹. This workforce need rises with, but is not limited to, areas of increasing rurality.

This is relevant to universities because they educate the majority of new entry allied health, dentistry, medical and nursing professionals that work across the multiple fields of aged care, disability and health. All university-based health professions education includes mandatory supervised clinical education within health and care services. These are usually referred to as clinical experience or placements. They provide opportunities for students to work directly with clients, qualified health practitioners and other staff in care services to further develop the knowledge, clinical and workplace skills learned at university.

There is a strong link between the settings in which health professional students undertake their clinical education and where they choose to work once qualified: it is well-established that quality clinical education experiences influence the likelihood that students will return to work in these settings as registered practitioners. Learning in different settings also increases graduates' workplace preparedness when they commence employment. This goes beyond the clinical skills that all graduates must demonstrate to attain registration. It also includes greater understanding of the operating environments, client needs, cultures and values in different service sectors. This is valuable knowledge and assists graduates to "hit the ground running" when they start work.

Currently, health professional student placements in disability services are limited. Various barriers outside of universities' control, contribute to this. Broadly they relate to the following:

¹ Evaluation of the NDIS 2018: https://apo.org.au/sites/default/files/resource-files/2018-04/apo-nid143516_1.pdf

- the private practice/fee-for-service nature of disability service providers – especially allied health – many of whom are also sole-practitioners;
- the general lack of a supervision payment to private practitioners for teaching health professional students within disability and other community-based care services²;
- inability for a supervising practitioner within disability and/or primary care settings to claim for a student-delivered service both under the NDIS or the MBS;
- lack of available supervision capacity – and lack of accessible national data, analysable at regional and local levels about number/type of disability service providers that could potentially provide this capacity; and
- the regulatory complexity for health practitioners of becoming a disability service provider.

All health practitioners provide care to a diverse range of clients, including those with disabilities. However, the above factors combine to deter many private practice allied health and other practitioners from offering services and supervision under the NDIS. It also prevents services from harnessing the well-recognised benefits that students bring^{3,4}. This has current and future service access implications for people with disabilities.

To achieve the health and wellbeing outcomes proposed in the framework, a disability-aware health workforce is required. One aspect of this that universities can assist with is through facilitating more clinical experiences with disability service providers. However to support this, mechanisms need to be put in place to overcome the barriers outlined above and enable health professional students to access supervised placements with disability providers/practitioners. Helpful steps towards this include:

- introducing a student supervision payment to health practitioners providing disability care, particularly private allied health providers, given that allied health is an area of identified, significant unmet workforce need under the NDIS;
- developing a national database, analysable at more granular levels, of disability health service providers. Data would include provider capacity/willingness for student supervision. Primary Health Networks are well positioned to facilitate this data collection.
- offering an initial, short-term disability-provider placement fund to universities. The fund could be used specifically for universities to work in partnership with disability providers /practitioners to increase practitioner supervision capacity and disability-specific student clinical experience.

Effective examples of these approaches already exist in other domains and can be used as models.

Learning and skills:

UA supports the intent of the learning and skills outcomes in the framework and recognises that these outcomes refer to multiple parts of the education sector. Universities already support students with disabilities to pursue higher education. There has been a steady increase in the enrollment of students with disabilities in universities over recent years. Between 2012 and 2018, such enrollments rose by 64.9 per cent compared to 18.6 per cent growth in overall enrollments. In 2018,

² The exception here is medical students in general practice which can receive a Practice Incentive Program (PIP) teaching payment for medical students if eligible.

³ Health Education and Training Institute (HETI) and NSW Interdisciplinary Clinical Training Networks (ICTN) 2015: Clinical Placements in NSW, 2015.:<https://bit.ly/37d5Nfo>

⁴ Buchanan et al 2014. Student clinical education in Australia: A University of Sydney scoping study. The University of Sydney

the most recent year for which figures are available, students with disability represented 7.3 per cent of all domestic undergraduates, up from 6.8 per cent the previous year⁵. Universities will continue to work to maintain this inclusion and support.

Conclusion

Universities are committed to supporting people with disabilities achieve their full potential both by:

- continuing to assist students with disabilities to participate in higher education; and
- developing a more disability-aware future health workforce.

However, barriers exist to enabling the later which are outside of universities' control.

Universities Australia is engaging with the Boosting the Local Care Workforce initiative about NDIS workforce and skills needs. We look forward to working more closely with the Department of Social Services regarding universities' broader roles in supporting the NDIS framework outcomes, particularly those related to health workforce, and welcome the opportunity to discuss with you the ideas proposed here.

For further information, please contact Rachel Yates, UA's Policy Director Health and Workforce on: email r.yates@uiveritiesaustralia.edu.au or by phone on 02 6285 8127.

⁵ Australian Disability Clearing House on Education and Training (ADCET). Higher Education Statistics: <https://www.adcet.edu.au/inclusive-teaching/understanding-disability/Higher-Education-Statistics/>

Appendix 1: Further details on relevant Health and Wellbeing and Learning and Skills outcome domains in the framework

Domain: Health and wellbeing	
Outcome: People with disability attain their highest possible health and wellbeing outcomes throughout their lives.	
Sub-outcome(s):	Example indicator(s):
<p>I can:</p> <ul style="list-style-type: none"> • access early intervention services • interact with health professionals who understand my needs <p>My GP and health care providers are accessible</p> <p>I have the best possible:</p> <ul style="list-style-type: none"> • health and wellbeing • mental health 	<p>Access to health services</p> <p>Access to aged care facilities that meets needs.</p>
Domain: Learning and skills	
Outcome: People with disability achieve their full potential through their participation in an inclusive, high quality education that is responsive to their needs. People with disability have opportunities to continue learning throughout their lives in formal and informal settings.	
Sub-outcome(s):	Example Indicator(s):
<p>I can:</p> <ul style="list-style-type: none"> • access a mainstream school, higher education institution or childhood education institution that is welcoming and inclusive. 	<p>Engagement in further education – vocational, tertiary.</p>

SUBMISSION TO: EDUCATING THE NURSE OF THE FUTURE - THE INDEPENDENT REVIEW OF NURSING EDUCATION

27/06/2019

INTRODUCTION

Universities Australia (UA) welcomes the opportunity to make a submission to *Educating the nurse of the future*, the first independent nursing education review since 2002. The purpose of the review is to examine how nurse preparation can best meet the service needs of the future health system.

UA is the peak national body for Australia's thirty-nine comprehensive universities. This submission is from a whole of sector perspective and has focused on those terms of reference relevant to the sector overall. It has been developed in consultation with UA's Health Professions Education Standing Group (HPESG). HPESG comprises representatives from the Councils of Deans of all health disciplines, including the Council of Deans of Nursing and Midwifery (CDNM). UA refers the reviewer to CDNM's separate submission for additional information.

RESPONSE TO THE REVIEW (See Appendix A for the full Terms of Reference)

NURSE EDUCATION IN AUSTRALIAN UNIVERSITIES

Australian universities play an important role in delivering nurse education. Most¹ offer approved courses leading to Registered Nurse (RN) and Nurse Practitioner (NP) registration. Many also provide other approved pre and post-registration nurse specialisation qualifications and some additionally offer Enrolled Nurse (EN) education courses. However, the major focus of nursing education in Australian universities is the provision of approved degree courses leading to RN – and to a lesser extent NP – registration². RN registration involves undertaking an approved Bachelor of Nursing (BN) degree. NP registration requires undertaking a Master of Nursing degree³. Many universities also provide other approved nurse specialisation qualifications, including midwifery, and bridging courses for overseas trained nurses at under- and postgraduate levels. EN registration involves undertaking an approved diploma of nursing course. This qualification is usually attained through the VET sector, however some dual-sector universities also offer EN courses.

ARTICULATION BETWEEN ENROLLED AND REGISTERED NURSES AND NURSE PRACTITIONERS

ENs, RNs and NPs are all distinct and different roles. While career progression from EN to NP is possible, each is a protected title which stands in its own right under the National Law⁴ and each has its own well-defined scope of practice and responsibility. Students may choose one nursing role over another in order to work in a particular way, rather than see their qualification as a step on a nursing career ladder. However, course articulation can be useful in providing pathways across different roles where warranted.

¹ About 84% of Universities Australia's 39 members

² In 2017, there were 64,592 Bachelor of Nursing and 634 Postgraduate/Masters in Nursing enrolments in Australian universities. Source: Higher Education Information Management System (HEIMS) 2019

³ Completion of an approved course is a necessary but not sufficient criterion for registration as an RN or NP. University courses are approved through accreditation by the Australian Nursing and Midwifery Accreditation Council against the NMBA's standards.

⁴ Health Practitioner Regulation National Law Regulation 2018: [HTTPS://BIT.LY/2N6PFZL](https://bit.ly/2N6PFZL)

Requirements for registration for each different nursing role are mandated by the Nursing and Midwifery Board of Australia (NMBA). Undertaking an approved course of study is a component of registration and all approved Australian nursing courses have met these professional accreditation standards. However, other factors relevant to registration lie outside the remit of education providers. Course articulation is therefore only one component in considering nursing career pathways.

Universities generally have effective links between EN and RN (Bachelor of Nursing or BN) courses. Articulation models can be based on variations of: credit-transfer arrangements; nested awards; VET-university guaranteed pathways; and collaborative curriculum partnerships. For example:

- in dual sector universities and in universities offering EN courses through university colleges there is usually a seamless transition between the two;
- in other situations, EN qualifications are invariably recognised by universities through mutual recognition programs whereby at least twelve months advanced standing is provided allowing ENs to enter the BN course at year two; and
- in other cases, an offer is made to enter the BN course through an equivalent ATAR that takes the EN qualification into account.

How the articulation occurs is a decision for each individual higher education institution.

NMBA requirements for registration as an NP include current registration and experience as an RN and undertaking an approved Master of Nursing (MoN) qualification. Approved courses are offered by roughly two thirds of Australian universities and are available across all jurisdictions. However, one obstacle to undertaking MoN courses in Australia is the lack of a national system or policy approach to the allocation of Commonwealth Supported Places (CSPs) for postgraduate study⁵. Only some MoN courses attract Commonwealth subsidies. Many do not – and when this occurs, postgraduate nursing study must be fully paid for by the student. Further, NP and other postgraduate nurse specialisation roles are rarely linked to significant salary increases. These factors can impede the uptake of postgraduate qualifications in nursing but lie outside of the remit of higher education providers.

THE EFFECTIVENESS OF NURSE EDUCATION

Australian nursing qualifications for both pre- and post-registration programs effectively fulfil the requirements of the nursing charter(s) against which they are set out.

Pre-registration programs: The charter for pre-registration nursing programmes in Australia is to prepare beginning practitioners. Current approved Bachelor of Nursing (BN) degrees leading to registration as an RN are full and comprehensive degrees and adequately cover the range of nursing skills required for a newly qualified nurse to practice. BNs include a minimum compulsory clinical placement component of 800 hours; however some universities provide more than this and/or augment further clinical education with simulation approaches.

After successfully completing a BN, a newly qualified nurse is ready to enter the workforce as part of a health service team with other nurses and health professionals. They have the basic skills, competencies and capabilities to safely and effectively do the job they were educated and trained for – within their qualification's scope of practice. Without such knowledge and skills, they would not have been approved to pass their degree. These skills and competencies have already been practiced many times during their degree course. However, like most professions, greater capability and confidence arise as these skills are even further bedded down in the workplace.

There is a definite role for health services to manage, mentor and orient new graduates to their service when they commence and as part of a nurse's ongoing professional development. Formal transition to practice programs are one way to do this; however they do not need to be mandatory as multiple other effective

⁵ Where CSPs are allocated, course costs to students are substantially reduced.

options exist. The way in which a new nurse's clinical skills and confidence are developed is ultimately a matter for the health service. It is useful, however, for health services and universities to have a realistic, shared and clearly articulated understanding and agreement of what a new graduate nurse at the start of their career looks like.

Post-registration programs: Postgraduate nurse training, either through postgraduate diplomas or through MoN degrees, similarly meet the nursing charters against which they are set. Postgraduate programs often provide deeper but more specialised knowledge in particular areas (e.g. paediatrics, child and family health, addiction medicine, aged care). Nurses undertaking such courses are already qualified RNs with some years of clinical experience. Nurses entering health service roles with such postgraduate qualifications already have well developed clinical skills and abilities. However, health services still need to provide orientation training, mentoring and continuing professional development to advanced practice nurses and NPs.

THE COMPETITIVENESS AND ATTRACTIVENESS OF AUSTRALIAN NURSING QUALIFICATIONS ACROSS INTERNATIONAL CONTEXTS

The competitiveness and attractiveness of Australian nursing qualifications can be considered from two main perspectives:

1. the ease and frequency with which Australian nurses are employed overseas; and
2. the demand for/numbers of international students undertaking nursing qualifications at Australian universities.

There is little available data in relation to point one. However, anecdotal evidence suggests that Australian RNs are employed with ease in many countries and in some cases, such as the UK, are actively sought out. The number of countries in which Australian nursing qualifications are automatically recognised is also a useful indicator. The NMBA is best placed to provide further information about this.

There has been a steady growth in the proportion of international students undertaking nursing courses in Australian universities in recent years – from 2.9 per cent of all nursing enrolments in 2001 to 13.5 per cent in 2017^{6,7}. Various factors influence where international students choose to study. However, the quality of Australian nursing courses is likely to be one determinant. In 2019, ten of the 33 Australian universities offering nursing courses were in the top 50 world university rankings for nursing courses and a number of others were ranked within the top 100⁸.

THE RESPECTIVE ROLES OF THE EDUCATION AND HEALTH SECTORS IN EDUCATING THE NURSING WORKFORCE

Nursing education, like most health professional education, is a shared responsibility between higher education providers and health services. In broad terms, universities focus on the educational component – that is, foundational, theoretical and clinical knowledge and clinical/skills development. Health services focus more on the training component – embedding and reinforcing clinical skills, health service/system culture, professionalism/working as part of a team and ongoing professional development. However, in reality, responsibility for many of these areas overlap. Responsibility for different education and training elements also varies depending on the model used for clinical education/placement: university facilitator model; health service supervisor model; or shared facilitation model.

Optimal education and training outcomes are more likely when health services and universities work collaboratively regarding graduate nurse skill requirements, clinical placements and quality supervision.

⁶ This has been part of a general increase in nursing enrolments over time for both domestic and international students.

⁷ This includes all nursing enrolments including BN, postgraduate and bridging courses but the main focus is BNs (RN courses).

⁸ QS World University Rankings 2019: <https://www.topuniversities.com/university-rankings/university-subject-rankings/2019/nursing>

Clinical placement capacity and the need to expand placements to non-traditional settings to better address workforce need is a growing issue for universities and health services and an area in which supported partnership approaches can make a significant difference⁹.

MEETING HEALTH SERVICE NEEDS

Health professional workforce is fundamental to health service delivery. Nurses are the largest health professional workforce in Australia¹⁰. Understanding the evolving education and training requirements of nurses – and other health professions – is key to providing effective care that meets changing community and health service needs.

Health workforce need is dynamic, affected by multiple factors including international, national and local situations, population change, disease profiles and models of care. It is also likely to change rapidly in the future with increasing technological development.

What the nurse of the future looks like within this dynamic and rapidly changing environment is unclear. What is clear though is that our whole health workforce will increasingly need to respond to:

- growing proportions of older people in the population;
- high levels of chronic disease;
- team based, consumer-focused models; and
- new modes of delivering and monitoring care (wearables, apps, telehealth).

Many of these approaches lie outside of traditional, hospital-based, acute care.

A greater need for nursing and other health professional workforce has already been identified in aged, primary, mental health and disability care, as well as in rural health services. (Nurses are Australia's most evenly distributed health workforce, however nurse shortages are growing, including in rural Australia.) Broader workforce signals also suggest that while lower skill, routine occupations are being replaced by automation, high skill, high touch occupations, management and leadership are workforce growth areas¹¹. These are already critical skills in many health professions, especially nursing. As technology and AI broaden their reach, nursing and nurse education will likely need a greater focus on both:

- technology and working *with* machines; and
- areas of ability where humans dominate, such as critical thinking, creativity, consumer service, social perception/judgement, and communication.

How these factors translate overall to the volume, skills mix (including EN, RN, and NP numbers), advanced practice scopes, distribution and education of nurses and other health professionals needs careful consideration. It involves ongoing communication, planning, data gathering and linkage between the multiple stakeholders and tiers of government who work across the health, social services and higher education sectors. UA continues to recommend the establishment of an enduring mechanism that brings these elements and stakeholders together on a frequent basis to determine Australia's evolving health workforce and associated education and training needs.

Close, ongoing and timely dialogue between the National Nursing and Midwifery Education Advisory Network (NNMEAN), the NMBA, the Australian Nursing and Midwifery Accreditation Council (ANMAC), universities and other higher education providers is an important first step towards this goal and will be critical to

⁹ TRACS to the Future: National Evaluation of Teaching and Research Aged Care Services (TRACS) Models, Final report 2015: <https://bit.ly/2E3Chsh>

¹⁰ In 2017, 323,122 nurses and midwives were registered and employed in Australia, of which 245,269 were RNs. This is roughly three times more than the next largest category of registered and employed health workforce, medical practitioners (95,194 in 2017).

¹¹ Enterprise Skills and the future of Work. Dr Andrew Charlton. UA conference 2019: <https://bit.ly/2KxLy1Z>

understanding how best to translate Australia's evolving nurse workforce needs into educational requirements¹².

The current review of the Australian Qualifications Framework (AQF), while not specific to nursing, may also offer opportunity to revisit learning outcomes that better reflect the skills and qualities that the future nurse workforce will require.

Recommendations

UA makes the following recommendations to better align nurse education and training with health service and workforce needs:

- 1. Expand clinical placements to non-traditional areas:** Most current nurse clinical placements occur within acute hospitals. Yet the majority of care is delivered outside of hospitals in the community, often in those settings of identified workforce need such as aged care. Increasing the number and duration of clinical placements in these non-traditional settings will help better educate, skill and distribute nurses to work in these areas¹³. However, many of these settings are not funded to teach students and/or face other barriers to student supervision¹⁴. Adequately resourced partnership approaches between these services and universities would support the expansion of placements in ways that better link nurse education and training with health, aged and disability service workforce needs.
- 2. Provide clear signals from the COAG Health Council (CHC) to universities and health professional Boards about future nurse workforce and education needs:** The COAG Health council is already advised about workforce by various committees¹⁵. However, detailed communications about future workforce need – particularly what new skills and capabilities will be necessary within and across different disciplines – are lacking. Clear signals from the CHC would support the NMBA, ANMAC, universities and health services to work more closely to integrate relevant developments into clinical education and curricula. It would also support health services and universities to determine how they can best meet the upskilling, reskilling and new-skills needs of existing nurses through bridging courses, micro-credentials and/or other education and qualifications.
- 3. Promote ongoing engagement and consultation between the Digital Health Agency, the Digital Health Cooperative Research Centre (CRC) and universities:** Timely and frequent communications about developments in digital health/technology to education providers will attune universities to the changing role of technology in healthcare and its concomitant impacts on nurse and other health professional education.
- 4. Consider a greater focus on nursing in the Rural Health Multidisciplinary Training (RHMT) Program:** The RHMT program provides Department of Health (DOH) funding to a number of universities to support clinical training and health workforce outcomes in rural Australia through the University Departments of Rural Health and Rural Clinical Schools. The program's current review offers opportunity for expansion relevant to increased nurse/other identified health workforce needs.

¹² NNMEAN already brings some of these groups together to advise on the planning, education, employment and immigration of nurses and midwives in Australia. However, there is a place for broader engagement to determine how nurse education can be better linked with aged and disability service needs and to look at nursing in the broader context of overall health workforce need.

¹³ It is well established that quality clinical placements are effective workforce distribution levers.

¹⁴ Barriers include lack of space/infrastructure, restrictions/lack of clarity regarding MBS and NDIS payment claims for student supervision, Aged Care Funding Instrument (ACFI) restrictions on how recipient funds can be used, lack of supervision capacity

¹⁵ The Health Services Principle Committee (HSPC) and The Australian Health Ministers Advisory Council (AHMAC)

APPENDIX A: REVIEW TERMS OF REFERENCE

Part 1 - to examine:

- the effectiveness of current educational preparation of and articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health service delivery
- factors that affect the choice of nursing as an occupation, including for men
- the role and appropriateness of transition to practice programs however named.
- the competitiveness and attractiveness of Australian nursing qualifications across international contexts

Part 2 - to consider:

- the respective roles of the education and health sectors in the education of the nursing workforce

Part 3 - to make recommendations on:

- educational preparation required for nurses to meet future health, aged care and disability needs of the Australian community including clinical training
- processes for articulation between different levels of nursing
- mechanisms for both attracting people to a career in nursing (both male and female) and encouraging diversity more broadly

Part 4 - to have regard to:

- regional needs and circumstances
- national and international trends, research, policies, inquiries and reviews related to nursing education